

FOR OFFICE USE ONLY

Podiatrist Checklist

- Endorsement Examination
- Application and Fee
- Date: _____ Check: _____
- Birth Certificate
- Photo
- Transcript
- Score/Certification From NBPME
- 3 Letters of Good Moral Character
- Verification of Residency Program
- License Verification from other states
- SSN Verification



FOR OFFICE USE ONLY

Receipt #

ID #

Issue Date

License #

**Rhode Island
Board of Examiners in Podiatry**

Room 104
3 Capitol Hill
Providence, RI 02908-5097

***Instructions and
License Application for:***

Podiatrist

License # _____

Name _____

- Endorsement** **Examination**

Applicant - Print Name (First/MI/Last)

- I am also applying for a RI Uniform Controlled Substances Registration (CSR) and I have attached the CSR application to this license application.

Phone: (401) 222-2828

TTY/TDD: (800) 745-5555

Fax: (401) 222-1272

GENERAL INFORMATION

Enclosures

The following materials and information should be enclosed within this application packet:

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Licensure Requirements

- Completed, notarized application.
- Fee of **\$410.00 (or \$550.00 with CSR application)** (NOTE: Application Fees are NON-REFUNDABLE).
- Three (3) original statements of good moral character from three unrelated people who have known the applicant for at least 2 years; letters must be signed, dated and have a return address
- Birth certificate (***original or a copy notarized as being a true copy of the original***), or if born outside the United States, proof of citizenship or lawful alien status, (***original or a copy notarized as being a true copy of the original***).
- One (1) recent identification photograph of the applicant, head and shoulder front view, approximately 2 x 2 inches in size.
- Official transcripts sent **directly** from your School of Podiatry of a 3 year accredited program (Doctorate Degree)
- Statement from responsible authority for the residency program verifying successful completion of the residency program, including a certificate of successful completion of the requirements.
- The results of the National Board of Podiatric Examination and the results of the Podiatric Medical Licensing Examination for States (PM LEXIS Exam) sent directly to this office.

Applications by Endorsement

- In addition to requirements listed above, License Verifications from the state(s) in which applicant holds or has held a license (Use "Interstate Verification Form - Other State Licenses" on page 9).

Rules and Regulations

The Rules and Regulations governing the Practice of Podiatry can be obtained at the Board web site:

<http://www.health.ri.gov/hsr/professions/podiat.php#Requirements>

Rhode Island General Laws pertaining to the Practice of Podiatry can be obtained at the following web site:

<http://www.rilin.state.ri.us/Statutes/TITLE5/5-29/INDEX.HTM>

APPLICATION PROCESS OVERVIEW

Application Process

All applications, communications and inquiries should be addressed to the Rhode Island Department of Health, Board of Podiatry, Room 104, 3 Capitol Hill, Providence, RI 02908-5097. You must submit your application and supporting credentials directly to the Board.

The licensure process in the State of Rhode Island is conducted by the Rhode Island Board of Examiners in Podiatry (Board).

In addition to the application, you must submit additional information directly to the Board. All items listed on the “checklist page” (page 8) must be submitted for an application to be considered complete. All applications are considered valid for 1 year from the day they are received at HEALTH. If you do not complete the application process within 1 year, a new application must be submitted. If you are approved to take the examination, the examination approval process does not expire within one year.

The Board meets four (4) times per year. Only applications which are complete, with all supporting credentials, will be forwarded to the Board for review and issuance of a license. Licenses will be issued within 7-10 working days following the Board meeting and are mailed to the address furnished in your application. You are responsible for notifying the Board office, in writing, if your address changes in the interim. The Board may be emailed an address change. The email address is located at the following web site.

To obtain your license number prior to receiving your license card, please refer to the HEALTH Licensee Lookup web site (Approximately ten (10) days after Board Meeting):

<http://www.health.ri.gov/hsr/professions/license.php>

HEALTH will not, for any reason, accelerate the processing of one applicant at the expense of others. Once completed, the application will be reviewed, and you will be contacted in writing.

Please continue to review the remaining portions of this application packet for instructions and other materials necessary to complete the Board application. If you have any questions about this application process, or would like to check on the status of your Board application, please contact this office at (401) 222-2828.



