

TEMPORARY LICENSE APPLICATION INFORMATION

Please read the following information before you submit a temporary license application.

A temporary license may be issued for:

- ◆ A temporary faculty appointment at a medical school in the Commonwealth of Massachusetts for the purposes of teaching;
- ◆ Locum tenens coverage for a physician who is ill or on maternity leave;
- ◆ Participation in a continuing medical education program, including learning a new procedure;
- ◆ A short-term faculty appointment at a medical school and a hospital affiliated with the medical school.

A temporary license is not an interim license while a full license is in process or for residency or fellowship training. If you are applying for a license to participate in a training program you may apply for a limited license or a full license. Before completing any license application, please review the general information and fees requirements at the Board's website. Click on Licensing Fees and General Information.

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

Temporary License Application Instructions

TABLE OF CONTENTS

Mission Statement	2
General Instructions for Temporary Medical License	2
Application Fee	2
Temporary License Categories.....	3
Instructions for Completing the Application Form.....	3
Other Names Used.....	3
Social Security Number	4
National Provider Identifier (NPI) Number	4
Medical Education	4
Postgraduate Education and Hospital Appointments	4
Other Temporary Application Forms	4
Medicare Tax Form.....	4
Authorization for Release of Information	4
Supplement to Application	4
Malpractice History Form	5
State License Verification.....	5
Letters of Appointment	6
Certificate of Moral and Professional Character	6
Evaluation Form.....	6
National Practitioner Data Bank	7
AMA Physician Profile	7
Medical Education Verification.....	7
Medical School Diploma.....	7
Forms E-1 and E-2.....	7
Address Changes	7
Practice of Medicine	8
Telephone Directory and Website Addresses	9

MISSION STATEMENT

The overriding mission of the Board of Registration in Medicine is to serve the public by striving to ensure that only qualified physicians are licensed to practice in the Commonwealth, and that those physicians and health care institutions in which they practice provide to their patients a high standard of care and support in an environment that maximizes the high quality of health care in Massachusetts.

GENERAL INSTRUCTIONS FOR TEMPORARY MEDICAL LICENSE

Please note that if you ever held a full license in Massachusetts, you must complete a lapsed application. The lapsed application and instructions are on the Board's website at www.mass.gov/massmedboard.

Completing the application and forms: Please read these instructions carefully before submitting an application for a temporary medical license. The application packet consists of the forms required for completing the application process.

- Print information in blue or black ball point pen. Illegible information will result in processing delays.
- Provide a response to each applicable piece of information which is asked of you in the application packet.
- Include all components of the requested information, especially complete names and addresses of medical schools and hospitals. Failure to submit full addresses will result in delays.

The processing time for a temporary license application is dependent on receipt of all documents. Routine processing of a temporary license application usually requires a minimum of four weeks after all documents are received and take longer if there are any malpractice or legal issues. After reviewing your file, we will notify you if additional documents are required. If you wish acknowledgment of receipt, please mail your application by certified mail, return receipt requested. Completed applications are presented to the Board bi-weekly.

This application is for U.S. and international medical graduates applying for temporary licensure.

1. U.S. applicants are graduates of medical schools in the United States or Canada or Puerto Rico.
2. International applicants are graduates of international medical schools (IMGs).

Please use the Temporary Checklist as a guide to identify the forms that must be completed by U.S. or international medical graduate applicants.

IMPORTANT: Make a copy of all forms submitted for your records. You will be required to provide a copy of your temporary license application to the healthcare facility.

APPLICATION FEE

The application-processing fee is nonrefundable. Please make a check in the amount of \$250.00 made payable to the Commonwealth of Massachusetts. A U.S. certified check or money order is preferred, but a personal check from a U.S. bank will be accepted. Applications will not be processed without the fee.

TEMPORARY LICENSE CATEGORIES

There are four (4) temporary license categories which may be granted by the Board to a physician pursuant to M.G.L. c.112, sec. 9B (1).

Category 1: Temporary Faculty Appointment

A visiting physician holding a license in another state, territory or country who has a temporary faculty appointment (instructor, associate professor, assistant professor or higher), certified by the dean of a medical school in the Commonwealth for purposes of medical education in an accredited hospital associated with the medical school. *Time Limit:* A temporary faculty license for faculty appointment is granted for twelve (12) months and may be renewed for a total of three (3) years. A request for renewal of temporary licensure must be submitted at least sixty (60) days prior to the expiration date.

Category 2: Temporary License for Physician Coverage

A Category 2 temporary license for a substitute physician in the Commonwealth may be granted to a physician who is licensed in another state, or a physician who is eligible for a Massachusetts medical license and is a diplomate of a specialty board approved by the AMA or AOA. Such temporary license enables him/her to act as a substitute physician for a fully licensed Massachusetts physician who is sick, on vacation or on maternity leave, etc. *Time Limit:* A Category 2 temporary license is limited to three (3) months or less and cannot be renewed.

Category 3: Enrollment in Medical Education Course

A Category 3 temporary license enables a physician with a current full medical license in another state, territory in the District of Columbia or another country to attend a course of continuing medical education (CME) in the Commonwealth of Massachusetts. *Time Limit:* A Category 3 temporary license for continuing medical education terminates automatically at the completion of the CME course and, in any event, at the end of three (3) months.

Category 4: Visiting Short-term Faculty

A short-term faculty temporary license may be granted to a physician who wishes to serve as visiting faculty in an accredited hospital associated with a medical school in Massachusetts. *Time Limit:* A temporary visiting short term faculty license expires in 30 days.

Instructions for Completing the Application Form

OTHER NAMES(S) USED

If the name on the first line of the application does not correspond with the name on the credentials, you must submit a notarized copy of the name change, whether by court order or by marriage certificate. If the name change document is written in a foreign language, you must submit an official U.S. notarized translation. Please go to the Board's website for the name change form:

http://www.mass.gov/eohhs/provider/licensing/occupational/physicians/licensing/for_ms/full-license/initial-full-licenses.html

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 from Board disciplinary cases. The Board considers this information highly confidential and not subject to release except as specifically authorized.

NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER

You must supply the Board of Registration in Medicine with a valid NPI number. If you do not have an NPI number, please go to the NPPE website at www.nppes.cms.hhs.gov and follow the instructions.

MEDICAL EDUCATION

List pre-medical and medical school(s) attended chronologically along with the dates you attended, whether or not a degree was received from that institution. If you are a U.S. graduate and attended medical school for more than four (4) years or there is a gap in your medical education, please explain why on a separate sheet of paper. If you are an international graduate and attended more than six (6) years of medical school, please explain why on a separate sheet of paper.

POSTGRADUATE EDUCATION AND HOSPITAL APPOINTMENTS

Chronologically list and date all educational, professional training experience and employment from the date of graduation from medical school to the present. Account for all periods of time, whether or not you were engaged in the practice of medicine. Please enclose a copy of your curriculum vitae by month and year.

Other Temporary Application Forms

MEDICARE TAX FORM

All applicants for temporary Massachusetts medical licensure must complete the Medicare Tax form and return it to the Board with the temporary license application.

AUTHORIZATION FOR RELEASE OF INFORMATION

The Authorization for Release of Information form must be completed and returned to the Board with the temporary license application.

SUPPLEMENT TO APPLICATION

Instructions for answering the questions on the Supplement form are included in the application packet. All of the questions on the Supplement form must be answered "yes" or "no." Please be careful in matching answers to questions. Pages 5-10 must be completed if you answer "yes" to any question(s).

MALPRACTICE HISTORY FORM

Complete the malpractice history form listing all liability carriers from the time you completed your postgraduate training to the present. Include the liability carrier for the time period when you were in a postgraduate training program only if you had a full license or you were named in a malpractice case during that period.

- Send a copy of the malpractice history form to all liability carriers whether or not a claim or suit was filed against you.
- You must include with your full license application: the original malpractice history form and the malpractice history reports received from your liability carriers detailing your medical malpractice history during the period of your coverage.
- When you receive your malpractice history report from your liability carrier, you should review it for accuracy and ensure that you have reported all malpractice cases to the Board
- You should make a copy of the malpractice history reports received from your liability carriers for your records and to ensure that you are aware of all instances where you have been named in a medical malpractice claim.
- You do not need to list a liability carrier for the time period when you were in a training program unless had a full license or you were named in a malpractice case.
- Complete a supplement form for each medical malpractice claim whether the case is open, closed or dismissed and follow the instructions on the supplement for the additional documents to be included with your full license application.

