



## OKLAHOMA OSTEOPATHIC PHYSICIAN AND SURGEON LICENSE APPLICATION PACKET

Dear Applicant:

The Oklahoma State Board of Osteopathic Examiners is pleased that you are interested in achieving licensure in the state of Oklahoma. As you can see from this packet, the process is lengthy. There are no shortcuts. There are no temporary licenses. The Board will review your application at one of the regularly-scheduled Board meetings before making a decision to grant you a license. The Board meets quarterly – the third Thursdays of March, June and September and the second Thursday of December.

### **Uniform Application for Physician State Licensure (UA):**

The Oklahoma State Board of Osteopathic Examiners is one of the first boards to incorporate the Uniform Application for Physician State Licensure (formerly the CLA-f) into its application process. This form will make it easier for physicians to apply for licensure in additional states that utilize the UA. The OSBOE also requires completion of its Pre-Licensing Packet (PLP).

### **The Federation Credentials Verification Service (FCVS):**

The Board highly recommends, but does not require, the use of FCVS to primary source verify core physician credentials as part of the licensure process. FCVS is a service of the Federation of State Medical Boards (FSMB) and was created to assist in license portability for physicians. Contact FCVS at 888-ASK-FCVS for additional information regarding the service and its fees and, if you have previously used their service, call FCVS to forward your credentials to the Oklahoma State Board of Osteopathic Examiners.

### **Important:**

In planning your practice activity, allow an ample timeframe in order to achieve licensure. Our staff must have time to receive and process your application before it is presented to the Board and to determine if it is necessary for you to appear for a personal interview on Board meeting day. Applications not completed by the first day of each meeting month (March, June, September, or December) may not be presented for approval until the next quarterly meeting. **Even if using FCVS, you must still apply for licensure in the State of Oklahoma by submitting the UA, the Oklahoma Pre-Licensing Packet, a licensure application fee of \$575.00, and certain other documentation.** To ensure that the process goes well, we suggest you follow the enclosed instructions carefully and completely. Should you have questions regarding the application form or process, feel free to contact the Board office for assistance.

Sincerely,

*Christi Aquino/Brandon Gambill*

Licensure Specialists

OKLAHOMA STATE BOARD OF OSTEOPATHIC EXAMINERS

4848 North Lincoln Boulevard, Suite 100

Oklahoma City, OK 73105

405.528.8625

**INSTRUCTIONS FOR COMPLETING YOUR LICENSURE APPLICATION TO THE OKLAHOMA STATE  
BOARD OF OSTEOPATHIC EXAMINERS**

The Board stresses that you must provide full details and dates, complete names, addresses and zip codes as required in the application. If you do not, the processing of your application will be delayed.

**The application contains two (2) parts – the UA and the PLP:**

(Uniform Application for Physician State Licensure and Oklahoma's Pre-Licensing Packet) Complete the application as instructed in each section. PLEASE TYPE OR PRINT IN INK. In addition, please note the following:

If you have taken all three parts of the National Board of Osteopathic Examiners sequence, you will use this method of application as your basis for licensure. Please contact the National Board directly at 773/714-0622 to request that a transcript of your grades be sent directly to the Oklahoma State Board of Osteopathic Examiners at 4848 North Lincoln Boulevard, Suite 100, Oklahoma City, OK, 73105. This step is referenced in the UA. **Note: If using FCVS, they will contact NBOME for you.**

If you have not taken all three parts of the NBOME and have taken the State Board Examination in another state, and received a license in that state, contact us to verify if you are eligible to apply by reciprocity. This is the only reason reciprocity applies. **Note: FLEX and USMLE examinations are not accepted by this Board as a basis for licensure.**

Computer-generated photos are not acceptable. Complete all physical identifiers in the spaces provided, even if you've provided them to FSVS.

The document verifying lawful presence in the United States must be completed and notarized. This is required by Oklahoma State Law and no other document may be substituted for this form.

For the **Data Bank Report (Self Query)**, you must complete and mail a Request for Information Form to the National Practitioner Data Bank, P.O. Box 10832, Chantilly, VA, 22021, (Telephone 800/767-6732 – The form is available at [www.npdb-hipdb.com](http://www.npdb-hipdb.com)) This is a **SELF-QUERY** of two (2) databases; follow the instructions for completion. When the response from the self-query is returned to you, mail it to this Board.

**ADDITIONAL INFORMATION**

Postgraduate training must be at least one (1) year of rotating internship, or its equivalent, in an accredited internship or residency program acceptable to the Board. To be deemed "equivalent" to a rotating internship, a first year postgraduate experience must contain the following:

- One (1) month – General Practice
- One (1) month – OB/GYN
- One (1) month – General Surgery
- One (1) month – Pediatrics
- Two (2) months – General Internal Medicine, and
- Three (3) months – Selectives, which means any of these core areas or Emergency Medicine, and
- Three (3) months – Electives, to complete a total of twelve months.

**A.** All licenses must be renewed each year prior to July 1st and you must obtain sixteen (16) hours of AOA approved 1-A or 1-B Continuing Medical Education credit hours each licensure year. Every other year *and* if practicing in Oklahoma, one hour of CME must be on the proper prescribing of drugs; the course must be approved by this Board.

**B.** You may request a DEA application approximately six (6) weeks before licensure.  
(Drug Enforcement Administration – Telephone 405/475-7500)

**C.** You may request an application *after* you have an Oklahoma License Number, from OBNDCC.  
(Oklahoma Bureau of Narcotics and Dangerous Drugs Control – 405/521-2885)

**D.** When requesting license verifications from states where you are or have been licensed, request through **Veridoc** for each participating board. Details are on their website: [www.veridoc.org](http://www.veridoc.org)



OKLAHOMA STATE BOARD OF OSTEOPATHIC EXAMINERS  
4848 North Lincoln Boulevard, Suite 100  
Oklahoma City, OK 73105  
Telephone: 405.528.8625

## ***PRE-LICENSING PACKET***

FULL NAME OF APPLICANT: \_\_\_\_\_

\*Name as you want it to appear on your license: \_\_\_\_\_

Osteopathic Specialty: \_\_\_\_\_

Board Certified:  Yes  No **If Yes**, by which board? \_\_\_\_\_

CURRENT practice activity:  PGY 1  Resident  Fellowship  Private  Other (explain):

Proposed location address and type of Oklahoma-based practice if license is granted:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Contact Telephone Numbers:

Cell: \_\_\_\_\_ Home: \_\_\_\_\_ Other: \_\_\_\_\_

Name of Undergraduate School (Not Medical School): \_\_\_\_\_

City/State: \_\_\_\_\_ Graduation Year: \_\_\_\_\_

### **ITEMS TO MAIL TO THE BOARD WITH THE PLP (Pre-Licensing Packet):**

1. PLP Packet – all 6 pages of this packet
2. Cashier's Check – \$575.00 (Application for Licensure Fee)
3. Notarized Copy of Birth Certificate or Passport
4. UA – Uniform Application for Physician State Licensure (formerly CLA-f)

### **ADDITIONAL ITEM (may be mailed separately):**

1. Data Bank Report from NPDB/HIPDB (Results of Self-Query)

<p>Have you ever been rejected for membership by, or requested to appear, before any medical or osteopathic society?</p> <p><b>If Yes,</b> provide the name and address of the society, dates and reasons on a separate page. Also, please furnish a separate letter addressed to each applicable society, which authorizes them to release whatever information this Board may require.</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>Have you ever been denied the privilege of taking an examination administered by any licensing agency?</p> <p><b>If Yes,</b> please provide the name of the examination and the name of the agency on a separate sheet of paper.</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>Have you ever been denied a license to practice osteopathic medicine?</p> <p><b>If Yes,</b> please provide full details on a separate page. This must include the state(s), date(s) and reason(s).</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>Have you ever been denied staff membership or employment with any licensed hospital, nursing home, clinic, health maintenance organization or other hospital care facility with an organized medical staff?</p> <p><b>If Yes,</b> provide full details, including addresses, on a separate page. Also, please furnish a separate letter addressed to each applicable institution or organization authorizing them to release whatever information this Board may require.</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>Have you ever been warned, censured, disciplined, had admissions monitored, had privileges limited, had privileges suspended, been put on probation, or ever been requested to withdraw from any medical practice, hospital, nursing home, clinic, health maintenance organization or other hospital care facility with an organized medical staff, in which you have trained, been a staff member, been an employee, been a partner, or held hospital privileges?</p> <p><b>If Yes,</b> provide full details, including addresses, on a separate page. Also, please furnish a separate letter addressed to each applicable institution or organization authorizing them to release whatever information this Board may require.</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>Have you ever been requested to resign, withdraw, or otherwise terminate your position with a medical practice, medical partnership, professional association, corporation, health maintenance organization or other medical practice organization, either public or private?</p> <p><b>If Yes,</b> provide full details, including addresses, on a separate page. Also, please furnish a separate letter addressed to each applicable entity authorizing them to release whatever information this Board may require.</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>Have you ever, for any reason, lost Board Certification in any specialty?</p> <p><b>If Yes,</b> provide full details on a separate page. Also, please furnish a separate letter addressed to the specialty board authorizing them to release whatever information this Board may require.</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>Has any licensing authority or disciplinary agency limited, probated, restricted, suspended or revoked a license or permit you have held?</p> <p><b>If Yes,</b> give full details on a separate page. This should include the state(s), date(s) and reason(s).</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>Have you ever voluntarily surrendered a license or permit issued to you by any licensing agency?</p> <p><b>If Yes,</b> give full details on a separate page. This should include the state(s), date(s) and reason(s).</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>Have you ever been requested to appear before any licensing or disciplinary agency?</p> <p><b>If Yes,</b> give full details on a separate page. This should include the state(s), date(s) and reason(s).</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No

<p>Have you ever been notified of any charges or complaints filed against you with any licensing or disciplinary agency?  <b>If Yes</b>, give full details on a separate page. This should include the state(s), date(s) and reason(s).</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>Have you ever been diagnosed or treated for any mental or physical illness that would hinder your ability to practice osteopathic medicine?  <b>If Yes</b>, give full details on a separate page. Also, please provide a separate letter addressed to each physician, therapist and/or institution authorizing them to release whatever information this Board may require. This letter will be used to verify the information you have given and to obtain records concerning your care and treatment.</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>Have you ever been chemically dependent?  <b>If Yes</b>, give full details on a separate page. In addition, please provide a separate letter addressed to each physician, therapist, institution and support group that provides care and treatment and after care, authorizing them to release whatever information this Board may require. This letter will be used to verify the information you have given and to obtain records concerning your care, treatment and participation.</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>Have you ever interrupted your training because of illness or impairment (physical or chemical)?  <b>If Yes</b>, provide full details including dates and the names and addresses of each training institution on a separate notarized statement. Furnish a separate letter addressed to each institution authorizing them to release whatever information this Board may require.</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>Have you ever been unable to practice osteopathic medicine because of illness or impairment?  <b>If Yes</b>, provide full details including information concerning your diagnosis and treatment and date of occurrence, treating physician(s) etc. in a separate notarized statement. Furnish a separate letter addressed to each, authorizing them to release whatever information this Board may require, including your medical records.</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>Have you ever been denied a Drug Enforcement Administration (DEA) certificate or a state bureau of narcotics controlled substances registration certificate, or been called before, or warned by any such agency or other lawful authority concerned with controlled substances?  <b>If Yes</b>, provide full details in a separate notarized statement.</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>Has the Drug Enforcement Administration (DEA) or any state bureau of narcotics ever limited, probated, restricted, suspended or revoked a license or permit you have held?  <b>If Yes</b>, provide full details, including dates, in a separate notarized statement.</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>Have you ever surrendered your federal or state controlled substances registration?  <b>If Yes</b>, provide full details, including dates, in a separate notarized statement.</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>Have you ever been arrested, fined, charged with or convicted of a crime, indicted, imprisoned or placed on probation?  <b>If Yes</b>, give full details of the arrest, dates, places and disposition of the case in a separate notarized statement. You must also furnish a certified court copy (with seal affixed) of the charge, the judgment, the sentence and/or dismissal order or other such documents attesting to the disposition. You need not include minor traffic and parking violations except those related to DUI, DWI or a similar charge.</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No

