CERTIFICATION

I graduated from the _____ located in _____
(Name of educational institution) (City/State)

_____. In the year of _____ and was awarded a

degree/Certificate in _____.
(nursing, medicine, etc.)

I ( ) did ( ) did not graduate from a foreign university. If yes, I passed the

( ) FLEX or ( ) ECFMG exam on _____.
(date)

My license to practice ( ) has ( ) has not been terminated, suspended, or revoked in any

State, the District of Columbia, Puerto Rico, or a Territory of the U.S., and currently ( )

is ( ) is not suspended in any state, District of Columbia, or Puerto Rico.

I currently hold an active medical license(s) in the following State(s):

State	License No.	Issued Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

I have an inactive medical license(s) in the following State(s). *

State	License No.	Issued Date
_____	_____	_____
_____	_____	_____

I am board ( ) certified ( ) eligible in the specialty of _____.

*Include reason license has lapsed or is inactive.

I hereby certify that for the purposes of application of the false statements provisions of the Program Fraud Civil Remedies Cat of 1986 (45 CFR 79), that to the best of my knowledge, each of the above statements is true, accurate, and does not omit any material fact that would render the statement false, fictitious, or fraudulent as a result of the omission.

_____ _____
Original Signature of Provider Date

_____ _____
Name of Provider (typed or printed) Date