If a malpractice history report is unavailable from the liability carrier due to merger or if the carrier is no longer in business, you must obtain a letter confirming the merger or closure from the Division of Insurance in the state where the liability carrier was registered.

YOU MUST COLLECT THE FOLLOWING DOCUMENTS AND SEND THEM TO THE BOARD WITH YOUR TEMPORARY LICENSE APPLICATION.

IMPORTANT: You will be requesting that certain documentation be returned to you directly. **The majority of these envelopes must have the signature of the endorser across the seal of the envelope. DO NOT OPEN THESE ENVELOPES.** The Board will not accept any opened envelopes and will return them to you. You will have to request this information again, which may delay the processing time of your temporary license application. The National Practitioner Data Bank will not have a signature across the seal of the envelope. Please make note of this and do not open the envelope. If you have to repeat the process to obtain this information, processing of your temporary license application may be significantly delayed.

STATE LICENSE VERIFICATION (Required for All Temporary License Categories)

Please submit the State License Verification to the state or province where you currently hold a full license in the United States or Canada, or in any other country, whether the license is active or inactive. This takes approximately four (4) weeks to process and the licensing board may charge a fee. You should contact your state licensing board for information. Please do not send your temporary license application to the Board until you have received the State License Verification from the state in which you currently hold a temporary license. Do not open the envelopes in which the license verification form is sent to you. If the seal on the envelope is opened, it will be returned to you and you will be required to repeat the process.

LETTERS OF APPOINTMENT (Required for All Categories)

Category 1: A Temporary Faculty License requires an appointment letter from the dean of a medical school in Massachusetts, documenting the beginning and ending dates of the faculty appointment and the faculty position. The chairman of the health care facility must provide a detailed job description describing the number of hours of faculty related job duties which must be more than fifty (50) percent of the work hours.

Category 2: A Temporary License for Physician Coverage requires a letter from the physician who is requesting coverage stating the reasons, beginning date and end date of the coverage.

Category 3: A Temporary License for Enrollment in Continuing Medical Education requires documentation from the continuing medical education sponsor as evidence of enrollment in the continuing medical education program.

Category 4: A Visiting Short-Term Faculty Temporary License requires an appointment letter from the dean of a medical school in Massachusetts, documenting the beginning and ending dates of the faculty appointment.

CERTIFICATE OF MORAL AND PROFESSIONAL CHARACTER (Required for Categories 1 and 2)

The Certificate of Moral and Professional Character must be completed and signed by the applicant and confirmed by a physician who has a current medical license in the United States.

- Attach a 2" x 2" color photograph of yourself taken within the past six (6) months and the photograph must be adequate for positive identification. A black and white photograph will not be accepted.
- The photograph must have the signature of the applicant, the date and the signature and seal of a U.S. Notary Public.
- The photograph must be original and not a photocopy taken from a book.
- The Certificate of Moral and Professional Character must be sent and signed by a physician legally authorized to practice medicine in the U.S. The designated physician must not be an applicant's relative, but should have known the applicant for at least two (2) years.
- The physician attesting to your moral and professional character must return the completed Certificate of Moral and Professional Character form to you in a sealed envelope. **Please inform the physician who is signing the form to place his/her signature across the affixed seal on the back of the envelope.**

EVALUATION FORM (Required for Categories 1 and 2)

Evaluations must be current and must be signed by a chief of service or department chairman at the healthcare facility where you have active medical staff privileges. The Board reserves the right to require evaluations for any of the temporary license categories and that they must be current within thirty (30) days of review by the Board. **Please inform the physician who is signing the form to place his/her signature across the affixed seal on the back of the envelope.** The evaluation must be sent to the Board with your temporary license application. **If the seal the envelope is broken, it will be returned to you and you will be required to repeat the process.**

NATIONAL PRACTITIONER DATA BANK (Required for Categories 1 and 2)

Please read the instructions to obtain a self-query Data Bank form. The form is available on-line at <http://www.npdb-hipdb.hrsa.gov>. You must complete the self-query form and print a hard copy which must be notarized and mailed directly to the Data Bank. You will receive the Data Bank profile in the mail and it must be included in the sealed envelope and sent to the Board of Registration in Medicine with your temporary license application.