<p>Have you ever forfeited collateral for breach or violation of any law, police regulation or ordinance, been summoned into court as a defendant, or has any lawsuit (other than malpractice) been filed against you?</p> <p><b>If Yes</b>, give full details in a separate notarized statement. You need not include traffic violations such as a speeding ticket where a bond was forfeited except those related to DUI, DWI or some similar charge. If you have ever been the defendant in any legal action, furnish a certified court copy (with seal affixed) of the original complaint, answer, judgment, settlement and/or disposition of the case. If it is pending, so state and have your attorney provide a letter regarding the case and its current status.</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>Have you ever been denied provider participation in any state Medicaid or federal Medicare program?</p> <p><b>If Yes</b>, give full details including dates and the names and addresses of the Medicaid or Medicare program in a separate notarized statement. Furnish a separate letter, addressed to each, authorizing them to release whatever information this Board may require.</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>Have you ever been terminated, sanctioned, penalized, or had to repay monies to any state Medicaid or federal Medicare program?</p> <p><b>If Yes</b>, give full details including dates and the names and addresses of the Medicaid or Medicare program in a separate notarized statement. Furnish a separate letter, addressed to each, authorizing them to release whatever information this Board may require.</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>Have you ever been a defendant in a legal action involving professional liability (malpractice) or had a professional liability claim paid in your behalf or paid such a claim yourself?</p> <p><b>If Yes</b>, complete Page 10 of the Common Licensure Application Form (CLA-F).</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>Are you now taking prescription medication of any kind?</p> <p><b>If Yes</b>, provide the pertinent information regarding the illness, giving rise to the need for the medication, the name of the drug(s), dosage, etc., in a separate notarized statement. This statement should also discuss who prescribes your medication, where you obtain it, etc. Provide a letter addressed to each prescribing physician, pharmacy and/or other entity, authorizing them to release any information this Board may require.</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No

*I hereby state, under oath, that I authorize an investigation to be made as to my moral character, professional reputation and fitness for the practice of osteopathic medicine, when, in the opinion of the Oklahoma State Board of Osteopathic Examiners, such an investigation is deemed necessary. I further certify that all statements I have made herein are true and I understand that the fee I submitted is not refundable.*

\_\_\_\_\_  
*(Applicant's Signature)*

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_

My commission expires: \_\_\_\_\_






My commission number: \_\_\_\_\_

\_\_\_\_\_  
*(Notary Public Signature & Seal)*

# FINGERPRINTS

NAME OF APPLICANT: \_\_\_\_\_

*TO BE COMPLETED BY A FEDERAL, STATE OR LOCAL LAW ENFORCEMENT OFFICER.  
Make impressions of applicant's fingers and thumb of right hand below:*

				
THUMB	INDEX	MIDDLE	RING	LITTLE

\_\_\_\_\_  
*Printed Name of Officer* (Signature of Officer)

\_\_\_\_\_  
*Agency Name* Date

\_\_\_\_\_  
*Business Address*

\_\_\_\_\_  
*City/State/Zip*

Note: An official FBI fingerprint card may be substituted for this form.





## Application for Physician Licensure Instructions

### Checklist

After completing the enclosed application, you are responsible for submitting the application along with certain documents. There are two different checklists below; one when you are using the Federation Credentials Verification Service (FCVS) and one when you are not using FCVS. Please use the checklist that applies to you.

	State does not require FCVS and you choose not to use FCVS	State requires or accepts FCVS and you are using FCVS
Completed Application (including state addendums)	<input type="checkbox"/>	<input type="checkbox"/>
State Licensure Verification form sent to the Board from all states in which you have ever held any healthcare license	<input type="checkbox"/>	<input type="checkbox"/>
Enclose the completed "Affidavit and Authorization for Release of Information" form with this application when submitting it to the Board	<input type="checkbox"/>	<input type="checkbox"/>
Notarized copy of birth certificate or current, valid passport	<input type="checkbox"/>	completed via FCVS
Medical Education Verification form sent to the Board by all medical schools attended – include a copy of your diploma (must be sealed by your school)	<input type="checkbox"/>	completed via FCVS
Medical school transcripts sent to the Board by your medical school	<input type="checkbox"/>	completed via FCVS
Fifth Pathway (if applicable) form sent to the Board from the medical school and institution – include a copy of your diploma (must be sealed by your school)	<input type="checkbox"/>	completed via FCVS
Postgraduate Training Verification form sent to the Board from all programs you attended	<input type="checkbox"/>	completed via FCVS
Enclose a copy of your postgraduate training certificate with this application when submitting it to the Board	<input type="checkbox"/>	completed via FCVS
Examination transcripts sent to the Board	<input type="checkbox"/>	completed via FCVS
ECFMG (if applicable) Status Report sent to the Board	<input type="checkbox"/>	completed via FCVS

**It is your responsibility to immediately notify the board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license being granted to you by the board.**

## Application for Physician Licensure

**1. Name:** Indicate your full legal name. If your name has changed at any time during your life and you are not using FCVS, you must submit a copy of the legal document (marriage certificate, divorce decree, etc.) supporting your name change.

### 1. Full Name (use no initials)

Last Name \_\_\_\_\_

First Name \_\_\_\_\_

Middle Name \_\_\_\_\_

Suffix \_\_\_\_\_

Maiden Name \_\_\_\_\_

M.D.  D.O.

\_\_\_\_\_  
All other names used

**2. Address/Phone:** Please complete all sections and indicate which address you wish to be used for public access and which is to be used for mailings from the medical board. Each state's law determines whether each address or phone number is a public record in the state in which you are applying. You may wish to contact the licensing authority for that state for further information. Many boards publish the "Public Access" address on their website; therefore, you should consider what your preferred address is for these purposes.

#### Practice Address

Public Access

Mailing

Street \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

City \_\_\_\_\_ State/Province \_\_\_\_\_ ZIP Code \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_

E-mail address \_\_\_\_\_

Alternate Phone (e.g. pager or cell phone) \_\_\_\_\_

#### Home Address

Public Access

Mailing

Street \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

City \_\_\_\_\_ State/Province \_\_\_\_\_ ZIP Code \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_

E-mail address \_\_\_\_\_

Alternate Phone (e.g. pager or cell phone) \_\_\_\_\_

Applicant Name: \_\_\_\_\_ Date: \_\_\_\_\_

**3. Identification:** If you are not using FCVS, you must submit either a notarized copy of your birth certificate or a notarized copy of your current, valid passport.

