

VERIFICATION OF LICENSE

Date: _____

Licensing agency _____

Address _____

RE: License Number _____

To Whom It May Concern:

I am applying for a contract with the Peace Corps. The application process requires that I ask the licensing agency to complete and return this form **by commercial express mail or fax only**, directly to:

Paul D. Coverdell Peace Corps Headquarters

Office of Medical Services

1111 20th St., NW

Washington, DC 20526

Attention: PCMO Program Coordinator

Fax: 202.692.1596

I give my consent for this information to be released to the Peace Corps and have signed below.

Sincerely,

Signature _____

Print Name _____

Address _____

_____ Telephone _____

VERIFICATION

The above named individual is currently licensed in the State of _____
as a _____

(RN, NP, PA, MD)

Issue date: _____

Expiration date: _____.

The license is in good standing: yes _____ no _____

There are restrictions: yes _____ no _____

Signed: _____ Print name: _____

Title: _____ Date: _____

VERIFICATION OF CERTIFICATION

Date: _____

Certifying agency _____

Address _____

RE: Certification Number _____

To Whom It May Concern:

I am applying for a contract with the Peace Corps. The application process requires that I ask the certifying agency to complete and return this form **by commercial express mail or fax only**, directly to:

Paul D. Coverdell Peace Corps Headquarters
Office of Medical Services
1111 20th St., NW
Washington, DC 20526
Attention: PCMO Program Coordinator

Fax: 202.692.1596

I give my consent for this information to be released to the Peace Corps and have signed below.

Sincerely,

Signed _____

Print Name _____

Address _____

_____ Telephone _____

VERIFICATION

The above named individual is currently certified as a _____
by _____

Issue date: _____ Expiration date: _____.

The certification is in good standing: yes _____ no _____

There are restrictions: yes _____ no _____

Signed: _____ Print name: _____

Title: _____ Date: _____

VERIFICATION OF DEGREE

Date: _____

College/university _____

Address _____

RE: Name of Degree _____ Date Awarded _____

To Whom It May Concern:

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Paul D. Coverdell Peace Corps Headquarters
Office of Medical Services
1111 20th St., NW
Washington, DC 20526
Attention: PCMO Program Coordinator

Fax: 202.692.1596

I give my consent for this information to be released to the Peace Corps and have signed below.

Sincerely,

Signature _____

Print Name _____

Address _____

_____ Telephone _____

VERIFICATION

The above named individual attended this college/university from _____ to _____

Degree Awarded: _____ Date: _____

Signed: _____ Print name: _____

Title: _____ Date: _____