

**Board of Registration in Medicine**  
**200 Harvard Mill Square, Suite 330, Wakefield, MA 01880**  
**Telephone: (781) 876-8210 Fax: (781) 876-8383**  
[www.mass.gov/massmedboard](http://www.mass.gov/massmedboard)

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**INITIAL LIMITED LICENSE INFORMATION**

**PLEASE NOTE:** As the applicant, you are responsible for the accuracy of this licensing information. If you have questions concerning the licensing process, contact the residency program coordinator or the residency training office at the Massachusetts hospital where your training will be undertaken.

**LIMITED LICENSE FEE:** The fee for a limited license is \$100.00. Please attach a personal check from a U.S. bank or money order in U.S. dollars payable to the Commonwealth of Massachusetts. Applications will not be processed without the fee.

**IMPORTANT INFORMATION:**

- Limited licenses are issued to physicians enrolled in postgraduate medical education programs in healthcare facilities in the Commonwealth of Massachusetts. All such training must be done in either an ACGME-accredited or AOA-approved program, or in a subspecialty clinical training or fellowship program in a training facility that has an approved program in the parent specialty. This information must be documented by the training program in **Section B** of this Limited License Application. You may practice medicine only in the training program approved with this application. With a limited license you are not allowed to “moonlight” under any circumstances.
- A physician who holds or who has ever held a full Massachusetts license is not eligible for a limited license.
- **You may not engage in direct or indirect patient care until your license has been approved by the Board and you have been appropriately credentialed by your healthcare facility.**
- Following Board approval of your limited license, your limited registration certificate verifying your registration number will be sent to your training program and they will provide you with a copy of the certificate. That license number will be retained for the duration of that training program. If you enter a different training program (for example, change from a residency in general surgery to a fellowship in plastic surgery) at the same facility or another training program, you must submit a Change of Program Application. A new license will be issued, assuming that you still qualify for limited license registration.
- Please be advised that your limited license expires at the end of the academic year or earlier if your training is completed before the end of the academic year. If you are continuing in a training program, a limited renewal application must be completed and sent to the Board at least 30 days prior to the end of the academic year. The issuance of a limited license beyond a total of seven years of training may be granted only by a majority vote of the Board.

**Grounds for Denial:** Each applicant’s qualifications for licensure in Massachusetts are reviewed on an individual basis. The Board has the authority to deny licensure based upon an applicant’s failure to meet the Board’s requirements for licensure; failure to provide satisfactory proof of good moral character; or because of acts which, were they engaged in by a licensee, would violate M.G.L. c. 112, Section 5 or 243 CMR 1.03(5).

## **The Limited License Application Kit:**

The Initial Limited License Application Kit is comprised of the following documents:

- Initial Limited License Application, including Sections A, B and C and supplemental pages if you answer “yes” to any of the questions.
- Medical Education Verification forms for premedical and medical education
- Authorization for Release of Information, which must be completed and included with your application
- Evaluation Form
- State License Verification(s) form for states where you have ever held a full license
- Affidavit for Social Security number (only if you do not have a U.S. Social Security number)
- Name Change form

In addition to these required forms, you must provide the Board with a current updated curriculum vitae from the date of your graduation from medical school to the present by month and year (Example: December 2013 to July 2014).

**Other name(s):** If you have had a name change, you must submit a notarized copy of your marriage certificate or a notarized copy of the court order changing your name. Please complete the Name Change and Duplicate License form and the Notary Public Attestation for Name Change form.

**Qualifying Examinations:** Applicants for a limited license must have passing scores on USMLE Step 1 and Step 2 (CK and CS), or the first two levels of COMLEX, or all parts of MCCQE (LMCC).

The Board will accept a copy of the USMLE scores, COMLEX, or MCCQE if they were part of the ERAS application that was sent directly from the original source to the training program. The exam report should be sent to the Board by the Graduate Medical Education staff with the initial limited license application. Otherwise, exam scores for USMLE may be obtained from the Federation of State Medical Boards (FSMB) at [www.fsmb.org](http://www.fsmb.org) or the National Board of Osteopathic Medical Examiners for COMLEX at [www.nbome.org](http://www.nbome.org) or the Medical Council of Canada at [www.mcc.ca](http://www.mcc.ca) for the MCCQE.

**NOTE:** If you completed USMLE Step 2, CS or CK after the ERAS report was sent to your training program, you must request your USMLE scores from the FSMB to be sent to your training program.

**Examination scores from applicants will not be accepted unless they were sent to the applicant from the primary source in a sealed envelope. If your examination scores were not sent directly to your training program by ERAS, you then must request them in a sealed envelope and include them with your limited license application.**

**Translations:** Original translations must be provided for any documents in a language other than English. The Board will accept an English translation if it was translated by your medical school and has an original medical school seal. If a transcript is provided in a language other than English, you must obtain an official translation by a translation company in the United States or at a U.S. Embassy. An Official U.S. Translation Company is a private organization located in the U.S. engaged solely in the practice of translating documents and inter-language communication, e.g. Berlitz, Polylingua, Inc., etc. These companies can be located by looking under Translators and Interpreters on the internet. An office of a U.S. translation company located outside the U.S. is acceptable. English translations received directly from the Medical School Dean, with the seal of the medical school, will be accepted.

If you wish to have original U.S. translations returned, you must provide sufficient postage. The Board of Registration in Medicine will keep your notarized copy and return the original to you.

## APPLICATION INSTRUCTIONS

**1-B. Other name(s):** If you have had a name change, you must submit a notarized copy of your marriage certificate or a notarized copy of the court order changing your name. Please complete the Name Change and Duplicate License form and the Notary Public Attestation for the Name Change form.

**2. Current residence:** Provide a mailing address and telephone number where you can be reached. You must immediately notify the Board of any change in this information.

**5. Social Security Number:** Your social security number may be used to facilitate the authorized sharing of information with designated agencies for identification of licensees for the following purposes: reporting of disciplinary actions to national data repository systems; tax default status; student loan default status; child support arrearages; Medicaid provider eligibility; possession of Massachusetts controlled substances registration; and collection of fines imposed in connection with Board disciplinary cases. The Board considers this information highly confidential and not subject to release except as specifically authorized. If you do not have a Social Security number, you must complete the Affidavit form and include it with your Initial Limited License Application.

**6. Name and address of Massachusetts training hospital:** This is the name of the healthcare facility at which you will be practicing with your initial limited license. This information should correspond with the information in Section B.

**7. Name of premedical school(s):** Supply the name of the school(s) at which you completed your undergraduate premedical education.

**11. Examinations completed:** Indicate all licensing examinations which you have completed. Please provide supporting evidence of these examinations by accessing the Federation of State Medical Board's (FSMB) on-line services to request your USMLE scores in a sealed envelope. **The Board will accept a copy of the USMLE scores, COMLEX, or MCCQE if they were part of the ERAS application that was sent electronically to the training program. Otherwise, you must request the examination scores to be sent to you in a sealed envelope.**

**12-A or B. Completion of medical school education:** If you answered "yes" to question #12-A or 12-B, please supply an explanation on a separate piece of paper. U.S medical graduates must explain the reason(s) for more than 4 years of medical education. International medical graduates must explain the reason(s) for more than 6 years of medical education. Please provide a written explanation for a leave of absence for research, public service, participation in an M.D., Ph.D. program, etc., and an explanation for "personal reasons." You must also contact your medical school to provide an explanation for any of the above.

**13. Time between graduation and start of training:** If you answered yes to this question, attach a detailed list of your activities, both professional and non-professional, and the dates in which you engaged in each of these activities, arranged in chronological order up to the present time. Be sure to include all employment experiences and training programs.

