License Verification Request
Out-of-State Telehealth Provider

Completed verifications must be mailed directly from the verifying agency to:

Telehealth
4052 Bald Cypress Way, Bin C-11
Tallahassee, FL 32399-1708

Part I: To Be Completed By Applicant

Name: _____
Last/Surname First Middle

Address: _____ _____
Street/P.O. Box Apt. No.

_____ _____ _____
City State ZIP

Profession: _____ **License Number:** _____ **State:** _____

I hereby authorize release of any information regarding my licensure status to the Division of Medical Quality Assurance.

Applicant's Signature: _____ **Date:** _____
MM/DD/YYYY

Part II: To Be Completed By State Licensing Agency

All verifications must be in English and meet the following criteria:

- Typed on an official state form or letterhead
- Include an official board seal
- Signature and title of state board official

The following information must be included in all verifications:

- Licensee name
- License number
- State or jurisdiction of licensure
- Licensure status
- Whether license is in good standing
- Date of issuance/expiration
- Licensure method (examination, grandfathering, reciprocity/endorsement)
- If this license has ever been encumbered (denied, revoked, suspended, surrendered, limited, placed on probation) please provide certified copies of documentation regarding the action taken with the completed license verification.