INSTRUCTIONS FOR COMPLETING THE BOARD APPLICATION

Read the following instructions and those throughout the application packet carefully before completing the Board application. Failure to submit all required information and appropriate documentation may result in processing delays. All of the information provided is subject to change.

General Instructions

1. Make a copy of the application and forms before you begin, in case you make a mistake.
2. Type your information or print in blue or black ball-point pen. Board staff will not make assumptions about illegible information. Be sure to print your name in the box provided on the cover page.
3. Provide a response to each section or question; otherwise, mark "N/A" for Not Applicable.
4. We suggest that you make a copy of your completed application before submitting it to the Board.
5. **It is your responsibility to check on the status of your application.**

Completing your Board Application

1. Complete the Board Application pages (5-8). You must respond to all components of the application as instructed. If you attach separate pages in continuation of the Board application, such pages **MUST** clearly indicate the section for which such information is being reported.
2. Make a check or money order (in U.S. Funds only) for the application fee of **\$410.00** (or **\$550.00** with CSR Application), made payable to "Rhode Island General Treasurer" and staple it to the upper left-hand corner of the first (Top) page of the application. These application fees are **NON-REFUNDABLE**.
3. **For those born in the US:** An original or notarized copy of birth certificate. **For those born outside the US:** An original or notarized copy of citizenship or lawful alien status.
4. Affix a recent 2" X 2" photo of yourself in the space provided (page 8).
5. Three (3) original statements of good moral character from three unrelated people who have know the applicant for at least 2 years; letters must be signed, dated and have a return address
6. A completed official transcript **sent directly** from the accredited school of Podiatric Medicine to the Board of Podiatry (**No student copies will be accepted**)
7. Statement from responsible authority for the residency program verifying successful completion of the residency program, including a certifice of successful completion of the requirements.
8. Scores/certification **sent directly** from the National Board of Podiatric Examination and the Podiatric Medical Licensing Exam for States (PM LEXIS Exam) to the Board of Podiatry
9. Complete CSR Application (page 10) if applicable.

Complete all application materials as instructed and arrange them in order as they appear in the application checklist (see page 8). Do not submit applications without all applicable information, documentation and fee. Mail these components of the application to:

Rhode Island Department of Health
Board of Examiners in Podiatry, Room 104
3 Capitol Hill
Providence, RI 02908-5097

Applications by Endorsement

In addition to the materials you mail to the Board, you must also mail information to other sources for verification. Follow these additional steps as described below:

1. Obtain licensure verification from all states where you hold, or have ever held, a license to practice podiatry. To obtain this verification, you must mail the Interstate Verification Form (page 9) to each licensing authority in which you are/were licensed. If you are licensed in Canada, send a copy to each province in which you are/were licensed.



State of Rhode Island Board of Examiners in Podiatry

Application for License to Practice as a Podiatrist

Refer to the Application Instructions when completing these forms. Type or block print only. Do not use felt-tip pens.

1. Name(s)

This is the name that will be printed on your License/Permit/Certificate and reported to those who inquire about your License/ Permit/ Certificate. Do not use nicknames, etc.

	<input style="width: 100%;" type="text"/> <small>Title (i.e., Mr., Mrs., Ms., etc.)</small>
	<input style="width: 100%;" type="text"/> <small>First Name</small>
	<input style="width: 100%;" type="text"/> <small>Middle Name</small>
	<input style="width: 100%;" type="text"/> <small>Surname, (Last Name)</small>
	<input style="width: 100%;" type="text"/> <small>Suffix (i.e., Jr., Sr., II, III)</small>
	<input style="width: 100%;" type="text"/> <small>Maiden, if applicable</small>
	<input style="width: 100%;" type="text"/> <small>Name(s) under which originally licensed in another state, if different from above (First, Middle, Last).</small>
	<input style="width: 100%;" type="text"/> <input style="width: 100%;" type="text"/>

2. Social Security Number

<input style="width: 100%;" type="text"/>	-	<input style="width: 100%;" type="text"/>	-	<input style="width: 100%;" type="text"/>					
---	---	---	---	---	---	---	---	---	---

U.S. Social Security Number

Please Refer to "Mandatory Addendum to License Application" on the last page of this application

3. Gender

Male Female

4. Date and Place of Birth

<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
<small>Month</small>	<small>Day</small>	<small>1</small>	<small>9</small>	<small>Year</small>							
<input style="width: 100%;" type="text"/> <small>City and State; OR Province and Country, etc., if NOT U.S.</small>											

5. Home Address

It is your responsibility to notify the board of all address changes.