**16-A. Leave of absence or termination.** You must provide a written explanation for a leave of absence from medical school or a postgraduate training program (including leaves of absences for research, public service, participation in a M.D./Ph.D. program, etc.) and an explanation for "personal reasons." You must also contact your medical school or postgraduate training program to provide an explanation for any of the above.

**SECTION B must be completed and signed by the designated official at the healthcare facility.**

**SECTION C must be completed by the applicant.**

## **INSTRUCTIONS FOR COMPLETING LIMITED LICENSE FORMS**

**Initial Limited License Application Form:** Complete **Sections A and C**, as well as any other forms that apply. After completion of **Sections A and C**, **forward** the application to the training program for completion of **Section B**.

**Medical Education Verification Form:** Pre-medical education must be certified by your medical school(s) on the Medical Education Verification form. You must have successfully completed a minimum of two (2) or more academic years at a legally chartered college or university. If you attended more than one medical school you must obtain verification from all medical schools. Do not open the envelope from your medical school and inform the members of your household not to open the envelope. If the seal on the envelope from your medical school is opened, the Medical School Verification form will not be accepted and you will be required to obtain a new Medical School Verification. This will delay the processing of your Limited License Application.

**Attendance:** The first two (2) years of medical school is defined as physical presence at the program for matriculation. Attendance during the third and fourth years of medical school is defined as enrollment in clinical study at the degree-granting institution and as further described by the Board of Registration in Medicine's regulations and under Medical Education Verification form above.

**Transfers:** If you have transferred from one medical school to another, please request a letter from the medical school's registrar's office explaining the reason(s) for the transfer. The letter should be sent to you and included with the Limited License Application. If the seal on the envelope is opened, you will be required to obtain a new letter and your application will be delayed.

**International Medical Graduates:** You may wish to send your Medical Education Verification form via an international carrier with a prepaid return envelope addressed to you and it must be included with your Initial Limited License application and other documents. If the Medical School Verification and transcripts are provided in a language other than English, you will be required to provide an official translation by a translation company in the United States or by a U.S.Embassy.

**Medical School Diploma:** International medical graduates must include a U.S. **notarized** copy of the medical school diploma with an original medical school seal with the initial limited license application. If your medical school diploma is not written in English, you must have it translated and notarized by a U.S. translation company or a U.S. Embassy. The medical school verification and all documents must be sent to you in sealed envelopes. If the seal is opened, you will be required to repeat the process.

**Please note:** The Board of Registration in Medicine (Board) will not grant a limited license prior to the medical school awarding you an M.D. or D.O. degree. In the event that your medical school has determined that you have *not* met the requirements for graduation, you must notify the Board within 24 hours following notification by your medical school.

**Authorization for Release of Information:** Sign and date the Authorization for Release of Information form and include it with your Initial Limited License Application.

**State License Verification:** If you are currently licensed, or if you have ever held a full license in the United States, Puerto Rico, or Canada, you must sign the State License Verification form and send it to the appropriate state medical licensing board. Request that the state licensing board send the verification of your license to you and include it with your Initial Limited License Application. If the seal on the envelope from the state board is opened, the State License Verification will not be accepted by the Massachusetts Board and you will be required to repeat the process.

**Evaluation Form:** If this is your first postgraduate training program, you do not need to complete the Evaluation Form.

If you ever had any postgraduate training in another state, whether or not it was completed, the Evaluation Form must be completed by the program director or the department chairman. If you were practicing medicine or had medical staff privileges, the Evaluation Form must be completed by the department chairman, department chief or another person who supervised your clinical activity. The Evaluation Form must be returned to you in a sealed envelope and included with your Initial Limited License Application. If the seal on the envelope is opened, it will be returned to you and then you will have to repeat the process.

### **International Medical Graduates**

**ECFMG Status Report:** The ECFMG Status Report will be sent directly to the Board from ECFMG electronically. Go to <https://cvsonline2.ecfm.org/ImgGenInfo.asp> for information and instructions on how to apply for your ECFMG status report.

### **Substantial Equivalency of Medical School Education and Off-Site Clinical Clerkships:**

In situations where an international medical graduate cannot comply with 243 CMR 2.03(1) (b), requiring substantial equivalency of medical school education, a Waiver Request may be submitted to the Board. If an applicant completed more than three (3) months of elective clinical training, or any required clinical training of the (2) two-year clinical study requirement outside of the primary teaching hospital of their medical school of attendance, a Waiver Request (Form J) and Forms E-1 and E-2 are required. You must send a copy of Form E-1 to your medical school and Form E-2 must be forwarded to the program director at the program where you completed each clinical clerkship. E-2's must be returned directly to the applicant in a sealed envelope.

The Board will review the applicant's medical school training and/or off-site clinical rotations to determine whether they are substantially equivalent to U.S. medical school training. In assessing the applicant's equivalency of medical education, the Board relies on the factors detailed in Policy 91-003. The Waiver for Substantial Equivalency of Medical School education, Board Policy 91-003 and the E-1 and E-2 forms are available at the Board's website. Requesting a waiver for substantial equivalency of medical school education may result in a delay in processing your limited license, as determinations on waiver requests are made by the Board on a case-by-case basis.

**Please note:** The Board has determined that the medical education at St. George's University School of Medicine, SABA University, Ross University School of Medicine and the American University of the Caribbean is substantially equivalent to U.S. medical school training. Graduates of St. George's University School of Medicine, SABA University, Ross University School of Medicine and the American University of the Caribbean do not have to submit a Waiver Request or Forms E-1 and E-2.

**Important Note:** Following the submission of your application for licensure, the Board may, at any time, request additional documentation to determine the applicant's compliance with the Board's statutes and regulations. Applicants who are not in compliance with the Board of Registration in Medicine's statutes and regulations may not be eligible for licensure.

## **LIMITED LICENSE APPLICATION CHECKLIST**

PRINT NAME \_\_\_\_\_  
(first) (middle) (last)

### **HAVE YOU INCLUDED THE FOLLOWING:**

- Check for \$100.00 payable to the Commonwealth of Massachusetts.
- Initial Limited License Application (all data fields completed, certification and supplement pages signed).
- Supplement form (all data fields completed, explanation provided on additional supplement pages for any “yes” answers).
- Section B completed by training program (all data fields completed).
- Authorization for Release of Information form completed.
- Curriculum Vitae - must be in chronological order by month and year (i.e., June 2014 to July 2015) from the date of medical school graduation. CV must not contain any gaps – all breaks from your education, training or clinical activity from the date of medical school graduation should also be included on your CV.

### Additional Items to be sent to the Board (APPLICANTS MUST NOT OPEN ENVELOPES)

- Examination scores: From the training program directly through ERAS **OR** access the Federation of State Medical Board’s (FSMB) on-line services at [www.fsmb.org](http://www.fsmb.org) or [www.nbome.org](http://www.nbome.org) for COMLEX or [www.mcc.ca](http://www.mcc.ca) for the MCCQE to request an examination score report (see instructions).
- Medical School Education Verification form from primary source (Medical School, FCVS, ECFMG).

### Additional Items for IMGs (APPLICANTS MUST NOT OPEN ENVELOPES)

- Medical School Diploma directly from primary source with medical school seal or notarized by a U.S. notary.
- Medical School Transcript directly from primary source with medical school seal. (If transcript is not provided in English, must be translated by a U.S. Translation Service.)
- ECFMG Status report (Request status report to be sent directly to the Board at <https://cvsonline2.ecfmg.org/ImgGenInfo.asp>)

### Additional Items for “Yes” Answers (APPLICANTS MUST NOT OPEN ENVELOPES)

- Malpractice – provide copies of open or closed malpractice reports, including the final judgment from your liability carrier or attorney, as well as a malpractice history report from your liability carrier.
- Criminal charge – provide police reports and court reports from the police department or courthouse in sealed envelopes.
- If fully licensed in another state – provide state license verifications for each state where you held a full license.

