LOUISIANA DEPARTMENT OF HEALTH
PROFESSIONAL LICENSE VERIFICATION

The purpose of this form is to certify that I have personally reviewed and verified that

_____ has a valid and current license to practice as a
(NAME OF EMPLOYEE)

_____ in the State of Louisiana. This license will expire on
(DISCIPLINE)

_____.
(DATE OF EXPIRATION)

_____ _____
Signature of Person Verifying License **Date**

_____
Print Name