

VERIFICATION OF OTHER STATE LICENSES

**Part 1** **APPLICANT:** Complete and sign Part 1 and send a copy of this form to each state board that ever issued you a license/certificate/registration to practice as an Athletic Trainer. Also use this form to send to each state board, including Maryland, that ever issued you a license/certification/registration to practice as ANY other health care practitioner. Please copy this form if you need to send it to more than one state board.

License Type: \_\_\_\_\_

State of Licensure: \_\_\_\_\_ License Number: \_\_\_\_\_

Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Name: \_\_\_\_\_  
 (Print) Last (Generational Indicator, Jr., III) First Middle Maiden

Social Security No. : \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Professional School of Graduation: \_\_\_\_\_ Year: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Part 2** **AUTHORIZED OFFICIAL OF STATE MEDICAL BOARD:** Please certify the following information regarding the above-listed individual and email this form to: [mdh.mbpcredentials@maryland.gov](mailto:mdh.mbpcredentials@maryland.gov).

_____	_____	_____	_____
License type	License number	Date Issued	Expiration Date

Is/was the license in good standing?  Yes  No

If not in good standing is/was it:  reprimanded  suspended  revoked  surrendered  Other

Was the license administratively revoked, suspended, or surrendered because the licensee did not renew?  Yes  No

If yes, please explain: \_\_\_\_\_

Other Derogatory Information or Pending Charges: \_\_\_\_\_

\_\_\_\_\_  
 Printed Name of Authorized Official

\_\_\_\_\_  
 Title of Authorized Official

\_\_\_\_\_  
 Signature of Authorized Official

\_\_\_\_\_  
 Direct Telephone Number

\_\_\_\_\_  
 Printed Name of State

\_\_\_\_\_  
 Date

