ATTACHMENT 1

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
DIVISION OF HEALTH RELATED BOARDS
METRO CENTER COMPLEX
665 MAINSTREAM DR. 2ND FL
NASHVILLE, TENNESSEE 37243

TENNESSEE MEDICAL LABORATORY BOARD
CLEARANCE FROM OTHER STATE LICENSURE BOARDS

APPLICANT: Please provide the information requested in the top box and then mail one (1) form to the licensure board in EACH state where you hold OR HAVE EVER HELD a license to practice any profession. (Copies of this form may be used.) NOTE: Some states require a fee for providing clearance information. To expedite your application, you may wish to contact the applicable state(s).

__________________________________________ was granted a license to practice ___________________________ with license ___________________________.

(Name of Applicant)  (Profession)

Number ___________________________ on ___________________________ in the State of ___________________________, The Medical Laboratory Board of Tennessee requests that I submit evidence of the current status of that license in your state. You are hereby authorized to release any information in your files, favorable or otherwise, directly to:

State of Tennessee
Medical Laboratory Board
Metro Center Complex
665 Mainstream Dr. 2nd FL
Nashville, TN 37243

Date: ___________________________  Applicant's Signature

_________________________________________

Applicant's typed or printed name

ADMINISTRATIVE OFFICE OF STATE LICENSURE BOARD, PLEASE COMPLETE:

Name In Full As It Appears On License: ___________________________

License Number ___________________________ Profession ___________________________ Date Issued ___________________________

Basis of issuance:  ____ Endorsement/Reciprocity with ___________________________ (State)

____ Written Examination ___________________________ (Name of Exam)

The license is currently active and registered?  yes  no

Is there any derogatory information on file?  yes  no

If yes, an explanation must be attached.

Authorized Signature ___________________________ Title ___________________________ Date ___________________________