The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Bureau of Health Professions Licensure
239 Causeway Street, Suite 500, Boston, MA 02114
Tel: 617-973-0800
TTY: 617-973-0988
www.mass.gov/dph/boards

AFFIDAVIT TO VERIFY SOCIAL SECURITY NUMBER AND 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:** ___ ___ ___ **-** ___ ___ **-** ___ ___ ___ ___**.**

Licensing Board: □ Dentistry □ Genetic Counselors □ Nursing □ Nursing Home Administrators
□ Perfusion □ Respiratory Care □ Pharmacy □ Physician Assistant □ Community Health Workers

License Type: _____ License Number: _____

1. I understand that the Division of Health Professions Licensure ("Division") 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. **I have attached a copy of my Social Security Card to this Affidavit.**
3. I understand that if the above-referenced Social Security Number is invalid or inaccurate, the Board shall not renew my license until corrected, and that the Board may commence disciplinary proceedings against my license.
4. I am submitting this form for the following purpose (please check one):
   - □ I am submitting my social security number for the first time.
   - □ I am correcting an inaccurate social security number.
   - □ I have been assigned a new social security number. I understand that the Division will not process this form without valid documentation showing authorization for the assignment of a different social security number. I have attached a certified copy of such documentation from
     - □ the Social Security Administration
     - □ a court of law

     to this Affidavit. My previous social security number was ___ ___ ___ **-** ___ ___ **-** ___ ___ ___ ___**.**
   - □ I am correcting an inaccurate DOB. I have attached a copy of my birth certificate or a current photo ID with DOB.

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

_____
(affiant)

On this ____ day of _____, 20___, before me, the undersigned notary public, _____,
(affiant)
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: