

Maryland Board of Chiropractic Examiners

4201 Patterson Ave., Suite 301

Baltimore, MD 21215

(410) 764-4726

www.dhmf.maryland.gov/chiropractic

REQUEST FOR LICENSE VERIFICATION

Please type or print all information.

Please include a check or money order in the amount of \$35 for each verification payable to the Maryland State Board of Chiropractic Examiners. No cash or credit cards accepted. Fees are non-refundable. Please allow 10-15 business days for processing.

List the agency / entity(s) to which verification should be sent:

1. Agency/Co. Name: _____

Attn: _____

Address: _____
Street City State Zip

2. Agency/Co. Name: _____

Attn: _____

Address: _____
Street City State Zip

Licensee's Name: _____ License No.: _____

Address: _____
Street City State Zip

Phone: _____ Email: _____

Date of Birth: _____ SSN: _____

Has your name changed since your last license or registration? ___Yes ___No

If yes, please print your former name below **and** submit **one** of the following: a current government-issued ID or a document that reflects your current legal name: driver's license; state-issued ID; passport, or court document reflecting name change.

Former Name: _____

I hereby authorize the Maryland State Board of Chiropractic Examiners to send verification letter(s) as indicated on this form.

Signature

Date