

## **Executive Order 318 Verification of Licensure or Certification Form**

Name						
	First		Middle Initial	Last		
Address						
	Street Address			City, State	Zip	
Phone		Email				

# COMPLETE AND SIGN THE SECTION BELOW WHICH IS APPLICABLE TO YOU

### This section to be completed by OUT OF STATE CLINICIANS ONLY

License/Certificate Number\_\_\_\_\_ Date Issued \_\_\_\_\_ Exp Date \_\_\_\_\_

## \*\*PLEASE ATTACH A COPY OF YOUR CURRENT LICENSE / CERTIFICATE OR AN OFFICIAL VERIFICATION FROM YOUR STATE'S LICENSING BOARD. OFFICIAL ONLINE VERIFICATIONS ARE ACCEPTABLE.\*\*

I have read and understand the Board's memo dated October 11, 2024 regarding regulatory relief offered by the Board, pursuant to Executive Order No. 318. I acknowledge that I have not been granted a credential to practice by the Board, but shall be allowed to practice pursuant to the terms and conditions in the Board's memo, until such time that Executive Order 318 has expired or the Board decides to rescind such waivers or modifications, in its sole discretion, whichever occurs first. Failure to comply with the terms and conditions set forth in the Board's memo shall result in the automatic revocation of my ability to practice in North Carolina, pursuant to Executive Order No. 318.

Signature

Date

#### This section to be completed by CLINICIANS FORMERLY LICENSED OR CERTIFIED IN NORTH CAROLINA

License/Certificate Number\_\_\_\_\_ Date Issued \_\_\_\_\_ Exp Date \_\_\_\_\_

I have read and understand the Board's memo dated October 11, 2024 regarding regulatory relief offered by the Board, pursuant to Executive Order No. 318. I acknowledge that I have not been granted a credential to practice by the Board, but shall be allowed to practice pursuant to the terms and conditions in the Board's memo, until such time that Executive Order 318 has expired or the Board decides to rescind such waivers or modifications, in its sole discretion, whichever occurs first. Failure to comply with the terms and conditions set forth in the Board's memo shall result in the automatic revocation of my ability to practice in North Carolina, pursuant to Executive Order No. 318.

Signature

Date

### This section to be completed by CURRENT STUDENTS IN A QUALIFYING PROGRAM

School	Degree Program				
Site/Agency Supervisor (Name and Phone #)					
School Supervisor (Name and Phone #)					
Professional Liability Insurance Provider					
	d October 11, 2024 regarding regulatory relief offered by				

There read and understand the Board's memo dated October 11, 2024 regarding regulatory relief offered by the Board, pursuant to Executive Order No. 318. I acknowledge that I have not been granted a credential to practice by the Board, but shall be allowed to practice pursuant to the terms and conditions in the Board's memo, until such time that Executive Order 318 has expired or the Board decides to rescind such waivers or modifications, in its sole discretion, whichever occurs first. Failure to comply with the terms and conditions set forth in the Board's memo shall result in the automatic revocation of my ability to practice in North Carolina, pursuant to Executive Order No. 318.

Signature

Date