AMA PHYSICIAN PROFILE (Required for Categories 1 and 2)

You may request your AMA Physician profile at the AMA website at <http://www.ama-assn.org/AMAProfiles> and follow the instructions. The AMA profile will be sent directly to the Board of Registration in Medicine. If you are an international medical graduate you must complete the AMA Authorization for Release form and send it to the AMA.

MEDICAL EDUCATION VERIFICATION (Required for Category 1 only)

Verification of premedical and medical education must be completed by the medical school. The Medical Education Verification form must be signed by the current dean, or designated official of the medical school that granted the degree, and sealed with the official school seal. If more than one medical school was attended, you must photocopy this form for each additional school. All forms must be completed, signed and sealed and sent to you in a sealed envelope and included with your temporary license application.

Additional Information for IMGs: You must forward the Medical Education Verification form directly to your medical school(s). The medical school must also submit to the Board your official transcripts, accompanied by an official translation, if necessary, in English by the medical school or a translation company in the U.S.

MEDICAL SCHOOL DIPLOMA

International medical graduates must provide a notarized copy of their medical school diploma. The notarization must be completed by a U.S. Notary and if it is not in English, it must be translated by a U.S. translation company.

FORMS E-1 AND E-2 FOR IMGs ONLY (Required for Categories 1 and 2)

In situations where an applicant cannot comply with 243 CMR 2.03(1)(b), requiring substantial equivalency of medical school education, a Waiver Request must be submitted to the Board. If an applicant completed more than three (3) months of any required or elective clinical rotations outside of the country of their medical school, a Waiver Request and Forms E-1 and E-2 are required. The Board will review the applicant's medical school training, and/or off-site clinical rotations and determine whether they are substantially equivalent to medical school training in the United States. A Waiver Request and Forms E-1 and E-2 may be obtained at the Board's website at http://www.mass.gov/eohhs/provider/licensing/occupational/physicians/licensing/for_ms/full-license/initial-full-licenses.html

ADDRESS CHANGES

The Board will send all correspondence to the address that you indicate is your mailing address. If you change your address, you must notify the Board within thirty (30) days in writing.

PRACTICE OF MEDICINE

Please be advised that, under Massachusetts law, you may not practice medicine in the state until you have received a license. The license applicant is responsible for determining that the Board has issued a license prior to practicing medicine in the Commonwealth of Massachusetts.

PLEASE MAKE A COPY OF YOUR TEMPORARY LICENSE APPLICATION AND DOCUMENTS BEFORE MAILING TO THE BOARD. YOU ARE REQUIRED TO PROVIDE ALL HEALTHCARE AFFILIATIONS WITH A COPY OF YOUR TEMPORARY LICENSE APPLICATION AND SUPPLEMENT FOR CREDENTIALING.

TELEPHONE DIRECTORY AND WEBSITE ADDRESSES

American Medical Association.....	(800) 621-8335
www.ama-assn.org	
Board of Registration in Medicine	(781) 876-8200
www.mass.gov/massmedboard	
Education Commission for Foreign Medical Graduates (ECFMG)	(215) 386-5900
www.ecfm.org	
Federal Drug Enforcement Administration (DEA)	(617) 557-2468
www.deadiversion.usdoj.gov	
Federation of State Medical Boards (FSMB)	(817) 868-4000
www.fsmb.org	
Massachusetts Department of Public Health--Controlled Substance License.....	(617) 753-8052
Massachusetts Medical Society	(781) 893-4610
www.massmed.org	
National Board of Medical Examiners (NBME)	(215) 590-9500
www.nbme.org	
National Board of Osteopathic Medical Examiners (NBOME)	(773) 714-0622
www.nbome.org	
National Practitioner Data Bank (NPDB).....	(800) 767-6732
www.npdb-hipdb.com	

