

Commonwealth of Massachusetts
Board of Registration in Medicine
560 Harrison Avenue, Suite #G-4, Boston, Massachusetts 02118
Telephone (617) 654-9830 www.massmedboard.org

INSTRUCTIONS

REQUESTS FOR REVIEW OF COMPLAINT FILES MUST BE ACCOMPANIED BY A WAIVER FORM PROVIDED BY THE BOARD OF REGISTRATION IN MEDICINE. NO OTHER FORMS WILL BE ACCEPTED.

The attached Waiver Form must be completed as directed and signed by the physician requesting a License Verification, Certified Statement or Letter of Good Standing (all are considered the same form).

The fee for completing a License Verification, Certified Statement or Letter of Good Standing is \$10.00 (ten dollars) per verification request.*

*Full License verifications and Limited License verifications are separate requests. The fee for each license verification is \$10.

Please make your check or money order payable to: **The Commonwealth of Massachusetts** and forwarded to:

**License Verification
Board of Registration in Medicine
560 Harrison Avenue, Suite #G-4
Boston, MA 02118**

PLEASE NOTE:

License Verification requests will not be processed if the Waiver Form is substituted, incomplete or the \$10 processing fee for each license verification request is not included.

Please include a stamped envelope with the name and address of the recipient. Allow at least three (3) weeks for processing license verification requests.

NOTICE TO THE APPLICANT

THIS REQUEST IS BEING RETURNED FOR THE FOLLOWING REASON(S):

- The Board's Waiver Form is not included**
- The \$10.00 fee has not been received and/or is incorrect**

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WAIVER FOR RELEASE OF INFORMATION

Completion of this waiver will authorize the release of information from the Board of Registration files to the entity listed below. This waiver form must be properly executed and no other waiver form is acceptable.

Information released pursuant to this waiver is based entirely on review of open and closed complaint files and does not include information in the license application, renewal application or any documentation that the Board of Registration is required to obtain by statute, e.g. court documents, insurance verifications and information from health care entities.

“I hereby authorize and direct the Massachusetts Board of Registration in Medicine to release any and all information it may have in its possession or control, including but not limited to the substance of any complaints or communication it may have received and the action or actions it may have taken in response, to the entity named below:”

(type or print clearly)

SEND LICENSE
VERIFICATION TO: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

(TYPE OR PRINT)

PHYSICIAN'S NAME: _____

BUSINESS ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

MASSACHUSETTS
LICENSE NUMBER: _____

SIGNATURE OF
PHYSICIAN: _____

Signed under the penalties of perjury

DATE: _____

This Release shall remain valid for one (1) year from the date of execution