**3. Identification**

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Date of Birth                      Birth City                      Birth State/Province                      Birth Country  
(mm/dd/yyyy)

\_\_\_\_                      \_\_\_\_\_                      \_\_\_\_\_                      Are you a U.S. Citizen?     Yes     No  
Gender                      Social Security Number                      NPI Number

Your social security number is required to facilitate reporting to the federal Healthcare Integrity & Protection Data Bank (42 U.S.C. Sections 1320a-7e(b), 5 U.S.C. Section 552a, and 45 C.F.R. pt. 61) and for accurate identification under the federal and state child support enforcement law (42 U.S.C. Section 666 and applicable state law). It may also be used for reporting to the National Practitioner Data Bank (42 U.S.C. Section 11101 and 45 C.F.R. pt. 60) and for other investigative/enforcement purposes in compliance with state laws governing physician discipline or as otherwise required by state or federal law.

The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. For more information on the NPI, please go to <http://www.cms.hhs.gov/NationalProvIdentStand/>.

**4. Medical School:** List all medical schools you have attended, even those from which you did not graduate, in chronological order. Attach an additional sheet if necessary. If you are not using FCVS, you must complete the attached "Medical Education Verification" form and send it to all medical schools you have attended. You must include a copy of your diploma to which the medical school must attach their seal prior to forwarding it to this Board. Additionally, the medical school must provide this Board with an official copy of your transcripts. The medical school must forward all documentation directly to this Board.

**4. Medical School** (attach additional pages if necessary)

1. School Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State/Province \_\_\_\_\_ ZIP Code \_\_\_\_\_  
Country \_\_\_\_\_  
Attendance Dates (From – To) \_\_\_\_\_  
Graduation Date \_\_\_\_\_ Degree \_\_\_\_\_

2. School Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State/Province \_\_\_\_\_ ZIP Code \_\_\_\_\_  
Country \_\_\_\_\_  
Attendance Dates (From – To) \_\_\_\_\_  
Graduation Date \_\_\_\_\_ Degree \_\_\_\_\_

Applicant Name: \_\_\_\_\_ Date: \_\_\_\_\_

**5. Fifth Pathway:** If you attended a Fifth Pathway program and are not using FCVS, you must complete the attached "Fifth Pathway Verification" form and send it to your medical school and to the institution where you completed your rotations. You must include a copy of your diploma. The medical school and institution must forward all documentation directly to this Board.

**5. Fifth Pathway (if applicable)**

1. Medical School Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State/Province \_\_\_\_\_ ZIP Code \_\_\_\_\_

Country \_\_\_\_\_

Attendance Dates (From – To) \_\_\_\_\_

Graduation Date \_\_\_\_\_ Degree \_\_\_\_\_

2. Medical School Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State/Province \_\_\_\_\_ ZIP Code \_\_\_\_\_

Country \_\_\_\_\_

Attendance Dates (From – To) \_\_\_\_\_

Graduation Date \_\_\_\_\_ Degree \_\_\_\_\_

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Applicant Name: \_\_\_\_\_ Date: \_\_\_\_\_

**6. Postgraduate Training:** List **all** postgraduate programs you have attended, even those you did not complete. Attach an additional sheet if necessary. If you are not using FCVS, you must complete the attached "Postgraduate Training Verification" form and send it to **all** postgraduate training programs you have attended. You must submit a copy of your certificate of program completion to this Board. Additionally, the postgraduate program must provide this Board with the Program Director's recommendation letter. The postgraduate program must forward all documentation directly to this Board.

**6. Postgraduate Training** (copy and attach additional pages if necessary)

Complete name and address of hospital where training was conducted (Do Not Abbreviate)

1. Hospital Name \_\_\_\_\_

Hospital Address \_\_\_\_\_

City \_\_\_\_\_

State/Province \_\_\_\_\_

ZIP Code \_\_\_\_\_

Country \_\_\_\_\_

PGY: (e.g., 1, 2, 3, etc.)  Internship  Residency  Fellowship  Research  Other

Accredited by:  ACGME  AOA  RCPSC  None  Other \_\_\_\_\_

Department/Specialty: \_\_\_\_\_

From: \_\_\_\_\_ / \_\_\_\_\_ To: \_\_\_\_\_ / \_\_\_\_\_ Successfully Completed? Yes  No  In Progress   
Month Year Month Year

2. Hospital Name \_\_\_\_\_

Hospital Address \_\_\_\_\_

City \_\_\_\_\_

State/Province \_\_\_\_\_

ZIP Code \_\_\_\_\_

Country \_\_\_\_\_

PGY: (e.g., 1, 2, 3, etc.)  Internship  Residency  Fellowship  Research  Other

Accredited by:  ACGME  AOA  RCPSC  None  Other \_\_\_\_\_

Department/Specialty: \_\_\_\_\_

From: \_\_\_\_\_ / \_\_\_\_\_ To: \_\_\_\_\_ / \_\_\_\_\_ Successfully Completed? Yes  No  In Progress   
Month Year Month Year

Applicant Name: \_\_\_\_\_ Date: \_\_\_\_\_

**6. Postgraduate Training (continued)**

3.Hospital Name \_\_\_\_\_

Hospital Address \_\_\_\_\_

City \_\_\_\_\_

State/Province \_\_\_\_\_

ZIP Code \_\_\_\_\_

Country \_\_\_\_\_

PGY: (e.g., 1, 2, 3, etc.)  Internship  Residency  Fellowship  Research  Other

Accredited by:  ACGME  AOA  RCPSC  None  Other \_\_\_\_\_

Department/Specialty: \_\_\_\_\_

From: \_\_\_\_\_ / \_\_\_\_\_ To: \_\_\_\_\_ / \_\_\_\_\_ Successfully Completed? Yes  No  In Progress   
Month Year Month Year

4.Hospital Name \_\_\_\_\_

Hospital Address \_\_\_\_\_

City \_\_\_\_\_

State/Province \_\_\_\_\_

ZIP Code \_\_\_\_\_

Country \_\_\_\_\_

PGY: (e.g., 1, 2, 3, etc.)  Internship  Residency  Fellowship  Research  Other

Accredited by:  ACGME  AOA  RCPSC  None  Other \_\_\_\_\_

Department/Specialty: \_\_\_\_\_

From: \_\_\_\_\_ / \_\_\_\_\_ To: \_\_\_\_\_ / \_\_\_\_\_ Successfully Completed? Yes  No  In Progress   
Month Year Month Year

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Applicant Name: \_\_\_\_\_ Date: \_\_\_\_\_

**7. Examination History:** If you are not using FCVS, you are responsible for contacting the appropriate examination entity and having a certified transcript of your scores sent directly to this Board.

