Fax to: AFCCVO
210-519-2724
Number of pages including this sheet: _____ Date of Request: (mm/dd/yyyy)

From: (Organization): MDG
Requestor:
E-mail:
Phone #: , Ext. Fax:

Request for Verification / Query

Provider's CCQAS record must contain data in order for request to be processed.

Request will be completed within 14 days or MTF will be notified of reason for delay.
****** Current signed release (or pg. 3 of the 1540), dated within the last year must be provided with this request ******

PROVIDER INFORMATION:
Provider's Full Name: ; Other Name(s) used:
Last Four SSN#: XXX-XX- DOB: (mm/dd/yyyy)
Type of Provider: F11 - AF ACTIVE DUTY

Specify if more than one:

☐	Qualifying Degree
☐	Other Degree:
☐	Internship
☐	Residency:
☐	Fellowship:
☐	ECFMG certificate
☐	Fifth Pathway
☐	Aerospace Medicine Primary Course
☐	License:
☐	National Registration
☐	National Certification:
☐	Board Certification:
☐	NPDB/HIPDB
☐	FSMB
☐	DHHS/OIG Sanction Query
☐	Other

Other:

Comments: