**Commonwealth of Massachusetts Board of Registration in Medicine**

**178 Albion Street, Suite 330 – Wakefield, MA 01880**

**Telephone: (781) 876-8210 Fax: (781) 876-8383**

[**www.mass.gov/massmedboard**](http://www.mass.gov/massmedboard)

|  |
| --- |
| **LIMITED LICENSE APPLICATION**  **AFFIDAVIT FOR SOCIAL SECURITY NUMBER** |
| **APPLICANT INSTRUCTIONS**: If you do not currently have a social security number, please complete the following affidavit and submit this form to your training program along with your limited license application. |
| I certify that:   * I do not have a social security number; * I have complied with all laws of the Commonwealth related to filing of Massachusetts state tax returns and payment of all Massachusetts state taxes; * I have complied with all the laws of the Commonwealth related to the withholding and remitting of child support pursuant to M.G.L. c. 119A; * I understand that the Board of Registration in Medicine will not renew my license without a social security number; * I will apply for a social security number; and * Upon receipt of my social security number, I will provide the Board of Registration in Medicine a copy of my social security card or other primary source verification letter documenting my social security number. |

|  |
| --- |
| **APPLICANT ATTESTATION** |
| Under the penalties of perjury, I declare that to the best of my knowledge and belief, the information contained herein is true, correct and complete. I understand that any falsification or misrepresentation of any item on this form or any attachment hereto may be a sufficient basis for denying or revoking a license.  **PRINTED NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |