



**RE-ENTRY TO PRACTICE COMMITTEE
MEDICAL EXAMINING BOARD
Room 121A, 1400 East Washington Avenue, Madison
Contact: Tom Ryan (608) 266-2112
May 16, 2018**

The following agenda describes the issues that the Committee plans to consider at the meeting. At the time of the meeting, items may be removed from the agenda. Please consult the meeting minutes for a record of the actions of the Committee. A quorum of the Board may be present during any committee meetings.

AGENDA

9:30 A.M.

(or immediately following the Medical Examining Board meeting)

OPEN SESSION – CALL TO ORDER – ROLL CALL

- A. Adoption of Agenda (1)**
- B. Approval of Minutes of April 18, 2018 (2-3)**
- C. Administrative Updates**
 - 1. Department and Staff Updates
- D. 2017 Medicine & Surgery Renewal Process (4-12)**
- E. Re-Entry to Practice (13-131)**
 - 1. Wisconsin Renewal Application
 - 2. Information Related to Re-Entry in Other States
 - 3. Minimal Data Set
 - 4. American Academy of Pediatrics (AAP) Re-Entry to the Workforce Inventory
 - 5. Center to Personalized Education of Physicians (CPEP) article, “Physicians Reentering Clinical Practice: Characteristics and Clinical Abilities”
 - 6. Topics for Next Meeting
- F. Public Comments**

ADJOURNMENT

MEETINGS AND HEARINGS ARE OPEN TO THE PUBLIC, AND MAY BE CANCELLED WITHOUT NOTICE.

Times listed for meeting items are approximate and depend on the length of discussion and voting. All meetings are held at 1400 East Washington Avenue, Madison, Wisconsin, unless otherwise noted. In order to confirm a meeting or to request a complete copy of the council’s agenda, please call the listed contact person. The council may consider materials or items filed after the transmission of this notice. Interpreters for the hearing impaired provided upon request by contacting the Affirmative Action Officer, 608-266-2112

**RE-ENTRY TO PRACTICE COMMITTEE
MEDICAL EXAMINING BOARD
MEETING MINUTES
APRIL 18, 2018**

PRESENT: David Bryce, M.D.; Mary Jo Capodice, D.O.; Rodney Erickson, M.D.; Lee Ann Lau, M.D.; David Roelke, M.D.

STAFF: Tom Ryan, Executive Director; Kate Stolarzyk, Bureau Assistant, Kimberly Wood, Program Assistant Supervisor; and other Department staff

CALL TO ORDER

Tom Ryan, Executive Director, called the meeting to order at 10:05 a.m. A quorum of five (5) members was confirmed.

ADOPTION OF AGENDA

Amendment to the Agenda

MOTION: David Roelke moved, seconded by Lee Ann Lau, to adopt the agenda as published. Motion carried unanimously.

ADMINISTRATIVE MATTERS

Election of Officers

CHAIR

NOMINATION: David Roelke nominated Lee Ann Lau for the Office of Chair.

Tom Ryan called for nominations three (3) times.

Lee Ann Lau was elected as Chair by unanimous consent.

VICE CHAIR

NOMINATION: Lee Ann Lau nominated David Roelke for the Office of Vice Chair.

Tom Ryan called for nominations three (3) times.

David Roelke was elected as Vice Chair by unanimous consent.

SECRETARY

NOMINATION: Lee Ann Lau nominated David Bryce for the Office of Secretary.

Tom Ryan called for nominations three (3) times.

David Bryce was elected as Secretary by unanimous consent.

2018 ELECTION RESULTS	
Chair	Lee Ann Lau
Vice Chair	David Roelke
Secretary	David Bryce

(Mary Jo Capodice was excused at 10:13 a.m.)

RE-ENTRY TO PRACTICE

Data Report Regarding Non-Renewals Returning Within 5 Years of 2011 MD and 2012 DO Renewal Deadlines

MOTION: David Roelke moved, seconded by David Bryce, to discuss possible questions for physicians regarding active clinical practice at initial licensure and renewal, identify options for an alternative renewal period, and options for facilitating re-entry to practice. Motion carried unanimously.

ADJOURNMENT

MOTION: David Roelke moved, seconded by David Bryce, to adjourn the meeting. Motion carried unanimously.

The meeting adjourned at 10:58 a.m.

2017 Medicine & Surgery Renewal Instructions

Step 1

- Log in using your license number and pin number. If you don't know your PIN, you can [click here](#) to use our PIN look-up tool located on our website.

Wisconsin Department of Safety and Professional Services Web Applications

Login Application Status DSPS Home Page License Look-up Main Menu PIN Look-up 	User Login Credential/License Number: <input type="text"/> <input type="text"/> PIN: <input type="text"/> Forgot Your PIN? <input type="button" value="Login"/> Building/Construction professionals should contact us directly at DPSSBCredentiaing@wi.gov (608) 266-2112 for address updates and questions about obtaining a copy of their credential. New applicants or pending applicants are unable to change their name and address online. Please email the department at dps@wisconsin.gov and provide your application ID number, profession applied for and the changes.
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Step 2

- Once you have logged into the portal, select Renew License from the Main Menu.

Main Menu

[Update Profile](#)

Update your name, mailing address, phone number and email address

[Renew License](#)

Complete all steps necessary to renew your license

[Payment Inquiry](#)

Check on the status of your payment after renewing.

[Print Wall Certificate](#)

Print your Wall Certificate.

[Download Wall Certificate](#)

Download your Wall Certificate.

[Print Wallet Card](#)

Print your Wallet Card.

[Download Wallet Card](#)

Download your Wallet Card.

[Print Governor-signed Wall Certificate](#)

Print your Governor-signed Wall Certificate.

[Download Governor-signed Wall Certificate](#)

Download your Governor-Signed Wall Certificate.

Wall Certificates and Governor Certificates can also be purchased for \$10. Complete and return this [order form](#).

[Logout](#)

Logout

Step 3

- Carefully read through Step 3 then click continue.

Professional Credential Renewal

Credential Number: ██████████	Profession: Medicine and Surgery
Renew By: 10/31/2017	Renewal Fee: \$141.00 Late Fee:

Welcome, let's begin your renewal.

Please Note: The online renewal process takes **2 full business days** to process fully in our system and payment will not post to your license until the following business day.

The Department of Safety and Professional Service (DSPS) no longer sends a physical copy of a new or renewed license. You should receive an email or a letter from the DSPS telling you to go online to print the license off of our website. There is also an option for you to order a printed wall certificate or a Governor signed wall certificate from DSPS for an additional \$10. (Note: DSPS prints the same document as is available to print at home.) Here is the link to the form: [Duplicate License/Governor Wall Cert Order Form](#).

We accept VISA, MasterCard, Discover, American Express and Electronic Checks.

[Payment Inquiry](#) - view information about previously submitted payments.

All fields must be completed. Please keep in mind that making a false statement in connection with any application for credential is grounds for revocation or denial.

System maintenance is done between 11:30 pm and 01:30 am everyday. During these times the application will not be available. We apologize for any inconvenience this may cause.

Step 4

- Carefully read through Step 4 then click continue.

Professional Credential Renewal

Credential Number: ██████████	Profession: Medicine and Surgery
Renew By: 10/31/2017	Renewal Fee: \$141.00 Late Fee:

Name/Address Change Information

On the next screen, you will be asked to update your address (where you would like things **Mailed**), name, phone number and email address. Please **ONLY** make changes if the information listed is incorrect. Also, please verify the email address on file is correct.

If you have a name change, you will need to submit proof of the name change to the Department including your license/credential number, date of birth and last four (4) digits of your SSN (Social Security Number). Please include a note to change it from (Old name) to (New name) and include your license number. The proof can be faxed to 608-251-3036 or mailed to the following: DSPS - Attn: Renewal, PO Box 8935, Madison, WI 53708-8935.

You will need to enter the last four (4) digits of your FEIN (Federal Employer Identification Number) **or** SSN if you do not have a FEIN, in order to continue forward with the renewal process.

If you have any questions, you may contact the Department at 608-266-2112 or email to dsps@wisconsin.gov.

Step 5

- Carefully read through your personal and contact information for accuracy. Please note that any name changes require proof of name change and should be submitted to the department via mail, fax, or email. To continue, enter your last 4 of SSN then click continue.

Professional Credential Renewal

Make sure the **mailing address for your credential** and your contact information are correct. If any of the fields with a * are blank you must add the information. Profile updates take 1 business day to process.

Do not use the back button on your browser.

Press Continue when finished.

Personal	
First Name:	<input type="text" value="Jane"/> *
Middle Name:	<input type="text"/>
Last Name:	<input type="text" value="Doe"/> *
Gender:	<input type="text" value="female"/> ▼
Date of Birth:	<input type="text" value="1/1/1900"/> *
	<small>(mm/dd/yyyy)</small>
Last 4 of SSN:	<input type="text" value="####"/> *
Contact	
Email:	<input type="text" value="jdoe@wisconsin.gov"/> *
Phone:	<input type="text" value="555"/>) <input type="text" value="5555555"/> ext. <input type="text"/>
Mailing Address	
Country:	<input type="text" value="United States"/> ▼
Attention:	<input type="text"/>
Address 1:	<input type="text" value="1400 E Washington Ave"/> *
	<small>Street Address, P.O. Box, etc.</small>
Address 2:	<input type="text"/>
	<small>Apartment, suite, unit, building, floor, etc.</small>
City:	<input type="text" value="Madison"/> *
State:	<input type="text" value="Wisconsin"/> ▼ *
Zip:	<input type="text" value="53708"/> *
Zip +4:	<input type="text"/>

Continue

Step 6

- Carefully read through each affidavit and check that you have read and understand. The last question pertains to any pending charges and/or convictions. Please note that answering Yes to the Conviction Declaration will not complete this requirement. If you have any pending charges and/or convictions you must complete and submit [Form #2252](#) via mail, fax, or email.

Professional Credential Renewal

Credential Number: ██████████	Profession: Medicine and Surgery
Renew By: 10/31/2017	Renewal Fee: \$141.00 Late Fee:

Affadavit of Credential Holder

I declare that I am the person referred to on this application and that all answers set forth are each and all strictly true in every respect. I understand that failure to provide requested information, making any materially false statement and/or giving any materially false information in connection with my application for a license/credential or for renewal or reinstatement of a license/credential may result in license/credential application processing delays; denial, revocation, suspension or limitation of my license/credential; or any combination thereof, or such other penalties as may be provided by law. I further understand that if I am issued a license/credential renewal, or reinstatement thereof, failure to comply with the statutes and/or administrative code provisions of the licensing authority may be cause for disciplinary action.

I have read and I understand the above affidavit of credential holder statement.

Continuing Duty of Disclosure

CONTINUING DUTY OF DISCLOSURE

I understand that I have a continuing duty of disclosure as long as my license/credential is current and valid. If information I have provided becomes invalid, incorrect or outdated, since the last renewal or issuance of my license/credential, I understand that I am obliged to provide any information to ensure the information on file for my license/credential remains current, valid, and truthful. I understand that the Department of Safety and Professional Services may view acts of omission as dishonesty and that my duty of disclosure exists as long as my license/credential is current and valid.

I have read and I understand the above continuing duty of disclosure statement.

Affidavit/Licensee Charges or Convictions

LICENSE/HOLDER CHARGES OR CONVICTIONS

A holder of any of the credentials/licenses set forth in [Wis. Stat. s. 440.03\(13\)\(b\)](#) who is convicted of a felony or misdemeanor, since the issuance of the license/credential or since the last renewal, in the state or elsewhere shall notify the department in writing of the date, place and nature of the conviction or finding within 48 hours after the entry of the judgment of conviction. Notice shall be made by mail and shall be proven by showing proof of the date of mailing the notice. Notice shall include a copy of the judgment of conviction and a copy of the complaint or other information which describes the nature of the crime and the judgment of conviction in order that the department may determine whether the circumstances of the crime of which the license/credential holder was convicted are substantially related to the practice of the license/credential holder. [Form 2252](#)s should be completed and submitted to the department along with the associated fees and all requested documents.

I have read and understand the above statement regarding the responsibility to report any convictions or misdemeanors, since the issuance or last renewal of my license.

Conviction Declaration Statement

Since your initial licensure or last renewal, do you have any pending charges and/or have you been convicted of any crimes (does not included minor traffic violations that do not involve alcohol or drugs, such as speeding, running stoplights, and seat belt violations).

- Yes
- No

Continue

Step 7

- Carefully read the legal status and check to continue. Please note that a change in legal status should be reported when your SSN, Name, or Address have changed since your last renewal.

Professional Credential Renewal

Credential Number: ██████████	Profession: Medicine and Surgery
Renew By: 10/31/2017	Renewal Fee: \$141.00 Late Fee:

Legal Status
If your legal status as a qualified alien or nonimmigrant lawfully present in the United States has changed since the issuance of your credential or your last renewal, please contact the Wisconsin Department of Safety and Professional Services at 608-266-2112 or dsps@wisconsin.gov . I have read and acknowledge this information. <input type="checkbox"/>

Step 8

- Please select all specialties that currently apply to your credential excluding disabled specialties.

Professional Credential Renewal

Credential Number: ██████████	Profession: Medicine and Surgery
Renew By: 10/31/2017	Renewal Fee: \$141.00 Late Fee:

Specialties
Please select all specialties that currently apply. Disabled specialties may only be selected at time of initial application.
<input type="checkbox"/> ACADEMIC MEDICINE
<input type="checkbox"/> ADMINISTRATIVE MEDICINE
<input type="checkbox"/> AEROSPACE MEDICINE
<input type="checkbox"/> ALCOHOLISM - CHEMICAL DEPENDENCY
<input type="checkbox"/> ALLERGY - IMMUNOLOGY
<input type="checkbox"/> ANESTHESIOLOGY
<input type="checkbox"/> AVIATION MEDICINE
<input type="checkbox"/> DERMATOLOGY
<input type="checkbox"/> EMERGENCY MEDICINE
<input type="checkbox"/> ENDOCRINOLOGY
<input type="checkbox"/> FAMILY PRACTICE

Step 9

- Carefully read through Step 9 then click continue.

Professional Credential Renewal

Credential Number: ██████████ **Profession:** Medicine and Surgery
Renew By: 10/31/2017 **Renewal Fee:** \$141.00 **Late Fee:**

Continuing Education Audit

The Medical Examining Board will conduct a Continuing Education compliance audit for Medicine and Surgery (MD) for the most recent biennium. Audit letters will be sent to randomly selected MD license/credential holders beginning in March 2018 in order to verify that 30 hours of AMA or AOA category I continuing education with two of the hours via a Board-approved course on responsible opioid prescription was completed by the randomly selected licensed MDs before December 31, 2017. License/credential holders selected for the audit will be notified in the audit notification letter that they must submit certificates of attendance to the Department verifying that they have completed the 30 required hours of continuing education. If your address on file is not current, you are encouraged to send notice of the address update to the Renewal Unit prior to December 31, 2017.

Continue

Step 10

- Carefully read the statement of continuing education then check to continue. Please note that you must check to continue and checking is considered an attestation to completing the continuing education by 12/31/2017.

Professional Credential Renewal

Credential Number: ██████████ **Profession:** Medicine and Surgery
Renew By: 10/31/2017 **Renewal Fee:** \$141.00 **Late Fee:**

I have completed or will complete 30 hours* of AMA or AOA Category I Continuing Education, including two (2) hours of a Board-approved course related to the Board's Opioid Prescribing Guidelines, pursuant to [Wis. Admin. Code ch. Med 13](#)** , on or before December 31, 2017. I will furnish evidence of completion to the Medical Examining Board upon request.

*Three (3) months of approved post-graduate training is equivalent to 30 hours of Category I credits. [Wis. Admin. Code ch. Med 13.04](#).

Pursuant to [Wis. Admin. Code ch. Med 13.02\(1g\)\(b\)](#), physicians that do **NOT hold a U.S. Drug Enforcement Administration number to prescribe controlled substances are **NOT** required to complete two (2) hours of a Board-approved course relating to the Board's Opioid Prescribing Guidelines.

Continue

Step 11

- Read and check if you would like to serve as an expert witness. Please note if you do not want to serve as an expert witness, you may click continue without checking the box.

Professional Credential Renewal

Credential Number: ██████████	Profession: Medicine and Surgery
Renew By: 10/31/2017	Renewal Fee: \$141.00 Late Fee:

Expert Witness
<input type="checkbox"/> Please check here if you are willing to serve as an expert witness in disciplinary proceedings.

Continue

Step 12

- Read and check if you would like to opt-out of disclosing your street address on any list requests of ten or more licensees provided by the department.

Professional Credential Renewal

Credential Number: ██████████	Profession: Medicine and Surgery
Renew By: 10/31/2017	Renewal Fee: \$141.00 Late Fee:

List Opt-Out
Per Wis. Stat. § 440.14, if you are an individual or a sole proprietor, you may declare that your street address and/or PO Box # not be disclosed on any list of ten or more credential holders that the department furnishes to another person. Please check the box below to make this declaration.
<input type="checkbox"/> Please do not disclose my street address and/or PO Box # on lists

Continue

Step 13

- Please read carefully and continue to the US Bank payment page to pay your renewal fee.

**State of Wisconsin
Department of Safety and Professional Services**

69187 - 020

MEDICINE AND SURGERY RENEWAL

DERRICK DOOLITTLE MD
200 FIRST STREET SW
ROCHESTER, MN 55905

Credential Renewal Fee Schedule:

due before 11/1/2017

**Total Owed: \$166.00
Total Paid: \$0.00
Balance Owed: \$166.00**

It is time to renew your license/credential from the Department of Safety and Professional Services.

- Processing time varies and can be approximately 10-15 working days. If you would like your license/credential fully renewed, please have all paperwork to the department 10-15 days
- A late fee will be assessed if postmarked date is after the expiration date.
- **Please SEE REVERSE SIDE for additional information and requirements for renewal.**

Internet renewal is available at <http://dsps.wi.gov> under "Online Services."

- Avoid delays in your renewal due to incomplete or missing information. Renewing online is fast, easy and secure.
- You will need your license/credential number and PIN that appear on the coupon **below** to access online renewal.
- The DSPS no longer sends a hard copy of a new or renewed license/credential. Please see the "Important Information" section on the back of this notice.

For paper renewal, please follow the instructions below.

- Name and address information provided to the Department is available for public inspection under Wisconsin law.
- You may substitute a business address as your address of record on file with the Department.
- You may also check the box on the form below to declare that your street address and/or PO Box # not be disclosed on any list of ten or more individuals that the department furnishes to another person per Wis. Stat. § 440.14.
- Fill in the gray boxes on the form below to show the **amount paid**.
- Please pay by credit card, check or money order **made payable to DSPS (Department of Safety and Professional Services)**.

Please Note: For all credit and debit card transactions, a 2% convenience fee will be assessed and will appear as a separate charge on your statement. This fee is non-refundable.

COMPLETE ADDITIONAL INFORMATION ON REVERSE SIDE

020R1/16CH.440

Detach and return coupon with payment

STATE OF WISCONSIN DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES

Medicine and Surgery

CREDENTIAL NO: STATUS: TOTAL DUE: DUE DATE: PIN:
69187 - 020 ACTIVE \$166.00 10/31/2017 XCH337

AMT PD. \$



VISA MASTERCARD AMEX DISCOVER

CARD # : _____

EXP. DATE: _____

SIGNATURE: _____

PLEASE PRINT NAME/ADDRESS
CHANGES IN THE SPACE BELOW

DERRICK DOOLITTLE MD
200 FIRST STREET SW
ROCHESTER, MN 55905
doolittle.derrick@mayo.edu

Do not disclose my street address/PO Box # on lists

STATE OF WISCONSIN
DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES
PO BOX 2974
MILWAUKEE WI 53201-2974

DO NOT WRITE BELOW THIS POINT - CONTINUED ON BACK

02000691870001410000166007

1. Review Legal Status Statement below.
2. Check, sign, date, and return the Certification of Continuing Education below.
3. Complete the Conviction Statement below.

IMPORTANT INFORMATION:

- If you do not renew your license/credential before 11/1/2017, you may not practice.
- By completing and returning my renewal paperwork to the DSPS, I understand that if information previously provided to the DSPS becomes invalid, incorrect or outdated, since the last renewal or issuance of my license/credential, I understand that I am obliged to provide this updated information to ensure the information on file for my license/credential remains current, valid, and truthful. I also understand that this includes and is not limited to license/credential holders of any of the credentials/licenses set forth in Wis. Stat. s. 440.03(13)(b) who is convicted of a felony or misdemeanor, since the issuance of the license/credential or since the last renewal, in the state or elsewhere shall notify the DSPS in writing of the date, place and nature of the conviction or finding within 48 hours after the entry of the judgment of conviction.
- The DSPS no longer sends a physical copy of a new or renewed license/credential. You should receive an email or a letter from the DSPS telling you to go online to print the license/credential off of our website. There is also an option for you to order a printed wall certificate or a Governor signed wall certificate from the DSPS for an additional \$10. (Note: The DSPS prints the same document as is available to print at home.)
- If you fail to renew within five years after license/credential expiration, you may be required to complete additional requirements to restore your license/credential.
- Making a false statement in connection with any application for license/credential is grounds for revocation or denial.
- Full payment must be received by the DSPS before your license/credential will be issued. If you do not apply for renewal by the renewal deadline, your license/credential will expire and you may no longer practice.

COMPLETE ADDITIONAL INFORMATION BELOW.

020R1/16CH.440

Legal Status Statement:

69187 - 020

If you do not have a Social Security Number on file with us or are exempt from having a Social Security Number, and/or your legal status as a qualified alien or nonimmigrant lawfully present in the United States has changed since your last renewal (or the issuance of your license if you have not renewed before), please contact the Wisconsin Department of Safety and Professional Services at 608-266-2112 or dsp@wisconsin.gov. I have read and acknowledge this information.

Certification of Continuing Education: (check, sign and date below)

I have completed or will complete 30 hours* of AMA or AOA Category I Continuing Education, including two (2) hours of a Board-approved course related to the Board's Opioid Prescribing Guidelines, pursuant to Wis. Admin. Code ch. Med 13**, on or before December 31, 2017. I will furnish evidence of completion to the Medical Examining Board upon request.

*Three (3) months of approved post-graduate training is equivalent to 30 hours of Category I credits. Wis. Admin. Code ch. Med 13.04.

**Pursuant to Wis. Admin. Code ch. Med 13.02(1g)(b), physicians that do NOT hold a U.S. Drug Enforcement Administration number to prescribe controlled substances are NOT required to complete two (2) hours of a Board-approved course relating to the Board's Opioid Prescribing Guidelines.

Conviction Statement: (check one)

Since your initial licensure or last renewal, do you have any pending charges and/or have you been convicted of any crimes (does not include minor traffic violations that do not involve alcohol or drugs, such as speeding, running stoplights, and seat belt violations).

YES NO

Signature: _____ Date: _____

**State of Wisconsin
Department of Safety & Professional Services**

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Dale Kleven Administrative Rules Coordinator		2) Date When Request Submitted: 5/4/18 Items will be considered late if submitted after 12:00 p.m. on the deadline date: ▪ 8 business days before the meeting																
3) Name of Board, Committee, Council, Sections: Reentry to Practice Committee of the Medical Examining Board																		
4) Meeting Date: 5/16/18	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? Other States Information – Application, Renewal, and Reentry Requirements																
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? <input type="checkbox"/> Yes (Fill out Board Appearance Request) <input checked="" type="checkbox"/> No	9) Name of Case Advisor(s), if required:																
10) Describe the issue and action that should be addressed: 																		
<table style="width: 100%; border: none;"> <tr> <td style="width: 30%; border: none;">11)</td> <td style="width: 40%; border: none; text-align: center;">Authorization</td> <td style="width: 30%; border: none;"></td> </tr> <tr> <td style="border: none;"><i>Dale Kleven</i></td> <td style="border: none;"></td> <td style="border: none; text-align: right;"><i>May 4, 2018</i></td> </tr> <tr> <td style="border: none;">Signature of person making this request</td> <td style="border: none;"></td> <td style="border: none; text-align: right;">Date</td> </tr> <tr> <td style="border: none;">Supervisor (if required)</td> <td style="border: none;"></td> <td style="border: none; text-align: right;">Date</td> </tr> <tr> <td colspan="3" style="border: none;">Executive Director signature (indicates approval to add post agenda deadline item to agenda) Date</td> </tr> </table>				11)	Authorization		<i>Dale Kleven</i>		<i>May 4, 2018</i>	Signature of person making this request		Date	Supervisor (if required)		Date	Executive Director signature (indicates approval to add post agenda deadline item to agenda) Date		
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Directions for including supporting documents: 1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director. 3. If necessary, Provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.																		

CALIFORNIA

From the Medical Board of California website:

What is required to renew a license?

