Medical License Verification

Date: [Insert Date]

[Recipient's Name]

[Recipient's Title]

[Institution/Organization Name]

[Address]

[City, State, Zip Code]

Dear [Recipient's Name],

This letter serves to verify the medical license of [Physician's Name], who is seeking continuing education credits from [Institution/Organization Name]. The details of the license are as follows:

- **License Number:** [License Number]
- **Issuing State:** [Issuing State]
- **Date of Issue:** [Date of Issue]
- **Expiration Date:** [Expiration Date]

[Physician's Name] has met all necessary requirements to maintain their medical license. Please feel free to contact our office for any further information or clarification regarding this verification.

Thank you for your attention to this matter.

Sincerely,

[Your Name]

[Your Title]

[Your Institution/Organization]

[Your Contact Information]