Arkansas Medical Staffing, LLC

Professional License/Certification Verification

Authorization:
I hereby release from all liability the company or person completing this form, and authorize them to release all information regarding my professional licenses/certificate and the current status.

_____ _____
Signature/Title Date

Please fill out the following information.

Name_____

Address/City/State/Zip_____

Licenses Number_____

Licenses Status_____

Expiration Date_____

Confirmation:
The above-named individual does not have any present actions or complaints pending and is considered in good standing with.

Other Comments_____

Verification Method used_____Date_____
Signature/Title_____

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Signature/Title_____

Verification Method used_____Date_____
Signature/Title_____

Verification Method used_____Date_____
Signature/Title_____