**IF THE SEAL ON ANY ENVELOPE IS BROKEN, THE DOCUMENTS WILL NOT BE ACCEPTED BY THE BOARD. PLEASE CONTACT THE PROGRAM COORDINATOR AT YOUR TRAINING PROGRAM IF YOU HAVE ANY QUESTIONS.**

**Commonwealth of Massachusetts - Board of Registration in Medicine**  
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**INITIAL LIMITED LICENSE APPLICATION**

**IMPORTANT:** Read the accompanying instructions before completing this form, and **print legibly** or type your answers. Please attach a \$100.00 check payable to the Commonwealth of Massachusetts.

**CHECK ONE:**  Graduate of a Medical School in the United States, Canada, or Puerto Rico (USMG)  
 Graduate of an International Medical School (IMG)

**NOTE: GRADUATES OF INTERNATIONAL MEDICAL SCHOOLS MUST COMPLETE ADDITIONAL FORMS.**

**SECTION A: Sworn Statement to be completed by applicant**

1-A. Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_

1-B. Other Name(s) \_\_\_\_\_

- |  | <u>YES</u>               | <u>NO</u>                |
|--|--------------------------|--------------------------|
| a) Since your graduation from medical school, have you ever been known under a different name or been licensed under a different name? | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Have you ever applied for licensure, or applied to sit for an examination, or taken an examination under a different name?          | <input type="checkbox"/> | <input type="checkbox"/> |

If you answer **yes**, you must provide additional information. (See instructions.)

2. Current Address: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

3. Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Place of Birth: \_\_\_\_\_  
Month Day Year

E-mail Address \_\_\_\_\_

4. Sex:  Male  Female 5. U.S. Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

6. Name of Massachusetts Training Program: \_\_\_\_\_

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City

Are you applying for licensure through the Federation Credentials Verification Service (FCVS)?  
 Yes  No

**PRINT NAME** \_\_\_\_\_

7. Name of premedical school(s): \_\_\_\_\_

Location: \_\_\_\_\_  
(City, State, Country)

8. Name of medical school(s): \_\_\_\_\_

Location: \_\_\_\_\_  
(City, State, Country)

Date of Graduation: \_\_\_\_/\_\_\_\_/\_\_\_\_ Degree:  M. D.  D. O. Other (specify) \_\_\_\_\_  
Month Day Year

9. Have you ever or are you currently engaged in postgraduate training in the U.S. or Canada?

Yes  No

Name of Postgraduate Training Program \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Training Dates: From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_ Specialty: \_\_\_\_\_

(Attach a list of any additional postgraduate training in the United States or Canada.)

10. List states (abbreviations) where you ever had a full license to practice medicine.

\_\_\_\_\_

11. Please indicate **all** the licensing examinations that you have completed with a passing score:

USMLE:  Step 1  Step 2 (CK)  Step 2 (CS)  Step 3

COMLEX:  Level 1  Level 2 (CE)  Level 2 (PE)  Level 3

LMCC  Other \_\_\_\_\_

**YES NO**

12. If you are a U.S. or Canadian graduate, did you take more than four (4) years to complete medical school; or if you are an international medical graduate, did you take more than six (6) years to complete medical school? (Include leave of absence for research, public service, M.D./Ph.D program, and personal reasons, etc.) (Please request that your medical school also provide an explanation.)

13. Has more than one year passed between the date of your graduation from medical school and the anticipated start date of your limited licensure in Massachusetts? (Include past or current training programs)

PRINT NAME \_\_\_\_\_

**SECTION B: TO BE COMPLETED AND SIGNED BY THE DESIGNATED OFFICIAL OF THE TEACHING PROGRAM AT WHICH THE APPLICANT HAS RECEIVED AN APPOINTMENT.**

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This certifies that \_\_\_\_\_ has been appointed  
(Name of Applicant)

to the position of  Intern  Resident  Fellow

in the specialty of \_\_\_\_\_ as a PGY \_\_\_\_\_

Department: \_\_\_\_\_ Subspecialty: \_\_\_\_\_

at \_\_\_\_\_  
(Name of Healthcare Facility)

beginning \_\_\_\_/\_\_\_\_/\_\_\_\_ to anticipated completion of training: \_\_\_\_/\_\_\_\_/\_\_\_\_.  
Month Day Year Month Day Year

**YES   NO**

- 1. Is the program accredited by the ACGME?
- 2. If **no**, is there an ACGME-approved training program in the applicant's specialty?
- 3. Have you reviewed Sections A and C of the limited license application?

Designated Official's Signature: \_\_\_\_\_

Type or Print Name: \_\_\_\_\_

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

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Telephone Number: \_\_\_\_\_

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**SECTION C: PAGES 4-7 MUST BE COMPLETED BY APPLICANT.**

PRINT NAME \_\_\_\_\_

**SECTION C: Read the instructions. Check either YES or NO to each question. Do not answer N/A. If you answer YES to any of these questions, you must provide details on the Limited License Supplement. You must answer all questions or your application will be returned to you.**

- |   | <u>YES</u>               | <u>NO</u>                |
|---|--------------------------|--------------------------|
| 14. While enrolled in college, medical school, graduate school or postgraduate training, were you ever the subject of any disciplinary action? (This includes action that was formal or informal, oral or written, voluntary or involuntary. A confidentiality agreement does not absolve you of your requirement to answer this question.) | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>If you answered “yes” to question 14, you must provide an explanation and a letter from the program director is required.</b>  |                          |                          |
| 15. Have you ever been terminated or granted a leave of absence by a medical school or any postgraduate training program, or have you ever withdrawn from a medical school or any postgraduate training program or had to repeat a year of postgraduate training?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Have you ever been placed on probation or remediation by a medical school, graduate school or any postgraduate training program?  | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>If you answered “yes” to 15 or 16, you must provide an explanation and request a letter of explanation from your medical school, graduate school, or postgraduate training program.</b>  |                          |                          |
| 17. Since your enrollment in college, have you been denied the privilege of taking or finishing an examination or been accused of or found to have cheated or engaged in improper conduct during an examination?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Have you ever been denied a medical license, whether full, limited or temporary, or have you withdrawn an application for medical licensure?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Have you ever surrendered a license to practice medicine or any professional license or has your license or certificate ever been revoked? (You do not need to report a lapsed license.)  | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Are you aware of any pending investigation or inquiry into your professional conduct by any entity, or are any disciplinary charges pending against you?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Since your completion of postgraduate training, has any disciplinary action ever been taken against you? (A confidentiality agreement does not absolve you of your requirement to answer this question.)  | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Have you been denied American Board of Medical Specialties or American Board of Osteopathic Medicine certification or has your certification ever been suspended or revoked?  | <input type="checkbox"/> | <input type="checkbox"/> |

