NCMB Compliance Request

Fitness To Practice Examination Provider Approval Request

Licensee Name *(full name and license type)*: _____

License #: _____

NCMB Case # *(if known)*: _____

Best Contact Phone # / Email Address: _____

Name of Proposed Examining Physician: _____

Proposed Examining Physician License #: _____

Board Certification / Area of Practice of Proposed Examining Physician: _____

Email Address of Proposed Examining Physician: _____

Practice Address of Proposed Examining Physician: _____

_____

Attestation

I attest that the Proposed Examining Physician listed above has been provided with a copy of my Order for Examination and has agreed to perform the Fitness to Practice Examination.

You are signing this Fitness to Practice Examination Provider Approval and attesting that the information that has been supplied by you is accurate and correct, to the best of your knowledge.

Signature: _____