Payment of the renewal fee, the \$25 mandatory fee for the Physician Loan Repayment Program and the \$12 mandatory fee for the Controlled Substance Utilization Review and Evaluation System / Prescription Drug Monitoring Program (CURES/PDMP), and completion of the following sections of the license renewal application:

1. Certification that you have met the continuing medical education (CME) requirements for renewal or that you meet the conditions that would exempt you from all or part of the requirements
2. Certification that you have disclosed on the renewal form the names of health-related facilities in which you or your family have a financial interest
3. Response to the License Discipline/Conviction Question
4. Completion of the Physician Survey

Disciplinary Action Disclosure:

When renewing, each licensee must disclose whether they have had any license disciplined by a government agency or other disciplinary body, or, have been convicted of any crime in any state, the USA and its territories, military court or a foreign country. License includes permits, registrations and certificates.

Conviction includes a plea of no contest and any conviction that has been set aside or deferred pursuant to sections 1000 or 1203.4 of the Penal Code, including infractions, misdemeanor, and felonies. You do not need to report a conviction for an infraction with a fine of less than \$300 unless the infraction involved alcohol or controlled substances.

Discipline includes, but is not limited to, suspension, revocation, voluntary surrender, probation, or any other restriction.

Physician Survey

Upon renewal of a physician's license, the Medical Board is required to collect certain data (Business & Professions Code sections 803.1, 2425.1 and 2425.3). The data collected includes: activities in medicine, specialty, zip code within California of physicians who are treating patients, training status, ethnicity, and foreign language fluency.

The goal of the survey is to gain a better understanding of the physician workforce in California. While we know how many licensed physicians reside in the state, there is little information regarding the time that is spent in actual clinical practice, or the location or specialty of that practice. Foreign language and ethnicity responses are voluntary.

Failure to Renew:

Practicing medicine without a valid license may lead to disciplinary action against a physician.

There is no grace period; if a license has not been renewed within 30 days following the expiration date, the Licensing Program will notify the physician by certified mail. The date a license expires, the status is changed to "delinquent" if the renewal application and fees due are not received.

If a license is renewed more than 90 days following the expiration date, the licensee is required to pay a penalty fee equal to 50% of the renewal plus a delinquency fee equal to 10% of the renewal fee, in addition to the renewal fee. The renewal of an expired license is retroactive to the expiration date if it is renewed within six months of the expiration date.

After a license has been in "delinquent" status for five years, the license is automatically canceled. A canceled license may not be reactivated by simply paying delinquent fees and penalties. The physician must apply for a new license and meet the current licensure requirements.



MEDICAL BOARD OF CALIFORNIA

Licensing Program



APPLICATION

TYPE OF APPLICATION						MBC Use Only	
(Check One)		(Check All That Apply)				Application Type <input type="checkbox"/>	
<input type="checkbox"/> U.S. or Canadian Medical School Graduate <input type="checkbox"/> International Medical School Graduate		<input type="checkbox"/> Physician's and Surgeon's License <input type="checkbox"/> Postgraduate Training Authorization Letter (PTAL) <input type="checkbox"/> Update Application: File # _____ <input type="checkbox"/> Limited Practice License					
PRIORITY REVIEW & EXPEDITED LICENSURE							
<input type="checkbox"/> Honorably Discharged Veterans of the Armed Forces - Must supply satisfactory evidence to the Board that you have served as an active duty member of the Armed Forces of the United States and were honorably discharged.						Priority Review <input type="checkbox"/>	
<input type="checkbox"/> Practice in Medically Underserved Area or Population - Must supply satisfactory evidence to the Board that you have accepted employment and intend to practice in an area of California formally designated as an underserved area or underserved population. Please see further details on our website at http://www.mbc.ca.gov/Applicants/Physicians_and_Surgeons/Underserved.aspx .						<input type="checkbox"/>	
<input type="checkbox"/> Temporary License for Spouse of Active Duty Member of the Armed Forces - Must supply satisfactory evidence to the Board that you are married to, or in a domestic partnership or other legal union with, an active duty member of the Armed Forces of the United States who is assigned to a duty station in California under official active duty military orders. In addition, you must meet the requirements listed in Business and Professions Code Section 115.6.							
PERSONAL INFORMATION							
Type or Print Legibly							
1. Legal Name		Last	First	Middle	Suffix	Legal Name <input type="checkbox"/>	
2. Other Names/Alias							
3. United States Social Security Number (SSN) or Individual Taxpayer Identification Number (ITIN)					<input type="checkbox"/> SSN <input type="checkbox"/> ITIN	SSN/ITIN <input type="checkbox"/>	
4. Date of Birth		(mm/dd/yyyy)		5. Gender		<input type="checkbox"/> Male <input type="checkbox"/> Female	DOB Gender <input type="checkbox"/> <input type="checkbox"/>
6. Address of Record		Mailing Address (40 characters maximum per line, including spaces)				Address of Record <input type="checkbox"/>	
This address will be used for all current correspondence during the review process and will be posted on the Board's website upon issuance of a license. If you are using a P.O. Box please list a confidential street address below.		Mailing Address continued (40 characters maximum per line, including spaces)					
		City	State/Province	Zip/Postal Code	Country		
Confidential Address (Only required if Address of Record is a P.O. Box)						Confidential Address <input type="checkbox"/>	
7. Telephone Numbers		Home #	Work #	Cell #		Telephone Numbers <input type="checkbox"/>	
8. E-mail Address (Required)						Email <input type="checkbox"/>	
9.		Have you served or are you currently serving in the military?			<input type="checkbox"/> Yes <input type="checkbox"/> No		Military <input type="checkbox"/>
10.		Are you requesting expediting of this application as a spouse or domestic partner of an active duty member of the Armed Forces?			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/>
MBC Use Only				Pathway	School Code	L1A	
Cashiering							

APPLICANT: (Print Legal Name)	DATE OF BIRTH: (mm/dd/yyyy)	MBC Use Only <input type="checkbox"/> Name & DOB PG Training Programs <input type="checkbox"/>
ACGME or RCPSC ACCREDITED POSTGRADUATE TRAINING PROGRAMS (Internship, Residency and Fellowship Programs)		
16. Have you participated in any ACGME-accredited postgraduate training programs in the United States or RCPSC-accredited postgraduate training in Canada?		<i>(If NO, please skip to question #24)</i> <input type="checkbox"/> Yes <input type="checkbox"/> No
List every program (internship, residency and fellowship) in which you have participated or are currently participating, regardless of whether the program was completed or any credit was granted. <i>(Use the Addendum to Question #16 Form if additional space is needed)</i>		
Facility Name	City, State/Province	Specialty
		Dates of Training (mm/dd/yyyy)
		Start
		End
		Start
		End
		Start
		End
NOTE: A "yes" response to question 17-23 requires a signed and dated written explanation. The <i>Explanation For Application Question</i> form may be used to provide your explanation.		
17. Have you ever received partial or no credit for a postgraduate training program?		<input type="checkbox"/> Yes <input type="checkbox"/> No
18. Have you ever taken a leave of absence or break from your training?		<input type="checkbox"/> Yes <input type="checkbox"/> No
19. Have you ever been terminated, dismissed or expelled from a program?		<input type="checkbox"/> Yes <input type="checkbox"/> No
20. Have you ever been placed on probation for any reason?		<input type="checkbox"/> Yes <input type="checkbox"/> No
21. Have you ever been disciplined or placed under investigation?		<input type="checkbox"/> Yes <input type="checkbox"/> No
22. Have you ever had any limitations or special requirements placed upon you for clinical performance, professionalism, medical knowledge, discipline, or for any other reason?		<input type="checkbox"/> Yes <input type="checkbox"/> No
23. Have you ever had a postgraduate training program contract not be renewed or offered for a following year?		<input type="checkbox"/> Yes <input type="checkbox"/> No
MEDICAL LICENSE		
24. Have you ever held or do you currently hold a medical license in any U.S. state, U.S. territory, or Canadian province?		<input type="checkbox"/> Yes <input type="checkbox"/> No
List medical license information for all licenses ever held below. Do not list temporary, training, or provisional licenses. <i>(Use the Addendum to Question #24 Form if additional space is needed.)</i>		
U.S. State, U.S. Territory or Canadian Province	License Number	Dates of Practice (mm/yyyy to mm/yyyy)
		to
L1C		

APPLICANT: (Print Legal Name)	DATE OF BIRTH: (mm/dd/yyyy)	MBC Use Only <input type="checkbox"/>
ABMS CERTIFICATION		
25. Are you currently certified by a Member Board of the American Board of Medical Specialties?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Name & DOB ABMS <input type="checkbox"/>
MALPRACTICE HISTORY		
26. Has a claim or an action ever been filed against you for the practice of medicine that resulted in a malpractice settlement, judgment, or arbitration?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Malpractice History <input type="checkbox"/>
DISCIPLINARY HISTORY		
These questions refer to discipline by any hospital, Military or Public Health Service, State Board, or other Governmental Agency of any U.S. state, U.S. territory, Canadian province, or foreign country.		
27. Have you ever had your DEA privileges denied, suspended, restricted, or terminated?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Disciplinary History <input type="checkbox"/>
28. Have you ever entered into any arrangement, agreement or plea in lieu of federal prosecution with the DEA to resolve an alleged violation of a federal or state drug statute or regulation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
29. Have you ever withdrawn an application for medical licensure in lieu of denial, disciplinary action, or for any other similar reason?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
30. Have you ever been denied a license to practice medicine?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
31. Is any denial pending against you?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
32. Have you ever had any license to practice medicine subjected to any disciplinary action?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
33. Is any disciplinary action pending against any of your licenses to practice medicine?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
34. Have you ever surrendered a license to practice medicine?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
35. Have you ever had any license to practice medicine revoked, suspended, or placed on probation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
36. Have you ever had any license to practice medicine subjected to any action including, <i>but not limited to</i> , informal or confidential discipline, consent orders, letters of warning, letters of reprimand, or citation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
37. Have you ever been charged with, or been found to have committed unprofessional conduct, professional incompetence, gross negligence, or repeated negligent acts by any medical licensing board or hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
38. Have you ever resigned from a medical staff in lieu of disciplinary or administrative action?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
39. Is any disciplinary action pending against your hospital or staff privileges?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
40. Have you ever had staff privileges in a hospital terminated, denied, suspended, limited, revoked, or not renewed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
41. Have you ever had any healing arts license or certificate disciplined by another state or federal territory?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
NOTE: A "yes" response to question 26-41 requires a signed and dated written explanation. The <i>Explanation For Application Question</i> form may be used to provide your explanation.		

L1D

APPLICANT: (Print Legal Name)	DATE OF BIRTH: (mm/dd/yyyy)	MBC Use Only <input type="checkbox"/>
CRIMINAL RECORD HISTORY		Name & DOB <input type="checkbox"/>
<p>Applicants who answer “NO” to the questions below, but have a previous conviction or plea, may have their application denied for knowingly falsifying the application. If in doubt as to whether a conviction should be disclosed, it is best to disclose the conviction on the application.</p> <p>For each conviction, you must submit certified copies of the arresting agency report, certified copies of the court documents (court docket) and a signed and dated descriptive explanation of the circumstances surrounding the conviction (i.e., dates and location of the incident and all circumstances surrounding the incident). If the documents were purged by the arresting agency and/or court, a letter of explanation from these agencies is required. In addition, you may submit evidence of rehabilitation.</p>		Criminal History <input type="checkbox"/>
42. Have you ever been convicted of, or pled guilty or nolo contendere to ANY offense in the United States, its territories, or a foreign country? <i>This includes every citation, infraction, misdemeanor and/or felony, including traffic violations. Convictions that were adjudicated in the juvenile court or convictions under California Health and Safety Code sections 11357(b), (c), (d), (e), or section 11360(b) which are two years or older should NOT be reported. Convictions that were later expunged from the record of the court or set aside pursuant to section 1203.4 of the California Penal Code or equivalent non-California law MUST be disclosed.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
43. Exclusive of juvenile court adjudications and criminal charges dismissed under section 1000.3 of the California Penal Code or equivalent non-California laws, or convictions under California Health and Safety Code section 11357(b), (c), (d), (e), or section 11360(b) which are two years or older, have you had a charge or conviction that was set aside or later expunged from the record of the court?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
44. Is any criminal action pending against you, or are you currently awaiting judgment and sentencing following entry of a plea or jury verdict?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
45. Are you a registered sex offender?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
PRACTICE IMPAIRMENT OR LIMITATIONS		
An affirmative answer to any of the questions below will require the Board to make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are eligible for licensure. Please note that a Limited Practice License may be available. Refer to the <i>Application Information for a Limited Practice License</i> for further information.		Limitations <input type="checkbox"/>
46. Have you ever been enrolled in, required to enter into, or participated in any drug, alcohol, or substance abuse recovery program or impaired practitioner program?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
47. Have you ever been treated for or had a recurrence of a diagnosed addictive disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
48. Have you ever been diagnosed with an emotional, mental, or behavioral disorder that may impair your ability to practice medicine safely?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
49. Have you ever been diagnosed with a neurological or other physical condition that may impair your ability to practice medicine safely?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
50. Do you have any other condition that may in any way impair or limit your ability to practice medicine safely?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
51. Do you suffer from a progressive disorder or a health condition that will likely result in a general decline in health or function that may impair or limit your ability to practice medicine safely?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
NOTE: A “yes” response to question 42-51 requires a signed and dated written explanation. The <i>Explanation For Application Question</i> form may be used to provide your explanation.		L1E

PHOTOGRAPH

Photograph

Affix a 2" X 2" Photo Here

Photo Must Be Recent and Must Be of your Head and Shoulder Areas Only

Altered Photographs are NOT Acceptable

Notice: All items in this application are mandatory. Failure to provide any of the requested information will delay the processing of your application. The information provided will be used to determine your qualifications for licensing per Section 2080 of the California Business and Professions Code, which authorizes the collection of this information. The information on your application may be transferred to other medical licensing authorities, the Federation of State Medical Boards, or other governmental law enforcement agencies. You have the right to review your application subject to the provisions of the Information Practices Act. The Chief of the Licensing Program is the custodian of records.

DECLARATION

The applicant, _____, **PRINT LEGAL NAME (First, Middle, Last, Suffix)**, _____, **DATE OF BIRTH (mm/dd/yyyy)**

being first duly sworn upon his/her oath deposes and says: that I am the person herein named subscribing to this application; that I have read the complete application, know the full content thereof, and declare under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; that I am the lawful holder of the degree of Doctor of Medicine as prescribed by this application, that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, were procured without fraud or misrepresentation or any mistake of which I am aware and that I am the lawful holder thereof. Further, I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past, present and future), or business and professional associates (past, present, and future), and all government agencies (local, state, federal, or foreign) to release to the Medical Board of California or its successors any information, files or records, including medical records, educational records, and records of psychiatric treatment and treatment for drug, alcohol and/or substance abuse or dependency, requested by that Board in connection with this application; or any further or future investigation by that Board necessary to determine any medical competence, professional conduct, or physical or mental ability to safely engage in the practice of medicine. I further authorize the Medical Board of California or its successors to release, in any investigation or proceeding, to the organizations, individuals or groups listed above any information which is material to this application or any subsequent licensure.

I UNDERSTAND THAT ANY OMISSION, FALSIFICATION OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT HERETO IS A SUFFICIENT BASIS FOR DENYING OR REVOKING A LICENSE.

SIGN LEGAL NAME: _____ **DATE:** _____

NOTARY SECTION

SIGNATURE OF APPLICANT: _____
(SIGN LEGAL NAME IN THE PRESENCE OF NOTARY)

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of _____

County of _____

Subscribed and sworn to (or affirmed) before me on this _____ day of _____, 20____,

by, _____ proved to me on the basis of satisfactory evidence
(PRINT APPLICANT'S LEGAL NAME)

to be the person who appeared before me.

NOTARY SEAL

SIGNATURE OF NOTARY PUBLIC

**MBC
Use Only**

Rev L1A-F

Staff Initials
& Date

Photograph

Applicant
Name & DOB

Applicant
Signature
& Date

Applicant
Signature

Applicant
Name &
Notary Date

Notary
Signature
& Seal

L1F

FLORIDA

From the Florida Board of Medicine website:

The department will renew your license upon receipt of:

1. Completed Renewal application
2. Evidence that you have practiced medicine or have been on the active teaching faculty of an accredited medical school for at least two years of the immediately preceding four years*
3. Verification of your current status relating to prescribing controlled substances for the treatment of chronic nonmalignant pain
4. Required fees (renewal and background screen fees).
5. Your current primary place of practice address
6. Login to complete Telehealth Survey
7. Login to verify your practitioner profile
8. Complete the financial responsibility form
9. Confirmation of required continuing education hours reported into the continuing education tracking system, CE Broker.

* If you have not actively practiced medicine for at least two years of the immediately preceding four years, the board shall require you to successfully complete a board-approved clinical competency examination prior to renewal of your license. The board has approved the Special Purpose Examination of the Federation of State Medical Boards of the United States (SPEX) as the board-approved clinical competency examination that must be completed prior to renewal of the license. For the purpose of this section, “actively practiced medicine” means the practice of medicine by physicians, including those employed by any governmental entity in community or public health, as defined in Chapter 458, Florida Statutes, including physicians practicing administrative medicine.

Any person holding an active license to practice medicine in the state may convert that license to a limited license for the purpose of providing volunteer, uncompensated care for low-income Floridians. The applicant must submit a statement from the employing agency or institution stating that he or she will not receive compensation for any service involving the practice of medicine. The application and all licensure fees, including neurological injury compensation assessments, shall be waived.

To ensure you receive notification from the department regarding the renewal, you must have on file with the department your current mailing address. Failure to renew an active or inactive license by the expiration date will result in the license being placed in delinquent status. Failure by a delinquent licensee to become active or inactive before the expiration of the current licensure cycle renders the license null and void without any further action by the board or the department.

Licensees requesting to reactivate their license from inactive or retired status are required to pay additional fees and comply with specific continuing education requirements. Please contact the board office at info@flboardofmedicine.gov to request your reactivation requirements.

A licensee who remains on inactive status for more than two consecutive biennial licensure cycles and who wishes to reactivate the license may be required to demonstrate the competency to resume active practice by sitting for a special purpose examination or by completing other reactivation requirements.

**MEDICAL DOCTOR
APPLICATION FOR LICENSURE**

Apply for your license online at www.flboardofmedicine.gov

Choose your application type:

- Endorsement (1021) Examination (1024)
- Military Veterans Fee Waiver

If you were honorably discharged from the U.S. armed services within 60 months of your application you will qualify for a waiver of the application fee and the initial licensure fee. In order to qualify, please check the box above indicating that you are seeking a waiver and submit a **DD-214 or NGB-22 form as proof of honorable discharge.**

- I plan to dispense medicinal drugs in the State of Florida for a fee or other remuneration and hereby register as required by Section 465.0276, F.S. I understand that the fee for the Dispensing Practitioner is \$100.00 in addition to the required initial license fee and will submit it along with the license fee.

1. PERSONAL INFORMATION

Name: _____ **Date of Birth:** _____
Last/Surname First Middle MM/DD/YYYY

Mailing Address: (The address where mail and your license should be sent)

Street/ PO Box Suite/Apt. No City

State Zip Country Phone Number

Physical Location: A Post Office Box is not acceptable. This address will be posted on the Department of Health's website. *If you do not have a current practice address, your mailing address will be used. When you obtain a practice address, you will be required to update your online practitioner profile.*

Street/ P.O. Box Suite/Apt. No City

State Zip Country Alternate Phone Number

Email Address: _____

Under Florida law, email addresses are public records. If you do not want your e-mail address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

Equal Opportunity Data: We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43 CFR 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female RACE: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Hispanic <input type="checkbox"/> Other

Yes No **Availability for Disaster:** Will you be available to provide health care services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster?

2. MEDICAL EDUCATION HISTORY

Federal Credentials Verification Services (FCVS) is not a requirement for licensure. FCVS will primary source verify and provide a copy of the medical school transcript(s), medical school diploma, medical school verification, name change document(s), national examination score report, ECFMG certificate, ECFMG verification and postgraduate training verifications. For more information about FCVS, visit their web-site at www.fcvs.org/.

Yes No Are you using the FCVS to verify your core credentials?

Yes No Have you completed the equivalent of 2 academic years of preprofessional, postsecondary education including, courses in anatomy, biology and chemistry prior to entering medical school?

Medical Education:

List in chronological order all medical schools attended, whether completed or not. Submit on a separate sheet if needed.

Medical School Name and Address:	From: (mm/yy)	To: (mm/yy)	Date Degree Received:

Fifth Pathway Certificate Holders:

If you answer "yes" to any of the following questions, you must request verifications to be sent directly to the Board office.

Yes No Did you attend an international medical school and do not possess a valid ECFMG Certificate?

Yes No Did you receive a bachelor's degree from an accredited United States college or University?

Yes No Did you study at a medical school which is recognized by the World Health Organization?

Yes No Did you complete all of the formal requirement of the International medical school, except the internship or social service requirements, and pass part I of the National board of Medical examination or the Education Commission for Foreign Medical Graduates Examination equivalent?

Yes No Did you complete an academic year of supervised clinical training in a hospital affiliated with a medical school approved by the Council on Medical Education of the American Medical Association and upon completion passed part II of the National Board of Medical Examiners examination or the Education Commission for Foreign Medical Graduates examination Equivalent?

Postgraduate Training:

Provide the following documentation to support your postgraduate training:

- Post-Graduate Training Form

In the table below list, in chronological order, all postgraduate training from the date you graduated from medical school to the present. Start with your first program and end with your last or current program. List all programs you began, whether you completed or received credit for the training.

Program Name and Full Mailing Address:	Specialty Area:	From: (mm/yy)	To: (mm/yy)	Did you receive credit? (Y/N)

Loan History:

- Yes No Are you currently in default on any health education loan or scholarship obligation?
(If "yes", explain on a separate sheet providing accurate details.)

3. EXAMINATION HISTORY

State Board (prior to 1974), State Board (after 1974) & SPEX, LMCC & SPEX, NBME, FLEX, USMLE III, or Combination (prior to 2000)

Request that the score report be sent directly to the Board of Medicine. NOTE: If you took a state Board examination and are not currently licensed in three other states, you must also request your SPEX score be sent.

Exam taken: _____ Date passed: _____
mm/dd/yy

4. LICENSURE HISTORY

Request verification of licensure status directly from the licensing entity or www.veridoc.org. Request international license verification(s) if you have practiced outside of the U.S. for at least two of the previous four years.

Yes No Do you now hold or have you ever held a license to practice medicine or any other profession in any US State or territory, or foreign country? Please list in table below.

Jurisdiction	Profession	License number

If you answer “yes” to any of the questions in this section, you are required to send an explanation and supporting documentation.

Yes No Have you had any application for a medical license or professional license denied by any state board or other governmental agency of any state, territory, or country?

Yes No Are you currently under investigation in any jurisdiction for an act or offense that would constitute a violation of Section 458.331, Florida Statutes?

Yes No Have you ever had any professional license or license to practice medicine revoked, suspended, placed on probation, or other disciplinary action taken in any state, territory or country?

5. PRACTICE/EMPLOYMENT HISTORY

List the year you legally first began to practice medicine, _____(yyyy). This would be the year you began practicing medicine and could be the date you began your postgraduate training.

Yes No Have you practiced medicine in another jurisdiction for two of the last four years **or** completed a board approved post-graduate training program within the last two years?

Yes No If your answer to the question above was “No,” have you passed a board approved clinical competency exam within the last year? If yes, then submit supporting documentation.

List in chronological order all employment for the last four (4) years.

Name and address of practice or employment	Type of employment	From: mm/yy	To: mm/yy

Yes No Do you currently hold staff privileges in any hospital, health institution, clinic or medical facility? List each facility below.

Name of facility

If you answer “yes” to the following questions, you are required to send an explanation and supporting documentation.

- Yes No Have you ever had any staff privileges denied, suspended, revoked, modified, restricted, not renewed, or placed on probation, or have you been asked to resign or take a temporary leave of absence or were otherwise acted against by any facility?
- Yes No Do you currently, or have you had, responsibility for graduate medical education within the last 10 years?

In the table below, list all institutions where you have had responsibility for graduate medical education or faculty appointment(s) at any medical school.

Name of institution

Yes No Are you certified by any specialty board recognized by the American Board of Medical Specialties or specialty board approved by the Florida Board of Medicine?

Board Name	Certification/ Specialty/Sub-Specialty	Date of Certification (mm/yy)

If you answer “yes” to any of the following questions, please explain on a separate sheet providing accurate details.

- Yes No Have you ever had any final disciplinary action taken against you by a specialty board or other similar national organization?
- Yes No Have you ever been denied or surrendered a DEA registration?

6. CRIMINAL HISTORY

If you answer "Yes" to the following question you are required to send the following items:

- a. Self-explanation describing in detail the circumstances surrounding each offense, including dates, city and state, charges and final results.
- b. Final Dispositions and Arrest Records for all offenses. The Clerk of the Court in the arresting jurisdiction will provide you with these documents. Unavailability of these documents must come in the form of a letter from the Clerk of the Court.
- c. Completion of Sentence Documents. You may obtain documentation from the Department of Corrections. The report must include the start date, end date and that the conditions were met.

- Yes No Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, **even if adjudication was withheld. Driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question.**
- Yes No I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the "Privacy Statement" document from the Federal Bureau of Investigation.

7. MILITARY HISTORY

- A. Yes No Have you ever been in the United States Military and/or Public Health Service?
- B. Yes No Have you ever been disciplined by any branch of the United States Armed Services or Public Health Services? If you answered "yes" please provide a detailed explanation and supporting documentation

8. CRIMINAL AND MEDICAID/MEDICARE FRAUD QUESTIONS

Applicants for licensure, certification or registration and candidates for examination may be excluded from licensure, certification or registration if their felony conviction falls into certain timeframes as established in Section 456.0635(2), Florida Statutes. If you answer "Yes" to any of the following questions, please provide a written explanation for each question. Supporting documentation includes court dispositions or agency orders where applicable.

1. Yes No Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction?

If you responded "No" to the question above, skip to question 2.

- a. Yes No If "yes" to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence and completion of any subsequent probation?
- b. Yes No If "Yes" to 1, for felonies of the third degree, has it been more than 10 years from the date of the plea, sentence and completion of any subsequent probation? (This question does not apply to felonies of the third degree under Section 893.13(6)(a), Florida Statutes)
- c. Yes No If "Yes" to 1, for the felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years from the date of the plea, sentence and completion of any subsequent probation?
- d. Yes No If "Yes" to 1, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or charges dismissed?
2. Yes No Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)?

If you responded “No” to the question above, skip to question 3.

a. Yes No If “Yes” to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended?

3. Yes No Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes?

If you responded “No” to the question above, skip to question 4.

a. Yes No If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years?

4. Yes No Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid Program?

If you responded “No” to the question above, skip to question 5.

a. Yes No Have you been in good standing with a state Medicaid program for the most recent five years?

b. Yes No Did the termination occur at least 20 years before the date of this application?

5. Yes No Are you currently listed on the United States Department of Health and Human Services Office of Inspector General’s List of Excluded Individuals and Entities?

If you answer “Yes” to the questions below, you are required to send the following items:

- **A statement indicating the date of each incident and the number for each case.**
- **An explanation of details for each case and your involvement for each case.**
- **Submit the enclosed Exhibit 1 form.**
- **A copy of the complaint, judgments and/or settlements for each case.**
- **Submit a complete copy of the trial record(s) of each case, including the trial transcript, evidentiary exhibits and final judgment in electronic format.**

Yes No Have you ever had a judgment entered against you for medical malpractice where the incident(s) of malpractice occurred after November 2, 2004?

Yes No Within the last 10 years have you had any liability claim(s) or action(s) for damages for personal injury settled or finally adjudicated in an amount that exceeds \$100,000.00?

10. FINANCIAL RESPONSIBILITY

The Financial Responsibility options are divided into two categories, coverage and exemptions. Check only one option of the ten provided as required by s. 458.320, Florida Statutes.

Category I: Financial Responsibility Coverage

- 1. I do not have hospital staff privileges, I do not perform surgery at an ambulatory surgical center and I have established an irrevocable letter of credit or an escrow account in an amount of \$100,000/\$300,000, in accord with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.
- 2. I have hospital staff privileges or I perform surgery at an ambulatory surgical and I have established an irrevocable letter of credit or escrow account in an amount of \$250,000/\$750,000, in accord with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.
- 3. I do not have hospital staff privileges, I do not perform surgery at an ambulatory surgical center and I have obtained and maintain professional liability coverage in an amount not less than \$100,000 per claim, with a minimum annual aggregate of not less than \$300,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F. S., from a risk retention group as defined under s. 627.942, F. S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self-insurance as provided in s. 627.357, F. S.
- 4. I have hospital staff privileges or I perform surgery at an ambulatory surgical and I have professional liability coverage in an amount not less than \$250,000 per claim, with a minimum annual aggregate of not less than \$750,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F. S., from a risk retention group as defined under s. 627.942, F. S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self-insurance as provided in s. 627.357, F. S.
- 5. I have elected not to carry medical malpractice insurance however, I agree to satisfy any adverse judgments up to the minimum amounts pursuant to s. 458.320(5)(g)1, F. S. I understand that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. I understand that such a sign or notice must contain the wording specified in s. 458.320(5)(g), F. S.

Category II: Financial Responsibility Exemptions

- 6. I practice medicine exclusively as an officer, employee, or agent of the federal government, the state, or its agencies or subdivisions.
- 7. I hold a limited license issued pursuant to s. 458.317, F. S., and practice only under the scope of the limited license.
- 8. I do not practice medicine in the State of Florida.
- 9. I meet all of the following criteria:
 - (a) I have held an active license to practice in this state or another state or some combination thereof for more than 15 years;
 - (b) I am retired or maintain part time practice of no more than 1000 patient contact hours per year;
 - (c) I have had no more than two claims resulting in an indemnity exceeding \$25,000 within the previous five-year period;
 - (d) I have not been convicted of or pled guilty or nolo contendere to any criminal violation specified in Chapter 458, F. S. or the medical practice act in any other state; and
 - (e) I have not been subject, within the past ten years of practice, to license revocation, suspension, or probation for a period of three years or longer, or a fine of \$500 or more for a violation of Chapter 458, F. S., or the medical practice act of another jurisdiction. A regulatory agency's acceptance of a relinquishment of license, stipulation, consent order, or other settlement offered in response to or in anticipation of filing of administrative charges against a license is construed as action against a license. I understand if I am claiming an exception under this section that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. See Section 458.320(5)(f), Florida Statutes, for specific notice requirements.
- 10. I practice only in conjunction with my teaching duties at an accredited medical school or its teaching hospitals. (Interns and residents do not qualify for this exemption).

If you select an exemption based on number 9, you must also complete the affidavit on the following page.

BOARD OF MEDICINE
Financial Responsibility Affidavit of Exemption

This affidavit is only required if you are claiming an Exemption based on number 9 on the preceding page.

I, _____, do hereby certify and attest that I meet all of the following criteria:

- (a) I have held an active license to practice in this state or another state or some combination thereof for more than 15 years;
- (b) I am retired or maintain part time practice of no more than 1000 patient contact hours per year;
- (c) I have had no more than two claims resulting in an indemnity exceeding \$25,000 within the previous five-year period;
- (d) I have not been convicted of or pled guilty or nolo contendere to any criminal violation specified in Chapter 458, F. S. or the medical practice act in any other state; and
- (e) I have not been subject, within the past ten years of practice, to license revocation, suspension, or probation for a period of three years or longer, or a fine of \$500 or more for a violation of Chapter 458, F. S., or the medical practice act of another jurisdiction. A regulatory agency's acceptance of a relinquishment of license, stipulation, consent order, or other settlement offered in response to or in anticipation of filing of administrative charges against a license is construed as action against a license. I understand if I am claiming an exception under this section that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. See Section 458.320(5) (f), F.S., for specific notice requirements.

Dated: _____

Signature: _____

STATE OF _____
COUNTY OF _____

Sworn to (or affirmed) and subscribed before me this _____ day of _____, by

(Signature of Notary Public - State of Florida)

(Print, Type, or Stamp Commissioned Name of Notary Public)

Personally Known _____ OR Produced Identification _____

Type of Identification Produced _____

11. FLORIDA BIRTH RELATED NEUROLOGICAL COMPENSATION ASSOCIATION

You must choose one of the three options described below. Please be sure to view the information about each exemption at www.nica.com. Check only one.

- | | | | |
|--------------------------|--------------------------|--------------------------|-----------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| \$5,000 | \$250 | \$0 | |
| Participating | Non-participating | Exempt | Amount enclosed |

If you choose "\$0 Exempt" provide appropriate documentation to the Board of Medicine and to NICA.

I have read the explanatory information provided by NICA, and I choose the option above.

_____	_____	_____
Signature	Date	Name

		Street Address

		City, State, Zip

If you are a participating or non-participating physician, or a physician claiming exemption, you must complete, sign and date this form and return it with your payment to this address.

Board of Medicine
4052 Bald Cypress Way, #C-03
Tallahassee, FL 32399-3253

If you are a physician claiming exemption, you must also send a copy of your completed, signed, and dated form with proof of your exemption to:

NICA
2360 Christopher Place
Tallahassee, FL 32308

If you have any questions about NICA or this form, please contact NICA at www.nica.com or (850) 488-8191.

12. STATEMENT OF APPLICANT

I state that these statements are true and correct. I recognize that providing false information may result in denial of licensure, disciplinary action against my license, or criminal penalties pursuant to Sections 456.067, 775.083, and 775.084, Florida Statutes. I state that I have read Chapters 456, 458 and 766.301-.316, Florida Statutes and Chapter 64B8, Florida Administrative Code.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Florida Board of Medicine information which is material to my application for licensure.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind. I state that my answers and all statements made by me herein are true and correct.

Should I furnish any false information in this application, I hereby agree that such act constitutes cause for denial, suspension, or revocation of my license to practice medicine in the State of Florida. If there are any changes to my status or any change that would affect any of my answers to this application I must notify the board within 30 days.

I understand that my records are protected under federal and state regulations governing Confidentiality of Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my records are protected under federal and state regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it.

Print name

Signature

Date

IOWA

From the Iowa Board of Medicine website:

Reinstating When License Is Inactive for Up to One Year

To reinstate a license that has been inactive for up to one year, licensee must do the following:

- Submit an application for reinstatement to the board
- Provide documentation of completion of Category 1 continuing medical education (CME), training for identifying and reporting abuse to children and/or dependent adults, chronic pain management training, and end-of-life training, if applicable
- Submit the reinstatement fee.

The number of CMEs required to reinstate a license would be the same amount that would have been required on the most recent license renewal. No hours earned in the inactive period may be carried over to a future license period. Training for identifying and reporting child abuse or dependent adult abuse is required every five years of physicians who provide primary care to adults and/or children. Click here to read about [Training for Identifying and Reporting Abuse of Children and/or Dependent Adults](#).

The board requires physicians who provide primary care to patients to complete 2 hours each of Category 1 credits for [Chronic Pain Management and End-of-Life Care](#) every five years. These requirements became effective August 17, 2011. Physicians who had permanent Iowa licenses on August 17, 2011, have until August 17, 2016, to complete the training, and then once every five years thereafter. The board encourages physicians to pursue this CME credit as soon as possible. If a physician's CME documentation is audited for cause or randomly after August 17, 2016, and there is no evidence they received the required CME prior to August 17, 2016, the physician would be in non-compliance with the administrative rule.

Upon receiving the completed application, staff may administratively reinstate the license and it will expire on the renewal date that would have been in effect if the licensee had renewed the license before the license expired.

The applicant who fails to submit all reinstatement information required within 365 days of the license's inactive date shall be required to meet the reinstatement requirements for licensees who have been inactive for more than twelve months.

Reinstating After License Is Inactive for More Than One Year

An individual whose license has been inactive for more than one year must do the following:

- Submit an application for reinstatement to the board
- Submit the non-refundable fee, which includes a criminal history background check
- Provide documentation of completion of 40 hours of Category 1 CME within the previous two years
- Provide documentation of completion of training for identifying and reporting abuse of children and/or dependent adults, chronic pain management, and end-of-life training, if applicable
- Verify other state licenses and any new post-graduate training since the licensee was originally licensed

- If the physician has not engaged in active practice in the past three years in any jurisdiction of the United States or Canada, the board may require the applicant to:
 - Successfully pass a competency evaluation approved by the board
 - Successfully pass SPEX, COMVEX-USA, or another examination approved by the board
 - Successfully complete a retraining program arranged by the physician and approved in advance by the board
- An individual who is able to submit a letter from the board with different reinstatement or reactivation criteria is eligible for reinstatement based on those criteria.

Licenses expired more than five years are considered relinquished and shall not be reinstated, reissued, or restored.

Application for Iowa Physician License

IOWA BOARD OF MEDICINE

400 S.W. 8th Street, Suite C, Des Moines, IA 50309-4686, (515)-281-6641

Section 1—Type of License

Indicate the type of license you are applying for below. If you have questions about the type of license you should apply for, call (515) 281-6641.

Permanent License—\$505 Application Fee

This license allows an M.D. or D.O. to practice medicine and surgery or osteopathic medicine and surgery in Iowa.

Resident License—\$205 Application Fee

This license is for physicians who are entering a post-graduate training program in Iowa. A resident license restricts a physician's practice to the board-approved program listed in Section 15 of the application and is valid only for practice within that program under the supervision of a licensed physician.

Special License—\$355 Application Fee

This license is for physicians who do not meet qualifications for permanent licensure, but are held in high esteem for their unique contributions to medicine and are being appointed as a member of the academic staff at a college of medicine or osteopathic medicine. A special license restricts a physician's practice to the college of medicine or osteopathic medicine.

Temporary License—\$155 Application Fee

This license is for physicians who are participating in one of the following board approved activities. Temporary licensure is not meant to be used as a way for a physician to practice before permanent licensure is granted. It is not intended for locum tenens physicians. Indicate which board approved activity you will be participating in.

Covering for an Iowa licensed physician who unexpectedly is not available to provide medical care to his/her patients.

Demonstrating or proctoring that involves providing hands-on patient care to patients in Iowa.

Conducting a procedure on a patient in Iowa when the consultant's expertise in the procedure is greater than that of the Iowa-licensed physician who requested the procedure.

Providing medical care to patients in Iowa if the physician is enrolled in an out-of-state resident training program and does not hold a resident or permanent license in the home state of the resident training program.

Serving as a camp physician.

Participating as a learner in a program of further medical education that allows hands-on patient care when the physician does not currently hold a license in good standing in any United States jurisdiction.

Another activity approved by the Board.

Reinstatement of Inactive Iowa License—\$555 Application Fee

This process applies only to physicians who hold a permanent Iowa license that has been inactive for more than 12 months.

Applicant Name:

Do you Qualify for Expedited Endorsement?

PLEASE READ

If you are applying for a permanent medical license, you may qualify for expedited endorsement. Expedited endorsement is a process that allows physicians who meet certain criteria to submit fewer application items as part of the licensure process.

Answer the following questions to determine if you qualify. If you answer “yes” to all of them, you qualify for expedited endorsement. The items listed below are the items from the application checklist you will not need to submit.

	YES	NO
1. Do you hold at least one permanent/full U.S. state/jurisdiction or Canadian medical license? (Training, temporary, limited licenses do not qualify).		
2. Do you have a permanent/full license without restrictions in every jurisdiction that you are licensed in?		
3. Have you practiced within the past five years? Practice must be continuous & active and outside of a training program.		
4. Are you free of any formal disciplinary actions, or active or pending investigations by a board, licensing authority, medical society, professional society, hospital, medical school, federal agency or institution staff sanctions in any state, country or jurisdiction?		
5. Do you hold current specialty board certification by an ABMS or AOA specialty board, excluding lifetime certification?		
6. Do you meet the minimum requirements for licensure? <u>For U.S. or Canadian Graduates:</u> <ul style="list-style-type: none">• Hold a medical degree• Completed one-year of post-graduate training that is approved (ACGME, AOA, RCPSC, or CFPC accredited) by the board• Passed a licensing exam <u>For International Medical Graduates</u> <ul style="list-style-type: none">• Hold a medical degree• Have a valid certification status with the ECFMG• Completed two-years of post-graduate training that is approved (ACGME, AOA, RCPSC, or CFPC accredited) by the board• Passed a licensing exam		

If you answered “yes” to all of the above questions, you do not need to submit the following items from the application checklist that is contained in this application packet.

Certification of Medical Education
Transcript of Medical Education
Copy of Diploma
Verification of Post-Graduate Training
ECFMG Certification Status Report & ECFMG Certificate

If board staff determines you do not qualify for expedited endorsement, you will be notified and requested to provide items needed for regular processing of the application. Board staff has the discretion to request information from the applicant that is required of regular processing if needed when reviewing expedited endorsement applicants.

Applicant Name:

Section 3—Birth Information

Complete every item. Provide your date of birth in month/day/year format.

Date of Birth:

City of Birth:

State of Birth:

Country of Birth:

Father's Full Name:

Mother's Full Name:

Section 4—Medical Education

List all medical schools you have attended, even those you did not graduate from. Provide an explanation below if 1) it took longer than five years or fewer than four years to complete your medical education, 2) had a break in your medical education, or 3) the end date of your education is different than the date of your degree.

Institution	City, State, Country	From (Mo/Yr)	To (Mo/Yr)

Degree Received:

Date of Degree (Mo/Yr):

A copy of my diploma is submitted herewith. I further state that I am the identical person to whom this diploma was granted, that the same was procured in the regular course of study without fraud or misrepresentation and that the copy presented is a true copy.

Explanation:

If you are an international medical graduate, are you currently certified by the Educational Commission for Foreign Medical Graduates (ECFMG) or did you complete a Fifth Pathway Program?

ECFMG: Yes No

Fifth Pathway Program: Yes No

Applicant Name:

Section 5—Post-Graduate Medical Training

List all post-graduate training programs you have attended in the United States or Canada, even those you did not complete. List internships, residencies, and fellowships separately. Applicants applying for a special or temporary license must also list post-graduate training programs attended outside the United States or Canada.

Name of Facility: Address: (Street, City, County, State, Zip)	From (Mo/Yr)	To (Mo/Yr)			
Type of Training:	Intern	Resident	Chief Resident	Fellow	Research
Program Specialty:					

Name of Facility: Address: (Street, City, County, State, Zip)	From (Mo/Yr)	To (Mo/Yr)			
Type of Training:	Intern	Resident	Chief Resident	Fellow	Research
Program Specialty:					

Name of Facility: Address: (Street, City, County, State, Zip)	From (Mo/Yr)	To (Mo/Yr)			
Type of Training:	Intern	Resident	Chief Resident	Fellow	Research
Program Specialty:					

Name of Facility: Address: (Street, City, County, State, Zip)	From (Mo/Yr)	To (Mo/Yr)			
Type of Training:	Intern	Resident	Chief Resident	Fellow	Research
Program Specialty:					

Applicant Name:

Section 8— Medical/Osteopathic License Information

List all state and Canadian provinces where you currently hold or have held any type of medical/osteopathic license. Do not guess on the license number or original issue date of your license, verify the information with the licensing agency prior to completing the application. You will be requested to correct any incorrect information. Applicants applying for a special or temporary license must also list licenses held outside the United States or Canada.

Not Applicable, check here if you have never held any medical/osteopathic licenses.

State/Country	License Number	Original Issue Date (Mo/Yr)	License Type (i.e. Training, Permanent)

Section 9— Other Professional License Information

List all state and Canadian provinces where you currently hold or have ever held any professional license, such as a chiropractic, nursing, or physician assistant license. Applicants applying for a special or temporary license must also list licenses held outside the United States or Canada.

Not Applicable, check here if you have not held any other professional licenses.

State/Country	License Number	Original Issue Date (Mo/Yr)	License Type & Profession (i.e. Training/Nurse)

Applicant Name:

Section 10—Examination Information

Indicate the license examination you have taken. If you took a combination of examinations, indicate all that are applicable to your examination history. Applicants who took longer than ten years to pass the USMLE or COMLEX are required to be specialty board certified by a member board of the American Board of Medical Specialties or the American Osteopathic Association. Applicants who do not meet this rule will need to request a waiver of this licensure rule. Contact the Director of Licensure & Administration at (515) 281-6492 to discuss requesting a waiver of this rule.

USMLE	Did you pass Steps 1-3 within ten years?	Yes	No
COMLEX	Did you pass Levels 1-3 within ten years	Yes	No
NBME			
NBOME			
FLEX			
LMCC			
State Board Examination	State:		
SPEX Examination within the last ten years			
Not Applicable			

Section 11—Practice Information

List your proposed Iowa practice or proposed post-graduate training location. If it is unknown, please explain. Indicate if you are specialty board certified by an American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) specialty board. If you are applying for a temporary or special license, list the specialties for which you are certified and indicate in which country.

Proposed Iowa Practice or Proposed Post-Graduate Training Program Address:
(Institution/Group, Street, City, State, Zip Code)

Are you ABMS specialty board certified?	Yes	No
Are you AOA specialty board certified?	Yes	No
Are you specialty certified in another country?	Yes	No
Specialty:	Date Certified:	Country:
1.	1.	1.
2.	2.	2.
3.	3.	3.

Applicant Name:

Section 12— Question Definitions

It is important to review the definitions below before answering the questions in this section.

"Ability to practice medicine with reasonable skill and safely" means all of the following:

The cognitive capacity to make appropriate clinical diagnoses, to exercise reasoned medical judgments and to learn and keep abreast of medical developments; The ability to communicate medical judgments and information to patients and other health care providers; and The capability to perform medical tasks such as physical examinations and surgical procedures, with or without the use of aids or devices.

"Medical condition" means any physiological, mental or psychological condition, impairment or disorder, including drug addiction and alcoholism.

"Chemical substances" means alcohol, legal and illegal drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" The medical condition has had an ongoing or adverse impact on the ability to function and practice.

"Improper use of drugs or other chemical substances" means all of the following: The use of any controlled drug, legend drug or other chemical substance for any purpose other than as directed by a licensed health care practitioner; and the use of any substance, including, but not limited to, petroleum products, adhesive products, nitrous oxide and other chemical substances for mood enhancement.

"Illegal use of drugs or other chemical substances" means the manufacture, possession, distribution or use of any chemical substances prohibited by law (e.g. heroin).

Iowa Physician Health Program (IPHP)

The IPHP is a confidential, voluntary program offered to physicians who may be dealing with impairment issues, such as, but not limited to alcohol or drug abuse, dependency or addiction, neuropsychiatric disorder, or physical disability. The IPHP develops an individualized program for each physician, with the goal of allowing the physician to continue to practice with reasonable skill and safety. Oftentimes, the Licensure Committee of the Board will refer physicians with impairment issues to the IPHP for review and bases licensure decisions on its recommendations.

To self-report to the IPHP or obtain additional information, contact the Coordinator of IPHP at 515-281-6491.

Applicant Name:

Section 12—Questions

Respond “yes” or “no” to each item. The Board expects full disclosure of events, whether you consider them to be minor or major in nature. It is better to disclose information than to not disclose it.

For every “yes” response, you must provide a separate statement of explanation that is signed and dated. This statement must include full details, including dates, locations, actions, organizations or parties involved. You must also provide the requested supporting documentation. The Board may request additional supporting information, if needed.

A criminal background check packet will be sent to your home address after your application has been submitted. Your answer to question #6 of the application and the question on the background check waiver should contain the same information. Discrepancies between the application and the criminal background check waiver could result in disciplinary action. Some states have court records available online, which you may want to review if you are unsure how to answer this question. Iowa’s court record website is www.iowacourts.state.ia.us.

Applicants must answer all questions. Current IPHP participants, may answer “No” to questions 1 through 5.

Yes No

1. Do you currently have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety?
If yes, provide a description of your condition and submit the “Verification of Medical Condition” form which is to be completed by your treating physician(s).
2. Are you receiving ongoing treatment or participating in a monitoring program that reduces or eliminates the limitations or impairments caused by either your medical condition or use of alcohol, drugs, or other chemical substances?
If yes, provide details of your treatment or program, copies of treatment evaluations, statement from the program indicating your progress and practice recommendations.
3. Does your field of practice, or the setting or the manner in which you have chosen to practice medicine, reduce or eliminate the limitations or impairments caused by your medical condition or use of alcohol, drugs or other chemical substances?
If yes, provide a description of your practice and how it has changed since the diagnosis of your medical condition.
4. Are you currently engaged in the illegal or improper use of drugs or other chemical substance?
If yes, provide an explanation.
5. Does your current use of alcohol, drugs or other chemical substances in any way impair or limit your ability to practice medicine with reasonable skill and safety?
If yes, explain your current usage and how this impairs your ability to practice.

Applicant Name:

Yes No

6. Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to a crime other than a minor traffic offense, in any jurisdiction? You must include all misdemeanors and felonies, even if adjudication was withheld by the court so that you would not have a record of conviction. (For example, you must report if your conviction was expunged, you received a deferred judgment, or you received an executive pardon.) Driving under the influence or driving while impaired is not a minor traffic offense.

If yes, provide details of the charge and the final outcome. Provide copies of any court/legal documents related to each incident.

7. During medical school, were you ever terminated, requested to withdraw, or placed on probation?

If yes, provide an explanation.

8. Have you ever received a certificate of non-compliance from the College Student Aid Commission regarding non-payment of a student loan?

If yes, provide an explanation.

9. Have you ever been terminated, asked to withdraw, or asked to repeat a portion of an internship, residency, or fellowship?

If yes, provide an explanation.

10. Have you ever received a warning or reprimand, been asked to participate in remediation or been placed on probation during an internship, residency or fellowship program?

If yes, provide an explanation.

11. Have you ever taken a leave of absence for any reason (maternity, family, personal, financial) during your medical school education, internship, residency, or fellowship?

If yes, provide an explanation.

12. Have you ever been denied a license to practice medicine or a license to practice another profession?

If yes, provide an explanation and a copy of the notice of denial.

13. Have you ever surrendered any professional license for any reason?

If yes, provide an explanation and a copy of all official documents relating to the surrender.

13a. If yes, was a license disciplinary action pending against you or were you under investigation by a professional licensing agency at the time you surrendered the license?

If yes, provide an explanation and a copy of all related official documents.

14. Have you ever been denied a Drug Enforcement Administration (DEA) or state controlled substance registration certificate?

If yes, provide an explanation and a copy of the notice of denial.

Applicant Name:

Yes No

15. Have you ever surrendered your state or controlled substances registration or had it restricted in any way?

If yes, provide an explanation and a copy of all official documents relating to this.

16. Aside from ordinary initial requirements of proctorship, have you had your clinical privileges or medical staff status at any hospital or health care entity, nursing facility, clinic, or other professional health care organization ever been limited, suspended, revoked, not renewed, voluntarily relinquished, denied, or subject to other disciplinary or probationary conditions?

If yes, provide an explanation and a copy of all related official documents.

17. Have you ever been terminated, sanctioned, penalized, had to repay monies to or been denied provider participation in any Medicaid, Medicare or other publicly funded healthcare program?

If yes, provide an explanation and a copy of all related official documents.

18. Have you ever been denied membership or renewal or been subject to any disciplinary action, sanction or warning in any medical or osteopathic organization or professional society?

If yes, provide an explanation and a copy of all related official documents.

19. Have you ever been investigated or subject to an inquiry/review by any professional licensing agency, including investigations or reviews which resulted in no formal action? (Answer "Yes" if you have ever been contacted by an investigator or Board agent to review a complaint or report filed against you.)

If yes, provide an explanation of the inquiry, including dates, state, charges, final outcome and a copy of all related official documents

20. Has any jurisdiction of the U.S. or other nation ever limited, restricted, warned, censured, placed on probation, suspended, revoked or filed charges against any license you held?

If yes, provide an explanation and a copy of all related official documents.

21. Are you in violation of any child support order or written agreement to pay child support?

If yes, provide an explanation.

22. Have any professional liability suits ever been filed against you?

If yes, complete the attached Professional Liability Suit Information form along with a copy of the requested legal documents listed on that form.

23. Have any judgments or settlements been paid on your behalf as a result of a professional liability case?

If yes, complete the attached Professional Liability Suit Information form along with a copy of the requested legal documents listed on that form.

Applicant Name:

Section 13— Affidavit of Applicant

Enter the state and county in which the affidavit is being notarized. Sign the affidavit in the presence of a notary. The notary must supply the jurisdiction at the beginning of the affidavit, sign, enter the date of the notarization, and the expiration date of his/her commission. Attach a recent photo of yourself that has been taken within the last 90 days.

State of: _____ **County of:** _____

I, _____
hereby swear or affirm, under penalty of perjury, that I am the person described and identified; that the attached photo is a true likeness of myself; that I am the person named in the diploma which accompanies this application; that I am the lawful holder of said diploma; that said diploma was procured in the regular course of instruction and examination without fraud or misrepresentation.

I certify that I have carefully read the questions on this application and have answered them completely and truthfully. I declare under penalty of perjury that my answers, and all other statements or information submitted by me in this application process, are true and correct. If it is determined at any time that I have provided misleading or false information on or in support of this application, I understand that my application may be denied or that I may be subject to disciplinary action and criminal prosecution if I am already licensed.

I understand that I am required to update answers or information submitted with this application if the response or the information changes during the time period the application is pending. I also understand that this application is a public record in accordance with Iowa Code chapter 22 and that application information is public information, subject to the exceptions contained in Iowa law. Finally, in submitting this application, I consent to any reasonable inquiry that may be necessary to verify the information I have provided on or in conjunction with this application.

I also declare, under penalty of perjury, that if I did not personally complete the foregoing application that I have fully read and confirmed each question and accompanying answer and take full responsibility for all answers contained in this application.

Signature of Applicant

Signature of Notary Public

Sworn/Affirmed to before me on

My commission expires:

Notary Seal or Stamp:

**ATTACH A RECENT
PHOTO THAT HAS
BEEN TAKEN WITHIN
THE LAST 90 DAYS
HERE**

Office Use Only
License Number: _____
Issue Date: _____
Expiration Date: _____
Initials: _____

Applicant Name:

Section 14— Authorization for Release of Information

All applicants must sign and date this section.

I, _____ (print name), do hereby authorize a disclosure of records concerning myself to the Iowa Board of Medicine (IBM). This release includes records of a public, private or confidential nature.

I acknowledge that the information released to the IBM may include material that is protected by federal and/or state laws applicable to substance abuse and mental health information. If applicable, I specifically authorize the release of confidential information to and from the IBM relating to substance abuse or dependence and/or mental health.

I further agree that the IBM may receive confidential information and records, including, but not limited to the following records:

- Medical Records
- Education Records
- Personnel or employment records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Post-graduate training (internship, residency, & fellowship) records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Any information the IBM deems reasonably necessary for the purposes set forth in this release.

Release of Liability. I do hereby irrevocably and unconditionally release, covenant not to sue, and forever discharge any person or entity, including but not limited to any medical school, residency or fellowship training program, hospital, health care provider, health care facility, licensing board, impaired practitioner program, agency, or organization, which releases information to the IBM pursuant to this release from any liability, claim, or cause of action arising out of the release of such information. I further irrevocably and unconditionally release, covenant not to sue, and forever discharge the IBM, the State of Iowa, and its employees and agents from any liability, claim, or cause of action arising out of the collection or release of information pursuant to this release.

A photocopy of this release form will be valid as an original thereof, even though the photocopy does not contain an original writing of my signature.

This authorization is valid until completion of the licensure process. I understand I have the right to revoke this authorization in writing, except to the extent that the IBM has already taken action in reliance upon this consent.

I have read and fully understand the contents of this "Authorization to Release Information."

Signature of Physician

Date

PROHIBITION ON REDISCLOSURE

This form does not authorize redisclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by state law for mental health records, federal requirements (42 C.F.R. Part 2) and state requirements (Iowa Code Ch. 228) prohibit further disclosure without the specific written consent of the patient except as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse or mental health information.

Applicant Name:

Section 15—Post-Graduate Training Program Certification

Applicants who are applying for a resident license must forward this section to the Resident Program Director at the proposed Iowa training program. The Program Director must complete and submit this section to the *Iowa Board of Medicine, 400 SW 8th Street, Suite C, Des Moines, IA 50309-4686.*

Resident Applicant's Name: _____
(First, Middle, Last)

Program Facility/Department : _____

Mailing Address: _____

City, State, Zip: _____

Proposed Training Program(s): _____

e.g. Family Practice, Internal Medicine. Residents who have an initial contract to participate in a preliminary year of general training followed by specialized training, e.g. one year of internal medicine followed by three years of dermatology, can participate in both programs under one resident license if the resident's license application specifies a combined program under this section.

Expected Start Date: _____ **Expected Date of Completion:** _____
(The expected date of completion will be the expiration date of the license.)

Is this training program accredited? Yes No If yes, by whom? _____

Program Director's Name: _____

E-Mail: _____ **Phone:** _____

Program Coordinator's Name: _____

E-Mail: _____ **Phone:** _____

I, _____, hereby certify that the above-named physician will be employed by this institution for resident training program, provided he/she has been duly licensed as a resident physician by the Iowa Board of Medicine. I further certify that I believe this applicant is qualified to practice as a resident physician in the State of Iowa. I have carefully examined the statements made in this application and believe them to be true in every respect.

I understand that the resident license is a restricted license valid only for practice within the program and department(s) approved by the Board on this application, and valid only for practice under the supervision of a licensed practitioner of medicine and surgery or osteopathic medicine and surgery.

Signature _____ Date _____

Office Use Only

License Number: R-

Issue Date:

Initials:

Applicant Name:

ILLINOIS

From Illinois Administrative Code:

Section 1285.120 Renewals

- a) Every license issued under the Act shall expire on July 31, 1990, and every third year thereafter. For the July 31, 1999 renewal, a licensee shall complete 50 hours of CME in accordance with Section 1285.110 of this Part. Thereafter, a licensee will be required to complete 150 hours in accordance with Section 1285.110 of this Part in order to renew the license. The holder of a license may renew such license during the month preceding the expiration date by paying the required fee stated in Section 21(e)(5) of the Act.
- b) It is the responsibility of each licensee to notify the Division of any change of address. Failure to receive a renewal form from the Division shall not constitute an excuse for failure to pay the renewal fee and to renew the license in a timely manner.
- c) Practicing or operating on a license that has expired shall be considered unlicensed activity and shall be grounds for discipline pursuant to Section 22 of the Act.
- d) Any licensee applying for renewal shall be entitled to a hearing in accordance with 68 Ill. Adm. Code 1110 prior to refusal of any renewal or any disciplinary action being taken by the Division against the licensee.

Section 1285.130 Restoration and Inactive Status

- a) A licensee seeking restoration of a license that has been expired for 3 years or less shall have a license restored upon payment of all lapsed renewal fees required by Section 21 of the Act, a completed physician profile in accordance with Section 1285.305, and proof of completion of 150 hours of continuing education in accordance with Section 1285.110.
- b) A licensee seeking restoration of a license that has been placed on inactive status for 3 years or less shall have the license restored upon payment of the current renewal fee, submission of a completed physician profile in accordance with Section 1285.305, and the continuing education requirements for the last renewal period.
- c) A licensee seeking restoration of a license after it has been expired or been placed on inactive status for more than 3 years shall file an application, on forms supplied by the Division, together with the fee required by Section 21 of the Act, a completed physician profile in accordance with Section 1285.305, and proof of completion of 150 hours of continuing education in accordance with Section 1285.110. The licensee shall also submit one or more of the following:

- 1) Sworn evidence of active practice in another jurisdiction. That evidence shall include a statement from the appropriate board or licensing authority in the other jurisdiction that the licensee was authorized to practice during the term of active practice.
 - 2) An affidavit attesting to military service as provided in Section 21 of the Act.
 - 3) Proof of successful completion (evidenced by Certification of Clinical Training) of an approved specialty residency program of at least 12 months in length within 3 years from the date of application.
 - 4) Proof of completion evidenced by Certification of Medical Education of a course of study of at least 960 classroom hours (one academic year) that includes no more than 25 clock hours of basic sciences and 40 clock hours of clinical sciences in a college approved by the Division under the Act within 3 years from the date of application.
 - 5) Successful completion of the Special Purpose Examination (SPEX) or the Comprehensive Osteopathic Medical Variable Purpose Examination for the United States of America (COMVEX-USA) within 3 years prior to the date of application. To be successful an applicant must receive a score of 75 or better.
 - 6) For individuals applying for a chiropractic license, proof of completion of 960 classroom hours (academic hours) in an accredited chiropractic program within 3 years from the date of application or the Special Examination for Chiropractic (SPEC) or its equivalent as approved by the Board.
- d) When the accuracy of any submitted documentation, or the relevance or sufficiency of the course work or experience is reasonably questioned by the Division because of discrepancies or conflicts in information, information needing further clarification, and/or missing information, the licensee seeking restoration of a license will be requested to:
- 1) provide information as may be necessary; and/or
 - 2) explain the relevance or sufficiency during an oral interview; or
 - 3) appear for an oral interview before the Medical Licensing Board designed to determine the individual's current competency to practice under the Act. Upon the recommendation of the Medical Licensing Board, an applicant shall have his or her license restored.

Illinois Department of Financial and Professional Regulation

Division of Professional Regulation

Application Checklist for Physicians

*In order for your application to be processed,
ALL REQUIRED SUPPORTING DOCUMENTATION MUST BE SUBMITTED
with the application and required fee unless otherwise directed in the instructions.*

Before you mail your application, check the following items to make sure your application is complete!

FOUR-PAGE APPLICATION REVIEW	COMPLETED
Part I. Application Category Information	
Part II. Applicant Identifying Information	
Part III. Education Information	
Part IV. Record of Licensure Information	
Part V. Record of Examination	
Part VI. Personal History Information	
Part VII. Examination Coding Information (if applicable)	
Part VIII. Child Support and/or Student Loan Information	
Part IX. Certifying Statement--Signed and Dated	
SUPPORTING DOCUMENTS	SUBMITTED
Application Fee	
Supporting Documents CCA and PH must be completed and submitted with each application. Your application will not be processed without completion of this form.	
VE-PC Form	
FCVS Physician Profile (optional)	
TN-MED Form	
ECFMG Certificate (copy)	
Medical School Diploma (copy)	
Proof of Pre-Medical and Medical Education (official transcript of grades issued by college or university with school seal affixed).	
Proof of Name Change (if applicable)	
ED-NON (IMG only)	
5th Pathway/Social Service (if applicable)	
CT (Certification of Licensure) Form from original and current state of licensure	
Exam Scores (sent directly from USMLE, FLEX, National Board, LMCC or State Board)	
Criminal Background Check	

All supporting documents may not be required. Please refer to application instructions for your specific method of licensure.

PART IV: Record of Licensure Information

If you have ever been licensed to practice the profession for which you are now making application, or held a related license, complete the information requested below. If you have ever held a temporary, trainee or apprenticeship license, or a permit, it must be listed here also. In addition, the INSTRUCTION SHEET enclosed with this Application package may instruct you to have Certification(s) of Licensure in other state(s) prepared and submitted in support of your application (contact other state(s) regarding possible fee). You must also list all other licenses held in Illinois, however, certification of licensure from Illinois is not required. Failure to disclose all licenses held may result in denial of your application or other appropriate action.

STATE	PROFESSION NAME	LICENSE NUMBER	DATE OF ISSUANCE	LICENSE STATUS (Active, Lapsed, etc.)
State of Original Licensure				
State of Current Licensure where you most recently have been practicing.				
Other States of Licensure				

(If additional space is needed, attach a separate sheet.)

PART V: Record of Examination

If you have ever taken a licensure examination in Illinois or any other state for the profession for which you are now making application, you must complete the information requested below. EACH EXAMINATION ATTEMPT MUST BE SHOWN. Failure to disclose an examination attempt may result in the denial of your application or other appropriate action.

NAME OF EXAMINATION	STATE	MONTH/YEAR	EXAM RESULTS
			(Passed, Failed, Absent)

(If additional space is needed, attach a separate sheet.)

PART VI: Personal History Information (This part must be completed by all applicants)	YES	NO
1. Have you been convicted of or pled guilty or nolo contendere to any criminal offense in any state or in federal court? Please do not give details on minor traffic charges, but do include information relating to Driving While Intoxicated (DWI) charges. <i>If yes, attach a personal statement describing the circumstances of the conviction and certified copies of court records of your conviction including the nature of the offense, date of discharge, and a statement from the probation or parole office. In general, a criminal conviction by itself does not usually result in denial of licensure.</i>		
2. Have you been convicted of a felony? <i>In general, a felony conviction by itself does not usually result in denial of licensure.</i>		
3. If yes, have you been issued a Certificate of Relief from Disabilities by the Prisoner Review Board? <i>If yes, attach a copy of the certificate.</i>		
4. Do you now have any disease or condition that presently limits your ability to perform the essential functions of your profession, including any disease or condition generally regarded as chronic by the medical community, i.e., (1) mental or emotional disease or condition; (2) alcohol or other substance abuse; (3) physical disease or condition? <i>If yes, attach a detailed statement, including an explanation whether or not you are currently under treatment.</i>		
5. Have you been denied a professional license or permit, or privilege of taking an examination, or had a professional license or permit disciplined in any way by any licensing authority in Illinois or elsewhere? <i>If yes, attach a detailed explanation.</i>		
6. Have you ever been discharged other than honorably from the armed service or from a city, county, state or federal position? <i>If yes, attach a detailed explanation.</i>		

PART VII: Examination Coding Information (This part is for examination applicants only)

Refer to the REFERENCE SHEET enclosed with this application package and complete the following:

a) CHART II - Select examination(s) you desire and enter Test Codes.

b) CHART III - Select the examination site you desire and enter Test Center Code:

--	--	--	--	--

c) CHART IV - Find your School of Graduation and enter school code:

--	--	--	--	--	--	--	--	--	--

d) Record the number of times you have taken this exam in Illinois or any other state:

--	--

PART VIII: Child Support and/or Student Loan Information (Every applicant is required by law to respond to the following questions)

1. In accordance with 5 Illinois Compiled Statutes 100/10-65(c), applications for renewal of a license or a new license shall include the applicant's Social Security number, and the licensee shall certify, under penalty of perjury, that he or she is not more than 30 days delinquent in complying with a child support order. **Failure to certify shall result in disciplinary action, and making a false statement may subject the licensee to contempt of court.**

Are you more than 30 days delinquent in complying with a child support order? Yes No
(NOTE: If you are not subject to a child support order, answer "no.")

2. In accordance with 20 Illinois Compiled Statutes 2105/2105-(5), "The Department shall deny any license or renewal authorized by the Civil Administrative Code of Illinois to any person who has defaulted on an educational loan or scholarship provided by or guaranteed by the Illinois Student Assistance Commission or any governmental agency of this State; however, the Department may issue a license or renewal if the aforementioned persons have established a satisfactory repayment record as determined by the Illinois Student Assistance Commission or other appropriate governmental agency of this State." (Proof of a satisfactory repayment record must be submitted.)

Are you in default on an educational loan or scholarship provided/guaranteed by the Illinois Student Assistance Commission or other governmental agency of this State? Yes No

PART IX: Certifying Statement

Under penalties of perjury, I declare that I have examined the application and all supporting documents submitted by me in connection therewith, and to the best of my knowledge, they are true, correct, and complete.

Signature of Applicant

Date

I UNDERSTAND THAT FEES ARE NOT REFUNDABLE. My signature above authorizes the Department of Financial and Professional Regulation to reduce the amount of this check if the amount submitted is not correct. I understand this will be done only if the amount submitted is greater than the required fee hereunder, but in no event shall such reduction be made in an amount greater than \$50.

IMPORTANT NOTICE: Completion of this form is necessary to accomplish the requirements outlined in 225 of the Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

**ILLINOIS DEPARTMENT OF FINANCIAL
AND PROFESSIONAL REGULATION
PERSONAL HISTORY INFORMATION**

SUPPORTING DOCUMENT

PH

NAME	LAST	FIRST	MIDDLE	SOCIAL SECURITY NUMBER
				____-____-____

In order for your application to be evaluated, you must respond to each of the following questions:	YES	NO
1. Have you ever been disciplined (including but not limited to restricted, suspended, or terminated) by any hospital or health care entity? If yes, attach a separate sheet with complete and accurate explanation.		
2. Have you ever resigned in lieu of discipline or while under investigation that could lead to any restriction, suspension, or termination by any hospital or health care entity? <i>If yes, attach a separate sheet with complete and accurate explanation.</i>		
3. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges involuntarily reduced, limited, placed on probation, relinquished, denied, revoked or suspended? You must answer yes if any of these actions are currently pending or if you have withdrawn or failed to proceed with an application for privileges/memberships. <i>If yes, attach a separate sheet with complete and accurate explanation AND request the hospital or health care facility to submit a report directly to the Department regarding the action.</i>		
4. Has your provider status ever been restricted, suspended or terminated by any insurance carrier, including but not limited to Medicare, Medicaid, Tricare or any private carrier? If yes, attach a separate sheet with complete and accurate explanation.		
5. Have you ever voluntarily surrendered a license to practice medicine in any state, country, or U.S. federal jurisdiction? This does not include allowing your license to expire solely due to non-payment of the renewal fee. <i>If yes, attach a separate sheet with complete and accurate explanation AND request all official disciplinary documents including initial complaint, stipulations, orders, agreements or reprimands be sent directly to the Department.</i>		
6. Have you ever withdrawn an application for a license to practice medicine or any temporary/resident license in any other state, country, or U.S. federal jurisdiction? <i>If yes, attach a separate sheet with complete and accurate explanation AND request all official disciplinary documents including initial complaint, stipulations, orders, agreements or reprimands be sent directly to the Department.</i>		
7. Have you ever been admonished, reprimanded, censured and/or disciplined in any way by any professional or medical society or association or committee thereof, or by any non-licensing governmental agency including but not limited to any governmental assistance agency? (Disciplinary actions include, but are not limited to, any allegations currently pending.) Disclose any stipulation to informal disposition in response to this question. <i>If yes, attach a separate sheet with a complete and accurate explanation and request all official disciplinary documents including initial complaint, stipulations, orders or reprimands be sent directly to the Department.</i>		

Certification Statement

Under penalties of perjury, I declare that I have examined this Form and all supporting documents and/or information submitted by me in connection therewith, and to the best of my knowledge, they are true, correct, and complete.

Signature of Applicant

Date

IMPORTANT NOTICE: Completion of this form is necessary to accomplish the requirements outlined in 225 of the Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

HEALTH CARE WORKERS CHARGED WITH OR CONVICTED OF CRIMINAL ACTS

SUPPORTING DOCUMENT

CCA

1. NAME LAST FIRST MIDDLE

3. PROFESSIONAL LICENSE NUMBER (if any)
_____ - _____

2. ADDRESS STREET, CITY, STATE, ZIP CODE

4. SOCIAL SECURITY NUMBER
_____ - _____

Pursuant to 20ILCS 2105-165(a), the Department requires the following professionals to disclose information regarding convictions pertaining to certain offenses. **Please check applicable profession.**

- | | | |
|--|---|--|
| <input type="checkbox"/> Acupuncturists | <input type="checkbox"/> Naprapaths | <input type="checkbox"/> Physician Assistants |
| <input type="checkbox"/> Advanced Practice Nurses | <input type="checkbox"/> Nursing Home Administrators | <input type="checkbox"/> Podiatrists |
| <input type="checkbox"/> Athletic Trainers | <input type="checkbox"/> Occupational Therapists | <input type="checkbox"/> Professional Counselors |
| <input type="checkbox"/> Audiologists | <input type="checkbox"/> Occupational Therapy Assistants | <input type="checkbox"/> Prosthetists |
| <input type="checkbox"/> Clinical Psychologists | <input type="checkbox"/> Optometrists | <input type="checkbox"/> Registered Nurses |
| <input type="checkbox"/> Clinical Social Workers | <input type="checkbox"/> Orthotists | <input type="checkbox"/> Registered Surgical Assistants |
| <input type="checkbox"/> Dental Hygienists | <input type="checkbox"/> Pedorthists | <input type="checkbox"/> Registered Surgical Technologists |
| <input type="checkbox"/> Dentists | <input type="checkbox"/> Perfusionists | <input type="checkbox"/> Respiratory Care Practitioners |
| <input type="checkbox"/> Genetic Counselors | <input type="checkbox"/> Pharmacists | <input type="checkbox"/> Speech Pathologists |
| <input type="checkbox"/> Licensed Clinical Professional Counselors | <input type="checkbox"/> Physical Therapists | |
| <input type="checkbox"/> Licensed Practical Nurses | <input type="checkbox"/> Physical Therapy Assistants | |
| <input type="checkbox"/> Licensed Social Workers | <input type="checkbox"/> Physicians, including Medical Doctors (M.D.), Doctors of Osteopathic Medicine (D.O.), and Chiropractic Physicians (D.C.) | |
| <input type="checkbox"/> Marriage and Family Therapists | | |
| <input type="checkbox"/> Medication Aide | | |

Any other license issued by the Department under the Acts listed in this Section and the Controlled Substances Act [740 ILCS 40], except for pharmacy technicians, issued to a person subject to the Code and this Part.

In order for your application to be evaluated, you must respond to each of the following questions:

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1) Are you currently charged with or have you been convicted of a criminal act that requires registration under the Sex Offender Registration Act? * | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) Are you currently charged with or have you been convicted of a criminal battery against any patient <i>in the course of patient care or treatment</i> , including any offense based on sexual conduct or sexual penetration? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) Are you required, as part of a criminal sentence, to register under the Sex Offender Registration Act? * | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) Are you currently charged with or have you been convicted of a forcible felony? * | <input type="checkbox"/> | <input type="checkbox"/> |

If YES to any of the above, attach a certified copy of the court records regarding your conviction, the nature of the offense and date of discharge, if applicable, as well as a statement from the probation or parole office.

Certification Statement

Under penalties of perjury, I declare that I have examined this Form and all supporting documents and/or information submitted by me in connection therewith, and to the best of my knowledge, they are true, correct, and complete.

Signature of Applicant _____ Email _____ Date _____

* DEFINITIONS

730 ILCS 150 et. seq.—Acts that require Sex Offender Registration:

(B) As used in this Article, "sex offense" means:

(1) A violation of any of the following Sections of the Criminal Code of 1961:

- 11-20.1 (child pornography),
- 11-20.3 (aggravated child pornography),
- 11-6 (indecent solicitation of a child),
- 11-9.1 (sexual exploitation of a child),
- 11-9.2 (custodial sexual misconduct),
- 11-9.5 (sexual misconduct with a person with a disability),
- 11-15.1 (soliciting for a juvenile prostitute),
- 11-18.1 (patronizing a juvenile prostitute),
- 11-17.1 (keeping a place of juvenile prostitution),
- 11-19.1 (juvenile pimping),
- 11-19.2 (exploitation of a child),
- 11-25 (grooming),
- 11-26 (traveling to meet a minor),
- 12-13 (criminal sexual assault),
- 12-14 (aggravated criminal sexual assault),
- 12-14.1 (predatory criminal sexual assault of a child),
- 12-15 (criminal sexual abuse),
- 12-16 (aggravated criminal sexual abuse),
- 12-33 (ritualized abuse of a child).

An attempt to commit any of these offenses.

(1.5) A violation of any of the following Sections of the Criminal Code of 1961, when the victim is a person under 18 years of age, the defendant is not a parent of the victim, the offense was sexually motivated as defined in Section 10 of the Sex Offender Management Board Act, and the offense was committed on or after January 1, 1996:

- 10-1 (kidnapping),
- 10-2 (aggravated kidnapping),
- 10-3 (unlawful restraint),
- 10-3.1 (aggravated unlawful restraint).

(1.6) First degree murder under Section 9-1 of the Criminal Code of 1961, when the victim was a person under 18 years of age and the defendant was at least 17 years of age at the time of the commission of the offense, provided the offense was sexually motivated as defined in Section 10 of the Sex Offender Management Board Act.

(1.7) (Blank).

(1.8) A violation or attempted violation of Section 11-11 (sexual relations within families) of the Criminal Code of 1961, and the offense was committed on or after June 1, 1997.

(1.9) Child abduction under paragraph (10) of subsection (b) of Section 105 of the Criminal Code of 1961 committed by luring or attempting to lure a child under the age of 16 into a motor vehicle, building, house trailer, or dwelling place without the consent of the parent or lawful custodian of the child for other than a lawful purpose and the offense was committed on or after January 1, 1998, provided the offense was sexually motivated as defined in Section 10 of the Sex Offender Management Board Act.

(1.10) A violation or attempted violation of any of the following Sections of the Criminal Code of 1961 when the offense was committed on or after July 1, 1999:

- 10-4 (forcible detention, if the victim is under 18 years of age), provided the offense was sexually motivated as defined in Section 10 of the Sex Offender Management Board Act,
- 11-6.5 (indecent solicitation of an adult),
- 11-15 (soliciting for a prostitute, if the victim is under 18 years of age),
- 11-16 (pandering, if the victim is under 18 years of age),
- 11-18 (patronizing a prostitute, if the victim is under 18 years of age),
- 11-19 (pimping, if the victim is under 18 years of age).

(1.11) A violation or attempted violation of any of the following Sections of the Criminal Code of 1961 when the offense was committed on or after August 22, 2002:

- 11-9 (public indecency for a third or subsequent conviction).

(1.12) A violation or attempted violation of Section 5.1 of the Wrongs to Children Act (permitting sexual abuse) when the offense was committed on or after August 22, 2002.

(2) A violation of any former law of this State substantially equivalent to any offense listed in subsection (B) of this Section.

(C) A conviction for an offense of federal law, Uniform Code of Military Justice, or the law of another state or a foreign country that is substantially equivalent to any offense listed in subsections (B), (C), (E), and (E5) of this Section shall constitute a conviction for the purpose of this Article.

* DEFINITIONS

A “**forcible felony**”, for the purposes of Section 2105-165 of the Code (section numbers are from the Criminal Code of 1961 [720 ILCS 5]) and 68 Illinois Administrative Code 1130.120 is one or more of the following offenses:

- a) First Degree Murder (Section 9-1);
- b) Intentional Homicide of an Unborn Child (Section 9-1.2);
- c) Second Degree Murder (Section 9-2);
- d) Voluntary Manslaughter of an Unborn Child (Section 9-2.1);
- e) Drug-induced Homicide (Section 9-3.3);
- f) Kidnapping (Section 10-1);
- g) Aggravated Kidnapping (Section 10-2);
- h) Unlawful Restraint (Section 10-3);
- i) Aggravated Unlawful Restraint (Section 10-3.1);
- j) Forcible Detention (Section 10-4);
- k) Involuntary Servitude (Section 10-9(b));
- l) Involuntary Sexual Servitude of a Minor (Section 10-9(c));
- m) Trafficking in Persons (Section 10-9(d));
- n) Criminal Sexual Assault (Section 11-1.20);
- o) Aggravated Criminal Sexual Assault (Section 11-1.30);
- p) Predatory Criminal Sexual Assault of a Child (Section 11-1.40);
- q) Criminal Sexual Abuse (Section 11-1.50);
- r) Aggravated Criminal Sexual Abuse (Section 11-1.60);
- s) Aggravated Battery (Section 12-3.05);
- t) Compelling Organization Membership of Persons (Section 12-6.5);
- u) Compelling Confession or Information by Force or Threat (Section 12-7);
- v) Home Invasion (Section 12-11);
- w) Robbery (Section 18-1);
- x) Armed Robbery (Section 18-2);
- y) Vehicular Hijacking (Section 18-3);
- z) Aggravated Vehicular Hijacking (Section 18-4);
- aa) Aggravated Robbery (Section 18-5);
- bb) Terrorism (Section 29D-14.9);
- cc) Causing a Catastrophe (Section 29D-15.1);
- dd) Possession of a Deadly Substance (Section 29D-15.2);
- ee) Making a Terrorist Threat (Section 29D-20);
- ff) Falsely Making a Terrorist Threat (Section 29D-25);
- gg) Material Support for Terrorism (Section 29D-29.9);
- hh) Hindering Prosecution of Terrorism (Section 29D-35);
- ii) Boarding or Attempting to Board an Aircraft with Weapon (Section 29D-35.1);
- jj) Armed Violence (Section 33A-2); and
- kk) Attempt (Section 8-4) of any of the above specified offenses.

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ILCS 60/1 et. seq. (Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

**CERTIFICATION OF EDUCATION
NON-LCME ACCREDITED
MEDICAL COLLEGE**

ED- NON

APPLICANT: Complete the applicant section of this form, then forward it to the school for completion of the remainder of the form. You are authorized to photocopy this form as necessary.

1. NAME LAST FIRST MIDDLE	2. DATE OF BIRTH ____ / ____ / ____ Month Day Year	3. PLEASE CHECK THE TYPE OF LICENSE FOR WHICH YOU ARE APPLYING: <input type="checkbox"/> Permanent Physician 036 <input type="checkbox"/> Temporary Physician 125
4. SOCIAL SECURITY NUMBER _____ OR CONTACT ID NUMBER FROM _____ IDFPR ACKNOWLEDGEMENT LETTER _____		

I hereby authorize a school official of the institution named above to furnish to the Illinois Department of Financial and Professional Regulation or its designated testing service the information requested below.

_____ Date _____ Signature of Applicant

APPLICANT: DO NOT COMPLETE ANY PORTION BELOW THE LINE.

DEAN OF MEDICAL SCHOOL: Complete the bottom portion of this page and the reverse side, then return to the applicant. If this part is partially or totally completed by the applicant or altered, the form will not be accepted. Complete dates in form of month/day/year are required where indicated.

A. NAME OF MEDICAL SCHOOL	ADDRESS	CITY, STATE	COUNTRY/PROVIDENCE
---------------------------	---------	-------------	--------------------

B. DATES OF ATTENDANCE - **EACH YEAR** MUST BE LISTED SEPARATELY. DO NOT GROUP DATES OF ATTENDANCE.

1st year
From ____ / ____ / ____ To ____ / ____ / ____
Month Day Year Month Day Year

2nd year
From ____ / ____ / ____ To ____ / ____ / ____
Month Day Year Month Day Year

3rd year
From ____ / ____ / ____ To ____ / ____ / ____
Month Day Year Month Day Year

4th year
From ____ / ____ / ____ To ____ / ____ / ____
Month Day Year Month Day Year

5th year
From ____ / ____ / ____ To ____ / ____ / ____
Month Day Year Month Day Year

6th year
From ____ / ____ / ____ To ____ / ____ / ____
Month Day Year Month Day Year

7th year
From ____ / ____ / ____ To ____ / ____ / ____
Month Day Year Month Day Year

INTERNSHIP YEAR, IF APPLICABLE
From ____ / ____ / ____ To ____ / ____ / ____
Month Day Year Month Day Year

C. BASIC SCIENCE COURSES

Anatomy
From ____ / ____ / ____ To ____ / ____ / ____
Month Day Year Month Day Year

Physiology
From ____ / ____ / ____ To ____ / ____ / ____
Month Day Year Month Day Year

Biochemistry
From ____ / ____ / ____ To ____ / ____ / ____
Month Day Year Month Day Year

Microbiology/Immunology
From ____ / ____ / ____ To ____ / ____ / ____
Month Day Year Month Day Year

Pathology
From ____ / ____ / ____ To ____ / ____ / ____
Month Day Year Month Day Year

Pharmacology/Therapeutics
From ____ / ____ / ____ To ____ / ____ / ____
Month Day Year Month Day Year

Preventative Medicine
From ____ / ____ / ____ To ____ / ____ / ____
Month Day Year Month Day Year

D. INDICATE LENGTH OF ACADEMIC YEAR _____ MONTHS. DATE MEDICAL DEGREE WAS CONFERRED ____ / ____ / ____
Month Day Year

E. CORE CLERKSHIP ROTATIONS.

COMPLETE DATES IN THE FORM OF MONTH/DAY/YEAR ARE REQUIRED. EACH ROTATION MUST BE A MINIMUM OF FOUR (4) WEEKS IN LENGTH AND COMPLETED WHILE ENROLLED IN THE MEDICAL COLLEGE CONFERRING DEGREE. CORE ROTATIONS WILL NOT BE ACCEPTED OR CO-VALIDATED FROM ANOTHER MEDICAL SCHOOL. (MPA Section 11 (A)(2).)

Internal Medicine Rotation

Started: ___/___/___ Completed: ___/___/___

Total WEEKS spent in clinical training rotation: _____

Facility Name: _____

City/State/Country: _____

Check **ONE**:

- Government owned/operated facility
- Medical school owned/operated facility
- Written Affiliation/Contract with facility
- Verbal Affiliation

Pediatrics Rotation

Started: ___/___/___ Completed: ___/___/___

Total WEEKS spent in clinical training rotation: _____

Facility Name: _____

City/State/Country: _____

Check **ONE**:

- Government owned/operated facility
- Medical school owned/operated facility
- Written Affiliation/Contract with facility
- Verbal Affiliation

Obstetrics/Gynecology Rotation

Started: ___/___/___ Completed: ___/___/___

Total WEEKS spent in clinical training rotation: _____

Facility Name: _____

City/State/Country: _____

Check **ONE**:

- Government owned/operated facility
- Medical school owned/operated facility
- Written Affiliation/Contract with facility
- Verbal Affiliation

Surgery Rotation

Started: ___/___/___ Completed: ___/___/___

Total WEEKS spent in clinical training rotation: _____

Facility Name: _____

City/State/Country: _____

Check **ONE**:

- Government owned/operated facility
- Medical school owned/operated facility
- Written Affiliation/Contract with facility
- Verbal Affiliation

Psychiatry Rotation**

Started: ___/___/___ Completed: ___/___/___

Total WEEKS spent in clinical training rotation: _____

Facility Name: _____

City/State/Country: _____

Check **ONE**:

- Government owned/operated facility
- Medical school owned/operated facility
- Written Affiliation/Contract with facility
- Verbal Affiliation

** The 4 week psychiatry core clerkship rotation may be completed as follows: 2 weeks must be completed formally and distinctly in psychiatry as verified by the medical school on this form. The other 2 weeks may be completed in other clinical rotations as verified by the applicant's affidavit. Contact the Division for the [Affidavit of Psychiatry Core Clerkship Rotations](#) form.

I hereby certify that the information above is true and accurate to the records of this medical college and in accordance with Section 11 (A)(2) of the Medical Practice Act and Section 1285.20 of the Administrative Rules. I further certify that the applicant received a medical degree from and was enrolled in this college at the time the core rotations were completed; that the core clinical clerkship rotations were conducted in the clinical teaching facilities either **owned or operated by this medical college; government owned or operated; OR formally affiliated or contracted; OR held a verbal affiliation agreement** with this medical college. In the case of a written agreement, it is certified that all affiliation agreements were in full effect at the time of the applicant's rotation and evaluations verifying passage of each core clerkship rotation were submitted by the supervising physician.

SEAL
OF
COLLEGE

Signature of Dean of Medical College

Print Name of Dean of Medical College

Date Completed

Printed Name of Medical College

RETURN THIS FORM TO APPLICANT

IMPORTANT NOTICE: Completion of this form is necessary to accomplish the requirements outlined in 225 of the Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

VERIFICATION OF EMPLOYMENT / EXPERIENCE-- PROFESSIONAL CAPACITY

SUPPORTING DOCUMENT

VE-PC

1. NAME LAST FIRST MIDDLE

2. PLEASE CHECK THE TYPE OF LICENSE FOR WHICH YOU ARE APPLYING:

3. ADDRESS STREET, CITY, STATE, ZIP CODE

Profession Code

- Permanent Physician License 036
- Temporary Physician Training License 125
- Chiropractic Physician License 038

4. DATE OF BIRTH

___ / ___ / ___

Month Day Year

5. SOCIAL SECURITY NUMBER

- - - - -

6. MAIDEN OR GIVEN SURNAME

Record work history chronologically for the five (5) years preceding the date of application beginning with present employment. Also list any breaks of six (6) months or longer in medical practice since graduation from medical school.

A. NAME OF PRACTICE / WORK LOCATION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

DATE OF EMPLOYMENT/ATTENDANCE

From ___ / ___ / ___

Month Day Year

To ___ / ___ / ___

Month Day Year

HOURS WORKED PER WEEK

TYPE OF EMPLOYMENT

Full-time Part-time

TOTAL TIME WORKED (Year/Month)

B. NAME OF PRACTICE / WORK LOCATION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

DATE OF EMPLOYMENT/ATTENDANCE

From ___ / ___ / ___

Month Day Year

To ___ / ___ / ___

Month Day Year

HOURS WORKED PER WEEK

TYPE OF EMPLOYMENT

Full-time Part-time

TOTAL TIME WORKED (Year/Month)

NAME (Last, First, MI):

SS#:

Profession:

C. NAME OF PRACTICE / WORK LOCATION		JOB TITLE	
ADDRESS STREET, CITY, STATE, ZIP CODE		DESCRIPTION OF DUTIES PERFORMED	
DATE OF EMPLOYMENT/ATTENDANCE	HOURS WORKED PER WEEK		
From ___ / ___ / ___ Month Day Year	TYPE OF EMPLOYMENT <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time		
To ___ / ___ / ___ Month Day Year			
TOTAL TIME WORKED (Year/Month)			
D. NAME OF PRACTICE / WORK LOCATION		JOB TITLE	
ADDRESS STREET, CITY, STATE, ZIP CODE		DESCRIPTION OF DUTIES PERFORMED	
DATE OF EMPLOYMENT/ATTENDANCE	HOURS WORKED PER WEEK		
From ___ / ___ / ___ Month Day Year	TYPE OF EMPLOYMENT <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time		
To ___ / ___ / ___ Month Day Year			
TOTAL TIME WORKED (Year/Month)			
E. NAME OF PRACTICE / WORK LOCATION		JOB TITLE	
ADDRESS STREET, CITY, STATE, ZIP CODE		DESCRIPTION OF DUTIES PERFORMED	
DATE OF EMPLOYMENT/ATTENDANCE	HOURS WORKED PER WEEK		
From ___ / ___ / ___ Month Day Year	TYPE OF EMPLOYMENT <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time		
To ___ / ___ / ___ Month Day Year			
TOTAL TIME WORKED (Year/Month)			
F. NAME OF PRACTICE / WORK LOCATION		JOB TITLE	
ADDRESS STREET, CITY, STATE, ZIP CODE		DESCRIPTION OF DUTIES PERFORMED	
DATE OF EMPLOYMENT/ATTENDANCE	HOURS WORKED PER WEEK		
From ___ / ___ / ___ Month Day Year	TYPE OF EMPLOYMENT <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time		
To ___ / ___ / ___ Month Day Year			
TOTAL TIME WORKED (Year/Month)			

PART III - CERTIFICATION OF EXAMINATION SCORES

A1. National or other Profession Specific Examination
(Record all available information)

Date of Examination _____

Scaled Score	_____	Raw Score	_____
Standard Deviation	_____	Corrected Score	_____
National Mean	_____	Percent Score	_____

A 2

SUBJECT	DATE	SCORE	SUBJECT	DATE	SCORE

B. State Constructed Examination

SUBJECT	DATE	SCORE	SUBJECT	DATE	SCORE

PART IV - FORMAL ACTIONS

- A. Is there now or has there ever been any formal action commenced against the applicant? Yes No
- B. Have there ever been any formal sanctions imposed against the applicant as a matter of public record including but not limited to fine, reprimand, probation, censure, revocation, suspension, surrender, restriction or limitation? (If yes, attach a certified copy of disciplinary action.) Yes No

PART V - RECIPROCAL REGISTRATION

This state does does not grant the same privilege of reciprocal registration to Illinois registrants.

I certify that the information contained herein is true and correct according to the official records of the State.

SEAL	_____	_____
	Print Name	Signature
	_____	_____
	Title	Date
	_____	_____
_____	Area Code ()	
Agency/Board Street Address	Telephone Number	
_____	_____	
City, State, ZIP Code		

Attention Licensing Agency/Board: RETURN THIS FORM TO THE APPLICANT.

Attention Applicant: FOR INCLUSION WITH APPLICATION PACKET.

NAME (Last, First, MI):

SS#:

Profession:

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ILCS 60/1 et. seq. (Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

CERTIFICATION OF POSTGRADUATE CLINICAL TRAINING

SUPPORTING DOCUMENT

TN-MED

(DPR)

APPLICANT: *Complete the applicant section. The remainder of this form must be completed by the postgraduate training program director of the institution at which you completed your training.*

1. NAME LAST FIRST MIDDLE 	2. DATE OF BIRTH ____ / ____ / ____ <small>Month Day Year</small>	3. SOCIAL SECURITY NUMBER ____ - ____ - ____
4. ADDRESS STREET, CITY, STATE, ZIP CODE 	5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application. <div style="text-align: center;"> _____ Profession Name _____ Profession Code </div>	
6. MAIDEN OR GIVEN SURNAME 	8. ISSUANCE DATE 	
7. ILLINOIS TEMPORARY LICENSE NUMBER (If applicable)	8. ISSUANCE DATE	

POSTGRADUATE CLINICAL TRAINING PROGRAM DIRECTOR

Complete the remainder of this form. RETURN THE COMPLETED FORM DIRECTLY TO THE APPLICANT.

This is to certify that the above-named applicant satisfactorily completed _____ months of postgraduate clinical training in _____
(Name of Specialty Program)

from _____ to _____ at the following hospital:
MM/DD/YYYY MM/DD/YYYY

Hospital: _____

Number and Street: _____

City, State and Zip Code: _____

I further certify that at the time of such training the program was accredited by:

the ACGME
 the AOA

the CFPC, RCPSC or FMLAC (Canadian Programs)
 not accredited in the US or Canada

Name of Postgraduate Clinical Training Program Director: _____

Signature of Postgraduate Clinical Training Program Director: _____

Date of this Certification: _____

**University/Hospital
S E A L**

Telephone No: _____

(If no seal, attach letter on letterhead stating no seal exists.)

MICHIGAN

From Michigan's Administrative Code:

Rule 338.2441 License renewals.

Rule 141. (1) This part applies to an application for renewal of a medical license under section 17031 of the code, MCL 333.17031 and a medical special volunteer license under section 16184 of the code, MCL 333.16184.

(2) An applicant for license renewal who has been licensed in the 3-year period immediately preceding the application for renewal shall accumulate a minimum of 150 hours of continuing education in activities approved by the board under R 338.2443 during the 3 years immediately preceding the application for renewal.

(3) Submission of an application for renewal shall constitute the applicant's certification of compliance with the requirements of this rule. The licensee shall retain documentation of meeting the requirements of this rule for 4 years from the date of applying for license renewal. Failure to comply with this rule is a violation of section 16221(h) of the code, MCL 333.16221(h).

(4) The department may select and audit a sample of licensees who have renewed their license and request proof of compliance with subrule (2). If audited, a licensee shall submit documentation as specified in R 338.2443.

R 338.2437 Relicensure.

Rule 137. (1) An applicant whose Michigan medical license has lapsed for less than 3 years preceding the date of application for relicensure may be relicensed under section 16201(3) of the code, MCL 333.16201(3), if the applicant meets both of the following requirements:

(a) Submits the required fee and a completed application on a form provided by the department.

(b) Submits proof to the department of accumulating not less than 150 hours of continuing education that meets the requirements of R 338.2443 during the 3 years immediately preceding the date of the application for relicensure.

(2) An applicant whose Michigan medical license has been lapsed for 3 years but less than 5 years shall satisfy the requirements of R 338.2437(1) and any of the following requirements:

(a) Presents evidence to the department that he or she was actively licensed as a medical doctor in another state at any time during the 3-year period immediately preceding the date of application.

(b) Takes and passes the Special Purpose Examination (SPEX) offered by the FSMB. The passing score shall be the score established by the FSMB for passing.

(c) Successfully completes a postgraduate training program that satisfies the requirements of R 338.2421(2), (3), (4), or (5).

(d) Successfully completes a physician re-entry program that satisfies either of the following requirements:

(i) Accredited by the coalition for physician enhancement.

(ii) Affiliated with a medical school that satisfies the requirements of R 338.2421(1).

(3) An applicant whose Michigan medical license has been lapsed for 5 years or more shall satisfy the requirements of R 338.2437(1) and any of the following requirements:

(a) Presents evidence to the department that he or she was actively licensed as a medical doctor in another state at any time during the 3-year time period immediately preceding the date of application.

(b) Successfully completes a post-graduate training program that satisfies the requirements of R 338.2421(2), (3), (4), or (5).

(c) Successfully completes a physician re-entry program that satisfies either of the following requirements:

(i) Accredited by the coalition for physician enhancement.

(ii) Affiliated with a medical school that satisfies the requirements of R 338.2421(1).

(4) If required to complete the requirements of subrule (2)(c), (2)(d), (3)(b), or 3(c) of this rule, the applicant may obtain an educational limited license for the sole purpose of completing that training.

(5) An applicant with an educational limited license may be relicensed under section 16201(3) or (4) of the code, MCL 333.16201(3) or (4), if he or she complies with subrule (1) of this rule and R 338.2429.

(6) An applicant shall have his or her license verified by the licensing agency of any state of the United States in which the applicant holds or has ever held a license to practice as a medical doctor. Verification shall include information the license is in good standing and, if applicable, the record of any disciplinary action taken or pending against the applicant.

Board of Medicine
 P.O. Box 30192
 Lansing, MI 48909
 (517) 335-0918
 www.michigan.gov/healthlicense

APPLICATION FOR MEDICAL DOCTOR LICENSE

Authority: Public Act 368 of 1978, as amended.

If this form is not completed, a license will not be issued

A controlled substance license is required for every person who prescribes, manufactures, distributes, or dispenses any controlled substance in Michigan. Information on obtaining a Federal controlled substance license may be obtained by contacting the Regional Branch, DEA, 431 Howard Street, Detroit, MI 48226 (1-800-882-9539).

Type or Print Only

I AM APPLYING FOR THE FOLLOWING:

- License by Examination Fee: \$150.00 71-4301-01
- Controlled Substance Fee: \$85.00 43-01 71-5315

Your check or money order drawn on a U.S. financial institution and made payable to the **STATE OF MICHIGAN** must accompany this application. **DO NOT SEND CASH.** Fees are deposited upon receipt and can only be refunded under refund rules promulgated by the Department.

Legal First Name	Legal Middle Name	Legal Last Name
U.S. Social Security Number	Date of Birth	Daytime Phone Number ()
Street Address		E-Mail Address
City	State	ZIP Code
All Previous Names and/or Birth Name Used (if applicable)		
Have you ever held a health professional license in Michigan? <input type="checkbox"/> Yes <input type="checkbox"/> No		Michigan Health Professional Permanent I.D. Number and Expiration Date

Board Use Only
License Number:
Controlled Substance License Number:
Date of Licensure:

Check the appropriate answer to each of the following questions. NOTE: Submit a detailed explanation for any YES answer you check on a separate sheet with your application.

1. Have you ever been convicted of a felony?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Have you ever been convicted of a misdemeanor punishable by imprisonment for a maximum of 2 years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Have you ever been convicted of a misdemeanor involving the illegal delivery, possession, or use of alcohol or a controlled substance (including motor vehicle violations)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Have you been treated for substance abuse in the past 2 years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Have you had 3 or more malpractice settlements, awards, or judgments in any consecutive 5 year period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Have you had one or more malpractice settlements, awards, or judgments totaling \$200,000 or more in any consecutive 5 year period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Have you ever had a federal or state health professional or controlled substance license revoked, suspended, or otherwise disciplined; been denied a license; or currently have disciplinary action pending against you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Have you ever been denied the privilege of taking an examination by any state medical board?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

The Department of Licensing and Regulatory Affairs will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

Name

9. Have you ever been censured, or requested to withdraw from a health care facility's staff or had your health care facility staff privilege involuntarily modified? Yes No
10. Do you hold or have you ever held a permanent medical license in any state, U.S. Territory or Canadian Province? If yes, list the state(s) U.S. Territory or Province in which you hold or have held a medicine license, the license or registration number, the date issued, and how the license was obtained. **DO NOT LIST TEMPORARY LICENSES. You must have each licensing agency verify licensure directly to this board office. (Attach additional sheets, if necessary)** Yes No

State, U.S. Territory or Province	License Number	Date of Issue	How obtained (Endorsement or examination)

Provide a complete chronological record of your educational preparation.
Attach additional sheets if necessary.

Name and Address of Institution	Dates of Attendance		Degree
	From	To	

Provide a description of your professional medical experience.
Attach additional sheets if necessary.

Name and Address of Employer	Dates of Practice		Duties
	From	To	

CERTIFICATION

I understand that it is the policy of this agency to secure a criminal conviction history as part of the pre-licensure screening process. I authorize this agency to use the information provided in this application to obtain a criminal conviction history file search from the Central Records Division of the Michigan Department of State Police or other law enforcement or judicial record-keeping organization.

I further consent to the release of information to this agency regarding any disciplinary investigations conducted by a similar licensure, registration, or specialty certification board of this or any other state, of the United States military, of the federal government, or of another country.

The statements in this application are true and correct. I have not withheld information that might affect the decision to be made on this application. In signing this application, I am aware that a false statement or dishonest answer may be grounds for denial of my application or revocation of my license and that such misrepresentation is punishable by law.

Signature of Applicant	Date
------------------------	------

Michigan Department of Licensing and Regulatory Affairs

Board of Medicine

P.O. Box 30192

Lansing, MI 48909

(517) 335-0918

www.michigan.gov/healthlicense

**CERTIFICATION OF MEDICAL EDUCATION FOR GRADUATES OF MEDICAL SCHOOLS
LOCATED IN THE UNITED STATES, ITS TERRITORIES, THE DISTRICT OF COLUMBIA, OR
THE DOMINION OF CANADA**

Authority: Public Act 368 of 1978, as amended
If this form is not completed, a license will not be issued.

INSTRUCTIONS TO APPLICANT:

Complete Section I. Type or print your legal name exactly as it appears on your application. For Section II, send this form to be completed by the Dean of the medical school you attended. This certification must be submitted directly to the Michigan Board of Medicine by the medical school.

SECTION I - APPLICANT INFORMATION

First Name	Middle Name	Last Name	
Social Security Number	Date of Birth	Daytime Telephone Number	
Street Address			
City	State	ZIP Code	
All Previous Names and/or Birth Name Used (if applicable)			
Date of Admission		Date of Graduation	

Signature of Applicant	Date
------------------------	------

APPLICANT: UPON COMPLETION OF SECTION I, SEND THIS FORM TO THE DEAN OF YOUR MEDICAL SCHOOL FOR COMPLETION OF SECTION II.

The Department of Licensing and Regulatory Affairs will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

Name

TO BE COMPLETED BY THE DEAN OR REGISTRAR OF THE MEDICAL SCHOOL

INSTRUCTIONS FOR COMPLETING SECTION II:

Please complete the following information. Return this completed certification directly to the Michigan Board of Medicine at the address shown on Page 1 of this form.

SECTION II - CERTIFICATION OF MEDICAL EDUCATION

Name of Medical School	
Street Address of Medical School	
City, State and ZIP Code	
<p>I certify that _____ attended the <small>(Applicant's Name)</small></p> <p>medical school named above from _____ to _____, <small>(Month/Day/Year) (Month/Day/Year)</small></p> <p>and was/will be granted the degree of _____ on <small>(Month/Day/Year)</small></p>	
_____ Signature of Dean or Registrar	_____ Date of Signature
_____ Print or Type Name of Dean or Registrar	(SEAL) If school has no seal, please indicate

CERTIFICATION OF POSTGRADUATE TRAINING

Authority: Public Act 368 of 1978, as amended
 If this form is not completed, a license will not be issued.

INSTRUCTIONS TO APPLICANT:

Complete Section I. Type or print your legal name exactly as it appears on your application. For completion of Section II, send this form to the Director of Medical Education where you completed your postgraduate training. This certification must be submitted directly to the Michigan Board of Medicine by the Director of Medical Education.

SECTION I - APPLICANT INFORMATION

First Name	Middle Name	Last Name
Social Security Number	Date of Birth	
Street Address		
City	State	ZIP Code
Daytime Telephone Number	All Previous Names and/or Birth Name Used (if applicable)	

Signature of Applicant	Date
------------------------	------

APPLICANT: UPON COMPLETION OF SECTION I, SEND THIS FORM TO THE DIRECTOR OF MEDICAL EDUCATION FOR COMPLETION OF SECTION II.

Name

TO BE COMPLETED BY THE DIRECTOR OF MEDICAL EDUCATION

INSTRUCTIONS FOR COMPLETING SECTION II:

Please complete the following information. Return this completed certification directly to the Michigan Board of Medicine at the address shown on Page 1 of this form.

SECTION II - CERTIFICATION OF POSTGRADUATE TRAINING

Name of Hospital
Street Address of Hospital
City, State and ZIP Code

I certify that _____ a graduate of the
 (Applicant's Name)

_____ medical school, has successfully completed postgraduate
 clinical training offered by the hospital named above from _____, to _____,
 (Month/Day/Year) (Month/Day/Year)

in the clinical area of _____.

Is this an active training program accredited by the ACGME, the College of Family Physicians of Canada, the Royal College of Physicians and Surgeons of Canada, or by the National Joint Committee on Accreditation of Preregistration Physician Training Programs of the Canadian Medical Association? Yes No

 Signature of Director of Medical Education

 Date of Signature

 Print or Type Name of Director of Medical Education

(SEAL)

If hospital has no seal, please indicate

NOTE: Certification of Postgraduate Training will not be accepted if signed and submitted more than 15 days prior to actual completion.

Board of Medicine

P.O. Box 30192

Lansing, MI 48909

(517) 335-0918

www.michigan.gov/healthlicense

CERTIFICATION OF PRACTICE IN AN ACADEMIC INSTITUTION

Authority: Public Act 368 of 1978, as amended
 If this form is not completed, a license will not be issued.

*** DO NOT COMPLETE THIS FORM UNLESS YOU HAVE HELD A CLINICAL ACADEMIC LICENSE ***

INSTRUCTIONS TO APPLICANT:

Complete Section I. Type or print your legal name exactly as it appears on your application. For Section II, send this form to be completed by your chief academic officer where you practiced under a **clinical academic limited license**. This certification must be submitted directly to the Michigan Board of Medicine by your Director of Medical Education.

SECTION I - APPLICANT INFORMATION

First Name	Middle Name	Last Name
Social Security Number	Date of Birth	
Street Address		
City	State	ZIP Code
Daytime Telephone Number	All Previous Names and/or Birth Name Used (if applicable)	

Signature of Applicant	Date
------------------------	------

APPLICANT: UPON COMPLETION OF SECTION I, SEND THIS FORM TO YOUR DIRECTOR OF MEDICAL EDUCATION WHERE YOU PRACTICED FOR COMPLETION OF SECTION II.

Name

TO BE COMPLETED BY THE DIRECTOR OF MEDICAL EDUCATION

INSTRUCTIONS FOR COMPLETING SECTION II:

Please complete the following information. Return this completed certification directly to the Michigan Board of Medicine at the address shown on Page 1 of this form.

SECTION II - CERTIFICATION OF PRACTICE IN AN ACADEMIC INSTITUTION

Name of Institution	
Street Address of Institution	
City, State and ZIP Code	
<p>I certify that _____ practiced medicine under a clinical <div style="text-align: center; margin-left: 150px;">Applicant's Name</div> academic limited license at the above institution in the clinical area of _____ from _____ to _____ and has functioned in the observation and <div style="text-align: center; margin-left: 100px;">Month/Day/Year Month/Day/Year</div> treatment of patients for not less than 800 hours per year and in so doing practiced medicine safely and competently. I further certify that the above-named academic institution meets all of the following requirements:</p> <p>A. Was the sole sponsor or a cosponsor, with either a medical school approved by the Michigan Board of Medicine or a hospital owned by the federal government and directly operated by the United States Department of Veterans' Affairs, of not less than 4 residency programs accredited by the Accreditation Council for Graduate Medical Education for not less than the 3 years immediately preceding the date of my signature below.</p> <p>B. Has spent not less than \$2,000,000 for medical education during each of the 3 years immediately preceding the date of my signature below. (As used in this statement, "medical education" means the education of physicians and candidates for degrees or licenses to become physicians, including physician staff, residents, interns and medical students).</p>	
_____ Signature of Director of Medical Education	_____ Date of Signature
_____ Print or Type Name of Director of Medical Education	<p>(SEAL)</p> <p>If institution has no seal, please indicate</p>

Board of Medicine

P.O. Box 30192

Lansing, MI 48909

(517) 335-0918

www.michigan.gov/healthlicense

**CERTIFICATION OF MEDICAL EDUCATION FOR
GRADUATES OF FOREIGN MEDICAL SCHOOL GRADUATES**

Authority: Public Act 368 of 1978, as amended
If this form is not completed, a license will not be issued.

INSTRUCTIONS TO APPLICANT:

Complete Section I. Type or print your legal name exactly as it appears on your application. For completion of Section II, send this form to the Dean of the medical school you attended. This certification must be submitted directly to the Michigan Board of Medicine by the medical school.

SECTION I - APPLICANT INFORMATION

First Name	Middle Name	Last Name
Social Security Number	Date of Birth	
Street Address		
City	State	ZIP Code
Daytime Telephone Number	All Previous Names and/or Birth Name Used (if applicable)	
Date of Admission	Date of Graduation	

Signature of Applicant	Date
------------------------	------

APPLICANT: UPON COMPLETION OF SECTION I, SEND THIS FORM TO THE DEAN OF YOUR MEDICAL SCHOOL FOR COMPLETION OF SECTION II.

The Department of Licensing and Regulatory Affairs will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

MINNESOTA

From the Minnesota statutes:

147.039 CANCELLATION OF LICENSE FOR NONRENEWAL.

The Board of Medical Practice shall not renew, reissue, reinstate, or restore a license that has lapsed on or after January 1, 1989, and has not been renewed within two annual license renewal cycles starting July 1, 1991. A licensee whose license is canceled for nonrenewal must obtain a new license by applying for licensure and fulfilling all requirements then in existence for an initial license to practice medicine in Minnesota.

APPLICATION FOR MEDICAL LICENSE

MINNESOTA BOARD OF MEDICAL PRACTICE
UNIVERSITY PARK PLAZA
2829 UNIVERSITY AVENUE SE, SUITE 500
MINNEAPOLIS, MINNESOTA 55414-3246
612-617-2130 or www.bmp.state.mn.us
Hearing Impaired-Minnesota Relay Service
Metro Area 297-5353
Outside Metro Area 1-800-627-3529



APPLICATION #: _____

CHECK/RECEIPT #: _____

AMT PAID: _____

LICENSE #: _____

Instructions to Applicant

1. The application will be returned if the fee is not included or the questions are not answered completely, accurately, and legibly.
2. Account for all time from the beginning of high school, whether spent in school, practice, or otherwise. Dates must include Month and Year. Attach separate sheet if necessary.
3. Failure to answer all questions completely and accurately, omission or falsification of material facts, alteration of application may be cause for denial of your application, or disciplinary action if you are subsequently licensed by the Board.
4. Incomplete applications may be destroyed after six months of inactivity.

ACCOUNT CODE	AMOUNT
635009 lic	_____
635010 app	_____
635064 cbc	_____

Medical Professional Name If your name has changed at any time during your life and you are not using FCVS, submit a copy of the legal documentation (marriage certificate, divorce decree, etc.).

Last Name _____

First Name _____

Middle Name _____

Maiden Name _____

All Other Names Used _____

Designated Address (Public, required by Minn. Stat. 13.41, Subd. 2, will be placed on license and on our website)

Street _____

City _____ State _____ Zip Code _____ Country _____

Phone _____ Email (optional) _____

Private Address (cannot be accessed by public)

Street _____

City _____ State _____ Zip Code _____ Country _____

Phone _____ Email (REQUIRED) _____

Intended Address (if known) Effective Date _____

Street _____

City _____ State _____ Zip Code _____ Country _____

Applicant Name _____ Last 4 digits of SSN _____ Date _____

Identification Submit a notarized copy of your US/Canadian driver's license.

Date of Birth (mm/dd/yyyy) _____ Birth City _____ Birth State _____
Birth County _____ Birth Country _____ Gender _____
Driver's license: State _____ Number _____ SSN _____ NPI _____
Height (ft/in) _____ Weight (lbs) _____ Hair Color _____ Eye Color _____

Minn. Stat. § 147.091 Subd. 7(d) requires all applicants to provide their social security number on their license application for the administration of the state tax code. Your social security number is private. Your social security number is also required to facilitate reporting of the DataBank and for accurate identification under the federal and state child support enforcement law. The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard and a unique number for covered health care providers.

Medical School List all medical schools you have attended including those from which you did not graduate. If you are not using FCVS, complete the "Medical Education Verification" form and send to all medical schools you have attended. Include a copy of your diploma for the medical school to attach their seal prior to forwarding to the Minnesota Board.

1. School Name _____
Address _____
City _____ State _____ Zip Code _____ Country _____
Attended from _____ to _____ Graduation Date _____ Degree _____
(mm/dd/yyyy) (mm/dd/yyyy) (mm/dd/yyyy)

2. School Name _____
Address _____
City _____ State _____ Zip Code _____ Country _____
Attended from _____ to _____ Graduation Date _____ Degree _____
(mm/dd/yyyy) (mm/dd/yyyy) (mm/dd/yyyy)

ECFMG Certification If ECFMG is applicable and you are not using FCVS, log on to www.ecfm.org/cvs/index.html for the request form or to submit the request online. Confirmations are sent directly to the Minnesota Board. .

Certificate Number _____ Issue Date _____ Valid Through Date _____

Military Service. Submit a notarized copy of military discharge papers (DD Form 214), if applicable.

Branch of Service _____ Entry Date (mm/dd/yyyy) _____ Release Date (mm/dd/yyyy) _____
Rank at Discharge _____ Type of Discharge _____

Exam History. Contact the appropriate examination entity (see instructions) and arrange to have a certified transcript of your scores sent **DIRECTLY** to this Board. See Fact Sheet for exam requirements. Please check all that apply:

___ FLEX ___ LMCC ___ National Board (NBME) ___ USMLE ___ NBOME/COMLEX
___ State Board Exam (prior to 1973) Which State? _____ Date(s) passed? _____

Applicant Name _____ Last 4 digits of SSN _____ Date _____

Proposed practice plans in Minnesota (if any): _____

Current* specialty board certification (check one):

American Board of Medical Specialties
 Royal College of Physicians and Surgeons of Canada
 College of Family Physicians of Canada
 American Osteopathic Association Bureau of Professional Education
 None of the above

Specialty _____
Issue Date _____
Expiration Date _____

*If it has been more than 10 years since your initial licensing exam, the SPEX exam is required unless currently specialty board certified.

US/Canadian Licensure Complete the attached "Licensure Verification" form and forward to US/Canadian board issuing any type of medical license including training, locum tenens, and temporary permit even if license is not current. Attach an additional sheet as necessary. The verifying entity must forward all documentation **DIRECTLY** to this Board. Some boards charge a fee for this information.

State _____ License Number _____ Date Issued _____
State _____ License Number _____ Date Issued _____

Countries (other than U.S. and Canada) in which you have ever been licensed:

Country _____ License Number _____ Date Issued _____
Country _____ License Number _____ Date Issued _____
Country _____ License Number _____ Date Issued _____

High school (attach a separate sheet, if necessary)

From (mo/yr): _____ High School _____
To (mo/yr): _____ City _____ State _____ Country _____

College education (attach a separate sheet, if necessary)

From (mo/yr): _____ College _____
To (mo/yr): _____ City _____ State _____ Country _____

Applicant Name _____ Last 4 digits of SSN _____ Date _____

Activities (copy and attach additional pages as needed) List below **all medical and non-medical activities** beginning with your graduation from high school to the present date including periods of unemployment and military duty and excluding post graduate training listed on page 5. For any non-working time, state on the form what your activities were (e.g. vacation, seeking employment). If you did locum tenens, list facilities where you worked.

From (mo/yr): Activity _____
 _____ Address _____
 To (mo/yr): City _____ State _____ Country _____
 _____ Position _____ % Clinical _____ %Administrative _____

From (mo/yr): Activity _____
 _____ Address _____
 To (mo/yr): City _____ State _____ Country _____
 _____ Position _____ % Clinical _____ %Administrative _____

From (mo/yr): Activity _____
 _____ Address _____
 To (mo/yr): City _____ State _____ Country _____
 _____ Position _____ % Clinical _____ %Administrative _____

From (mo/yr): Activity _____
 _____ Address _____
 To (mo/yr): City _____ State _____ Country _____
 _____ Position _____ % Clinical _____ %Administrative _____

From (mo/yr): Activity _____
 _____ Address _____
 To (mo/yr): City _____ State _____ Country _____
 _____ Position _____ % Clinical _____ %Administrative _____

From (mo/yr): Activity _____
 _____ Address _____
 To (mo/yr): City _____ State _____ Country _____
 _____ Position _____ % Clinical _____ %Administrative _____

From (mo/yr): Activity _____
 _____ Address _____
 To (mo/yr): City _____ State _____ Country _____
 _____ Position _____ % Clinical _____ %Administrative _____

Applicant Name _____ Last 4 digits of SSN _____ Date _____

Postgraduate Training: List **all** postgraduate programs you have attended, even those you did not complete. If you are not using FCVS, you must complete the attached "Post graduate Training Verification" form and send to **all** postgraduate training programs you have attended. Submit a copy of your certificate of program completion. The post graduate program must forward the documentation **DIRECTLY** to this Board. Copy and attach additional pages if necessary

1. Hospital Name _____
Hospital Address _____
City _____ State _____ Zip Code _____ Country _____
PGY: (e.g., 1, 2, 3, etc.) ___ Internship ___ Residency ___ Fellowship ___ Research ___ Other
Department/Specialty _____
From ____/____/____ To ____/____/____ Successfully Completed? ___ Yes ___ No ___ In Progress
Month Year Month Year

2. Hospital Name _____
Hospital Address _____
City _____ State _____ Zip Code _____ Country _____
PGY: (e.g., 1, 2, 3, etc.) ___ Internship ___ Residency ___ Fellowship ___ Research ___ Other
Department/Specialty _____
From ____/____/____ To ____/____/____ Successfully Completed? ___ Yes ___ No ___ In Progress
Month Year Month Year

3. Hospital Name _____
Hospital Address _____
City _____ State _____ Zip Code _____ Country _____
PGY: (e.g., 1, 2, 3, etc.) ___ Internship ___ Residency ___ Fellowship ___ Research ___ Other
Department/Specialty _____
From ____/____/____ To ____/____/____ Successfully Completed? ___ Yes ___ No ___ In Progress
Month Year Month Year

4. Hospital Name _____
Hospital Address _____
City _____ State _____ Zip Code _____ Country _____
PGY: (e.g., 1, 2, 3, etc.) ___ Internship ___ Residency ___ Fellowship ___ Research ___ Other
Department/Specialty _____
From ____/____/____ To ____/____/____ Successfully Completed? ___ Yes ___ No ___ In Progress
Month Year Month Year

Applicant Name _____ Last 4 digits of SSN _____ Date _____

Attestation questions Except for questions 1-4, please answer all questions by selecting Yes or No and provide an explanation when requested. Questions 1-4 do not have "No" as an option for confidentiality reasons. If you have a condition addressed by questions 1-4 and you are NOT participating in Health Professionals Services Program (HPSP) for monitoring of the condition, you must answer "Yes" to the applicable question(s). If you do not have this condition, OR if you are participating in HPSP for monitoring of this condition, do not answer the applicable question(s). For questions 1-2, the terms "impaired" and "limited" include but are not limited to impairments or limitations related to physical, psychological, or emotional disorders or conditions, or chemical dependency or chemical abuse. The purpose and intended use of this information is to enable the Board to determine whether you meet statutory and rule requirements for licensure. This information is classified as private while your application is pending and public after your license is granted. Exception: "Yes" answers are confidential during any investigation and private thereafter. This information will NOT be included in the profiling. If responses to questions change during the time your application is pending, you must make the board aware of the new information. If additional space is necessary please attach a separate sheet.

Yes 1. Is your cognitive, communicative, or physical capability to engage in the practice of medicine or surgery with reasonable skill and safety impaired or limited in any way? Please describe.

Yes No 1a. If yes, are the limitations or impairments reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? Please describe.

Yes No 1b. If yes, are the limitations or impairments reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? Please describe.

Yes 2. Does your use of alcohol or chemical substance(s), including prescription medications, in any way impair or limit your ability to practice medicine with reasonable skill and safety? Please describe.

Yes 3. Are you engaged in any illegal use of controlled substances including the use of illegal controlled substances (e.g. heroin, cocaine) or illegal use of legal controlled substances (i.e. not obtained pursuant to a valid prescription of a licensed health care provider)? Please describe.

Yes No 3a. If yes, have you taken any steps (i.e. treatment, psychotherapy, participation in a support group) to discontinue or reduce such use? Please describe.

Yes No 3b. If yes, are you not participating in a supervised rehabilitation program or professional assistance program which has as a component a monitoring regimen designed to assure that you are not currently engaging in the use of illegal controlled substances? Please describe.

Applicant Name _____ Last 4 digits of SSN _____ Date _____

Yes 4. Have you within the past five years been advised by your treating physician that you have a mental, physical, or emotional condition, which, if untreated, would be likely to impair your ability to practice medicine with reasonable skill and safety? If you answer this question "yes", please answer the following:

Yes No 4a. With regard to any condition referenced above, are you being treated so that such impairment is avoided?

Yes No 4b. With regard to any condition referenced above, are you in compliance with the recommended treatment?

Yes No 4c. With regard to any condition referenced above, has your treating physician advised you that you are able to practice medicine with reasonable skill and safety?

4d. Please explain _____

4e. Identify your treating physician _____

Yes No 5. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism, or other sexual behavior disorders? Please describe.

Yes No 6. Have you ever been the subject of an investigation by any Federal, State, or Local agency having jurisdiction over controlled substances? If so, give particulars.

Yes No 7. Have you ever been denied a license, or the privilege of taking an examination before any medical examining board, or has a conditioned license been issued to you by any state medical board or licensing authority? If so, give particulars.

Yes No 8. Has your license to practice medicine in any state or country been voluntarily or involuntarily (i.e. by medical Board Order or any other form of disciplinary action) revoked, suspended, restricted, or conditioned by a Medical Board or other licensing authority? If so, give particulars.

Yes No 9. Have you ever been notified of any investigation by any state medical board, medical society, or any hospital of any complaints against you relative to the practice of medicine, or have you been reprimanded or censure by any medical society or licensing board? If so, give particulars.

Yes No 10. Have you ever been a defendant in any malpractice lawsuits, had any malpractice settlement, or have any pending? If so, give a detailed clinical explanation of each case on the Malpractice Liability Claims Information form as well as documentation of outcome (insurance papers or court documents).

Yes No 11. Have your hospital privileges been restricted or revoked? If so, give particulars.

Applicant Name _____ Last 4 digits of SSN _____ Date _____

Yes No 12. Have there ever been any criminal charges filed against you? This includes charges of disorderly conduct, assault or battery, or domestic abuse, whether the charges were misdemeanor, gross misdemeanor, or felony. This also includes any offenses which have been expunged or otherwise removed from your record by executive pardon. If so, submit a personal statement regarding the date of conduct, state and local jurisdiction in which the charges were filed, date of closure, what role you played, and the outcome.

Yes No 13. Have there ever been any charges of Driving While Intoxicated (DWI) or Driving Under the Influence (DUI) or other impaired driving offenses involving alcohol or other chemical filed against you? If so, submit a detailed personal statement regarding the date of conduct, state and local jurisdiction in which the charges were filed, explaining in detail the incident and consequences including whether a CD evaluation was done (if so, submit results), and description of current drinking habits.

Yes No 14. Have you ever voluntarily or involuntarily surrendered your DEA certificate or the right to prescribe controlled substances? If so, give particulars.

Applicant Name _____ Last 4 digits of SSN _____ Date _____

Certificate of Ethical and Moral Character

This certificate must be signed by **two** licensed physicians who are personally acquainted with the applicant.

1.

I certify that the photograph attached is a recent one and likeness of Dr. _____

And that s/he is a person of good ethical and moral character.

