COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
STATE BOARD OF MEDICINE
STATE BOARD OF OSTEOPATHIC MEDICINE
P.O. BOX 2649
HARRISBURG, PA 17105

WAIVER OF SOCIAL SECURITY NUMBER VERIFICATION STATEMENT

Name: _____
Last **First** **Middle**

Profession: _____

This is to verify that I do not have a social security number for the following reason (s):

_____

_____

_____

I verify that the statement made above is true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa. C.S. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my license.

I also acknowledge that I will provide the Board with my Social Security Number as soon as it is obtained.

_____
Signature Date