The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Bureau of Health Professions Licensure
Drug Control Program
250 Washington Street, 3rd Floor, Boston, MA 02108
Tel: 617-973-0800
TTY: 617-973-0988
www.mass.gov/dph/boards

AFFIDAVIT TO VERIFY NAME, SOCIAL SECURITY NUMBER, AND/OR DATE OF BIRTH

Full name: _____
(Last) (First) (Middle) (Maiden/Previous)

Address: _____
(No.) (Street) (City) (State/Country) (Zip/Postal Code)

Date of Birth: _____ **Social Security Number: ___ ___ ___ - ___ ___ - ___ ___ ___ ___.**
(mm/dd/yyyy)

License Type: _____ MCSR Number: _____

1. I understand that the Bureau of Health Professions Licensure ("Bureau") is required by law (Mass. Gen. Laws ch. 30A, s. 13A and ch. 119A, §16) to collect the Social Security Number of every licensee and applicant.
2. I verify that the above-referenced Social Security Number is the number that the Social Security Administration issued to me, and that it is both accurate and valid.
3. I understand that if the above-referenced Social Security Number or Date of Birth is invalid or inaccurate, the Program shall not renew my registration until corrected.
4. I am submitting this form for the following purpose (please check one):
   - ☐ I am correcting an inaccurate social security number.
     I have attached proof of my Social Security number to this Affidavit.
   - ☐ I am correcting an inaccurate DOB.
     I have attached a copy of my birth certificate or a current photo ID with DOB.
   - ☐ I am correcting an inaccurate name
     I have attached a copy of my birth certificate, marriage certificate, or a current photo ID with name.

ATTESTATION:
By signing this Affidavit, I certify, under the pains and penalties of perjury, that the information provided herein is truthful and accurate.

_____
Affiant