**7. Examination History**

List each licensure examination, U.S. or international, you have taken (USMLE, NBME, NBOME, LMCC, Etc.). If additional space is necessary, please enclose a separate sheet with your application and include all the information below.

Examination	Most Recent Date taken(Month/Year)	Passed (P) or Failed (F)	Number of attempts
State Board Exam _____ State _____	_____	<input type="checkbox"/> P <input type="checkbox"/> F	_____
FLEX Pre-1985 _____	_____	<input type="checkbox"/> P <input type="checkbox"/> F	_____
FLEX Component 1 _____	_____	<input type="checkbox"/> P <input type="checkbox"/> F	_____
FLEX Component 2 _____	_____	<input type="checkbox"/> P <input type="checkbox"/> F	_____
LMCC – Single _____	_____	<input type="checkbox"/> P <input type="checkbox"/> F	_____
LMCC – Part I _____	_____	<input type="checkbox"/> P <input type="checkbox"/> F	_____
LMCC – Part II _____	_____	<input type="checkbox"/> P <input type="checkbox"/> F	_____
NBME Part I _____	_____	<input type="checkbox"/> P <input type="checkbox"/> F	_____
NBME Part II _____	_____	<input type="checkbox"/> P <input type="checkbox"/> F	_____
NBME Part III _____	_____	<input type="checkbox"/> P <input type="checkbox"/> F	_____
SPEX _____	_____	<input type="checkbox"/> P <input type="checkbox"/> F	_____
NBOME Part I _____	_____	<input type="checkbox"/> P <input type="checkbox"/> F	_____
NBOME Part II _____	_____	<input type="checkbox"/> P <input type="checkbox"/> F	_____
NBOME Part III _____	_____	<input type="checkbox"/> P <input type="checkbox"/> F	_____
COMLEX-USA Level 1 _____	_____	<input type="checkbox"/> P <input type="checkbox"/> F	_____
COMLEX-USA Level 2, CE _____	_____	<input type="checkbox"/> P <input type="checkbox"/> F	_____
COMLEX-USA Level 2, PE _____	_____	<input type="checkbox"/> P <input type="checkbox"/> F	_____
COMLEX-USA Level 3 _____	_____	<input type="checkbox"/> P <input type="checkbox"/> F	_____
COMVEX _____	_____	<input type="checkbox"/> P <input type="checkbox"/> F	_____
USMLE Step I _____	_____	<input type="checkbox"/> P <input type="checkbox"/> F	_____
USMLE Step II, CS _____	_____	<input type="checkbox"/> P <input type="checkbox"/> F	_____
USMLE Step II, CK _____	_____	<input type="checkbox"/> P <input type="checkbox"/> F	_____
USMLE Step III _____	_____	<input type="checkbox"/> P <input type="checkbox"/> F	_____

Applicant Name: \_\_\_\_\_ Date: \_\_\_\_\_

**8. ECFMG:** If ECFMG is applicable and you are not using FCVS, you are responsible for contacting ECFMG and having a certified "Status Report" forwarded directly to this Board. There is a separate fee for this report. Reports can be obtained through the ECFMG website at [www.ecfm.org](http://www.ecfm.org).

**8. ECFMG** (if applicable)

Certificate Number \_\_\_\_\_ Issue Date \_\_\_\_\_ Valid Through Date \_\_\_\_\_

**9. State/Province Professional Licensure** whether temporary or permanent: List all states and Canadian provinces where you currently hold or have ever held any type of medical/osteopathic license or certification. You must also complete the attached "Licensure Verification" form (Form #1) and forward it to all states or provinces in which you have held any health care license or certification. The verifying entity must forward all documentation directly to this Board. Some state boards charge a fee for this information. Contact the state board where you hold or held a license to determine their requirements.

**9. State Licensure – MD or DO only – attach additional pages if necessary**

1. State/Province \_\_\_\_\_ Type \_\_\_\_\_ License Number \_\_\_\_\_ Status \_\_\_\_\_ Issue Date \_\_\_\_\_  
(MD, DO)
2. State/Province \_\_\_\_\_ Type \_\_\_\_\_ License Number \_\_\_\_\_ Status \_\_\_\_\_ Issue Date \_\_\_\_\_  
(MD, DO)
3. State/Province \_\_\_\_\_ Type \_\_\_\_\_ License Number \_\_\_\_\_ Status \_\_\_\_\_ Issue Date \_\_\_\_\_  
(MD, DO)
4. State/Province \_\_\_\_\_ Type \_\_\_\_\_ License Number \_\_\_\_\_ Status \_\_\_\_\_ Issue Date \_\_\_\_\_  
(MD, DO)
5. State/Province \_\_\_\_\_ Type \_\_\_\_\_ License Number \_\_\_\_\_ Status \_\_\_\_\_ Issue Date \_\_\_\_\_  
(MD, DO)
6. State/Province \_\_\_\_\_ Type \_\_\_\_\_ License Number \_\_\_\_\_ Status \_\_\_\_\_ Issue Date \_\_\_\_\_  
(MD, DO)
7. State/Province \_\_\_\_\_ Type \_\_\_\_\_ License Number \_\_\_\_\_ Status \_\_\_\_\_ Issue Date \_\_\_\_\_  
(MD, DO)
8. State/Province \_\_\_\_\_ Type \_\_\_\_\_ License Number \_\_\_\_\_ Status \_\_\_\_\_ Issue Date \_\_\_\_\_  
(MD, DO)
9. State/Province \_\_\_\_\_ Type \_\_\_\_\_ License Number \_\_\_\_\_ Status \_\_\_\_\_ Issue Date \_\_\_\_\_  
(MD, DO)
10. State/Province \_\_\_\_\_ Type \_\_\_\_\_ License Number \_\_\_\_\_ Status \_\_\_\_\_ Issue Date \_\_\_\_\_  
(MD, DO)

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Applicant Name: \_\_\_\_\_ Date: \_\_\_\_\_



**All Other Health Care Licensure/Certification** (e.g., RN, PA, etc.) - attach additional pages if necessary.

1. State/Province \_\_\_\_\_ Type \_\_\_\_\_ License Number \_\_\_\_\_ Status \_\_\_\_\_ Issue Date \_\_\_\_\_
2. State/Province \_\_\_\_\_ Type \_\_\_\_\_ License Number \_\_\_\_\_ Status \_\_\_\_\_ Issue Date \_\_\_\_\_
3. State/Province \_\_\_\_\_ Type \_\_\_\_\_ License Number \_\_\_\_\_ Status \_\_\_\_\_ Issue Date \_\_\_\_\_
4. State/Province \_\_\_\_\_ Type \_\_\_\_\_ License Number \_\_\_\_\_ Status \_\_\_\_\_ Issue Date \_\_\_\_\_
5. State/Province \_\_\_\_\_ Type \_\_\_\_\_ License Number \_\_\_\_\_ Status \_\_\_\_\_ Issue Date \_\_\_\_\_

**10. Chronology of Activities:** List ALL activities (medical, non-medical and postgraduate training) in chronological order beginning with medical school graduation to the PRESENT date, using **MONTH** and **YEAR**. For any non-working time, you **MUST** state on the form exactly what your activities were, such as "vacation" or "seeking employment," as well as your permanent address. If you worked for a physician-staffing group or did locum tenens, you must list all facilities where you worked and include complete dates and addresses. **DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM.** Be sure to indicate the percentage of working time spent in clinical administrative duties.

**10. Chronology of Activities** (copy and attach additional pages if necessary)

Dates: From/To	Practice/Employment
1. From: Month: _____ Year: _____ To: Month: _____ Year: _____	Practice/Employment Name _____ (or list non-working time as indicated above) Practice/Employment Address _____ City _____ State/Province _____ ZIP Code _____ Country _____ Position and Department _____ % Clinical _____ % Administrative _____ Employment <input type="checkbox"/> Staff Privileges <input type="checkbox"/> Affiliation <input type="checkbox"/> Other _____
2. From: Month: _____ Year: _____ To: Month: _____ Year: _____	Practice/Employment Name _____ (or list non-working time as indicated above) Practice/Employment Address _____ City _____ State/Province _____ ZIP Code _____ Country _____ Position and Department _____ % Clinical _____ % Administrative _____ Employment <input type="checkbox"/> Staff Privileges <input type="checkbox"/> Affiliation <input type="checkbox"/> Other _____

Applicant Name: \_\_\_\_\_ Date: \_\_\_\_\_

Dates: From/To	Practice/Employment
3. From: Month: _____ Year: _____  To: Month: _____ Year: _____	Practice/Employment Name _____ (or list non-working time as indicated above)  Practice/Employment Address _____ City _____ State/Province _____ ZIP Code _____ Country _____ Position and Department _____ % Clinical _____ % Administrative _____ Employment <input type="checkbox"/> Staff Privileges <input type="checkbox"/> Affiliation <input type="checkbox"/> Other _____
4. From: Month: _____ Year: _____  To: Month: _____ Year: _____	Practice/Employment Name _____ (or list non-working time as indicated above)  Practice/Employment Address _____ City _____ State/Province _____ ZIP Code _____ Country _____ Position and Department _____ % Clinical _____ % Administrative _____ Employment <input type="checkbox"/> Staff Privileges <input type="checkbox"/> Affiliation <input type="checkbox"/> Other _____
5. From: Month: _____ Year: _____  To: Month: _____ Year: _____	Practice/Employment Name _____ (or list non-working time as indicated above)  Practice/Employment Address _____ City _____ State/Province _____ ZIP Code _____ Country _____ Position and Department _____ % Clinical _____ % Administrative _____ Employment <input type="checkbox"/> Staff Privileges <input type="checkbox"/> Affiliation <input type="checkbox"/> Other _____
6. From: Month: _____ Year: _____  To: Month: _____ Year: _____	Practice/Employment Name _____ (or list non-working time as indicated above)  Practice/Employment Address _____ City _____ State/Province _____ ZIP Code _____ Country _____ Position and Department _____ % Clinical _____ % Administrative _____ Employment <input type="checkbox"/> Staff Privileges <input type="checkbox"/> Affiliation <input type="checkbox"/> Other _____

Applicant Name: \_\_\_\_\_ Date: \_\_\_\_\_

**11. Malpractice Liability Claims Information** (copy this form to report multiple claims)

Name of patient involved: \_\_\_\_\_

In which state did the action take place? \_\_\_\_\_ Case number (if applicable) \_\_\_\_\_

Which court? \_\_\_\_\_

(If private compromise or settled before initiation of civil action, state here)

Current status of claim: \_\_\_\_\_

- Open (pending)
- Closed (settled or judgment)
- Dismissed (no money paid out)
- Other \_\_\_\_\_

Amount of judgment or settlement \$ \_\_\_\_\_ Amount paid on your behalf \$ \_\_\_\_\_

Month and year of event precipitating claim: \_\_\_\_\_

Month and year of lawsuit: \_\_\_\_\_

Insurance carrier at time: \_\_\_\_\_

What is/or was your status?       Primary defendant       Co-defendant       Other \_\_\_\_\_

Please provide specifics in reference to the adverse event including the allegations and your role in the event:

\_\_\_\_\_  
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Applicant Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Affidavit and Authorization for Release of Information:** You must attach a recent (less than 6 months old) passport quality, color photograph of yourself to this form. Take the form to a notary public and sign the form in the presence of the notary public. The notarized form then must be sent directly to this Board.

