



DATE:

MEMORANDUM FOR AFIT CIMQ

FROM:

SUBJECT: Verification / Re-verification of Professional Medical License

1. This letter serves to document that primary source verification of your Active medical license was performed.

NAME:

STATE OF LICENSURE:

DATE OF LICENSE EXPIRATION

DATE OF VERIFICATION / RE-VERIFICATION:

2. Proof of verification is maintained in the
3. The provider has been briefed that it is his / her responsibility to maintain a current, valid, and unrestricted professional medical license.

VALIDATOR'S SIGNATURE

SIGNATURE BLOCK (Typed name, grade, title)

Credential Department