VERIFICATION OF LICENSE - PODIATRIST

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

State of Hawaii
Hawaii Medical Board

APPLICANT

Name (First, Middle)	(LAST)	Social Security No.
Address (Include apt. no., city, state and zip code)		License No.
		Date Issued

I hereby authorize the licensing agency of the state or county of _____ to furnish the information below to the Hawaii Medical Board (HMB) and I authorize the HMB and its agents to use the information in evaluating my application.

Date: _____ SIGN HERE: _____

LICENSING AGENCY

This is to certify that the above-named individual was issued license number _____

Date license issued: _____

Date license expires: _____

License status:
- ☐ current
- ☐ lapsed since: _____
- ☐ inactive since: _____

Has this license ever been encumbered in any way (revoked, suspended, surrendered, limited, placed on probation, currently pending disciplinary action, being investigated? ☐ YES ☐ NO
(Please explain "YES" response and attach copy of board's final order and related information.)

Do your files contain any derogatory information on this applicant? ☐ YES ☐ NO
(Please explain "YES" response and attach copy of board's final order and related information.)

Exam Date(s):

_____

_____

Signature: _____

Title: _____

State: _____

Date: _____

BOARD SEAL

TO THE AGENCY: Return this form **directly** to the Hawaii Medical Board. P.O. Box 3469, Honolulu, HI 96801

Print Form