MAURA T. HEALEY
Governor

KIMBERLEY DRISCOLL
Lieutenant Governor

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Bureau of Health Professions Licensure
250 Washington Street, Boston, MA 02108

KATHLEEN E. WALSH
Secretary

ROBERT GOLDSTEIN, MD, PhD Commissioner

Tel: 617-624-6000

AFFIDAVIT OF MILITARY SERVICE STATUS

I, _____ being duly sworn, do depose and state under the penalties of perjury that:
(please print full name)

1. I am engaged in the active service of the armed forces as defined in M.G.L. ch. 4, §7, cl. 43. The start date and end date for my current tour are: _____ to _____
(start date) (end date)
2. Within 90 days of discharge from active military duty, I will notify the Bureau of Health Professions Licensure of my discharge, in writing, and I will include a copy of my Report of Separation (DD-214).
3. I am attaching to this affidavit a copy of my military identification card and a copy of my military orders on which I have circled or highlighted the start and end dates for my current tour.
4. I am submitting this affidavit to demonstrate applicability of VALOR Act provisions to:

   ☐ an existing MA license/registration/certification already issued: _____
   (license/registration/certificate no.)

   ☐ an application for a licensure/registration/certification

   Please provide the name of the board of registration and license type for which you are applying.

   _____ _____
   Board of Registration: **License Type:**

5. I understand that unless I already possess a MA license/registration/certification, I need to separately submit an application, and additional documents in the manner specified on the application form or related instructions for the specific type of license, registration or certification that I seek.

Subscribed and sworn by me under the pains and penalties of perjury on this ___ day of _____, 20___.

_____
(Signature)

On this ____ day of _____, 20___, before me, the undersigned notary public, personally appeared _____, proved to me through satisfactory evidence of identification, which were _____, to be the person whose name is signed on the preceding, and who swore or affirmed to me that the contents of the document are truthful and accurate to the best of his/her knowledge and belief.

_____
Notary Public
My Commission Expires: _____

Please complete this form and sign before a Notary, then mail the original form to the attention of:
Valor Act Liaison, Bureau of Health Professions Licensure, 250 Washington Street, Boston, MA 02108
Form eff. 09/08/16