**PRINT NAME** \_\_\_\_\_

- |  | <u>YES</u>               | <u>NO</u>                |
|--|--------------------------|--------------------------|
| 23. Have you ever withdrawn an application for hospital privileges or appointment, or have you ever been denied medical staff membership, advancement in medical staff status or association with a health care facility, or has such denial been recommended by a medical staff committee, administration or governing body?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Have you ever relinquished any medical staff membership or association with a health care facility?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Has your medical staff membership, medical privileges, medical staff status or association with a health care facility ever been limited, suspended, revoked, not renewed or subject to probationary conditions, or has processing toward any of those ends been instituted or recommended by a medical staff committee, administration or governing board?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Have you ever been charged with any criminal offense? (You must report being arrested, arraigned, indicted or convicted, even if the charges against you were dropped, filed, dismissed or otherwise discharged. A charge of operating under the influence or its equivalent is reportable. A medical malpractice claim is a civil, not a criminal, matter and need not be reported for purposes of this question.)                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Has your privilege to manufacture, distribute, administer, possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted or surrendered, or have you ever been called before or warned by any state or other jurisdiction, including a federal agency, regarding such privileges?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim, or has such a suit been settled, adjudicated or otherwise resolved?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Has any lawsuit, other than a medical malpractice suit, ever been filed against you which is related to your practice of medicine, or has such a suit been settled, adjudicated or otherwise resolved?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Has any professional liability insurance provider ever restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition on your coverage, or have you ever voluntarily restricted, limited or terminated your insurance coverage in response to any inquiry by a professional liability insurance provider?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Have you ever had an application for membership as a participating provider denied by any third-party payor, Medicare or Medicaid (any state), or have you ever been the subject of any termination, suspension or probation proceedings instituted by any third-party payor, Medicare or Medicaid (any state), or have you ever been restricted from receiving payments from any third-party payor, Medicare, Medicaid (any state)? | <input type="checkbox"/> | <input type="checkbox"/> |

**CONFIDENTIAL MEDICAL INFORMATION**

**Before completing the following questions, refer to the instructions for definitions and additional information. If answering “yes” to any of the questions, you must provide details on the Limited License Supplement. For purposes of the following questions, “currently” does not mean on the day of, or even the weeks or months preceding the completion of this application. It means recently enough to have an impact on one’s functioning as a licensee, or within the past two years.**

- |     |   | <b><u>YES</u></b>        | <b><u>NO</u></b>         |
|-----|---|--------------------------|--------------------------|
| 32. | Do you have a medical or physical condition that currently impairs your ability to practice medicine?                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 33. | Have you engaged in the use of any substance(s) with the result that your ability to practice medicine is currently impaired?           | <input type="checkbox"/> | <input type="checkbox"/> |
| 34. | Have you ever refused to submit to a test to determine whether you had consumed and/or were under the influence of chemical substances? | <input type="checkbox"/> | <input type="checkbox"/> |

*If you have a substance use disorder or mental or physical health diagnosis that impacts your ability to practice medicine, the Board encourages you to seek assistance voluntarily and to abide by any recommendations of your health care provider.*

*When the Board receives notice of a substance use disorder, its primary mission is to protect the public; however, the Board also seeks to ensure successful rehabilitation through the physician’s participation in approved treatment programs and supervised structured aftercare. Similarly, when the Board receives notice of a mental health or physical health diagnosis that impacts a physician’s ability to practice, the Board needs to ensure that the physician can practice medicine safely.*

*In regard to issues of physician impairment, whether the impairment is caused by a substance use disorder, or a mental or physical health diagnosis, the Board works cooperatively with the Massachusetts Medical Society’s Physician Health Services (PHS) and encourages physicians to contact PHS to determine what services may be available to them in order to ensure their safe practice of medicine. Please call PHS at (781) 434-7404.*

**If your responses to Questions 15-34 change while your application is pending, you must notify the Board of the new information immediately. Please note that your license expires at the end of the academic year and must be renewed. A limited licensee may practice medicine only at the institution or its affiliates. With a limited license you are not allowed to “moonlight” under any circumstances.**

**PRINT NAME** \_\_\_\_\_

**CERTIFICATIONS**

- Pursuant to M.G.L. c. 62C, § 49A, I certify under the penalties of perjury that, to the best of my knowledge and belief, I have filed any Massachusetts state tax returns and paid any Massachusetts state taxes that are required under law and that I have complied with all laws of the Commonwealth related to withholding and remitting child support. (*Note:* This applies even if you reside out of the state or out of the country.)
- Pursuant to G.L. c. 112, § 1A, I will fulfill my obligation to report abuse or neglect of children as required by G.L. c. 119, §51A.
- I will read the Board’s regulations, 243 C.M.R. 1.00 through 3.00.
- To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.
- Under the penalties of perjury, I declare that I have examined this limited license application and all its accompanying instructions, forms and statements, and to the best of my knowledge, and belief the information contained herein is true, correct and complete.

Applicant’s Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

PRINT NAME \_\_\_\_\_

## INITIAL LIMITED LICENSE APPLICATION SUPPLEMENT

**For all questions, please attach additional pages, whenever necessary, using the same format.**

### **QUESTIONS #14, 20 & 21 – Disciplinary action.**

Name of agency or institution taking action: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Description: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**You must arrange for the appropriate agency or institution to submit copies of all official documentation and correspondence related to any disciplinary action. Documents should be sent directly to you in a sealed envelope.**

### **QUESTIONS #15 & 16 – Medical school or any postgraduate training termination, leave of absence, withdrawal, repeating a year of training, probation, or remediation.**

Name of institution: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Dates of attendance: From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_

Description: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**You must arrange for the appropriate institution to submit copies of all official documentation and correspondence regarding any termination, leave of absence, withdrawal, requirement to repeat, probation, or remediation. Documents should be sent directly to you in a sealed envelope.**

### **QUESTION #17 – Examination denial; improper conduct.**

Name of organization: \_\_\_\_\_ Name of exam: \_\_\_\_\_

Action: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**You must arrange for the appropriate agency or institution to submit copies of all official documentation and correspondence regarding any examination denial or improper conduct. Documents should be sent directly to you in a sealed envelope.**

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**PRINT NAME** \_\_\_\_\_

**QUESTIONS #18 & 19 – Medical license application denial, withdrawal, surrender, or revocation.**

Describe circumstances under which license application was withdrawn or denied, or license was surrendered or revoked.

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

State: \_\_\_\_\_ Year: \_\_\_\_/\_\_\_\_/\_\_\_\_

**You must arrange for the appropriate agency or institution to submit copies of all official documentation and correspondence regarding any medical license application denial or withdrawal and any license surrender or revocation. The documents must specify the reason(s) and should be sent directly to you in a sealed envelope.**

**QUESTION #22 – ABMS or AOA certification denial, suspension, or revocation.**

Specialty Board: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Explain reason(s) for loss or denial: \_\_\_\_\_

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

**Please contact the certifying board to provide a letter explaining the reason(s) for the denial, suspension, or revocation. The letter should be sent directly to you in a sealed envelope.**

**QUESTIONS #23, 24 & 25 –Medical staff membership, status, or privileges, or association with a health care facility.**

Name of facility: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Description: \_\_\_\_\_

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

**You must arrange for the appropriate agency or institution to submit copies of all official documentation and correspondence regarding any affirmative responses to Questions 23, 24 and 25. Documents should be sent directly to you in a sealed envelope.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**PRINT NAME** \_\_\_\_\_

**QUESTION #26 – Criminal offenses.**

Court: \_\_\_\_\_ Charge(s): \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Describe the circumstances leading up to criminal offenses. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Status: \_\_\_\_\_

**You must arrange for your lawyer, the police department, or the court to submit copies of the indictment, complaint, judgment or other disposition in any criminal offenses in which you were a defendant. Documents should be sent directly to you in a sealed envelope.**

**QUESTION #27 – Controlled substances privileges.**

Type of restriction: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Describe the circumstances of restriction: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**You must arrange for the appropriate agency or institution to submit a copy of all official orders, findings of fact, and correspondence related to any suspension, revocation, denial, restriction or surrender of controlled substance privileges. Documents should be sent directly to you in a sealed envelope.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**PRINT NAME** \_\_\_\_\_

**QUESTION #28 – Malpractice claims.**

For each instance of alleged malpractice, you must provide the following information.

Claimant's name: \_\_\_\_\_ Date of incident: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Insurer's name: \_\_\_\_\_

Insurer's Address: \_\_\_\_\_

Description of claim (allegations only: this does not constitute an admission of fault or liability).

Allegation: \_\_\_\_\_ Allegation: \_\_\_\_\_ Allegation: \_\_\_\_\_

**REQUISITE DESCRIPTIVE INFORMATION:**

1. Patient's condition at point of your involvement: \_\_\_\_\_

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

2. Patient's condition at end of treatment: \_\_\_\_\_

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

3. The nature and extent of your involvement with the patient: \_\_\_\_\_

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

4. Your degree of responsibility for the course of treatment leading to the claim: \_\_\_\_\_

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

5. If incident resulted in patient's death, indicate cause of death according to autopsy or patient chart:

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

6. Legal representative's name: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**(Question #28 continued on next page)**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**PRINT NAME** \_\_\_\_\_

**QUESTION #28 (continued)**

Current status of claim:     Closed     Pending

Was the case resolved before the entry of a verdict?     Yes     No

What was the decision?     Dismissed before trial     Plaintiff Verdict     Defense Verdict

Decision determined by:     Judge     Jury

If a payment was made:    Amount allocated to you: \$ \_\_\_\_\_    Payment Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

In addition to the information listed above, you must arrange for your lawyer or liability carrier to submit a copy of the following documents directly to the Board for the following malpractice cases:

Open case – a copy of the complaint naming the physician as a defendant.

Closed case – a copy of the complaint and final judgment, settlement and release or other final disposition of each claim, even if you were dismissed from the case by the court and/or if the case was closed with or without prejudice and the amount of monies paid on your behalf.

Dismissed case – a copy of the dismissal if you were dismissed before the case was reviewed by a tribunal or jury. The dismissal must include the name or initials of the patient and confirmation that no monies were paid on your behalf.

NOTE: Please be advised that the Board may request pertinent medical records or additional information.

**QUESTION #29 – Civil lawsuits (other than medical malpractice).**

Plaintiff's name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Your legal representative's name: \_\_\_\_\_

Description of claim (this does not constitute admission or liability): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Outcome of lawsuit: \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**PRINT NAME** \_\_\_\_\_

**QUESTIONS #30 & 31– Liability insurance provider, third-party payor, Medicare and Medicaid (any state).**

Name of Organization: \_\_\_\_\_ Date of action: \_\_\_\_/\_\_\_\_/\_\_\_\_

Action: \_\_\_\_\_

Describe reason(s) for action: \_\_\_\_\_

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

**You must arrange for your liability carrier or appropriate institution or agency to submit documents regarding any restrictions, limitations, terminations, denials, etc. Documents should be sent directly to you in a sealed envelope.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**PRINT NAME** \_\_\_\_\_

**CONFIDENTIAL MEDICAL INFORMATION**

**QUESTION #32 – Medical condition.**

If you answered “yes” to Question #32, please provide the specifics of your condition and any related treatment, including dates and diagnoses. In addition, provide any adjustments or interventions you may have made or taken to ameliorate or address the impact of your medical condition on your current practice, including a change of specialty or field of practice, or participation in any supervised rehabilitation program, professional assistance or retraining program, or monitoring program.

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**QUESTION #33 – Use of chemical substances.**

If you have obtained medical treatment related to your use of substances, please provide the specifics of your treatment, including dates and diagnoses. In addition, provide any adjustments or interventions you may have made or taken to ameliorate or address the impact of your use of substances on your current practice, including participation in any supervised rehabilitation program or monitoring program.

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**QUESTION #34 – Refusal to take screening test.**

If you answered “yes” to Question #34, please set forth a description of the circumstances leading to the refusal to take the screening test and any resulting criminal or disciplinary consequences.

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**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

Board of Registration in Medicine  
200 Harvard Mill Square, Suite 330  
Wakefield, MA 01880  
Telephone: (781) 876-8210 Fax: (781) 876-8383  
[www.mass.gov/massmedboard](http://www.mass.gov/massmedboard)

**MEDICAL EDUCATION VERIFICATION – FORM A**

**APPLICANT INSTRUCTIONS:** Please complete the waiver for release of information and forward this form to your university/medical school(s) or university of graduation for verification. **Please note: Fourth year medical students must include the letter to the medical school registrar and Form B.**

**Waiver for Release of Information**

I authorize the medical school/university listed below to provide any and all information pertaining to my medical education at your institution.

Applicant's Signature: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name (Please type or print): \_\_\_\_\_  
(Last Name) (First Name) (Middle Initial)

Other Name(s) (Please type or print.): \_\_\_\_\_

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

Address: \_\_\_\_\_ City: \_\_\_\_\_ State or Province: \_\_\_\_\_

**INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL**

Please complete Form A. For fourth year medical graduates, please complete Form B after the student completes the degree requirements. Please include a copy of the official transcript (which indicates courses taken, dates and hours of attendance, scores, grades, or evaluations) and return to the applicant in a sealed envelope. Please sign or stamp across the seal on the envelope.

**APPLICANT'S EDUCATIONAL HISTORY**

If name of institution was different from the above-named institution when applicant attended, please enter name below:

\_\_\_\_\_

**Premedical Education:** Does your school have a premedical school education requirement?  Yes  No

If yes, indicate where the applicant completed premedical school.

Applicant's Undergraduate School: \_\_\_\_\_

Undergraduate School Address: \_\_\_\_\_

**Enrollment and Participation:**

Our records indicate that \_\_\_\_\_  
(Print the applicant's name): (Last name) (First name) (Middle Initial)

attended our medical school for a total of \_\_\_\_\_ weeks (must be included) of continuous medical education on the following dates from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_.  
month/day/year month/day/year

**This applicant:**

- Check one:  **was awarded the degree of** \_\_\_\_\_ on \_\_\_\_/\_\_\_\_/\_\_\_\_  
month/day/year
- will be awarded the degree of** \_\_\_\_\_ on \_\_\_\_/\_\_\_\_/\_\_\_\_  
**(Form B must also be completed and returned directly to the Board.)** month/day/year
- was not awarded a degree because:** \_\_\_\_\_

**Unusual Circumstances:** The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. All questions must be answered. **If you answer "YES" to any of the questions below, please enclose an explanation.**

	<u>YES</u>	<u>NO</u>
1. Was the medical school training more than <u>four (4) years</u> for U.S. graduates <u>or 6 years</u> for international medical graduates, or did the applicant take any leaves of absence (i.e. for research, public service, participation in an M.D./Ph.D. program) or for any "personal reasons"?	<input type="checkbox"/>	<input type="checkbox"/>
2. Was the applicant ever placed on probation or remediation?	<input type="checkbox"/>	<input type="checkbox"/>
3. Was the applicant ever disciplined or under investigation?	<input type="checkbox"/>	<input type="checkbox"/>
4. Were any negative reports ever filed by instructors regarding the applicant?	<input type="checkbox"/>	<input type="checkbox"/>

**Please provide a detailed explanation for any of the above questions** \_\_\_\_\_  
\_\_\_\_\_

**AFFIX INSTITUTIONAL SEAL HERE**

**(If the institution does not have a seal, this form must be notarized.)**

**INTERNATIONAL MEDICAL SCHOOLS MUST ATTACH A COPY OF THE MEDICAL SCHOOL DIPLOMA AND A TRANSCRIPT OR PROVIDE AN EXPLANATION.**

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

Print Name: \_\_\_\_\_

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

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

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

**This form must be stamped with the institutional seal or notarized. Please return to the applicant with the medical school transcripts in a sealed envelope with the signature of the Dean or the seal of the medical school affixed on the back of the envelope. Thank you.**

**COMMONWEALTH OF MASSACHUSETTS**  
**Board of Registration in Medicine**  
**200 Harvard Mill Square, Suite 330, Wakefield, MA 01880**  
**Telephone: (781) 876-8210 Fax: (781) 876-8383**  
**www.mass.gov/massmedboard**

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Dear Registrar:

The Massachusetts Board of Registration in Medicine (hereinafter “the Board”) will not grant a limited license to an applicant unless that applicant has been awarded a medical degree. Since the rationale for the Board’s licensing regulations and statutes is to ensure that only qualified applicants are licensed, the Board has determined that an applicant must be awarded a medical degree prior to granting a limited license to practice medicine in Massachusetts.