SIGNATURE	DATE	LICENSE NUMBER	STATE OF ISSUE
PRINT OR TYPE FULL NAME			

CERTIFICATION OF IDENTIFICATION

Certification of Notary Public is required.

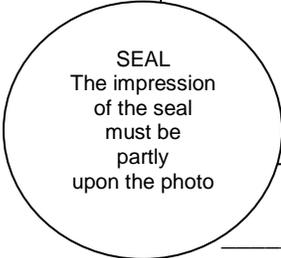
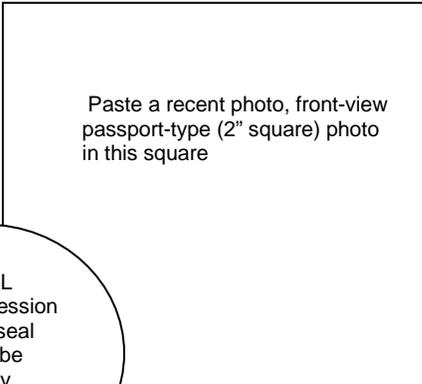
State: _____ County: _____

I certify that on the date set forth below, the individual named above did appear Personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document. Sworn to before me by the

applicant on this _____ day of _____, _____.

Notary Public Signature _____

Expiration Date ____ / ____ / ____
Month Day Year



 Applicant's Signature

2.

I certify that the photograph attached is a recent one and likeness of Dr. _____

And that s/he is a person of good ethical and moral character.

SIGNATURE	DATE	LICENSE NUMBER	STATE OF ISSUE
PRINT OR TYPE FULL NAME			

Applicant Name _____ Last 4 digits of SSN _____ Date _____

Affidavit and Release

I, the undersigned, hereby certify under oath that I am the person described and identified; that I have not engaged in any of the acts prohibited by the statutes of Minnesota: that I am the person named in the diploma, which accompanies this application; that I am the lawful holder of said diploma; that said diploma was procured in the regular course of instruction and examination without fraud or misrepresentation.

I hereby authorize all educational institutions, hospitals, medical institutions or organizations, clinics, my references, personal physicians, employers (past and present), business and professional associates (past and present), all governmental agencies and instrumentalities (local, state, federal or foreign) to release to this licensing Board any information, files, or records including (but not limited to) transcripts, medical records, personnel files, and any information, favorable or otherwise, the Board may require for its evaluation of my professional, ethical, and physical qualifications for licensure in Minnesota.

I hereby release, discharge, and exonerate the Board, its agents, and representatives, and any person furnishing information to the Board from any and all liability of every nature and kind arising out of the furnishing of oral information or of documents, records, or other information to the Board.

I have carefully read the questions in the in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension or revocation of my license to practice medicine in Minnesota. I understand that I am required to update my application with pertinent information to cover the time period between date of application and date approved by the Board.

State of: _____, County of: _____

Sworn to before me this _____ day of _____, _____.

Signature of Applicant

Date of signature (must correspond to date of notarization)

Signature of Notary Public
My Commission Expires: _____

RIGHTS OF SUBJECTS OF DATA

The information on your application is requested by the Minnesota Board of Medical Practice. The purpose and intended use of this information is to enable the Board to determine whether you meet statutory and rule requirements for licensure. The information is classified as private while your application is pending or if your application is denied, and as public if your license is granted. You are required to submit this information. Your application will not be processed without it and the form will be returned to you for completion. This information may be used as the basis for further investigation by the Board into your qualifications. Under some circumstances, the information could become available to other agencies or persons authorized by law to have access. Attach a separate page for detailed explanations, when appropriate. Failure to answer all questions completely and accurately, omission or falsification of material fact, alteration of application may be cause for denial of your application, or disciplinary action if you are subsequently licensed by the Board.

Applicant Name _____ Last 4 digits of SSN _____ Date _____

NORTH CAROLINA

From North Carolina's administrative code:

21 NCAC 32B .1350 REINSTATEMENT OF PHYSICIAN LICENSE

(a) "Reinstatement" is for a physician who has held a North Carolina License, but whose license either has been inactive for more than one year, or whose license became inactive as a result of disciplinary action (revocation or suspension) taken by the Board. It also applies to a physician who has surrendered a license prior to charges being filed by the Board.

(b) All applicants for reinstatement shall:

(1) submit a completed application which can be found on the Board's website in the application section at <http://www.ncmedboard.org/licensing>, attesting under oath or affirmation that information on the application is true and complete, and authorizing the release to the Board of all information pertaining to the application;

(2) submit documentation of a legal name change, if applicable;

(3) supply a certified copy of the applicant's birth certificate if the applicant was born in the United States or a certified copy of a valid and unexpired U.S. passport. If the applicant does not possess proof of U.S. citizenship, the applicant shall provide information about the applicant's immigration and work status which the Board shall use to verify the applicant's ability to work lawfully in the United States. Applicants who are not present in the U.S. and who do not plan to practice physically in the US shall submit a written statement to that effect.

(4) furnish an original ECFMG certification status report of a currently valid certification of the ECFMG if the applicant is a graduate of a medical school other than those approved by LCME, AOA, COCA, or CACMS. The ECFMG certification status report requirement shall be waived if:

(A) the applicant has passed the ECFMG examination and successfully completed an approved Fifth Pathway program (original ECFMG score transcript from the ECFMG required); or

(B) the applicant has been licensed in another state on the basis of a written examination before the establishment of the ECFMG in 1958;

(5) submit the AMA Physician Profile; and, if the applicant is an osteopathic physician, also submit the AOA Physician Profile;

(6) submit a NPDB/HIPDB report dated within 60 days of the application's submission;

(7) submit a FSMB Board Action Data Bank report;

(8) submit documentation of CME obtained in the last three years, upon request;

(9) submit two completed fingerprint cards supplied by the Board;

(10) submit a signed consent form allowing a search of local, state, and national files to disclose any criminal record;

(11) provide two original references from persons with no family or material relationship to the applicant. These references shall be:

(A) from physicians who have observed the applicant's work in a clinical environment within the past three years;

(B) on forms supplied by the Board;

(C) dated within six months of submission of the application; and

(D) bearing the original signature of the author;

(12) pay to the Board a non-refundable fee pursuant to G.S. 90-13.1(a), plus the cost of a criminal background check; and

(13) upon request, supply any additional information the Board deems necessary to evaluate the applicant's qualifications.

(c) In addition to the requirements of Paragraph (b) of this Rule, the applicant shall submit proof that the applicant has:

(1) within the past 10 years taken and passed either:

(A) an exam listed in G.S. 90-10.1 (a state board licensing examination; NBME; NBOME; USMLE; FLEX; COMLEX; or MCCQE or their successors);

(B) SPEX (with a score of 75 or higher); or

(C) COMVEX (with a score of 75 or higher);

(2) within the past ten years:

(A) obtained certification or recertification of CAQ by a specialty board recognized by the ABMS, CCFP, FRCP, FRCS or AOA; or

(B) met requirements for ABMS MOC (maintenance or certification) or AOA OCC (Osteopathic continuous Certification);

(3) within the past 10 years completed GME approved by ACGME, CFPC, RCPSC or AOA; or

(4) within the past three years completed CME as required by 21 NCAC 32R .0101(a), .0101(b), and .0102.

(d) All reports shall be submitted directly to the Board from the primary source, when possible. If a primary source verification is not possible, then a third party verification shall be submitted.

(e) An applicant shall be required to appear in person for an interview with the Board or its agent to evaluate the applicant's competence and character if the Board needs more information to complete the application.

(f) An application must be complete within one year of submission. If not, the applicant shall be charged another application fee plus the cost of another criminal background check.

(g) Notwithstanding the above provisions of this Rule, the licensure requirements established by rule at the time the applicant first received his or her equivalent North Carolina license shall apply. Information about these Rules is available from the Board.

21 NCAC 32B .1360 REACTIVATION OF PHYSICIAN LICENSE

(a) "Reactivation" applies to a physician who has held a physician license in North Carolina, and whose license has been inactive for up to one year except as set out in Rule .1704(e) of this Subchapter. Reactivation is not available to a physician whose license became inactive either while under investigation by the Board or because of disciplinary action by the Board. (b) In order to reactivate a Physician License, an applicant shall:

(1) submit a completed application which can be found on the Board's website in the application section at <http://www.ncmedboard.org/licensing>, attesting under oath that the information on the application is true and complete, and authorizing the release to the Board of all information pertaining to the application;

(2) supply a certified copy of the applicant's birth certificate if the applicant was born in the United States or a certified copy of a valid and unexpired US passport. If the applicant does not possess proof of U.S. citizenship, the applicant shall provide information about the applicant's immigration and work status which the Board shall use to verify the applicant's ability to work lawfully in the United States; Those applicants who are not present in the US and who do not plan to practice physically in the US shall include a statement to that effect in the application.

(3) submit a FSMB Board Action Data Bank report;

(4) submit documentation of CME obtained in the last three years;

(5) submit two completed fingerprint record cards supplied by the Board;

(6) submit a signed consent form allowing search of local, state, and national files for any criminal record;

(7) pay to the Board a non-refundable fee pursuant to G.S. 90-13.1(a), plus the cost of a criminal background check; and

(8) upon request, supply any additional information the Board deems necessary to evaluate the applicant's competence and character, if the Board needs more information to complete the application.

(c) An applicant may be required to appear in person for an interview with the Board or its agent to evaluate the applicant's competence and character.

(d) Notwithstanding the above provisions of this Rule, the licensure requirements established by rule at the time the applicant first received his or her equivalent North Carolina license shall apply. Information about these Rules is available from the Board.

21 NCAC 32B .1370 REENTRY TO ACTIVE PRACTICE

(a) An applicant for licensure who has not actively practiced or who has not maintained continued competency for the two-year period immediately preceding the filing of an application for a license shall complete a reentry agreement as a condition of licensure.

(b) The first component of a reentry agreement involves assessing the applicant's current strengths and weaknesses in the intended area(s) of practice. The process may include testing and evaluation by colleagues, educators or others.

(c) The second component of the reentry agreement is education. Education shall address the applicant's area(s) of needed improvement and consist of a reentry period of retraining and education upon terms based on the factors set forth in Paragraph (d) of this Rule.

(d) Factors that may affect the length and scope of the reentry plan include:

(1) The applicant's amount of time out of practice;

(2) The applicant's prior intensity of practice;

(3) The reason for the interruption in practice;

(4) The applicant's activities during the interruption in practice, including the amount of practice relevant continuing medical education;

(5) The applicant's previous and intended area(s) of practice;

(6) The skills required of the intended area(s) of practice;

(7) The amount of change in the intended area(s) of practice during the time the applicant has been out of continuous practice;

(8) The applicant's number of years of graduate medical education;

(9) The number of years since the applicant completed graduate medical education; and

(10) As applicable, the date of the most recent ABMS, AOA or National Commission on Certification of Physician Assistant certification or recertification.

(e) If the Board approves an applicant's plan for reentry, the approved plan shall be incorporated by reference into a reentry agreement and executed by the applicant, the Board, and any applicable Board agents assisting with the reentry agreement.

(f) After the reentry agreement has been executed, and the applicant has completed all other requirements for licensure, the applicant shall receive a License. The licensee may not practice outside of the scope of the reentry agreement during the reentry period.

(g) Unsatisfactory completion of the reentry agreement or practicing outside the scope of the reentry agreement shall result in the automatic inactivation of the licensee's license unless the licensee requests a hearing within 30 days of receiving notice from the Board.

(h) Upon successful completion of the reentry agreement, the Board shall terminate the reentry agreement.

Table 25 (continued)
Physician Re-entry Regulations

	Board has policy on physician re-entry to practice*	Length of time out of practice after which re-entry program completion is required	Board developing/ planning to develop policy	Decided on Case-by-Case Basis	SPEX/ COMVEX May Be Required	CME May Be Required	Notes
Maryland	Yes	5 yrs	—	Yes	Yes		A physician with license on inactive status or who has failed to renew a license by the 2-month late renewal period and who wishes to practice medicine may apply for reinstatement.
Massachusetts	No		Yes				Must complete "re-entry to practice plan."
Michigan	No		No			Yes	Complete 150 hours of CME with a minimum of 75 hrs AMA Category 1 within immediately previous 3 yrs from date of application.
Michigan DO	No		No			Yes	(See above)
Minnesota	Yes	3 yrs	—	Yes	Yes	Yes	Assessment or mentorship may be required.
Mississippi	Yes	3 yrs	—				Board-approved physician assessment or clinical skills assessment program.
Missouri	No		Yes				
Montana	Yes	2 yrs	—		Yes		
Nebraska	Yes	2 yrs	—	Yes			May issue a re-entry license (Neb. Rev. Stat. 38-202601).
Nevada	Yes	1 yr	—		Yes	Yes	PACE, CPEP peer review, preceptorship, or fellowship may be required.
Nevada DO	Yes		—			Yes	Additional \$500 and proof of CME for inactive yrs required to reactivate practice.
New Hampshire	No		Yes	Yes			
New Jersey	Yes	5 yrs	—	Yes	Yes	Yes	See Board regulation NJAC 13:35-3.14
New Mexico	Yes	2 yrs	—			Yes	Mini-Sabbatical or CPEP may be required.
New Mexico DO							
New York	No		No				A licensed physician in inactive status must re-register.
North Carolina	Yes	2 yrs	—			Yes	Completion of re-entry program required. See 21 NCAC 32B.1370
North Dakota	No		Yes	Yes			Re-entry plan developed, as appropriate.
Ohio	Yes	2 yrs	—		Yes		Exam to determine current fitness to practice or Board certification or recertification examination may be required (Sec 4731.222)
Oklahoma	No		Yes				
Oklahoma DO	No		No	Yes			
Oregon	Yes	2 yrs	—				A physician out of practice more than 24 months may be required to take a competency exam or training. Refer to OAR 847-020-0183.
Pennsylvania	Yes	4 yrs	—		Yes	Yes	Re-entry to practice plan may be required, to include completion of a clinical skills assessment program, refresher training, mentorship program, a mini-residency, passing ABMS board exams, etc.
Pennsylvania DO	No		Yes		Yes	Yes	Additional training may be required, as well as completion of application and payment of fee.
Puerto Rico							
Rhode Island	No		Yes			Yes	Mentorship may be required.

(continued on next page)

In the spaces below, give an accurate record of your educational preparation. **Be sure to complete items A-E for each school.** Please print. List diploma or degree titles in original language and translate. If no diploma or degree, indicate number of credits earned. Attach additional sheets if necessary.

A. NAME OF SCHOOLS ATTENDED AND LOCATIONS	B. NUMBER OF YEARS ATTENDED	C. ATTENDANCE		D. TITLE OF DIPLOMA OR DEGREE OBTAINED (INDICATE MONTH/YEAR OBTAINED)	E. IF NO DIPLOMA OR DEGREE, INDICATE NUMBER OF CREDITS EARNED
		Entrance Date	Leaving Date		
<p><i>High School or Secondary School</i></p> <p>School Name _____ A _____</p> <p>City _____ State/Country _____</p>	B	____/____ C ____/____ mo yr mo yr		D	E
<p><i>Postsecondary Preprofessional School(s) (Exclusive of Medical School)</i></p> <p>School Name _____</p> <p>City _____ A State/Country _____</p> <p>School Name _____</p> <p>City _____ State/Country _____</p>	B	____/____ C ____/____ mo yr mo yr		D	E
<p><i>Medical Education (Professional, list all medical schools attended)</i></p> <p>School Name _____</p> <p>City _____ A State/Country _____</p> <p>School Name _____</p> <p>City _____ State/Country _____</p>	B	____/____ C ____/____ mo yr mo yr		D	E

If you completed clinical clerkships in a country other than where your medical school is located, give the dates and location of these clerkships. Attach additional sheets if necessary.

Inclusive Clerkship Dates	Clinical Area	Name of Health Care Facility And Address	Medical School with which Clerkship Affiliated and Address

17 Are you licensed or have you ever been licensed as a physician in any other state or country? Yes No
 If **yes**, list each jurisdiction. If appropriate, you must also submit a Form 3A or 3B. See *Examination Requirements* section of instructions.

State or Country	Date License Issued	Number	Basis of Licensure			Any Limitations on License
			Examination (Date passed)	Endorsement	Other	

18 Are you applying for licensure on the basis of a Fifth Pathway program? Yes No
 If Yes, list name and location of medical school or hospital and the inclusive dates of attendance.

Name and Location of Medical School or Hospital	Inclusive Dates of Attendance

19 List in English, all specialty qualifications you have earned. (i.e., Board Specialty Certification or Diplomate Certificate)

Name of Qualifications	Name and location of organization issuing credential

20 I will be applying to the Federation of State Medical Boards (FSMB) for USMLE Step 3
 OR
 I have successfully completed the examination combination indicated below:

EXAMINATION COMBINATIONS

<input type="checkbox"/> USMLE Steps 1, 2, and 3	<input type="checkbox"/> USMLE Step 1, NBME Part II, and USMLE Step 3
<input type="checkbox"/> FLEX Parts I, II, and III	<input type="checkbox"/> USMLE Steps 1 and 2 and NBME Part III
<input type="checkbox"/> FLEX Components I and II	<input type="checkbox"/> USMLE Step 1, NBME Part II, and FLEX Component II
<input type="checkbox"/> NBME Parts I, II, and III	<input type="checkbox"/> NBME Part I, USMLE Step 2, and FLEX Component II
<input type="checkbox"/> NBME Parts I and II and USMLE Step 3	<input type="checkbox"/> USMLE Steps 1 and 2 and FLEX Component II
<input type="checkbox"/> NBME Part I, USMLE Step 2 and NBME Part III	<input type="checkbox"/> NBME Parts I and II and FLEX Component II
<input type="checkbox"/> NBME Part I, and USMLE Steps 2 and 3	<input type="checkbox"/> FLEX Component I and USMLE Step 3
<input type="checkbox"/> USMLE Step 1, and NBME Parts II and III	<input type="checkbox"/> NBOME Parts I, II, and III
	<input type="checkbox"/> Other: _____

Date examination sequence was completed _____

21

Provide a chronological list of all activities **since graduation from professional school to the present**. Include residency, employment and vacation periods. Be sure there are **no gaps in time** from the **ending date of one activity** to the **beginning date of the next activity**. **Any gap in time will cause a delay in the processing of your application**. Attach additional sheets if necessary.

Graduation Date from Medical School: _____ / _____ / _____
mo. day yr.

1. Beginning _____ / _____ Ending _____ / _____ Type of activity Residency Employment Vacation
month year month year (if residency or employment, fill out name and address below)

Name of Employer/Facility _____

Address _____
Street City State ZIP Code

2. Beginning _____ / _____ Ending _____ / _____ Type of activity Residency Employment Vacation
month year month year (if residency or employment, fill out name and address below)

Name of Employer/Facility _____

Address _____
Street City State ZIP Code

3. Beginning _____ / _____ Ending _____ / _____ Type of activity Residency Employment Vacation
month year month year (if residency or employment, fill out name and address below)

Name of Employer/Facility _____

Address _____
Street City State ZIP Code

4. Beginning _____ / _____ Ending _____ / _____ Type of activity Residency Employment Vacation
month year month year (if residency or employment, fill out name and address below)

Name of Employer/Facility _____

Address _____
Street City State ZIP Code

5. Beginning _____ / _____ Ending _____ / _____ Type of activity Residency Employment Vacation
month year month year (if residency or employment, fill out name and address below)

Name of Employer/Facility _____

Address _____
Street City State ZIP Code

22

If you hold a New York State license in another profession, indicate the profession, your license number and date of licensure below.

Profession	License Number	Date of Initial Licensure (mm/dd/yy)
_____	_____	____ / ____ / ____
_____	_____	____ / ____ / ____
_____	_____	____ / ____ / ____
_____	_____	____ / ____ / ____

23

CHILD ABUSE IDENTIFICATION AND REPORTING: (check only one of the following.)

- I graduated from a **medical school** in New York State after September 1, 1990.
- I completed the child abuse coursework and have enclosed a certificate of completion from an approved provider.
- I am filing for an exemption to the requirement and have enclosed the exemption form.
- I am going to take the Child Abuse Identification course and submit the required form.

CITIZENSHIP/IMMIGRATION STATUS

Federal law and the Regulations of the Commissioner of Education (8 NYCRR §59.4) limit the issuance of professional licenses, registrations and limited permits to United States citizens or qualified aliens. To comply with Federal law and Commissioner's regulation, you must complete this section of this form and check the appropriate box below which indicates your citizenship/immigration status.

I am:

- A. A United States citizen or National.
- B. An alien lawfully admitted for permanent residence in the United States.
- C. An alien granted asylum under Section 208 of the Immigration and Nationality Act.
- D. A refugee granted asylum under Section 207 of the Immigration and Nationality Act.
- E. An alien paroled into the United States under Section 212 (d)(5) of the Immigration and Nationality Act for a period of at least 1 year.
- F. An alien whose deportation is being withheld under Section 241 (b)(3) of the Immigration and Nationality Act.
- G. An alien granted conditional entry pursuant to Section 203 (a)(7) of the Immigration and Nationality Act as in effect prior to April 1980.
- H. Non Immigrant (Temporarily in U.S.) Please list Visa type or immigration status or attach a copy of your passport if you are not required to have a Visa to enter the United States: _____
- I. I am an alien not unlawfully present in the United States pursuant to the Deferred Action for Childhood Arrivals (DACA) relief or similar relief from deportation. Please specify: _____
- J. I do not reside in the United States.

If you checked any of the boxes from B-I, enter your alien registration number or control number issued by the United States Citizenship and Immigration Services (USCIS): USCIS number: _____

QUESTIONS ABOUT YOUR IMMIGRATION STATUS AND WHETHER OR NOT IT IS A QUALIFYING STATUS UNDER FEDERAL LAW SHOULD BE DIRECTED TO THE U.S. CITIZENSHIP AND IMMIGRATION SERVICES (USCIS) BY CALLING 1-800-375-5283, OR VISIT THEIR WEB SITE AT WWW.USCIS.GOV.

CHILD SUPPORT OBLIGATION:

Everyone applying for a professional license, permit, or registration, or any renewal thereof, must file a written statement that, as of the date of the filing, she or he is, or is not, under an obligation to pay child support*. **Individuals who are four months or more in arrears in child support or who have failed to comply with a summons, subpoena or warrant relating to a paternity or child support proceeding may be subject to suspension of their business, professional, drivers and/or recreational licenses and permits.** The intentional submission of false written statements for the purpose of frustrating or defeating the lawful enforcement of support obligations is punishable under section 175.35 of the Penal Law.

You must complete this section before we can issue the credential for which you have applied. Individuals who are not in compliance with their obligation to pay child support can be issued a credential for no more than six months in order to comply with their child support obligations.

Check only A or B below. If you check B, you must check one of the five statements listed below it.

- A I am **not** under an obligation to pay child support;
- OR
- B I am under an obligation to pay child support *and* (please check only one of the following)
- I am current and **am not** four months or more in arrears in the payment of child support; or,
- I am making payments by income execution or by court agreed payment plan or by a plan agreed to by the parties; or,
- The child support obligation is the subject of a pending court proceeding; or,
- I am receiving public assistance or supplemental security income; or,
- None of the above four statements apply.

*New York State General Obligations Law, section 3-503

26 GENDER AND ETHNICITY: (This item is optional.)

Information on gender and ethnicity is sought solely to allow the Education Department to collect and analyze data concerning diversity in the licensed professions. The ethnic and gender data you provide will be used only for statistical, research, and program evaluation purposes. It will not be released to the public. This information has absolutely no bearing on your qualification for licensure.

GENDER: Male Female

ETHNICITY: White (not Hispanic)

Black (not Hispanic)

Asian

Hispanic

Native American

27 EDUCATION REVIEW

I give permission to the New York State Education Department to release my examination results to my professional school for the confidential purposes of program review and institution research and planning. I may rescind this authority at any time by notifying the Division of Professional Licensing Services in writing.

Yes No Please initial: _____

28 AFFIDAVIT WITH ACKNOWLEDGMENT (Notarization required.)

APPLICANT

I declare and affirm that the statements made in this application, including accompanying documents, are true, complete and correct. I understand that any false or misleading information in, or in connection with, my application may be cause for denial or loss of licensure and may result in criminal prosecution. **This form must be signed and dated in the presence of a Notary Public.**

Signature of the applicant: _____

Date _____ / _____ / _____
Month Day Year

NOTARY

State of _____ County of _____

On the _____ day of _____ in the year _____ before me, the above signed, personally appeared _____, personally known to me or proved to me on the
Applicant Name

basis of satisfactory evidence to be the individual whose name is subscribed to this application and acknowledged to me that he/she executed the application and swore that the statements made by him/her in the application and all supporting materials are true, complete, and correct.

Notary Public signature _____

Notary ID number _____

Notary Stamp

Expiration date _____ / _____ / _____
Month Day Year

Mail this form and appropriate fee to: New York State Education Department, Office of the Professions, PO Box 22063, Albany, NY 12201. DO NOT SEND CASH. Make check or money order payable to the New York State Education Department.

