



LETTER OF LICENSE VERIFICATION REQUEST

PLEASE NOTE: ALL INFORMATION MUST BE COMPLETED

Date Submitted: [] [] - [] [] - [] [] [] []

RI Department of Health License Number: _____

Current Name on Health License: _____

Date of Birth: [] [] - [] [] - [] [] [] [] Social Security Number: [] [] [] [] [] [] [] [] [] []

Home Address: _____

City: _____ State: _____ ZipCode: _____

Home Telephone Number: _____ Home Fax Number: _____

Home Email Address: _____

Please provide the name and address of the person/agency where you want this verification mailed. If the person/agency has a form to be completed please attach it to this completed form.

Name: _____

Address: _____

City: _____ State: _____ ZipCode: _____

"Pursuant to Rules and Regulations Pertaining to the Fee Structure for Licensing, Laboratory, and Administrative Services Provided by the Department of Health [R23-1-17-FEE] effective December 10, 2012, there is a \$50.00 fee for a letter of license verification. Please complete the above section and submit it with a \$50.00 certified bank check or money order, (personal checks will NOT be accepted), made payable to the "Rhode Island General Treasurer" to the following address: Rhode Island Department of Health Data Entry Unit Room 103 3 Capitol Hill Providence, RI 02908 Please allow 4-6 weeks for processing.

Office Use Only [] Fee Paid Date: _____ Initials _____