Previously, a medical school verified either an applicant’s graduation from medical school or the applicant’s anticipated graduation from medical school. We recognize that there are certain circumstances under which an applicant would not graduate, as expected, from medical school, for example: 1) failure to either take or pass Step 2 of the USMLE; 2) uncorrected failing grades in a preclinical course; 3) uncorrected failing or marginal performance in a clinical clerkship; or 4) failure to meet any other curriculum requirements. Therefore, the Board has initiated a new procedure for the verification of medical school education.

All applicants must have Form A, copy attached, of the Medical School Verification completed by their medical school. An additional form is required for applicants who are fourth year medical school students and who have completed the requirements for the M.D./D.O. degree, but have not yet been awarded the degree. For these applicants, the medical school must complete Form B of the Medical School Verification form, copy attached. Any state medical board to whom you have certified an applicant’s graduation would wish to be notified immediately regarding a medical school’s determination that the applicant *will not* graduate, as reported on Form B. In addition, fourth year medical school students are required to notify the Board within twenty-four hours of notification by the medical school that they have not met the medical school’s graduation requirements. The notification form entitled “Medical School Status Update” is available on the Board’s website at [www.mass.gov/massmedboard](http://www.mass.gov/massmedboard).

The Board appreciates your assistance in making your students aware of these new requirements. Should you have any questions, please contact me at the above listed number.

Sincerely,

Licensing Division

## Form B

### Medical School Verification Form

Applicants who are fourth year medical school students and who have completed the requirements for the M.D./D.O. degree, but have not yet been awarded the degree are also required to have this form completed by their medical school.

Original signature of the Dean or another medical school official is required to complete the requested information. Signature stamps will not be accepted.

Any state medical board to whom you have certified an applicant's graduation would wish to be notified immediately regarding a medical school's determination that the applicant will not graduate.

**Please complete Form A and return it to the sender. This Form B must be sent to the Board of Registration in Medicine after the student completes the degree requirements.**

My signature below certifies that \_\_\_\_\_  
(Student's Name)

has completed the requirements for the  M.D. degree  D.O. degree

from \_\_\_\_\_  
(Name of Medical School)

and will receive the degree on \_\_\_\_/\_\_\_\_/\_\_\_\_.

Signature of Certifying Official: \_\_\_\_\_  
(Original Signature is required – Stamps not accepted)

Printed Name: \_\_\_\_\_

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

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

**The completed Form B may be faxed to the Limited License Coordinator at (781) 876-8383 or mailed to the Board of Registration in Medicine, 200 Harvard Mill Square, Suite 330. Wakefield, MA 01880. Telephone: 781-876-8210.**

**Thank you.**

**Board of Registration in Medicine**  
**200 Harvard Mill Square, Suite 330 - Wakefield, MA 01880**  
**Telephone: (781) 876-8210 Fax: (781) 876-8383**  
**www.mass.gov/massmedboard**

**STATE LICENSE VERIFICATION**

**Applicant's Instructions:** Complete the waiver for release of information and forward this form to every state board where you are currently licensed or were ever licensed in the past. Contact the individual state board(s) for information on verification processing fees before you mail this form.

**Applicant's Waiver for Release of Information:**

I am applying for licensure in the Commonwealth of Massachusetts and the Board of Registration in Medicine requires that this form be completed by each state where I hold or have ever held licensure. I hereby authorize the release of any information in your files, favorable or otherwise.

Signature of physician: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Print or type name: \_\_\_\_\_

License number: \_\_\_\_\_ Status of license:  Active  Inactive  Other \_\_\_\_\_

**TO BE COMPLETED BY STATE BOARD**

1. Name of medical school of graduation: \_\_\_\_\_

2. Date of graduation: \_\_\_\_/\_\_\_\_/\_\_\_\_ License number: \_\_\_\_\_ Date of issue: \_\_\_\_/\_\_\_\_/\_\_\_\_

3. Basis for licensure: \_\_\_\_\_  
Name(s) of medical licensing examinations(s)

4. Expiration date of license: \_\_\_\_/\_\_\_\_/\_\_\_\_

5. Status of license (*check one*):  good standing  revoked  suspended

6. If revoked or suspended, please explain: \_\_\_\_\_  
\_\_\_\_\_

	YES	NO
7. Has the licensee ever been on probation?	<input type="checkbox"/>	<input type="checkbox"/>

8. Has the licensee ever been requested to appear before the board?	<input type="checkbox"/>	<input type="checkbox"/>
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If "yes," please explain: \_\_\_\_\_  
\_\_\_\_\_

Other derogatory information: \_\_\_\_\_

Remarks: \_\_\_\_\_

Signed: \_\_\_\_\_

**BOARD SEAL**

Print Name: \_\_\_\_\_

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

State Board: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**PLEASE RETURN THE STATE LICENSE VERIFICATION TO THE APPLICANT IN A SEALED ENVELOPE WITH THE BOARD SEAL OR THE SIGNATURE OF THE PERSON COMPLETING THIS FORM ON THE BACK OF THE ENVELOPE.**

**Board of Registration in Medicine**  
**200 Harvard Mill Square, Suite 330 - Wakefield, MA 01880**  
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**www.mass.gov/massmedboard**

**EVALUATION FORM**

I hereby authorize the representatives or staff of the facility listed below to provide the *Board of Registration in Medicine* with any and all information requested in this evaluation form, whether such information is favorable or unfavorable, and I hereby release from any and all liability the named facility and/or any person for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice.

Signature of applicant: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Please PRINT your name: \_\_\_\_\_

Name of facility: \_\_\_\_\_ State: \_\_\_\_\_

**INSTRUCTIONS TO THE CHIEF OF SERVICE, PROGRAM DIRECTOR OR SUPERVISOR, WHO MUST BE A PHYSICIAN: Please complete items #1-7 below and return to the applicant with your name affixed across the envelope seal.**

1. How long have you worked with the applicant? From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_

A. In what capacity?  supervisory  other: \_\_\_\_\_

B. Date(s) of applicant's affiliation at facility: From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_

C. Applicant's Status:  Intern  Resident  Fellow  Staff Member  Other \_\_\_\_\_

2. Has the applicant's privileges to admit or treat patients ever been modified, suspended, reduced or revoked?  No  Yes (if "yes" please explain below)

\_\_\_\_\_

\_\_\_\_\_

3. Please rate the following (if "BELOW AVERAGE" or "POOR", explain in detail on the back of this evaluation and/or attach a separate sheet).