OHIO

From the Ohio statutes:

4731.222 Determining applicant's fitness to resume practice.

(A) This section applies to both of the following:

(1) An applicant seeking restoration of a license or certificate issued under this chapter that has been in a suspended or inactive state for any cause for more than two years;

(2) An applicant seeking issuance of a license or certificate pursuant to section [4731.17](#) or [4731.295](#) of the Revised Code who for more than two years has not been engaged in the practice of medicine and surgery, osteopathic medicine and surgery, or a limited branch of medicine as any of the following:

(a) An active practitioner;

(b) A participant in a program of graduate medical education, as defined in section [4731.04](#) of the Revised Code;

(c) A student in a college of podiatry determined by the state medical board to be in good standing;

(d) A student in a school, college, or institution giving instruction in a limited branch of medicine determined by the board to be in good standing under section [4731.16](#) of the Revised Code.

(B) Before restoring a license or certificate to good standing for or issuing a license or certificate to an applicant subject to this section, the state medical board may impose terms and conditions including any one or more of the following:

(1) Requiring the applicant to pass an oral or written examination, or both, to determine the applicant's present fitness to resume practice;

(2) Requiring the applicant to obtain additional training and to pass an examination upon completion of such training;

(3) Requiring an assessment of the applicant's physical skills for purposes of determining whether the applicant's coordination, fine motor skills, and dexterity are sufficient for performing medical evaluations and procedures in a manner that meets the minimal standards of care;

(4) Requiring an assessment of the applicant's skills in recognizing and understanding diseases and conditions;

(5) Requiring the applicant to undergo a comprehensive physical examination, which may include an assessment of physical abilities, evaluation of sensory capabilities, or screening for the presence of neurological disorders;

(6) Restricting or limiting the extent, scope, or type of practice of the applicant.

The board shall consider the moral background and the activities of the applicant during the period of suspension or inactivity, in accordance with section [4731.09](#), [4731.19](#), or [4731.52](#) of the Revised Code. The board shall not restore a license or certificate under this section unless the applicant complies with sections [4776.01](#) to [4776.04](#) of the Revised Code.

(a) If a physician's registration permit has expired, the physician may register for a new permit without monetary penalty during the first 30 days following expiration. If a physician's permit has been expired for longer than 30 days, but less than 91, the physician may obtain a new permit by submitting to the board a completed permit application, the registration fee, and a \$75 penalty fee.

(b) If a physician's registration permit has been expired for longer than 90 days but less than one year, the physician may obtain a new permit by submitting a completed permit application, the registration fee, and a \$150 penalty fee.

(c) If a physician's registration permit has been expired for one year or longer, the physician's license is automatically canceled, unless an investigation is pending, and the physician may not obtain a new permit.

(d) In accordance with §156.008(a) of the Act, practicing medicine after the expiration of the 30-day grace period under subsection (a) of this section without obtaining a new registration permit for the current registration period has the same effect as, and is subject to all penalties of, practicing medicine without a license and may be subject to criminal penalties under §165.152 of the Act. However, the Board interprets §156.005 of the Act to provide the exclusive sanction that may be imposed by the board for practicing medicine after the 30-day grace period and within one year after expiration.

(e) All penalty fees must be paid before a physician may be determined eligible for a registration exception or CME exemption.

RULE §173.2

Profile Update and
Correction Form

(a) The board shall develop a Profile Update and Correction Form (the "Form") which allows for corrections and/or updates to the profile information to be made by the physician. The physician must submit all changes to profile information upon this Form, or indicate on the Form that no changes are necessary. The Form shall contain the date the information will be made available to the public and will allow the physician to request a copy of the physician's profile. Upon such request, and when the profile information has been updated, the board shall provide a copy to the physician. The Form will be made available in hard copy and on the Internet.

(b) Compliance with the request for information from the board is mandatory. Failure to return the completed Form to the board shall be considered non-compliance. Non-compliance shall result in nonrenewal of the physician's license until such time as the physician provides the requested information.

(c) Submission of false or misleading information or omission of required information by the physician shall be considered grounds for disciplinary action.

(d) All data contained in the profile shall indicate the source of the data and the last update date.

Contents of the physician profile are described at <http://www.tmb.state.tx.us/page/content-online-profile-system>

Text Facsimile of Online Physician Licensure Application

Login

Physician Licensure Application

- Information you enter will automatically saved at the end of every page.
- You must complete the application within 15 days or your information will be deleted.
- Some of the questions may direct you to download a supplemental form and submit it, along with any relevant records.
- Pay the license fee using one of the follow:
 - MasterCard,
 - Visa,
 - Discover,
 - American Express, or
 - Electronic Check.

Do you need to renew a current license?

Go to: <http://www.tmb.state.tx.us/page/renewal-physician-online-registration-registration>. If you are unable to log on, please contact the Board Offices at (512) 305-7030.

Check Your Eligibility

FAQ

Processing times can vary depending on the acceptability of submitted items and the complexity of your application. Some of the factors that can increase complexity are “yes” answers to the professionalism questions on this application.

Enter to create a new application or to return to a saved application

Asterisk (*) indicates response required

Email*

Date of Birth (MM/DD/YYYY):*

Continue

Identification

Asterisk (*) indicates response required.

If you have an application with the Federal of State Medical Boards, do you want us to access it?

If you have an application with the Federation of State Medical Boards, do you want us to access it?

If you choose to use the FSMB information, some of this application will be pre-populated for you. You must answer all required questions and pay the Texas application fee in order for your application to be processed.

If you have previously submitted a Uniform Application through the Federation of State Medical Boards (FSMB), you can pre-populate some of this application with that information by clicking on the button below. You will first need to submit the Uniform Application to the Texas Medical Board to get the confirmation email from FSMB containing the Submit ID requested. If you do not receive the confirmation email after submitting the Uniform Application to us, contact ua@fsmb.org.

If you are using FCVS for credentials verification, you can choose to pre-populate most of your Uniform Application with your FCVS profile information. If your FCVS profile needs to be updated, you should first complete a subsequent application with FCVS before working on your Uniform Application to ensure the correct information is used. You will also need to have FCVS designate the Texas Medical Board to receive your FCVS profile. Contact them at 888-275-3287 or through the messaging tool within FCVS for the designation or if you have any questions.

Get FSMB information

For JP first and last name, provide your name as it is listed on either your current driver license, issued by a state driver license bureau in the United States, or your current passport. We will furnish this information to the testing center that administers the [jurisprudence exam \(JP\)](#). Your name must match exactly when you present your identification at the testing center, or you will not be allowed to take the exam.

JP first Name*

JP Last Name*

Full Name as wish to appear on receipt*

Your name, as entered in the next 4 fields, will be the name that appears on your license and your physician profile on the web site.

Applicant First name*

Applicant Middle name*

Applicant Last name*

Suffix

Social Security Number (###-##-#### or #####)*:

Alternate names:

Application Type*:

Federation Credentials Verification Service* Using FCVS?

- Yes
- No

Expediting Factors

Applicants, who agree to treat Medicare and Medicaid patients, practice in a medically underserved area, a health professional shortage area, or a rural area may be eligible for expedited handling. In addition, if you are a military service member, or the spouse of a military service member, assigned to a unit headquartered in Texas, your application may be eligible for expedited handling.

If you would like to request that your application be expedited, please select all that apply:

- Medicaid/Medicare
- Medically Underserved Areas
- Health Professional Shortage Areas
- Rural Areas
- Military Service Member (active duty)
- Spouse of a Military Service Member (active duty)

Initial information will be sent to you at this email address once your application is received in our office. If this is not the email address you want to use, create a new log in with the correct email address. You will receive instructions to access our online messaging system at this email within 2 business days of application submission.

Email Address: facsimile@tmb.state.tx.us

Gender*:

- Male
- Female

Country of Birth*

If you were born in the United States, please select your state of birth.

US State of Birth:

Date of Birth (MM/DD/YYYY)*

Race*:

Are you of Hispanic Origin?*

- Yes
- No

If you are a Texas high school graduate, please provide the county where your high school is located.

Texas High School County:

Please provide the city in which you plan to practice.

Texas Planned Practice location –City

Self-Designated Specialty

Select your specialty from the drop down list. If you are unable to locate your specialty on the list, please select "Other Specialty".

Primary Specialty*:

Secondary Specialty:

Continue

Address

Please provide your current mailing address and **daytime** U.S. phone number. **It is your responsibility to notify the Board in writing if you have a change of address.**

All correspondence will be sent to the mailing address. When entering a foreign address, leave the State blank and provide a Country.

Asterisk (*) indicates response required.

Mailing Address

Mailing address 1*:

Mailing Address 2:

City*:

State:

Country*:

Telephone Number (###-###-####)

Continue

Training and Work History

- List all U.S. or Canadian post-graduate training since graduation from medical school.
- List all professional affiliations for the past 5 years. Include hospitals, clinics, military assignments, government agencies, and locum tenens assignments.
- If you are a solo practitioner and you have not held any level of hospital affiliations in the past 5 years, you must provide information about your referral sources to be used in your evaluation. Select Solo Practice as the "Position" and use the Facility/Employer fields for the addresses of your referral sources. In the "Department" field, enter the city and state of your practice.
- List all periods of unemployment or employment outside the field of medicine. For periods of unemployment, use your home address.
- To indicate a current position, enter today's date as an end date.
- You must send [our evaluation form](#) (Form L) to each facility listed, including training programs and professional affiliations.
- If a listed facility is no longer operating, please submit [Form Q](#).

Add Training and Work History

Position*:	<input type="text"/>
Department*:	<input type="text"/>
Start Date (MM/DD/YYYY)*:	<input type="text"/>
End Date (MM/YYYY)*:	<input type="text"/>
Facility/Employer Name*:	<input type="text"/>
Facility/Employer Street*:	<input type="text"/>
Facility/Employer City*:	<input type="text"/>
Facility/Employer State*:	<input type="text"/>
Facility/Employer ZIP/Postal Code*:	<input type="text"/>
Facility/Employer Province*:	<input type="text"/>
Facility/Employer Country*:	<input type="text"/>
Facility/Employer Phone Number (###-###-####)*:	<input type="text"/>
	<input type="button" value="Submit"/> <input type="button" value="Cancel"/>

PROFESSIONAL HISTORY – PG.1

Attention - This is important: Be sure to disclose all relevant circumstances, disciplinary actions, charges, or convictions. A false response to any of these questions may be grounds for disciplinary action, or even denial of licensure. Avoid some of the common excuses heard from people who fail to disclose, such as:

- My attorney told me I didn't have to disclose the criminal conduct or disciplinary actions.
- I didn't think the prior conduct had anything to do with the profession.
- I didn't think the disciplinary action, arrest, charges, or conviction was still on my record.
- I didn't think it was subject to disclosure because I received a deferred sentence/judgment.
- My program director/faculty advisor said it wouldn't appear on my record.

All supplemental forms listed can be found on the [Additional Forms](#) section of our website.

Asterisk (*) indicates response required.

Question 1 *

Have you ever been issued a Texas medical license?

- Yes
 No

If you answered "Yes" to the question above, record your Texas license number (ex: A1234)

Texas License Number:

Question 2 *

Have you ever been issued any other permit/license to train or practice in Texas? (Examples - Institutional Permit, Physician in Training Permit, Visiting Professor Permit, or Faculty Temporary License)

- Yes
 No

Question 3

List all states in which you have applied for or have been granted licensure or certification as any type of healthcare provider. Choose a type of license and state from the drop down lists below. If you are unable to locate your license type, please use "Unassigned", and be aware that this will delay the processing of your application. Use [Form AA](#) if you have more than five licenses.

Type of License

State

Type of License

State

Arrest/Criminal History

This is important:

The Board will run queries with the Texas Department of Public Safety and the FBI to verify your criminal history. Both entities maintain records, often beyond the time that courts keep them. Please be aware that if you have **ever** been arrested, charged, or convicted of a misdemeanor or a felony, the record of those events will be reported as a result of the fingerprint inquiry.

Serious traffic offenses such as reckless driving, driving under the influence of alcohol and/or drugs, hit and run, evading a peace officer, failure to appear, driving while the license is suspended or revoked **MUST** be reported. This list is not all-inclusive. If in doubt as to whether an offense should be disclosed, it is better to disclose the offense on the application.

Matters in which you were diverted, deferred, pardoned, or pled nolo contendere MUST be disclosed.

If you believe your offense was **sealed or expunged**, you **must** be able to provide a copy of the expunction or non-disclosure order if requested.

If you are in doubt as to how to respond to the questions, full and honest disclosure is highly recommended.

If you answer "Yes" to any question in this section, you are required to submit records and a statement. See [Form R](#).

Question 4*

Have you ever been arrested?

- Yes
- No

Question 5 *

Have you ever been charged with any violation of the law regardless of outcome? (Unless the offense involved alcohol or drugs, you may exclude: 1) traffic tickets; and, 2) violations with fines of \$250 or less.)

- Yes
- No

Question 6 *

Are you currently the subject of a grand jury or criminal investigation?

- Yes
- No

Question 7 *

Have you ever been placed on probation?

- Yes
- No

Question 8 *

Have you ever been granted deferred adjudication or any other type of pretrial diversion?
(Unless the offense involved alcohol or drugs, you may exclude: 1) traffic tickets; and, 2) violations with fines of \$250 or less.)

- Yes
- No

Question 9 *

Have you ever been convicted of an offense or imprisoned?

- Yes
- No

Including the incidents you reported in Questions 4-9 above, have you been convicted of, or received deferred adjudication for, a felony, a Class A or Class B misdemeanor for a violation relating to:

(required - see Tex. Occ. Code, Sec. 156.001(e)). If you answer "Yes", submit [Form R](#).

Question 9a *

Medicare, Medicaid or insurance fraud

- Yes
- No

Question 9c *

Sexual or assaultive offenses

- Yes
- No

Question 9d *

Tax fraud or evasion

- Yes
- No

Actions by Health Professional Licensing or Certification Authorities

(Including but not limited to licensing and/or regulatory agencies, specialty boards and licensing exam administration authorities.)

If you answer "Yes" to any question in this section, you are required to submit records and a statement. See [Form S](#).

Question 10 *

Have you ever withdrawn an application for a license, permit, or certification as a healthcare professional?

- Yes
- No

Question 11 *

Have you ever been determined ineligible for a license, permit, or certification as a healthcare professional?

- Yes
- No

Question 12 *

Are you currently the subject of an investigation by any health professional licensing or certification authority?

- Yes
- No

Question 13 *

Have you ever had limitations, conditions, or restrictions placed on a healthcare professional license?

- Yes
- No

Question 14 *

Have you ever been disciplined by any healthcare professional licensing authority?

- Yes
- No

Question 15 *

Have you ever been allowed to voluntarily surrender your license in lieu of action by any licensing authority?

- Yes
- No

Question 16 *

Have you ever been the subject of a confidential or non-disciplinary action by a licensing authority?

- Yes
- No

Question 17 *

Have your federal or state controlled substance permits ever been revoked, restricted, or denied?

- Yes
- No

Medical Education, Training, and Employment

If you answer "Yes" to any question in this section, you are required to submit records and a statement. See [Form U](#).

Unusual Circumstances in Medical School

Question 18 *

Did you take a leave of absence or break of four weeks or longer during medical school? (for any reason)

- Yes
- No

Question 19 *

Have you ever withdrawn from a medical school for any reason?

- Yes
- No

Question 20 *

In medical school, did you ever receive a written warning or documented counseling about your behavior?

- Yes
- No

Question 21 *

In medical school, were any limitations or special requirements placed on you for professionalism or behavioral issues?

- Yes
- No

Question 22 *

Was any disciplinary action taken against you in medical school?

- Yes
- No

Question 23 *

Were you ever delayed promotion or advancement to the next level or year in medical school?

- Yes
- No

Question 24 *

Did you ever take a leave of absence during training? (For any reason)

- Yes
- No

Question 25 *

Have you ever resigned from a training program? (For any reason, including transfer to another program)

- Yes
- No

Question 26 *

In training, were any limitations or special requirements placed on you for professionalism or behavioral issues?

- Yes
- No

Question 27 *

In training, did you ever receive a written warning or documented counseling about your behavior?

- Yes
- No

Question 28 *

Were you ever placed on probation for any reason during training?

- Yes
- No

Question 29 *

Are you currently under investigation by your training program?

- Yes
- No

Question 30 *

In training, were any of your privileges or duties ever reduced, suspended, or revoked?

- Yes
- No

Question 31 *

Have you ever received partial or no credit for a postgraduate training program?

- Yes
- No

Question 32 *

In training, were you ever delayed promotion or advancement to the next level?

- Yes
- No

Question 33 *

In training, were you ever informed your contract would not be renewed?

- Yes
- No

Question 34 *

Have you ever been suspended, terminated, or dismissed from a training program?

- Yes
- No

Unusual Circumstances During Professional Practice or Military Service

If you answer "Yes" to any question in this section, you are required to submit records and a statement. See [Form U](#).

Question 35 *

Have you ever been placed on a performance or quality improvement plan of any type for any reason?

- Yes
- No

Question 36 *

Were you ever issued a formal or informal warning, censure, or reprimand?

- Yes
- No

Question 37 *

Were additional limitations or requirements placed on you for any reason?

- Yes
- No

Question 38 *

Were you ever placed on disciplinary probation?

Were you ever issued a formal or informal warning, censure, or reprimand?

- Yes
- No

Question 39 *

Were your privileges or duties ever reduced, suspended, revoked, or denied?

- Yes
- No

Question 40 *

Were you ever terminated, dismissed, or was your resignation requested?

- Yes
- No

Question 41 *

Did you ever voluntarily resign in lieu of further investigations or other action?

- Yes
- No

Question 42 *

Are you currently under investigation by any governmental agency, health care entity, or professional organization?

- Yes
- No

Question 43 *

Have you ever had a complaint, allegation, or investigation result in the non-renewal of contract?

- Yes
- No

Malpractice History

If you answer "Yes" to any questions in this section, you are required to submit [Form I](#) and [Form V](#).

Question 44 *

Has a complaint ever been filed against you in a court (i.e., a lawsuit) seeking damages relating to your conduct in providing or failing to provide a medical or health care service?

- Yes
- No

Question 45 *

Has there been:

- (a) a settlement of a claim without the filing of a lawsuit, or
- (b) a settlement of a lawsuit

made by you or on your behalf involving damages relating to your conduct in providing or failing to provide a medical or health care service?

- Yes
- No

Question 46 *

While serving in the U.S. military or the Public Health Service, or while employed, contracted or privileged by a federal facility was a complaint filed in court (i.e., a lawsuit) seeking damages relating to your conduct in providing or failing to provide a medical or health care service?

- Yes
- No

If you answered Yes to Question 44, 45, 46 above, what is the total number of cases?

Enter the number here:

Mental and Physical Health

If you answer "Yes" to any of the following questions, you are required to submit [Form W](#).

Question 47 *

Have you self-referred to the Texas Physicians Health Program? What is [PHP](#)?

- Yes
- No

Question 48 *

Within the past five (5) years, have you abused or have you been addicted to alcohol or drugs or have you been treated or monitored for alcohol or substance abuse dependency?

- Yes
- No

Question 49 *

Within the past five (5) years, have you been diagnosed with or treated for any: psychotic disorder, delusional disorder, mood disorder, major depression, personality disorder, or any other mental condition which impaired or does impair your behavior, judgment, or ability to function in school or work?

- Yes
- No

Question 50 *

Within the past five (5) years, have you had or do you currently have any physical or neurological condition, including any disease or condition generally regarded as chronic which impaired or does impair your behavior, judgment, or ability to function in school or work?

- Yes
- No

Question 51 *

If you answered "Yes" to questions 48 or 49, are the limitations caused by your mental condition or substance abuse/dependency problem reduced or ameliorated because you receive ongoing treatment (with or without medication) or because you participate in a monitoring program?

- Yes
- No

Educational History

Question 52 *

Have you completed 60 hours of college courses other than in medical school for credit towards a Bachelor of Arts or Bachelor of Science degree?

- Yes
- No

Question 53

Degree Awarded (YYYY)*

Question 54 *

Use the drop down list below to locate your medical school. If you are unable to locate your school, please choose "Unassigned", and be aware that this will delay the processing of your application.

- Yes
- No

Country

State

Medial School

Question 55*

Year degree was awarded (YYYY)*

International Applicants Only

Question 56*

Did you complete a Fifth Pathway or Pre-Internship program?

- Yes
- No

Question 57 *

Did you complete your entire primary, secondary, and premedical education in the country where your medical school is located?

- Yes
- No

Question 58 *

ECFMG Certification Number
(no dashes/hyphens allowed)

Examination History

Select every qualifying examination from the list below that you have ever attempted *:

- a. NBME
- b. NBOME
- c. FLEX
- d. USMLE
- e. COMLEX
- f. State Board Examination

Specialty Board Certification History

You may enter up to three ABMS or BOS board certifications and the year certification was awarded. Use the drop down lists below to locate your board certification.

Specialty Board Certification History - Primary Certification

Certification

Certification Year (YYYY)

Specialty Board Certification History - Sub-specialty Certification

Certification

Certification Year (YYYY)

Specialty Board Certification History - Additional Certification

Certification

Certification Year (YYYY)

Review

*Review screen prior to submitting payment.

Attestation

I affirm that I am the person herein named subscribing to this application; that I have read the complete application, know the full content thereof, and declare under penalty of perjury, that all of the information contained herein, and evidence or other credentials submitted herewith, are true and correct; that I am the lawful holder of an M.D. or D.O. degree as prescribed by this application, that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, was procured without fraud or misrepresentation or any mistake of which I am aware, and that I am the lawful holder thereof.

Further, I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past, present and future), business or professional associates (past, present and future) and all governmental agencies (local, state, federal, or foreign) to release to the Texas Medical Board or its successors any information, files or records, including medical records, educational records, and records of psychiatric treatment and treatment for drug and/or alcohol abuse or dependency, requested by the Board in connection with this application, necessary to determine my medical competence, professional conduct, or physical and/or mental ability to safely engage in the practice of medicine. I further authorize the Texas Medical Board or its successors to release to the organizations, individuals, or groups listed above, any information, which is material to this application, or any subsequent licensure.

I hereby affirm that I will provide the Board with updated information to be received by the Board within 15 days of my becoming aware of any event that occurs after submission of my application that renders any response, although complete and correct when made, no longer complete or correct. Further, failure to provide updates may result in an adverse action against my application.

I understand that falsification or misrepresentation of any item or response on this application or any supplemental information is a sufficient basis for denying my application, revoking a license, a determination of ineligibility, or another adverse action against my application or revoking my license after issuance.

I agree to these terms.

Continue

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Re-Entry to Practice Workgroup		2) Date When Request Submitted: Items will be considered late if submitted after 12:00 p.m. on the deadline date which is 8 business days before the meeting	
3) Name of Board, Committee, Council, Sections: Re-Entry to Practice Workgroup			
4) Meeting Date: 4/30/2018	5) Attachments: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	6) How should the item be titled on the agenda page? Reference Materials	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session	8) Is an appearance before the Board being scheduled? <input type="checkbox"/> Yes (Fill out Board Appearance Request) <input checked="" type="checkbox"/> No	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed: http://www.fsmb.org/globalassets/advocacy/policies/framework-for-a-minimal-physician-data-set.pdf Note: The FSMB <i>Report of the Special Committee on Reentry to Practice</i> (HOD 2012) defines the clinically active physician as one who, at the time of license renewal, is engaged in direct, consultative, or supervisory patient care, or as further defined by the states. Clinically inactive physician is defined as one who is not engaged in direct, consultative or supervisory patient care at the time of license renewal, but who, as a result of their professional activities, influences the care provided by clinically active practitioners.			
11) Authorization			
Signature of person making this request		Date	
Supervisor (if required)		Date	
Executive Director signature (indicates approval to add post agenda deadline item to agenda)		Date	
Directions for including supporting documents: 1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director. 3. If necessary, provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.			

**State of Wisconsin
Department of Safety & Professional Services**

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request:		2) Date When Request Submitted:	
		Items will be considered late if submitted after 4:30 p.m. and less than: <ul style="list-style-type: none"> ▪ 10 work days before the meeting for Medical Board ▪ 14 work days before the meeting for all others 	
3) Name of Board, Committee, Council, Sections: MEB Physician Re-Entry to Practice Committee			
4) Meeting Date: 5/16/2018	5) Attachments: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	6) How should the item be titled on the agenda page? A Physician ReEntry Into the Workforce Inventory	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing? No	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed: Background material: http://physician-reentry.org/wp-content/uploads/AAPReentryInventory.pdf https://onlinelibrary.wiley.com/doi/abs/10.1002/chp.20106			
11) Authorization			
Signature of person making this request		Date	
Supervisor (if required)		Date	
Bureau Director signature (indicates approval to add post agenda deadline item to agenda)		Date	