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**Affidavit  
And  
Authorization For Release of Information**

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my application and that all documents, forms or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the Application for Physician Licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge and exonerate the Board, its agents or representatives and any person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the Board.

I will immediately notify the board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice medicine being granted to me by the board.

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my license or permit to practice medicine.

\_\_\_\_\_  
Applicant's Signature (must be signed in the presence of a notary)

\_\_\_\_\_  
Applicant's Printed Last Name

\_\_\_\_\_  
Applicant's Printed First Name, Middle Initial, and Suffix (e.g., Jr.)

\_\_\_\_\_  
Date of Signature

Applicant Photograph

Securely tape or glue in this square a current front-view 2" x 2" passport-type color photograph of yourself.

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**NOTARY**

Dated \_\_\_\_\_ Signed \_\_\_\_\_

State of \_\_\_\_\_ County of \_\_\_\_\_

SUBSCRIBED AND SWORN TO before me this \_\_\_\_\_ day of, \_\_\_\_\_ 20\_\_\_\_.

My commission expires: \_\_\_\_\_ (NOTARY PUBLIC SIGNATURE & SEAL)

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Applicant Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Licensure Verification Form**  
(Copy this form for multiple licenses)

**Form #1**

I am applying for a license to practice medicine. The Board requires that this form be completed by each state or Canadian province in which I hold or have held licenses, whether now current or not. Please complete the form and return it directly to the following Board: \_\_\_\_\_

**TO BE COMPLETED BY APPLICANT**

Applicant Name: _____				
Last	First	Middle	Suffix	
Date of Birth: _____		Social Security Number: _____		License Number: _____
				<small>(From State/Province you are sending this form to)</small>
<i>The applicant's social security number is to be used for purposes of identification and may not be used for any other reason.</i>				
I hereby authorize the licensing agency of the State/Province of _____ to furnish the information to the Board indicated below.				
Signature of Applicant _____				Date _____
Board Name: _____				
Address: _____				
Street	City	State/Province	ZIP Code	

**TO BE COMPLETED BY STATE LICENSING BOARD OR CANADIAN PROVINCE**

Name of Licensee: \_\_\_\_\_

Last First Middle Suffix

License Type: \_\_\_\_\_ License #: \_\_\_\_\_ Issue Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Is this license current?  Yes  No If No, please explain: \_\_\_\_\_

1) Have formal disciplinary proceedings been initiated against applicant's license by a disciplinary authority in your state?  
 Yes  No  Cannot answer under state law  
If Yes, please explain: \_\_\_\_\_

2) Has the applicant ever been warned, censured, placed on probation, formal consent, reprimand or in any other manner disciplined; or has the applicant's license ever been revoked, suspended or, in any other manner, limited by a licensing or disciplinary authority in your state?  
 Yes  No  Cannot answer under state law  
If Yes, please explain: \_\_\_\_\_

Board Authorized Signature: \_\_\_\_\_

**Affix Board Seal Here**

Title: \_\_\_\_\_

Date: \_\_\_\_\_

Please return this form to the Board listed at the top of this form.

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Applicant Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Medical School Verification – Page 1 of 4**

(Copy this form for multiple schools)

Applicant Instructions: For applicants not using FCVS, complete Section 1 and Section 2 of this form then send this form to your medical school along with a copy of your diploma. Request the Dean or designated official to complete Section 3 of this form and return this form, the sealed copy of your diploma (to be sealed by your medical school) and a copy of your official transcripts directly to this Board.

**Section 1: Applicant Information**

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

Middle Name: \_\_\_\_\_

Suffix: \_\_\_\_\_

Name if different when diploma awarded: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

The applicant's social security number is to be used for purposes of identification and may not be used for any other reason.

Waiver for release of information: I authorize the medical school below to provide any and all information pertaining to my medical education at your institution to the below listed Medical Board.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

**Section 2: Instructions to the Dean or designated official of medical school**

Please complete Section 3 of this form, certify the enclosed copy of the above named applicant's diploma by placing your school seal on it, enclose an official copy of the transcripts of the above named physician and forward all of this information directly to this Board to the following address:

Board Name: \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State/Province \_\_\_\_\_

ZIP Code \_\_\_\_\_

Medical School Verification – Page 2 of 4

(Copy this form for multiple schools)

Section 3: Medical School Verification

Medical School Name: \_\_\_\_\_

School name if different when the above applicant attended: \_\_\_\_\_

Medical School Address: \_\_\_\_\_

Street City State/Province ZIP Code

Hours of undergraduate education required for admission into your school: \_\_\_\_\_

Applicant's Attendance Dates: From \_\_\_\_\_ To \_\_\_\_\_ Graduation Date: \_\_\_\_\_ Degree: \_\_\_\_\_

(Indicate N/A if not applicable) (Indicate N/A if not applicable)

Total weeks of education applicant attended your school: \_\_\_\_\_

I certify that to the best of my knowledge and belief the foregoing is a true, accurate and complete statement of the record of the individual named on this form.

Signature: \_\_\_\_\_

Print name: \_\_\_\_\_

AFFIX INSTITUTIONAL SEAL HERE

Title: \_\_\_\_\_

(If no seal is available, this form must be notarized)

Date: \_\_\_\_\_

Phone number: \_\_\_\_\_ Fax: \_\_\_\_\_

E-mail: \_\_\_\_\_

VERIFICATION OF MEDICAL EDUCATION

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the individual's medical education. Please check the appropriate response and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation (attach additional pages as necessary).

**Medical School Verification – Page 3 of 4**

(Copy this form for multiple schools)

1. Does this individual's official records reflect (an) interruption(s) or extension(s) in his/her medical education?

Response  YES  NO

If YES, please select the reason(s) for, indicate the dates of the interruption(s) or extension(s) and check whether the interruption/extension was approved or unapproved.

	From Mo/Yr	To Mo/Yr	Approved	Unapproved
Personal/Family			<input type="checkbox"/>	<input type="checkbox"/>
Academic remediation			<input type="checkbox"/>	<input type="checkbox"/>
Health			<input type="checkbox"/>	<input type="checkbox"/>
Financial			<input type="checkbox"/>	<input type="checkbox"/>
Participation in joint degree program (e.g., MD/PhD)			<input type="checkbox"/>	<input type="checkbox"/>
Participation in non-research special study (e.g., fellowship, international experience)			<input type="checkbox"/>	<input type="checkbox"/>
Participation in non-degree research			<input type="checkbox"/>	<input type="checkbox"/>
Other			<input type="checkbox"/>	<input type="checkbox"/>
Please Specify: _____				

2. Does this individual's official records reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? Response  YES  NO

If YES, please select the reason(s) for the probation, indicate the date(s) of placement on and removal from probation and attach additional documentation to this report.

