State of Utah

Department of Commerce
Division of Occupational and Professional Licensing

EMPLOYMENT VERIFICATION FORM

This is NOT an application for licensure. **Licensee/Physician:** Submit this form to all hospitals, facilities and employers in the state of Utah where 25% of your practice occurs. Complete only the top portion and submit the form to the employer/hospital for completion.

LICENSEE INFORMATION

Full Legal Name: _____
First *Middle* *Last*

All Previous Legal Names: _____

SSN: _____ **Date of Birth:** _____

EMPLOYMENT INFORMATION

Hospital/Facility/Employer, you must answer all of the following questions and provide any additional information in order for this form to be considered complete.

It Is Hereby Certified That:: _____
Name of Licensee/Physician

Is/Was Employed At: _____
Name of Hospital/Clinic

Located At: _____
Street Address (including Unit/Ste #) *City* *State* *Zip*

From: _____ **To:** _____
MM/DD/YYYY *MM/DD/YYYY*

Average Number of Days Worked in Utah Per Month: _____

Average Number of Hours Worked in Utah Per Week: _____

Is the licensee/physician currently practicing at your facility/location in Utah? Yes ☐ No ☐
**Indicate NO if the licensee/physician continues to hold privileges, but is not currently practicing.*

Is the licensee/physician scheduled to return to your facility to provide services in Utah in the future? Yes ☐ No ☐

**If YES, indicate the scheduled date(s) and duration of upcoming assignment:* _____

<u>Completed By The Medical Staff Office</u>:

Title of Individual Supplying Information: _____

Print Name**:** _____ Signature: _____

Date: _____ Phone: _____ Email: _____