New Jersey Office of the Attorney General
Division of Consumer Affairs
State Board of Medical Examiners
P.O. Box 183
Trenton, New Jersey 08625
(609) 826-7100

Verification of State License/Examination Form

I, _____ , born _____
First Name Middle Initial Last Name Month / Day/ Year

*Social Security number _____ - _____ - _____ , hold/held medical license _____
Registration Number

issued by _____ . I am requesting that you complete this verification form and mail
State

it to State Board of Medical Examiners (address above) as per my authorization. Thank you.

I hereby authorize the State of _____ to release all of the information in its files concerning my license/exmnation and any actions or pending actions against my license to the State Board of Medical Examiners.

_____ _____
Signature Date

*Pursuant to N.J.S.A. 54:50-24 et seq. of the New Jersey taxation law, N.J.S.A. 2A:17-56.44e of the New Jersey Child Support Enforcement Law, Section 1128E(b)(2)A of the Social Security Act and 45 C.F.R. 60.7, 60.8 and 60.9, the Board is required to obtain your Social Security number. Pursuant to these authorities, the Board is also obligated to provide your Social Security number to:

a. the Director of Taxation to assist in the administration and enforcement of any tax law, including for the purpose of reviewing compliance with State tax law and updating and correcting tax records;

b. the Probation Division or any other agency responsible for child support enforcement, upon request; and

c. the National Practitioner Data Bank and the H.I.P. Data Bank, when reporting adverse actions relating to health care professionals.

Section 2 - To be completed by the licensing/examination entity

The State of _____ certifies that _____ was issued license
State Name of Physician

registration _____ . Date Issued _____ Expiration Date _____
License Number Month / Day / Year Month / Day / Year

The status of this license is currently: ☐ Active ☐ Inactive ☐ Other (specify) _____

1. Is the license in good standing? ☐ Yes ☐ No
   If "No," please attach details and certified copies of any orders.

2. To your knowledge, has this physician ever been disciplined by your board or any other regulatory agency? ☐ Yes ☐ No
   If "Yes," please attach details and certified copies of any orders.

3. Is there presently or has there been in the past a disciplinary proceeding against this licensee? ☐ Yes ☐ No
   If "Yes," please attach details and certified copies of any orders.

4. Is there presently or has there been in the past an investigation conducted relative to this licensee? ☐ Yes ☐ No
   If "Yes," please attach details and certified copies of any orders.

Please attach additional comments or information that the Board should consider prior to determining this applicant's eligibility for licensure.

Section 3 - State Licensing Examination Verification

After a written examination administered by this Board in the following subjects:

_____

_____ and upon obtaining a general average of _____ percent, the above license was issued.

Section 4 - Certification

_____ _____

Printed name and title of Certifying Official | Signature of Certifying Official

Date form completed _____

Month / Day / Year

Please return directly to: BMEApp@dca.njoag.gov

Board Seal

BME-VSL-17