# OFFICE OF PROFESSIONAL LICENSURE AND HEALTH PLANNING

P.O. Box 222995
CHRISTIANSTED, VI 00822-2995

*FILLABLE FORM*
***MUST** TYPE*

## License Verification / Good Standing Letter Request & Invoice

**LICENSE TYPES**

(DC) -Chiropractic
(MD, DO) -Medicine and Surgery
(RPH, PharmD) -Pharmacist
(PT, DPT) -Physical Therapy
(DVM) -Veterinary Medicine
CON) -Certificate Need
(ND, OT, MT) -Allied Health Clearance Letter
(DDS, DMD) -Dentistry
(PA, PA-C) -Physician Assistant
(CPTI, CPT, RPT, PPT) Pharmacy Technician
(PTA) -Physical Therapy Assistant
(RVT)-Veterinary Technician
Pharmacy
Other: _____
(RDH) -Dental Hygienist
(PSY, PSYD, MA Psych Assoc.) -Psychologist
(CTO, OD) -Optometry
(DPM) -Podiatry
(RRT) -Radiology Technician

| Name | License Type | License No. | Qty. | Subtotal |
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| Total Quantity & Amount Due: | | | | |

## Verifications will be emailed to:

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|---|---|
| Name | |
| Contact Person | |
| Agency | |
| Email Address | |

**Please attach authorization to request a license verification if you are not the license holder.*
*Remit this form and **$35.00 fee per provider.***

*Acceptable forms of payment are: credit card authorization form (below), certified check or money order, made payable to "**GOV'T of the VI**" to:*

**Professional Licensure and Health Planning**
c/o VI Dept. of Health-STX
P.O. Box 222995
Christiansted, VI 00822-2995
(340) 643-8992
plhpverify@doh.vi.gov

Signature

Date

# One (1) Time Credit Card Payment Authorization

Sign and complete this form to authorize the **"The Government of the VI" (Virgin Islands Department of Health)** 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 permission is for a single transaction only and does not provide authorization for any additional unrelated debits or credits.

I _____ authorize __**Government of the VI** to charge the
**(Cardholder's Full Name)** **(Merchant's Name)**

credit card account indicated below the amount of _____
**US $ Amount**

Payment for _____ for _____ License #_____
**First, Middle, Last Name (Licensee/Entity)** **Credential Application, Registration, License Renewal, CON, Verification, Copies, etc.** **If Applicable**

## Billing Information

Billing Address: _____ Cell phone # _____

City, State, Zip: _____ Email: _____

## Card Details

*"If you are **not** the **Applicant or License holder** please include **a Copy of a Government Issued ID."***

☐ Visa ☐ MasterCard
Cardholder's Name as it Appears on Card _____

Credit Card 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