LETTER OF FACILITY LICENSE VERIFICATION REQUEST

PLEASE NOTE: ALL INFORMATION MUST BE COMPLETED

Date Submitted: ____ - ____ - ____

RI Department of Health License Number:

Facility Name on Health License:

Contact Person:

Facility Address

City: State ZipCode

Contact Person Telephone Number: Fax Number:

Contact Person Email

Please provide the name and address of the person/agency where you want this verification mailed.
If the person/agency has a form to be completed please attach it to this completed form.

Name:

Address:

City: State: ZipCode

"Pursuant to *Rules and Regulations Pertaining to the Fee Structure for Licensing, Laboratory, and Administrative Services Provided by the Department of Health [R23-1-17-FEE]* effective December 10, 2012, there is a $50.00 fee for a letter of license verification. Please complete the above section and submit it with a $50.00 certified bank check or money order, **(personal checks will NOT be accepted)**, made payable to the "Rhode Island General Treasurer" to the following address:

Rhode Island Department of Health
Data Entry Unit
Room 105A
3 Capitol Hill
Providence, RI 02908

Please allow 4-6 weeks for processing.

Office Use Only

☐ Fee Paid

Date:_____Initials_____