<input style="width: 100%;" type="text"/> <small>1st Line Address (Apartment/Suite/Room Number, etc.)</small>											
<input style="width: 100%;" type="text"/> <small>Second Line Address (Number and Street)</small>											
<input style="width: 100%;" type="text"/> <small>City</small>						<input style="width: 100%;" type="text"/>		<input style="width: 100%;" type="text"/> - <input style="width: 100%;" type="text"/> <small>State Zip Code</small>			
<input style="width: 100%;" type="text"/> <small>Country, if NOT U.S.</small>											
<input style="width: 100%;" type="text"/>				<input style="width: 100%;" type="text"/> - <input style="width: 100%;" type="text"/>				<input style="width: 100%;" type="text"/>			
<small>Home Phone</small>				<small>Home Fax</small>							
<input style="width: 100%;" type="text"/> <small>Email Address (Format for email address is Username@domain e.g. applicant@isp.com)</small>											

6. Primary Business Address

It is your responsibility to notify the board of all address changes.

This address will appear on the Department of Health web site.

<input style="width: 100%;" type="text"/> <small>Name of Business/Work Location</small>											
<input style="width: 100%;" type="text"/> <small>1st Line Address (Department/Suite/Room Number, etc.)</small>											
<input style="width: 100%;" type="text"/> <small>Second Line Address (Number and Street)</small>											
<input style="width: 100%;" type="text"/> <small>City</small>						<input style="width: 100%;" type="text"/>		<input style="width: 100%;" type="text"/> - <input style="width: 100%;" type="text"/> <small>State Zip Code</small>			
<input style="width: 100%;" type="text"/> <small>Country, if NOT U.S.</small>											
<input style="width: 100%;" type="text"/>				<input style="width: 100%;" type="text"/> - <input style="width: 100%;" type="text"/>				<input style="width: 100%;" type="text"/>			
<small>Business Phone</small>				<small>Extension</small>				<small>Business Fax</small>			

7. Preferred Mailing Address

Please check ONE

Please use my Home Address as my preferred mailing address

Please use my Business Address as my preferred mailing address

8. Qualifying Education

Please list the name and information about the school that you attended that qualifies you for this license.

Grid for Type of School (University, College, etc.)

Type of School (University, College, etc.)

Grid for Name of School

Name of School

Date Graduated (Month and Year grids)

9. Other State Licensure

List all states or countries in which you are now, or ever have been licensed to practice podiatry, or any other profession.

Form for listing other state licensure with checkboxes for Active/Inactive



DOCUMENTATION: You must send a Interstate Verification Form to each entity. (See page 9)

10. Criminal Convictions

Respond to the question at the top of the section, then list any criminal conviction(s) in the space provided.

If necessary, you may continue on a separate 8 1/2 X 11 sheet of paper.

Have you ever been convicted of a violation, plead Nolo Contendere, or entered a plea bargain to any federal, state or local statute, regulation, or ordinance or are any formal charges pending; including use of illicit substances or operating a motor vehicle while intoxicated. (Please include any offenses which have been expunged from your record)?

Yes/No checkboxes

Abbreviation of State and Conviction¹ (e.g. CA - Illegal Possession of a Controlled Substance):

Grid for listing criminal convictions with Month/Year sub-grids



¹For purposes of this section, a person shall be deemed to be convicted of a crime if he/she plead guilty or if he/she was found or adjudged guilty by a court of competent jurisdiction or has been convicted of a felony by the entry of Nolo Contendere in any state.

11. Questions

Check either Yes or No for each question.

If necessary, you may continue on a separate 8 1/2 X 11 sheet of paper.

1. Has any Health Professional license, certificate, registration or permit you hold or have ever held, been disciplined or are any formal charges pending? Yes/No

2. Have you ever been denied a license, certificate, registration or permit in any state? Yes/No

NOTE: If you answer "Yes" to any question, you are required to furnish complete details, including date, place, reason and disposition of the matter.

12. Affidavit of Applicant

Complete this section and sign in the presence of a notary public.

Make sure that you and the notary public have completed all components accurately and completely.