3.19.14

COMMONWEALTH OF MASSACHUSETTS - BOARD OF REGISTRATION IN MEDICINE
 200 Harvard Mill Square, Suite 330, Wakefield, MA 01880
 (781) 876-8210 www.mass.gov/massmedboard

TEMPORARY LICENSE CHECKLIST

There are four (4) temporary license categories described in the instruction booklet and each category requires specific documents. Please identify the temporary license category you are requesting, and refer to the checklist below for the documents which must be completed. **Do not send your temporary license application to the Board until you have received all of the documents from the primary source.**

- CHECK ONE:**
- Category 1 Faculty appointment at a medical school in Massachusetts.
 - Category 2 Substitute physician coverage
 - Category 3 Continuing medical education participation
 - Category 4 Visiting short-term faculty

Description	Cat. 1	Cat. 2	Cat. 3	Cat. 4	Mail to:
Temporary License Fee - \$250.00	✓	✓	✓	✓	Board of Registration
Temporary License Application	✓	✓	✓	✓	Board of Registration
Curriculum vitae	✓	✓	✓	✓	Board of Registration
Medicare Tax Form	✓	✓	✓	✓	Board of Registration
Authorization for Release of Information	✓	✓	✓	✓	Board of Registration
Supplement Form*	✓	✓	✓	✓	Board of Registration
Medical Education	✓				Medical School
Moral and Professional Certificate	✓	✓			Board of Registration
Evaluation Form	✓	✓			Department chairman or chief at primary hospital
State License Verification	✓	✓	✓	✓	State License Board
Original Malpractice History Form listing liability carriers since postgraduate training with dates of coverage and policy numbers	✓	✓	✓	✓	Board of Registration
Malpractice history reports from all liability carriers since postgraduate training listed on your Malpractice History Form	✓	✓	✓	✓	Board of Registration
Malpractice claim report(s) or letter of intent for open or closed malpractice cases from the attorney or liability carrier(s) in sealed envelopes	✓	✓	✓	✓	Board of Registration
AMA Profile	✓	✓			AMA
National Practitioner Data Bank Profile	✓	✓			Data Bank
Letter from the Dean confirming faculty appointment	✓			✓	Board of Registration
Letter from applicant accepting faculty appointment	✓				Board of Registration
Letter from covering physician		✓			Board of Registration
Letter from Department Director or Chief of Service listing job responsibilities	✓				Board of Registration
Letter from Chief of Service requesting physician to participate in care of patient				✓	Board of Registration
Letter of acceptance from applicant	✓	✓	✓	✓	Board of Registration
Letter from the CME sponsor as evidence of enrollment in the CME program			✓		Board of Registration

*Please read the instructions on the Supplement Form. If you answer "yes" to any of the questions on that form, you will be required to provide additional information.



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

TEMPORARY LICENSE APPLICATION

Temporary License Requested: Cat.1 Cat. 2 Cat. 3 Cat. 4
(Read instruction booklet)

Application Fee: Please enclose a check or money order in the amount of \$250.00 made payable to the Commonwealth of Massachusetts.

Check One: U.S./Canadian Graduate International Graduate

Legal Name (do not use nicknames or initials, unless they are part of your legal name)

Last Name (type or print clearly) First Middle Suffix (Jr., etc.)

M.D. D.O. Ph.D. Other degree _____

Other Name(s) Used - List any other name(s) you have used which may appear on your identifying documents, such as medical education and examination records. If not applicable, check here

Entire Last Name (type or print clearly) First Middle Suffix (Jr., etc.)

Date of Birth: ____/____/____ Social Security Number: ____/____/____ NPI# _____
Month Day Year (See Instructions)

Place of Birth: _____
City State/Province/Territory Country if not United States

Home Address: _____
Number and Street

City State/Province/Territory Zip (or postal) Code

Business Address: _____
Number and Street

City State/Province/Territory Zip (or postal) Code

Business Telephone: (____) _____, ext. _____ Home Telephone: (____) _____

E-mail Address: _____ Fax #: _____

Preferred Mailing Address: Home address Business Address

Note: The Board will use your mailing address for all correspondence.

