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 SPOUSE STATUS

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

1. I am a professional _____ and I currently hold a registration, certificate and/or license in a state other than the Commonwealth of Massachusetts to practice in this capacity.

2. My spouse is a member of the armed forces of the United States. My spouse is the subject of a military transfer to the Commonwealth of Massachusetts. I left employment in another state to accompany my spouse to the Commonwealth of Massachusetts.

3. I have attached to this affidavit (1) a copy of my license/certificate/registration, (2) a copy of my military identification card, and (3) a copy of my spouse's transfer orders to this affidavit.

4. I am submitting this affidavit to demonstrate applicability of VALOR Act provisions to my 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. 7.20.22