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# Commonwealth of Massachusetts
# Division of Professional Licensure
## BOARD OF REGISTRATION OF ALLIED HEALTH PROFESSIONS

1000 Washington Street • Boston • Massachusetts • 02118

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UNDERSECRETARY OF CONSUMER AFFAIRS AND BUSINESS REGULATION

**CHARLES BORSTEL**
DIRECTOR, DIVISION OF PROFESSIONAL LICENSURE

## VERIFICATION REQUEST

**Massachusetts' Licensee:** Please provide the information requested below to process your verification request. Additionally, please forward this request **along with** a check or money order for $15.00 payable to: the Commonwealth of Massachusetts.

**To Be Completed By Licensee (Please Print In Ink)**

I, the undersigned Licensee, was granted a license to practice ________________________________
*(Profession)*

with license number ________________ on ________________________ in the Commonwealth of
(*License #)* *(Date)*

Massachusetts. I request that the Board of Registration of Allied Health forward verification of my licensure to the recipient stated below:

Name:________________________________________________________________________

Street:________________________________________________________________________

City:_____________________________________________ State _____________________

Zip Code: _______________________

Furthermore, I hereby **authorize** the Board of Registration of Allied Health to release my information, **favorable or otherwise**, directly to the above stated recipient.

*Licensee's signature* ***& Date*** ___________________________

*Licensee's printed or typed name*_________________________

*Licensee's Address:*________________________

*Licensee's phone #:* __________________________________________