



## LICENSE VERIFICATION REQUEST FORM

Official verification reports are provided to another state licensing board, jurisdiction, or individual for license confirmation status in the State of Montana. A fee of \$20.00 must accompany this request. Once received, the verification will be completed within five (5) business days. Please complete the following:

### LICENSING BOARD OR PROGRAM VERIFICATION IS REQUESTED FROM:

Board of Alternative Health Care	Board of Nursing Home Administrators
Board of Athletic Trainers	Board of Occupational Therapy Practice
Board of Behavioral Health	Board of Optometry
Board of Chiropractors	Board of Pharmacy
Board of Clinical Laboratory Science Practitioners	Board of Physical Therapy Examiners
Board of Dentistry	Board of Psychologists
Board of Funeral Service	Board of Radiologic Technologists
Board of Hearing Aid Dispensers	Board of Respiratory Care Practitioners
Board of Massage Therapy	Board of Speech-Language Pathologists and Audiologists
Board of Medical Examiners	Board of Veterinary Medicine
Board of Nursing	

License Number \_\_\_\_\_ License Type \_\_\_\_\_

Date of Birth \_\_\_\_\_ ( i.e., Naturopath, Dentist, LPN, Social Worker, etc.)  
NOTE: For Physicians (MD/DO) and Physician Assistants, please contact [www.veridoc.org](http://www.veridoc.org)

Name on Montana License \_\_\_\_\_

Preferred Mailing Address \_\_\_\_\_  
PO BOX # OR STREET ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

### SEND COMPLETED VERIFICATION TO:

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Country \_\_\_\_\_

Please mail this completed request with the \$20.00 fee made out to the appropriate Board or Licensing Program.

Do Not Send Cash.

(NAME OF BOARD OR PROGRAM)  
PO BOX 200513  
HELENA MONTANA 59620-0513

Please note: Returned checks will be assessed a \$30.00 fee. This includes insufficient funds, stopped payment, and/or missing signature.