OFFICE OF PROFESSIONAL LICENSURE AND HEALTH PLANNING
PO Box 222995
CHRISTIANSTED, VI 00822-2995

License Verification / Good Standing Letter Request

Name ________________________________

License Type _________________________

License Number _______________________

Send Verification to:

Name	
Agency	
Street Address	
City, State Zip Code	

Please remit this form and $10.00 processing fee (the regular processing time is 7 calendar days; 24 Hour Rush Fee is $35.00 payable to "GOV'T of the VI" mail or email to:

Professional Licensure and Health Planning

c/o VI Dept. of Health-STX
PO Box 222995
Christiansted, VI 00822
(340)718-1311 xt 3849
ramona.liger@doh.vi.gov

c/o VI Dept. of Health-STT
1303 Hospital Ground, Ste. 10
St. Thomas, VI 00802
(340)774-7477 xt 5694
jahkesha.archibald@doh.vi.gov

_____________________________ Signature

_____________________________ Date

One (1) Time Credit Card Payment Authorization

Sign and complete this form to authorize the **"<u>The Government of the VI" (Virgin Islands Department of Health)</u>** to make a one-time charge to your credit card as listed below.
By signing this form (electronically or otherwise), you give **The Government of the VI" (Virgin Islands Department of Health)** permission to debit your account for the amount indicated below. This is permission is for a single transaction only and does not provide authorization for any additional unrelated debits or credits.

I ___________________________________authorize _**<u>Government of the VI</u>** to charge my
(Cardholder's Full Name) **(Merchant's Name)**

credit card account indicated below the amount of $_________________
Amount

This payment is for _______________________of my **VI** _________**License #**__________.
application, CON, license registration, license renewal, verification, Other(indicate) — license type — If applicable

Billing Information

Billing Address_________________________Cell phone # ________________________
City, State, Zip_______________________ Email________________________________

Credit Card Details

☐ Visa ☐ MasterCard
Cardholder**'s** Name as it Appears on Card ______________________________
Account/CC Number___________________________
Expiration Date ____ /____
CVV _________
Zip Code__________

I authorize the **Government of the VI (Department of Health)** to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the services indicated and in the amount indicated above only and is valid for one (1) time use only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

___________________________________ ________________
cardholder original signature date