

**STATE OF ARIZONA NATUROPATHIC PHYSICIANS MEDICAL BOARD**

1400 W. Washington Suite 230, Phoenix Arizona 85007

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**Request for written verification of your Arizona Naturopathic Medical license**

There is a \$5.00 fee for written verification.

A personal check or money order is required, made payable to AZND Board.

Name and license number of Naturopathic Physician requesting this verification.

Last Name: \_\_\_\_\_ First Name \_\_\_\_\_

License Number \_\_\_\_\_ Expiration Date \_\_\_\_\_

Last 4 digits of SS# \_\_\_\_\_ Date \_\_\_\_\_

I am requesting written verification of my license to be mailed directly to: Indicate the agency or person you would like the verification mailed to. Include the full mailing address. If you have a specific agency form, please include it with this request.

TYPE ADDRESS BELOW