Date: [Insert Date]

To Whom It May Concern,

This letter serves to verify the medical license of Dr. [Full Name], who holds the license number [License Number]. Dr. [Last Name] is currently licensed to practice medicine in the state of [State] as of [License Issue Date].

Please find the details of Dr. [Last Name] below:

- Full Name: Dr. [Full Name]
- License Number: [License Number]
- Date of Issue: [Issue Date]
- Expiration Date: [Expiration Date]
- Specialty: [Specialty]

If further information is required, please do not hesitate to contact our office at [Phone Number] or [Email Address].

Sincerely,

[Your Name]

[Your Title]

[Your Organization]

[Your Address]

[City, State, Zip Code]