I, _____, being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents.

I hereby authorize all hospital(s), institution(s) or organizations(s), my references, personal physicians, employers (past and present) and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Rhode Island Board of Podiatry any information which is material to my application for licensure.

I have read carefully both the statute and associated Regulations for the licensure of podiatrists in Rhode Island. Further, I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I knowingly furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice Podiatry in the State of Rhode Island.

I understand that relevant portions of my records are protected under the Federal and State Regulations governing Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the law. I understand that my records are protected under the Federal and State Laws and Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations.

I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Board of Examiners in Podiatry of any change in the answers to these questions after this application and this affidavit is signed.

Signature of Applicant

Date of Signature (MM/DD/YY)

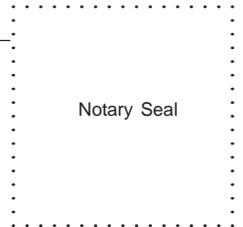
The foregoing instrument was acknowledged before me this _____ day of _____, 20_____, by _____, who is personally known to me or has produced _____ as documentation and did / did not take an oath.

Name of Notary (Print, Type or Stamp)

Signature of Notary

Notary No/Commission No.

Commission Expiration Date (MM/DD/YY)

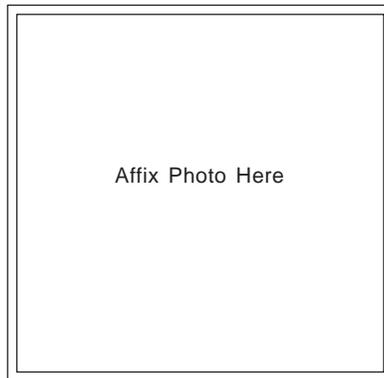


13. Recent Photograph

Securely tape or glue in this square a current 2" x 2" photograph of yourself (alone).

Photographs must be recent, passport type photo, clear, front view, full face without a hat or dark glasses.

Full length photos will not be accepted.



Write your name on the back of the photograph, and provide the date that the photograph was taken.

Date of Photograph

APPLICATION CHECKLIST

Please review the following checklist to ensure you have satisfied all components of the application process. Some items may not apply.

Board Application

- I have read and understand the "Instructions for Completing the Board Application."
- I have carefully read RIGL 5-29 and R5-29POD.
- I have completed the Rhode Island Board application as instructed (pages 5-7).
- I have completed Section 12, "**Affidavit of Applicant**" and had the form notarized by a notary public.
- I have attached a photograph to Section 13, "**Recent Photograph**" as instructed. I have verified that it meets the photograph requirements as stated in the application.
- I have a **check or money order** made payable (in U.S. funds only) to the "**Rhode Island General Treasurer**" in the amount of **\$410.00** (or **\$550.00 with CSR application***) and attached have it to the upper left-hand corner of the first (cover/top) page of the application.
- I have arranged my Board Application materials in following order:
 1. Fee (attached as instructed)
 2. Board Application (cover/top page, and pages 5-7)
 3. RI Uniform Controlled Substances Registration (CSR) (page 10, If Applicable)
 4. Supporting documentation as required. [Note: Pages containing additional information in continuation of the Board application MUST indicate the section for which the information is being reported.]
 5. Completed "Mandatory Addendum to License Application" - Verification of Social Security Number form (p. 11)
- I have mailed the above application materials directly to the Board of Podiatry, Department of Health.
- I have requested the following credentials be submitted directly to the BOARD:
 1. Three (3) original statements of good moral character from three unrelated people who have known the applicant for at least 2 years; letters must be signed, dated and have a return address
 2. Official Podiatry School Transcript
 3. Statement from responsible authority for the residency program verifying successful completion of the residency program, including a certificate of successful completion of the requirements.
 4. The results of the National Board of Podiatric Examination and the results of the Podiatric Medical Licensing Examination for States (PM LEXIS Exam)

Endorsement Candidates

- I have completed and mailed the following forms as instructed:
 1. Interstate Verification form (page 9), if applicable



Rhode Island Board of Podiatry

Room 104, 3 Capitol Hill
Providence, RI 02908-5097
(401) 222-2828

Substitute forms are not acceptable, copy this form as needed.

