

License Verification Website Account Application

In order for the Board to grant access to the License Verification website for your organization, please supply ALL of the following information. These fields are all required.

The username and password **will be emailed** to the Organization Administrator. Please be sure to **print your email address clearly!** The Organization Administrator is responsible for distributing the username and password to all authorized users within the organization.

Organization Information

Name: _____

Address: _____

City: _____

State: _____ Zip: _____ Country: _____

Organization Administrator Information

First Name: _____ Last Name: _____

Title: _____

Phone: _____

Email: _____

(please print clearly)

I certify this request for access is for use by an authorized hospital, health plan or health-related organization, and I am the designated representative of the organization listed above. The organization will protect the supplied account information from unauthorized use and treat the physician NPI as confidential.

Signature: _____ Date: _____

Fax this completed form **along with a cover letter on official organization letterhead to 781-876-8383.**