	Superior	Above Average	Average	Below Average	Poor
Clinical knowledge					
Clinical competency					
Professional judgment					
Character and ethics					
Technical skills					
Relationships with staff					
Relationship with patients					
Cooperativeness/ability to work with others					

(Continued on page 2)

4. Has this applicant ever been the subject of disciplinary action or had staff privileges, employment or appointment at this hospital or facility voluntarily or involuntarily denied, suspended, revoked or has (s)he resigned from the medical staff in lieu of disciplinary action? If "yes" please explain below.  NO  YES

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5. PLEASE COMMENT ON THE PHYSICIAN'S STRENGTHS OR WEAKNESSES AND/OR ANY OTHER INFORMATION THAT YOU MAY HAVE TO ASSIST IN THIS EVALUATION.

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6. The above comments are based on the following:

- Close personal observation
- General impression
- A composite of previous evaluations by other physicians
- Other \_\_\_\_\_

7. **RECOMMENDATIONS:**

- Recommend for licensure in Massachusetts.
- Recommend for licensure in Massachusetts, with the following reservations:

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- Do not recommend for the following reason(s):

---

Signature: \_\_\_\_\_ (check one)  M.D. or  D.O.

Print Your Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Academic title or position: \_\_\_\_\_ Phone number: \_\_\_\_\_

Specialty/Service or Department: \_\_\_\_\_

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

**PLEASE RETURN THE COMPLETED EVALUATION TO THE APPLICANT IN A SEALED ENVELOPE WITH YOUR SIGNATURE AFFIXED ACROSS THE ENVELOPE SEAL.**

**COMMONWEALTH OF MASSACHUSETTS  
BOARD OF REGISTRATION IN MEDICINE  
200 Harvard Mill Square, Suite 330, Wakefield, MA 01880  
www.mass.gov/massmedboard**

**AUTHORIZATION FOR RELEASE OF INFORMATION, DOCUMENTS AND RECORDS**

I, \_\_\_\_\_  
(type or print your complete name)

request and authorize every person, institution, professional licensing board of any state in which I hold or may have held a license to practice my profession, hospital, clinic, government agency (local, state, federal or foreign), law enforcement agency, or other third parties and organizations and their representatives to release information, records, transcripts and other documents concerning my professional qualifications and competency, ethics, character and other information pertaining to me to the Massachusetts Board of Registration in Medicine.

I further request and authorize that the requested information, documents, and records be sent directly to:

Board of Registration in Medicine  
200 Harvard Mill Square, Suite 330  
Wakefield, MA 01880

Attention: Licensing

**Immunity and Release**

I hereby extend absolute immunity to and release, discharge, and hold harmless from any and all liability: 1) the Board of Registration in Medicine, its agents, representatives, directors and officers; 2) other agencies, institutions, hospitals and clinics providing information, their representatives, directors and officers; and 3) any third parties and organizations for any acts, communications, reports, records, transcripts, statements, documents, recommendations or disclosures involving me, made in good faith and without malice, requested or received by the Board of Registration in Medicine.

By my signature below, I acknowledge that information, documents and records required to be furnished by another organization, educational institution, hospital, individual or any person or groups of persons has been sent to me directly from the primary source in a sealed envelope and that none of the seals have been broken. I understand that the Board of Registration in Medicine will not accept any such information, records or documents forwarded by me unless they are in sealed envelopes.

A photocopy or facsimile of this authorization shall be as valid as the original and shall be valid up to one year from the date signed.

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

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

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

\_\_\_\_\_  
Applicant's Date of Birth (month/day/year)

**Board of Registration in Medicine**  
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**www.mass.gov/massmedboard**

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**NAME CHANGE AND DUPLICATE LICENSE REQUEST**

Please read the following instructions for requesting a name change as a result of marriage or court order attached to the Notary Public Attestation For Name Change form.

**NAME CHANGE AS A RESULT OF MARRIAGE OR BY A COURT ORDER**

*Please submit the following:*

- A notarized copy of the marriage certificate from the jurisdiction in the United States in which the licensee was married (if you were married outside of the United States, you must submit your original marriage certificate with a self-addressed envelope to be returned to you), or a notarized copy of a court order.
- A current passport-sized color photograph (2 x 2) which has been attested to by a notary public or other official authorized to administer oaths. The attestation must identify the individual represented in the photograph and state that the photograph accurately depicts the individual so identified. Please complete the Notary Public Attestation for Name Change form.
- Your original wall certificate and your wallet sized card (full licensees only).

Print Name: \_\_\_\_\_ MA License #: \_\_\_\_\_

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

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**For Office use only**

Date Rec: \_\_\_\_/\_\_\_\_/\_\_\_\_  Photograph notarized/dated  Board photograph confirmed

Name changed  Wallet card printed/mailed  Wall Certificate printed/mailed

Date Completed: \_\_\_\_/\_\_\_\_/\_\_\_\_ Board Staff \_\_\_\_\_

Approved by: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**NOTARY PUBLIC ATTESTATION FOR NAME CHANGE**

- **INSTRUCTIONS TO THE APPLICANT:** A current passport-sized color photograph (2 x 2) which has been attested to by a notary public or other official authorized to administer oaths. The attestation must identify the individual represented in the photograph and state that the photograph accurately depicts the individual so identified. The photograph must have the signature of the applicant, the date and the signature and seal of a U.S. Notary Public.

**IDENTIFICATION PHOTOGRAPH**

Attach a recent 2 x 2 color photograph on the left side. Black and white photographs will not be accepted. The photograph must be current within the past six months.

***You must sign your name and the date in the presence of a Notary.***

**I swear or affirm that the contents of this document are truthful and accurate to the best of my knowledge and belief.**

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Print Name: \_\_\_\_\_

**NOTARY ATTESTATION**

**I certify that the photograph above is a genuine likeness of the maker of the signature, who personally appeared before me this day. The maker of the signature provided satisfactory evidence of identification, which was \_\_\_\_\_**

**Subscribed and sworn to before me:**

Signature of Notary: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Print name of Notary: \_\_\_\_\_

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

*Notary Public Seal or Stamp*

COMMONWEALTH OF MASSACHUSETTS

BOARD OF REGISTRATION IN MEDICINE

POLICY 91-03

(Adopted June 26, 1991)

BOARD PROCEDURE REGARDING  
REQUEST FOR WAIVER OF 243 CMR 2.03(1)(b):  
APPLICANTS FOR POST-GRADUATE TRAINING/LIMITED LICENSURE

In situations where a limited license applicant cannot comply with 243 CMR 2.03(1)(b), requiring substantial equivalency of medical school education, the applicant must submit a waiver request pursuant to 243 CMR 2.03(4).

In order for the Board to grant such a waiver request, section 2.03(4), incorporating by reference G.L. c. 112, § 2, requires that the Board determine that the applicant's course of medical school education is substantially equivalent, in its entirety, to a U.S. medical school graduate's education. In addition, the Board must determine that licensure of this applicant would not impair the public health, safety and welfare. It is the applicant's responsibility to demonstrate that s/he is qualified under both of the above-mentioned standards.

The Licensing Committee will review each such application on a case-by-case basis. The assessment and determination of the applicant's equivalency of complete medical education and eligibility for training in Massachusetts may include, but not be limited to, the following factors:

1. Quality of basic science education
2. Quality of clinical clerkship experience (evaluations required)
3. Number of years and quality of post-graduate training (evaluations required)
4. Licensure in other states
5. Other distinctions; honors, awards, publications, Board certification
6. Nature and quality of anticipated training program, including degree and quality of supervision
7. Licensing Committee recommendation from personal interview with applicant (interview to include but not limited to inquiry regarding the applicant's education, professional commitment, and assessment of communication skills)
8. Foreign Medical Graduate Examination in the Medical Sciences (FMGEMS), Federation of State Medical Boards Licensing Exam (FLEX), or United States Medical Licensing Exam (USMLE) results.