INTERSTATE VERIFICATION FORM - OTHER STATE LICENSE(S)

I am applying for a license to practice as a Podiatrist in the State of Rhode Island. The Rhode Island Board of Podiatry requires that the following form be completed by the jurisdiction(s) in which I hold or have held a license. This constitutes authority for you to release all information in your files, favorable or otherwise, directly to the Rhode Island Board of Podiatry at the above address.

Print/Type Full Name _____ Signature _____ Date _____

Previous Names Used _____ Social Security Number _____ Date of Birth _____

License Number _____ Date Issued _____

THIS SECTION TO BE COMPLETED BY THE PODIATRY BOARD

Podiatry Program Completed:	Location:	Graduation Date:
Licensed by Examination? <input type="checkbox"/> Yes <input type="checkbox"/> No	Applicant has completed and passed the National Certification Exam: <input type="checkbox"/> Yes <input type="checkbox"/> No	
License Status: <input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Lapsed	Original Date Issued:	Expiration Date:

Questions:

- Has this licensee ever been investigated by your Board? Yes No
- Has this licensee incurred any disciplinary proceedings in your state, or is any action pending? Yes No
- Has the applicant's license ever been denied, surrendered, reprimanded, suspended, revoked or placed on probation? Yes No
- Do you know of any information that may discredit this person? Yes No

If you answer "Yes" to questions 1-4, please provide a written explanation below, and attach a copy of all supporting documentation (e.g., Board order, complaint, etc.).

Certification:

Signature _____ Date _____

Type or Print Name _____

Title _____

Full Name of Licensing Board _____



Please Affix Board Seal Here

Please return directly to the Board at the above address. Thank you for your prompt cooperation.

Substitute forms are not acceptable



Rhode Island Board of Podiatry

Room 104 3 Capitol Hill
Providence, RI 02908-5097
(401) 222-2828

Rhode Island Uniform Controlled Substances Act Registration (CSR)

I am applying for a Rhode Island Uniform Controlled Substances Act Registration (CSR). I understand that there is an additional \$140.00 fee for this Registration and that the check or money order must be made out to the "RI General Treasurer".

Print/Type Full Name	Rhode Island Business Name	
Signature	Rhode Island Business Address	Business Telephone
Date	Business Fax	

Complete this application for registration to prescribe controlled substances in the State of Rhode Island	The Rhode Island Uniform Controlled Substances Act can be accessed at the following web Site: http://www.rilin.state.ri.us/Statutes/Title21/21-28/index.htm						
A CSR is not required if there will be no controlled substances prescriptions prescribed in this state. The CSR is renewed at the same time that the professional license is renewed. NOTE: Read Important Information on the bottom of this application.	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th colspan="2" style="text-align: center; padding: 5px;">Drug Schedule (Check all that apply)</th> </tr> <tr> <td style="text-align: center; padding: 5px;"><input type="checkbox"/> Schedule II</td> <td style="text-align: center; padding: 5px;"><input type="checkbox"/> Schedule III</td> </tr> <tr> <td style="text-align: center; padding: 5px;"><input type="checkbox"/> Schedule IV</td> <td style="text-align: center; padding: 5px;"><input type="checkbox"/> Schedule V</td> </tr> </table> <p>A Copy of the DEA Registration must be provided to the Board within 60 Days of its issuance by the DEA. The DEA Registration must be issued to your Rhode Island Practice Address in order for it to be valid. If you are relocating from another state, you need to apply for a DEA Registration that is specific to Rhode Island. See The bottom of this form for information on how to contact DEA.*</p> <p>All Applicants MUST answer the following:</p> <p>A. Has the applicant been convicted of, or entered a plea of nolo contendere to a violation of any state or federal law relating to manufacturing, distributing, possessing, prescribing, administering or dispensing of drugs presently defined as controlled substances under Chapter 21-28, General Laws of Rhode Island? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>B. Has the registration application or registration of the applicant, corporation, firm, partner, or officer of the applicant been surrendered, revoked, suspended or denied under any law of the United States or of any state relating to drugs presently defined as controlled substances under Chapter 21-28 of the General Laws of Rhode Island, or is such action pending? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="text-align: center;">If you answered "Yes" to question "A" or "B" attach an explanation to this form.</p>	Drug Schedule (Check all that apply)		<input type="checkbox"/> Schedule II	<input type="checkbox"/> Schedule III	<input type="checkbox"/> Schedule IV	<input type="checkbox"/> Schedule V
Drug Schedule (Check all that apply)							
<input type="checkbox"/> Schedule II	<input type="checkbox"/> Schedule III						
<input type="checkbox"/> Schedule IV	<input type="checkbox"/> Schedule V						