	From Mo/Yr	To Mo/Yr
<input type="checkbox"/> Academic Probation		
<input type="checkbox"/> Probation for unprofessional conduct/behavioral reasons		
<input type="checkbox"/> Probation for other reason		
Please specify reason: _____		

3. Does this individual's official records reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? Response  YES  NO

If YES, please provide detailed documentation/information about the circumstances and outcome(s): \_\_\_\_\_  
 \_\_\_\_\_



**Medical School Verification – Page 4 of 4**

(Copy this form for multiple schools)

4. Does this individual's official records reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical school or parent university? Response  YES  NO

If YES, please provide detailed documentation/information about the circumstances and outcome(s):

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5. Does this individual's official records reflect that there were ever any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason?

Response  YES  NO

If YES, please provide detailed documentation/information about the nature of the limitations or special requirements.

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**Postgraduate Training Verification - Page 1 of 3**

(Copy this form for multiple programs)

Applicant Instructions: For applicants not using FCVS, complete Section 1 and Section 2 of this form then send this form to your training program. Request the Program Director or designated official to complete Section 3 of this form and return this form and the Program Director's recommendation letter directly to this Board.

**Section 1: Applicant Information**

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

Middle Name: \_\_\_\_\_

Suffix: \_\_\_\_\_

Name if different when diploma awarded: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

The applicant's social security number is to be used for purposes of identification and may not be used for any other reason.

Waiver for release of information: I authorize the Postgraduate Training Program below to provide any and all information pertaining to my medical education at your institution to the below listed Medical Board.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

**Section 2: Instructions to the PROGRAM DIRECTOR or designated official of POSTGRADUATE TRAINING PROGRAM.**

Please complete Section 3 of this form and attach a recommendation letter from the Program Director and forward this information directly to this Board at the following address:

Board Name: \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State/Province \_\_\_\_\_

ZIP Code \_\_\_\_\_

**Postgraduate Training Verification - Page 2 of 3**

(Copy this form for multiple programs)

**Section 3: Postgraduate Training Verification**

Institution Name: \_\_\_\_\_

Institution Address: \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_

State/Province \_\_\_\_\_

ZIP Code \_\_\_\_\_

Affiliated Medical School Name: \_\_\_\_\_

Program Type/Specialty: \_\_\_\_\_

Postgraduate Year: \_\_\_\_\_

- Internship     
  Residency     
  Fellowship     
  Research     
  Chief Resident

Other: \_\_\_\_\_

From Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ To Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Successfully Completed?:  Yes  No  In Progress  
 (The definition of Successfully Completed is: In each year of training, did the applicant demonstrate sufficient academic and clinical ability to qualify for advancement without conditional or probationary status to the next year and next progressive level of responsibility in a designated specialty program?)

Accredited by:  ACGME  AOA  LCGME  RSC  CFPC  RCPSC  APPAP  None of these

**Unusual Circumstances:**

Did this individual ever take a leave of absence or break from his/her training?  Yes  No

Was this individual ever placed on probation?  Yes  No

Was this individual ever disciplined or placed under investigation?  Yes  No

Were any negative reports for behavioral reasons ever filed by instructors?  Yes  No

Were any limitations or special requirements placed upon this individual because  Yes  No

of questions of academic incompetence, disciplinary problems or any other reason?

Please explain any "Yes" response from above (attach additional pages if necessary): \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Postgraduate Training Verification - Page 3 of 3**

(Copy this form for multiple programs)

***I certify that to the best of my knowledge and belief the foregoing is a true, accurate and complete statement of the record of the individual named on this form.***

Signature: \_\_\_\_\_

Print name: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

Phone number: \_\_\_\_\_

Fax: \_\_\_\_\_

E-mail: \_\_\_\_\_

**AFFIX INSTITUTIONAL SEAL HERE** (If no seal is available, this form must be notarized)

If you completed Section 5 of the application, you must complete this form  
**Fifth Pathway Verification**

Applicant Instructions: For applicants not using FCVS, complete Section 1 and Section 2 of this form then send this form to the director of your 5th Pathway Program. Request the Program Director or designated official to complete Section 3 of this form and return this form and the Program Director’s recommendation letter directly to this Board.

**Section 1: Applicant Information**

Last Name: \_\_\_\_\_ Suffix: \_\_\_\_\_  
First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_  
Name if different when diploma awarded: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_

The applicant’s social security number is to be used for purposes of identification and may not be used for any other reason.

Waiver for release of information: I authorize the Postgraduate Training Program below to provide any and all information pertaining to my medical education at your institution to the below listed Medical Board.

\_\_\_\_\_  
Applicant’s Signature Date

**Section 2: Instructions to the PROGRAM DIRECTOR or designated official**

Please complete Section 3 of this form and attach a recommendation letter from the Program Director and forward this information directly to this Board at the following address:

Board Name: \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State/Province \_\_\_\_\_ ZIP Code \_\_\_\_\_

**Section 3: Medical School Verification**

Medical School Name: \_\_\_\_\_  
School name if different when the above applicant attended: \_\_\_\_\_  
Applicant’s Attendance Dates: From \_\_\_\_\_ To \_\_\_\_\_ Program Completion Date: \_\_\_\_\_  
(Indicate N/A if not applicable)

***I certify that to the best of my knowledge and belief the foregoing is a true, accurate and complete statement of the record of the individual named on this form.***

Signature: \_\_\_\_\_  
Print name: \_\_\_\_\_  
Title: \_\_\_\_\_  
Date: \_\_\_\_\_  
Phone number: \_\_\_\_\_  
Fax: \_\_\_\_\_  
E-mail: \_\_\_\_\_

**AFFIX INSTITUTIONAL SEAL HERE**  
(if no seal is available, this form must be notarized)