The Licensing Committee will evaluate the application with attention to these factors, as well as any other relevant information, and in its discretion recommend approval or denial of the license application to the full Board.

If the Board approves the limited license application, the applicant should be aware that granting of a waiver for limited licensure is not equivalent to a determination that an applicant's full license application waiver request will be granted; there are separate and independent guidelines for evaluation of waiver requests pursuant to a full licensure application.

APPLICANT'S NAME \_\_\_\_\_

FORM J: WAIVER REQUEST

**Complete each section below. DO NOT cross-reference to other documents. If you need more space to complete the information, you may attach additional sheets as needed. Please type your answers or print clearly.**

1. List the Board licensing requirement(s) for which you are seeking a waiver:

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2. List **all** institutions where medical school basic science education was completed (include location of each institution):

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3. List **all** institutions where you obtained clinical experience while in medical school; include location of institution, starting and ending dates, and total number of weeks for each rotation and field of clinical experience.

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APPLICANT'S NAME \_\_\_\_\_

4. List **all** post-graduate training institutions, field of specialty, location of institution, length of training program, and whether the institution had an ACGME-approved program in the field specified. Also, you **must** have a copy of the Board's Evaluation Form (attached) completed by your supervisor at **EACH** program, and have the evaluation(s) submitted **directly** to the Licensing Division at the Board of Registration in Medicine. The Board encourages submission of additional, specific evaluations and letters of recommendation.

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5. List **all** post-training experience, including location, nature of practice, length of time of practice. Also, you **must** have a copy of the Board's Evaluation Form completed by a physician supervisor or close peer physician from **EACH** practice site, and have the evaluation(s) submitted **directly** to the Licensing Division at the Board of Registration in Medicine. The Board encourages submission of additional, specific evaluations and letters of recommendation.

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6. List **all** states in which you have held full licensure (use abbreviations). If you do not have "good standing" status in any state in which you are licensed or have been licensed, you **must** also indicate that here.

NAME OF STATE: \_\_\_\_\_

LICENSE STATUS (current or inactive): \_\_\_\_\_

APPLICANT'S NAME \_\_\_\_\_

7. List certification(s) by American Specialty Boards, with date of your certification(s).

Name of Specialty Board: \_\_\_\_\_ Date Certified: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name of Specialty Board: \_\_\_\_\_ Date Certified: \_\_\_\_/\_\_\_\_/\_\_\_\_

8. List honors and awards received, publications, and other distinctions here (attach copies):

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

9. Indicate SPEX exam results (if taken): \_\_\_\_\_

APPLICANT'S SIGNATURE \_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_



**INTERNATIONAL MEDICAL GRADUATES:** Complete form E-1 if you have completed any required, or more than three (3) months of elective, medical school clinical study as a part of the two (2) year medical school clinical study requirement outside of the primary teaching hospital of the medical school of attendance. .

**INSTRUCTIONS:** Please complete the following information regarding all of the applicant's clinical training and include school transcripts with this form.

Name of Applicant: \_\_\_\_\_ Training Institution: \_\_\_\_\_

Area of Study	Name of Program Director	Name of Supervisor	Name and Address of Hospital	Was This Hospital the Primary Teaching Hospital for Your Medical School? (YES/NO)	Was This Hospital an Affiliated Teaching Hospital for your Medical School at the Time the Applicant Completed Clerkships There? (YES/NO) If YES, See Instructions.
				<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

Signature of Dean or Designated Official: \_\_\_\_\_

SCHOOL SEAL

Name (please print): \_\_\_\_\_

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

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

Name of Applicant: \_\_\_\_\_

Area of Study	Name of Program Director	Name of Supervisor	Name and Address of Hospital	Was This Hospital the Primary Teaching Hospital for Your Medical School? (YES/NO)	Was This Hospital an Affiliated Teaching Hospital for your Medical School at the Time the Applicant Completed Clerkships There? (YES/NO) If YES, See Instructions.
				<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
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				<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO



**Commonwealth of Massachusetts Board of Registration in Medicine  
200 Harvard Mill Square, Suite 330, Wakefield, MA 01880**

**ELECTIVE MEDICAL SCHOOL CLINICAL STUDY VERIFICATION**

**FORM E-2** is only for international medical graduates who have completed any required or more than three (3) months of elective medical school clinical study as a part of the two (2) year medical school clinical study requirement outside of the primary teaching hospital of the medical school of attendance.

**INSTRUCTIONS:** A COPY OF THIS FORM MUST BE SUBMITTED BY THE APPLICANT DIRECTLY TO EACH TRAINING INSTITUTION WHERE YOUR OFFSITE CLINICAL TRAINING WAS COMPLETED. FORMS MUST BE RETURNED **TO THE APPLICANT IN A SEALED ENVELOPE**. THIS FORM MAY BE DUPLICATED AS NECESSARY.

Name of Applicant: \_\_\_\_\_

Clinical Area: \_\_\_\_\_ Type (Elective or Required): \_\_\_\_\_

Dates of Attendance: From \_\_\_\_/\_\_\_\_/\_\_\_\_ To \_\_\_\_/\_\_\_\_/\_\_\_\_ Weeks of Credit: \_\_\_\_\_

Name of Instructor or Supervisor: \_\_\_\_\_

Name of Program Director: \_\_\_\_\_

Is/was instructor/supervisor fully-licensed to practice medicine in your state/country?  YES  NO

If hospital is in the United States, is program approved by ACGME?  YES  NO

If hospital is outside the U.S. or is non-ACGME approved, how many beds does the hospital have? \_\_\_\_\_

Did the Dean of the student's medical school approve the student's participation in this program in advance?  YES  NO

Did the supervisor of this clinical training hold a faculty appointment at the student's medical school?  YES  NO

If **yes**, indicate term of appointment (dates): From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_

Number of students from applicant's school who simultaneously participated in this clerkship: \_\_\_\_\_

Number of students from U.S. medical school(s) affiliated with this hospital who simultaneously participated in this clerkship: \_\_\_\_\_

Name(s) of U.S. medical school(s) affiliated with this hospital: \_\_\_\_\_

PLEASE PROVIDE A COPY OF THE STUDENT'S EVALUATIONS FOR THIS CLERKSHIP AND ANY ADDITIONAL INFORMATION REGARDING THE APPLICANT'S CLINICAL TRAINING EXPERIENCE AT YOUR INSTITUTION.

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_

Name and Title (please print or type): \_\_\_\_\_

Name and Address of Institution: \_\_\_\_\_

HOSPITAL SEAL (If no seal, indicate so) \_\_\_\_\_

**Board of Registration in Medicine**  
**200 Harvard Mill Square, Suite 330 - Wakefield, MA 01880**  
**Telephone: (781) 876-8210 Fax: (781) 876-8383**  
**www.mass.gov/massmedboard**

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**AFFIDAVIT FOR SOCIAL SECURITY NUMBER**

**INSTRUCTIONS:** Please complete this form and return it to the address above.

I certify that:

- I do not have a social security number;
- I have complied with all laws of the Commonwealth related to the filing of Massachusetts state tax returns and payment of all Massachusetts state taxes; and
- I have complied with all the laws of the Commonwealth related to the withholding and remitting of child support pursuant to M.G.L. c. 119A.

I understand that the Board of Registration in Medicine will not renew my license without a social security number. Therefore, I will apply for a social security number and provide the Board of Registration in Medicine with my social security number as soon as I receive my social security card.

Under the penalties of perjury, I declare that, to the best of my knowledge and belief, the information contained herein is true, correct and complete.

PRINT NAME: \_\_\_\_\_

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_