Important Information

Issuance of a Rhode Island Controlled Substances Registration is contingent upon registration by the U.S. Drug Enforcement Administration. If denied a "DEA Registration", the Rhode Island Controlled Substances Registration becomes "VOID". Licensed drug facilities and licensed practitioners with prescriptive privileges cannot dispense, possess, store or ship controlled substances in or into the State of Rhode Island without a valid drug facility or professional license. Rhode Island Controlled Substances Registration (CSR), and a federal Drug Enforcement Administration (DEA) Registration. Practitioners may only prescribe, dispense, possess, and store controlled substances within their particular "scope of practice". "Controlled Substances" for purposes of this application, means a prescription drug in Schedules II through V, pursuant to the Rhode Island Uniform Controlled Substances Act, and 21 CFR 1300 of the Federal Code of Regulations. Schedule I drugs are used by researchers, and require the submission of a protocol.

Without a Rhode Island CSR and federal DEA Registration, licensed drug facilities, and practitioners with prescriptive privileges, may dispense or possess non-controlled prescription medications under its facility or professional license. A CSR will not be granted to an applicant whose BOARD licensure application is "pending" in this state.

A Rhode Island Controlled Substances Registration must be obtained prior to applying for the DEA Registration. Federal regulations require that applicants comply with individual state requirements prior to issuance of a DEA Registration. Once the CSR is issued, applicants must apply to the U.S. Drug Enforcement Administration for a federal registration using that agency's DEA Form 224 (New Application for Retail Pharmacy, Hospital/Clinic, Practitioner, Teaching Institution, or Mid-Level Practitioner). Applicants may apply on-line for the DEA Registration at the following web site: www.deadiversion.usdoj.gov/drugreg/reg_apps/index.html

*You can also receive an application, or check the status of a pending DEA Registration by contacting the Drug Enforcement Administration at the following location: Registration Unit, US Drug Enforcement Administration, JFK Federal Building, 15 New Sudbury Street, Boston, MA 02203-0131, Telephone (888) 272-5174.

NOTE:

- Schedules II, III, and IV of section 21-28-2.08 will become void unless dispensed within thirty (30) days of the original date of the prescription.
- Prescriptions in schedules III, IV and V cannot be written for more that one hundred (100) dosage units and not more than one hundred (100) dosage units may be dispensed at one time. For purposes of this section, a dosage unit shall be defined as a single capsule, tablet or suppository, or not more than one (1) teaspoon of an oral liquid.
- Prescriptions in schedule II may be written for up to a 30-day supply, with a maximum of two hundred and fifty (250) dosage units, as determined by the prescriber's directions for use of the medication.



Rhode Island Department of Health

3 Capitol Hill, Providence RI , 02908-5097

MANDATORY ADDENDUM TO LICENSE APPLICATION

Tax Payer Status Affidavit / Identity Verification

All persons applying or renewing any license, registration, permit or other authority (herein after called "licensee") to conduct a business or occupation in the state of Rhode Island are required to file all applicable tax returns and pay all taxes owed to the state prior to receiving a license as mandated by state law (RIGL 5-76) except as noted below.

In order to verify that the state is not owed taxes, licensees are required to provide their Social Security Number, or Federal Tax Identification Number (for businesses) as appropriate. These numbers will be transmitted to the Division of Taxation to verify tax status prior to the issuance of a license.

Licensee Declaration

- I hereby declare, under penalty of perjury, that I have filed all required state tax returns and have paid all taxes owed.
- I have entered a written installment agreement to pay delinquent taxes that is satisfactory to the tax administrator.
- I am currently pursuing administrative review of taxes owed to the state.
- I am in federal bankruptcy. (Case # _____)
- I am in state receivership. (Case # _____)
- I have been discharged from bankruptcy. (Case # _____)

Type of Professional License for which you are applying.

Full Name (Please Print or Type)

Social Security Number

Signature

Phone Number (including area code if not 401)

Date

This form must be completed, signed and attached to your license application for processing.