OFFICE OF PROFESSIONAL LICENSURE AND HEALTH PLANNING
P.O. BOX 222995
CHRISTIANSTED, VI 00822-2995
(340) 718-1311 Ext. 3647/3849

License Verification / Good Standing Request & Invoice

LICENSE TYPES

(DC) -Chiropractic (MD, DO) -Medicine and Surgery (PA, PA-C) -Physician Assistant (PSY, PSYD, MA Psyche Assoc.) -Psychologist
(RDH) -Dental Hygenist (CTO, OD) -Optometry (PT, DPT) -Physical Therapy (DPM) -Podiatry
(DDS, DMD) -Dentistry (RPH, PharmD) -Pharmacist (PTA) -Physical Therapy Assistant (DVM) -Veterinary Medicine
(ND, OT, MST) -Allied Health Clearance Letter

Name	License Type	License No.	Qty.	Subtotal
Total Quantity & Amount Due:			**0**	**$ 0.00**

Send Verification to:

Email Address: _____

OR

Name: _____

Agency: _____

Street Address: _____

City, State, Zip Code: _____

Please ÁÔÔÁÃÈ ÁÕÔÈÏÒÉÚÁÔÉÏÎ Ô Ï ÒÅÑÕÅÓÔ Á ÌÉÃÅÎÓÅ ÔÅÓÔÉÍÃÁÔÉÏÎ ÉÓ ÙÏÕ ÁÒÅ Î ÏÔ ÔÈÅ ÌÉÃÅÎÓÅÅ ÈÏÌÄÅÒ. Remit this form and ***$10.00 pÒÏÃÅÓÓÉÎÇ ÆÅÅ ¡ÔÈÅ ÒÅÇÕÌÁÔÒÒ ÐÒÏÃÅÓÓÉÎÇ ÔÉÍÅ Í Ä ü ÃÁÌÌÅÄÒ ÄÁÙÓ¶¶ φψ ÈÏÕÒ ÒÕÓÈ ÆÅÅ Εχωϐτ τ (per provider).***

*Acceptable forms of payment are: credit card authorization form (below), certified check or money order; made payable to "**GOV'T OF THE VI**" to:*

Professional Licensure and Health Planning

c/o VI Dept. of Health-STX
P.O. Box 222995
Christiansted, VI 00822-2995

c/o VI Dept. of Health-STT
1303 Hospital Ground, Ste. 10
St. Thomas, VI 00802

_____ _____

Signature Date

One (1) Time Credit Card Payment Authorization

Sign and complete this form to authorize the **"The Government of the VI" (Virgin Islands Department of Health)** to make a one-time charge to your credit card as listed below.

By signing this form (electronically or otherwise), you give **The Government of the VI" (Virgin Islands Department of Health)** permission to debit your account for the amount indicated below. This is permission is for a single transaction only and does not provide authorization for any additional unrelated debits or credits.

I _____ authorize __**Government of the VI** to charge the
(Cardholder's Full Name) **(Merchant's Name)**

credit card account indicated below the amount of _____
US $ Amount

Payment for _____ _____ for _____
First, Middle, Last Name (Licensee/Entity) credential application, registration, license renewal, CON, verification, copies, etc.

Billing Information

Billing Address_____ Cell phone # _____

City, State, Zip _____ Email_____

Card Details

☐ Visa ☐ MasterCard++
Cardholder's Name as it Appears on Card _____

Credit Card Number#_____

Expiration Date ____ /_____ CVV _____ Zip Code _____

*"Please include **a copy of a government issued ID** if you are **not** the **applicant or license holder."***

I authorize the **Government of the VI (Department of Health)** to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the services indicated and in the amount indicated above only and is valid for one (1) time use only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

_____ _____
cardholder original signature date