OFFICE OF PROFESSIONAL LICENSURE AND HEALTH PLANNING

P.O. Box 222995
CHRISTIANSTED, VI 00822-2995

License Verification / Good Standing Letter Request & Invoice

LICENSE TYPES

(DC) -Chiropractic
(MD, DO) -Medicine and Surgery
(RPH, PharmD) -Pharmacist
(PT, DPT) -Physical Therapy
(DVM) -Veterinary Medicine
CON) -Certificate Need
(ND, OT, MT) -Allied Health Clearance Letter

(DDS, DMD) -Dentistry
(PA, PA-C) -Physician Assistant
(CPTI, CPT, RPT, PPT) Pharmacy Technician
(PTA) -Physical Therapy Assistant
(RVT)-Veterinary Technician
Pharmacy
Other: ______________________________________

(RDH) -Dental Hygienist
(PSY, PSYD, MA Psych Assoc.) -Psychologist
(CTO, OD) -Optometry
(DPM) -Podiatry
(RRT) -Radiology Technician

Licensee / Facility Name ____

License Type _________________________

License Number _______________________

Verification will be emailed to:

Name	
Contact Person	
Agency	
Email Address	

Please attach authorization to request a license verification if you are not the license holder. Remit this form and* *$10.00 fee per provider.*** ***Note: Beginning October 1, 2024 all verifications will be $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
P.O. Box 222995
Christiansted, VI 00822-2995
(340) 643-8992
plhpverify@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 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 ____________________ License #_________
First, Middle, Last Name (Licensee/Entity) **Credential Application, Registration, License Renewal, CON, Verification, Copies, etc.** **If Applicable**

Billing Information

Billing Address: ____________________________ Cell phone # ________________________

City, State, Zip: ______________________ Email: ____________________________

Card Details

*"If you are **not** the **Applicant or License holder** please include **a Copy of a Government Issued ID."***

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

Credit Card Number# ______________________________

Expiration Date ____ / _______ CVV _________ Zip Code _________

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