APPLICANT'S NAME: _____

Pre-medical School

	<u>From</u>	<u>To</u>
Facility: _____ Degree: _____	____/____/____	____/____/____
Street: _____ City: _____ State: _____		
Facility: _____ Degree: _____	____/____/____	____/____/____
Street: _____ City: _____ State: _____		

Medical School

Facility: _____ Degree: _____	____/____/____	____/____/____
Street: _____ City: _____ State: _____		
Facility: _____ Degree: _____	____/____/____	____/____/____
Street: _____ City: _____ State: _____		

Date of medical school graduation: _____
(Month and Year)

Note: U.S. graduates must include a written explanation for the duration of medical education longer than four (4) years, and for any breaks in medical education.

International graduates must provide a written explanation for the duration of medical education longer than six (6) years and any breaks in medical education.

Postgraduate Education

List all postgraduate training from medical school to the present in chronological order. List the name and address of the facility, your position, e.g. PGY 1, 2, fellow, etc. and dates of affiliation. You must account for all periods of training or postgraduate work from the time you graduated from medical school.

	<u>From</u>	<u>To</u>
Facility: _____ Position: _____	____/____/____	____/____/____
Street: _____ City: _____ State: _____		
Facility: _____ Position: _____	____/____/____	____/____/____
Street: _____ City: _____ State: _____		
Facility: _____ Position: _____	____/____/____	____/____/____
Street: _____ City: _____ State: _____		

APPLICANT'S NAME: _____

Hospital Affiliations and Employment

List hospital appointments where you had active staff privileges in chronological order. Include the name and address of the facility, your position and dates of affiliation in postgraduate training, in chronological order. Also include periods of unemployment or employment outside of medicine. Attach a separate sheet of paper if necessary.

		<u>From</u>	<u>To</u>
Facility: _____	Position: _____	____/____/____	____/____/____
Street: _____	City: _____	State: _____	
Facility: _____	Position: _____	____/____/____	____/____/____
Street: _____	City: _____	State: _____	
Facility: _____	Position: _____	____/____/____	____/____/____
Street: _____	City: _____	State: _____	
Facility: _____	Position: _____	____/____/____	____/____/____
Street: _____	City: _____	State: _____	

1. List other states (abbreviations) where you are currently or have ever been licensed: _____
2. Are you certified by the American Board of Medical Specialties? Yes No
3. List Board Certification(s): _____
4. Have you attached an up-to-date copy of your curriculum vitae? Yes No
5. Reason for requesting a Massachusetts medical license: _____

6. Name of Facility: _____
7. Address: _____ City: _____
8. Anticipated starting date in Massachusetts: ____/____/____

Under the penalties of perjury, I declare that I have examined this temporary 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.

Signature of Applicant

____/____/____
Day Month Year

TEMPORARY LICENSE APPLICATION SUPPLEMENT

PRINT NAME: _____ DATE: ____/____/____

IMPORTANT NOTE: If you answer “yes” to any of these questions, you must provide the additional information on pages 5-11.

QUESTIONS

YES **NO**

- | | | | |
|------|--|--------------------------|--------------------------|
| 1. | 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"/> |
| 2-A. | 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"/> |
| 2-B. | 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"/> |
| 3. | If you are a US 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. | 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"/> |
| 5. | Have you ever been denied a medical license, whether full, limited, temporary, or have you withdrawn an application for medical licensure? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. | 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"/> |
| 7. | 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"/> |
| 8-A. | 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"/> |
| 8-B. | 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"/> |

- | | | <u>YES</u> | <u>NO</u> |
|-------|--|--------------------------|--------------------------|
| 9-A. | Have you ever relinquished any medical staff membership or association with a health care facility? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9-B. | 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"/> |
| 9-C. | 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"/> |
| 10. | 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, expunged 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"/> |
| 11. | 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"/> |
| 12. | 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"/> |
| 13. | 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"/> |
| 14-A. | Has any medical malpractice claim ever 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"/> |
| 14-B. | 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"/> |

CONFIDENTIAL INFORMATION

If answering “yes” to any of the questions, provide details on the supplemental pages for questions 15-17. 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 impact one’s functioning as a physician.

- | | | <u>YES</u> | <u>NO</u> |
|-----|---|--------------------------|--------------------------|
| 15. | Do you have a medical or physical condition that currently impairs your ability to practice medicine? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. | 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"/> |
| 17. | 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 1-17 change while your application is pending, you must immediately notify the Board of the new information.

PRINT NAME: _____ DATE: ____/____/____

CERTIFICATIONS

- Pursuant to M.G.L. c. 112, § 2 and 243 CMR 2.07(15), I certify that I will not charge to or collect from a Medicare beneficiary more than the Medicare “reasonable charge” for services, in compliance with Chapter 475 of the Acts of 1985. (*Note:* Signing this certification does not imply that you will participate in the Medicare program).
- 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. (*Note:* This applies even if you reside out of the state or out of the country.)
- Pursuant to G.L.c. 62C, § 49A, to the best of my knowledge and belief, I am in compliance with M.G.L. c. 119A relating to withholding and remitting child support.
- Pursuant to M.G.L. c. 119, § 51A, I certify under the penalties of perjury that I will fulfill my obligation to report abuse or neglect of children.
- I will read the Board’s regulations, 243 CMR 1.00 through 3.00.

I certify under the penalties of perjury that all information on this form, and all attached pages, is true, to the best of my knowledge.

SIGNATURE: _____ DATE: ____/____/____

PRINT NAME: _____ DATE: ____/____/____

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

QUESTIONS #1, 8A, 8B – 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.

QUESTION #2-A or 2-B – 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 agency or institution to submit copies of all official documentation and correspondence regarding any leave of absence, withdrawal, failure to complete, requirement to repeat, termination, probation, or remediation. Documents should be sent directly to you in a sealed envelope.

QUESTION #3 – Medical school more than 4 years for U.S. or Canadian graduates or more than 6 years for international medical graduates.

Name of institution: _____ Date: ____/____/____

State or Country: _____ Dates of attendance: From: ____/____/____ To: ____/____/____

Explanation: _____

PRINT NAME: _____ DATE: ____/____/____

QUESTION #4 – 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.

QUESTIONS #5 & 6 – Medical license application denial or withdrawal; license 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 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 #7 – 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.

PRINT NAME: _____ DATE: ____/____/____

QUESTIONS #9-A, 9-B, 9-C – Medical staff membership, status, 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 9-A through 9-C. Documents should be sent directly to you in a sealed envelope.

QUESTION #10 – Criminal Offenses.

Court: _____ Charge(s): _____ Date: ____/____/____

Describe the circumstances leading up to criminal proceedings. _____

Status: _____

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

QUESTION #11 – 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.

PRINT NAME: _____ DATE: ____/____/____

QUESTIONS #12 &13– 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, denials, or revocations. Documents should be sent directly to you in a sealed envelope.

PRINT NAME: _____ DATE: ____/____/____

QUESTION #14-A – 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 #14-A continued on next page)

PRINT NAME: _____ DATE: ____/____/____

QUESTION #14-A (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 #14-B – 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: _____

CONFIDENTIAL MEDICAL INFORMATION

QUESTION #15 – Medical condition.

If you answered “yes” to Question 15, 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.

QUESTION #16 – Substance use.

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.

QUESTION #17 - Refusal to take a screening test for chemical substances.

If you answered “yes” to Question 17, please provide a description of the circumstances leading to your refusal to take the screening test and any resulting criminal or disciplinary consequences.

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

MEDICARE/TAX FORM

INSTRUCTIONS:

Please sign this form and return it with your application. Massachusetts General Laws Chapter 62C, §49A, requires that you complete this statement to obtain licensure to practice a profession:

I, _____,
(type or print name)

certify, under the penalties of perjury, to the best of my knowledge and belief, that I have filed all state tax returns and paid all state taxes required by state law.

SIGNED: _____ DATE: _____

Social Security Number: _____

Massachusetts General Laws Chapter 112, §2, and 243 CMR 2.07 (15) require that you complete the following statement:

I will not charge to, or collect from, a Medicare beneficiary more than the Medicare “reasonable charge” for services, in compliance with Chapter 475 of the Acts of 1985.

