REQUEST FOR OSTEOPATHIC PHYSICIAN PROFILE

Access this form via website at: **cca.hawaii.gov/pvl**

State of Hawaii
Hawaii Medical Board
P.O. Box 3469
Honolulu, HI 96801

TO THE APPLICANT: Complete the Applicant section and mail to:

American Osteopathic Association
Department of Membership and Information Services
142 East Ontario Street
Chicago, IL 60611-2864
Toll-free phone: (800) 621-1773
Fax: (312) 202-8200

APPLICANT

Name (First-Middle)	(LAST)	Social Security No.
Address (Include apt. no., city, state and zip code)		AOA Number
		Date of Birth
Osteopathic School of Graduation and Address		Date of Graduation

I am an applicant for licensure in the State of Hawaii. It is requested that you send my osteopathic physician profile directly to the Hawaii Medical Board at the address below. I authorize the AOA to indicate on this form if there is any previous or pending disciplinary action against my license in any state.

Date _____ BY _____
(Signature of Applicant)

AOA

To AOA: Please complete and return to the Hawaii Medical Board, P.O. Box 3469, Honolulu, Hawaii 96801, or by email at: **medical@dcca.hawaii.gov**.

☐ Agrees with AOA records.

☐ Does not agree with AOA records (include explanation).

Date _____ BY _____
Member and Information Service

Print Form

This material can be made available for individuals with special needs. Please call the Licensing Branch Manager at (808) 586-3000 to submit your request.

DOS-06 0816R