Date: [Insert Date]

Clinic Name: [Insert Clinic/Practice Name]
Address: [Insert Street Address]
City, State, Zip: [Insert City, State, Zip Code]
Phone Number: [Insert Phone Number]
Fax Number: [Insert Fax Number]
Email Address: [Insert Email Address]

RE: Prescribing Physician Credentials and Facility Verification

To Whom It May Concern,

This letter serves to verify the professional credentials and clinic information for the prescribing physician listed below:

Physician Information:

- **Full Name:** [Insert Physician Name]
- **Title:** [e.g., MD, DO, NP, PA]
- **Medical License Number:** [Insert License Number]
- **State of Licensure:** [Insert State]
- **DEA Registration Number:** [Insert DEA Number]
- **NPI Number:** [Insert NPI Number]
- **Board Certification:** [Insert Specialty, e.g., Internal Medicine]

Clinic/Facility Details:

- **Facility Type:** [e.g., Private Practice, Outpatient Clinic, Hospital]
- **Tax ID / EIN:** [Insert Tax ID]
- **Office Hours:** [Insert Hours of Operation]

The aforementioned physician is currently in good standing and is authorized to prescribe medications and treatments in accordance with state and federal regulations. All prescriptions issued from this facility are documented in the patient's permanent electronic medical record.

Should you require further documentation, such as a copy of the medical license or DEA certificate, please contact our administrative office at [Insert Phone Number].

Sincerely,

[Signature]
[Typed Name of Physician or Clinic Manager]
[Title]