Pharmacy License Verification for Academic Purposes

[Your Name]

[Your Title]

[Your Institution]

[Institution Address]

[City, State, Zip Code]

[Email Address]

[Phone Number]

[Date]

[Recipient's Name]

[Recipient's Title]

[Pharmacy Board/Organization Name]

[Board Address]

[City, State, Zip Code]

Dear [Recipient's Name],

I am writing to request the verification of pharmacy license for [License Holder's Name], who is currently applying for [specific academic program or purpose] at [Your Institution Name]. The verification is essential to ensure compliance with our academic requirements.

Please provide the following information:

- License Number
- License Status (Active/Inactive)
- Issuance Date
- Expiration Date

We appreciate your assistance in this matter and look forward to your prompt response. If you require any additional information, please do not hesitate to contact me.

Thank you for your attention to this request.

Sincerely,

[Your Full Name]

[Your Position]