FLORIDA DEPARTMENT OF HEALTH

LICENSE VERIFICATION FORM

(Mail to each state where you were/are licensed)

To:	FROM: Department of Health Board of Medicine Anesthesiologist Assistants 4052 Bald Cypress Way BIN #C03 Tallahassee, Florida 32399-3253

The Anesthesiologist Assistant listed below has submitted an application for licensure in Florida. He/she states that he/she was licensed/registered in your state as a healthcare practitioner. Please complete and return this form as soon as possible. Thank you for your cooperation.

***Completed by applicant**

*Name:	First Middle LAST		
*SS#:	- -	*DOB:	/ /

Completed by Medical Board

Profession:		License #:	
Issue date:		Expiry date	

Was a temporary certificate issued prior to full licensure? YES☐ NO☐		
License #	Issue date:	Expiry date:

Has any disciplinary action ever been taken against this license? YES☐ NO☐
If yes, please explain.

Verified by: (signature)

Name: (please print)

SEAL

Title: