

[Your Name]

[Your Address]

[City, State, Zip Code]

[Email Address]

[Phone Number]

[Date]

[Recipient Name]

[Recipient Title]

[Institution Name]

[Institution Address]

[City, State, Zip Code]

Dear [Recipient Name],

I hope this message finds you well. I am writing to request verification of a medical license held by [License Holder's Name], who is applying for [specific purpose, e.g., employment, credentialing, etc.].

Please find the relevant details below:

- License Holder's Name: [License Holder's Name]
- License Number: [License Number]
- Date of Birth: [Date of Birth]
- State of License: [State]
- Issue Date: [Issue Date]
- Expiration Date: [Expiration Date]

We would greatly appreciate your assistance in confirming the validity of this medical license at your earliest convenience. If you require additional information, please feel free to contact me using the details provided above.

Thank you for your attention to this matter.

Sincerely,

[Your Name]

[Your Position, if applicable]

[Your Institution, if applicable]