



**Government of the District of Columbia  
Department of Health**



**HEALTH REGULATION AND LICENSING ADMINISTRATION  
BOARD OF MEDICINE**

**SSN AFFIDAVIT**

I, \_\_\_\_\_, do hereby state under penalty of perjury the following:  
(Name)

As of the date that my signature appears on this affidavit, I have not been issued a United States Social Security Number (SSN).

I have/will undertake efforts to obtain a SSN and will provide the SSN to the Board within fifteen (15) days of receiving it, and no later than 120 days of program onset date.

I understand that if I obtain a SSN and fail to timely submit the SSN to the Board, the Board may take appropriate action, which may affect my continued status as a postgraduate physician enrolled in the District of Columbia Medical Training License Program. In addition I understand that if I do not obtain a SSN within 120 days of program onset date I could jeopardize my continued participation in the Medical Training Program.

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature)

Sworn and subscribed to before me this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_ (Year)

\_\_\_\_\_  
(Notary Public)