OFFICE OF PROFESSIONAL LICENSURE AND HEALTH PLANNING
PO Box 222995
CHRISTIANSTED, VI 00822ςζςωωυ

License Verification / Good Standing Letter 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 Number _____

Send Verification to:

Email Address OR	
Name Agency	
Street Address	
City, State Zip Code	

Please attach authorization to request a license verification if you are not the license holder. Remit this form and* *$10.00 processing fee (the regular processing time is 7 calendar days)****;* ***24 hour rush fee $35.00*** ***(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
PO Box 222995
Christiansted, VI 00822
(340)718-1311 ext. 3849
ramona.liger@doh.vi.gov
renise.james@doh.vi.gov

c/o VI Dept. of Health-STT
1303 Hospital Ground, Ste. 10
St. Thomas, VI 00802
(340)774-7477 ext. 5694
jahkesha.archibald@doh.vi.gov

_____ 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