

Request for validation of registration (license to practice)

Instructions to licensing authority: Please complete the form and kindly send it **directly in a sealed envelope** to the Danish Patient Safety Authority, Islands Brygge 67, 2300 Copenhagen S, Denmark.

Name of applicant:

Date of birth:

Profession:

Status of registration: (x)

Active/current¹

☐

Expired²

☐

Restricted³

☐

Not registered⁴

☐

1. The applicant has not been found guilty of any misconduct or lack of fitness to practice, and no cautions or conditions have been applied to his/her registration.

2. The license expired on the (date):

3. Kindly attach explanation if registration has ever been revoked, suspended, limited or restricted in any way.

4. Reason(s):

Date of registration:

Registration expires on:

Name of licensing authority:

Address:

Email:

Phone:

Date:

Print name:

Signature:

Stamp
and/or seal