Medical License Verification

Date: [Insert Date]

[Recipient's Name]

[Association Name]

[Association Address]

[City, State, Zip Code]

Dear [Recipient's Name],

This letter serves to verify the medical license of Dr. [Physician's Full Name], who is seeking affiliation with [Association Name]. We confirm that Dr. [Last Name] holds a valid medical license issued by the [Issuing Authority] in the state of [State]. The details of the license are as follows:

- License Number: [License Number]
- Issue Date: [Issue Date]
- Expiration Date: [Expiration Date]
- Specialty: [Medical Specialty]

Should you require any additional information or verification, please feel free to contact our office at [Contact Phone Number] or [Email Address].

Thank you for considering Dr. [Last Name] for membership in [Association Name].

Sincerely,

[Your Name]

[Your Title]

[Your Organization]

[Your Address]

[City, State, Zip Code]

[Contact Phone Number]

[Email Address]