

Pharmacy License Verification

Date: [Insert Date]

[Recipient Name]

[Recipient Title]

[Professional Association Name]

[Association Address]

[City, State, Zip Code]

Dear [Recipient Name],

This letter serves as verification of the pharmacy license held by [Pharmacist's Full Name] for membership purposes in [Professional Association Name]. We confirm that [he/she/they] is currently licensed to practice pharmacy in [State] under license number [License Number], issued on [Issue Date] and valid until [Expiration Date].

Please feel free to contact our office at [Phone Number] or [Email Address] should you require any additional information or further verification.

Thank you for your attention to this matter.

Sincerely,

[Your Name]

[Your Title]

[Pharmacy Name]

[Pharmacy Address]

[City, State, Zip Code]