

# Pharmacy License Verification

Date: [Insert Date]

To Whom It May Concern,

This letter serves to verify the pharmacy license of:

**Pharmacist Name:** [Insert Name]

**License Number:** [Insert License Number]

**State/Country:** [Insert State/Country]

**Date of Issue:** [Insert Date of Issue]

**Expiration Date:** [Insert Expiration Date]

The aforementioned pharmacist holds a valid and active pharmacy license issued by the [Insert Regulatory Body] in accordance with the regulations of [Insert State/Country].

If you require any further information or verification, please do not hesitate to contact our office at:

**Phone:** [Insert Phone Number]

**Email:** [Insert Email Address]

Thank you for your attention to this matter.

Sincerely,

**[Your Name]**

[Your Position]

[Pharmacy Name]

[Pharmacy Address]

[City, State, Zip Code]