Note: Signing this form does not imply that you will participate in the Medicare program.

SIGNED: _____ DATE: _____

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/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)

**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**

CERTIFICATE OF MORAL AND PROFESSIONAL CHARACTER

INSTRUCTIONS TO THE APPLICANT: This form must be signed by a physician legally authorized to practice medicine in the United States. Someone who has known you for at least one year and is not a relative should execute this statement. The Board of Registration in Medicine prefers statements from physicians licensed to practice in Massachusetts. **The form must be notarized by a U.S. Notary Public.**

PHOTOGRAPH	CERTIFICATION OF MORAL AND PROFESSIONAL CHARACTER
<p>Attach a recent 2 x 2 <u>color</u> photograph. Black and white photographs will not be accepted.</p> <p>You must sign your name in the presence of a U.S. Notary Public.</p> <p>_____</p> <p>Signature of applicant</p> <p>I certify that the photograph above is a genuine likeness of the maker of the signature above.</p> <p>_____</p> <p>Signature of Notary</p> <p>_____</p> <p>My commission expires</p>	<p>This certifies that I have been personally acquainted with the physician named below:</p> <p>_____</p> <p style="text-align: center;">(name of applicant)</p> <p>for _____ years. I believe that the above named physician is of good moral character and worthy of confidence and recommend him/her to the Massachusetts Board of Registration in Medicine.</p> <p>_____</p> <p>Signature of Certifying Physician</p> <p>_____</p> <p>License Number _____ State _____</p> <p>_____</p> <p>Type or print name clearly</p> <p>Address: _____</p> <p>_____</p> <p>City: _____ State: _____ Zip: _____</p> <p>Telephone: (_____) _____</p> <p>Date: ____/____/____</p>

Instructions to the certifying physician: Please answer every question, date this form, and return it to the applicant in a sealed envelope with your signature across the seal.

MEDICAL EDUCATION VERIFICATION

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: ____/____/____

Print or Type Name: _____ U.S. Social Security No: ____/____/____
(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 and complete Form B if the above-named applicant has not been awarded a degree. 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 on the following dates (indicate the *month, day and year* separately for each academic year in the section below):

<u>ATTENDANCE DATES:</u>	<u>FROM</u>	<u>TO</u>	<u>FROM</u>	<u>TO</u>
	___/___/___	___/___/___	___/___/___	___/___/___
	___/___/___	___/___/___	___/___/___	___/___/___
	___/___/___	___/___/___	___/___/___	___/___/___

The applicant attended _____ total weeks or _____ total months (must be included) of not less than 32 weeks in each academic year of continuing on-campus education.

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 or <u>six (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? | <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 if you answered "YES" to 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.

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

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					

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

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

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:

- 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.

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"/>
---	--------------------------	--------------------------

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
Telephone: (781) 876-8210 Fax: (781) 876-8383
www.mass.gov/massmedboard

MALPRACTICE HISTORY REQUEST FORM

Applicant's Instructions: Please list the names of your liability carriers and send a signed copy of this form to each of your current and all past liability carrier(s). You must provide your malpractice history reports if you ever had a full license in any state. You do not need to supply your malpractice history reports while participating in an ACGME postgraduate training program unless you had a full license or you were named in a malpractice case. This form must be returned to the Board with your license application.

Please provide the following information on the malpractice history report:

1. the name(s) of the claimant(s)
2. nature and date of claim(s)
3. amounts paid, if any, and
4. other disposition or information in its possession, custody or control on my current policy number, and/or any other policy I have had with this or any other carrier
5. dates of policy coverage must be included.

Liability Carrier's Instructions: Please report any open or closed cases that have gone to trial, whether or not monies were paid, and provide a copy of the complaint or summons, disposition or judgment and amount of monies paid on behalf of the applicant. If the applicant does not have any claims history, please indicate that on your letterhead. If your company's name has changed, please provide any former company names. The information should be sent to the applicant.

Liability Carrier: _____ From: ____/____/____ To: ____/____/____
City: _____ State: _____ Policy #: _____

Liability Carrier: _____ From: ____/____/____ To: ____/____/____
City: _____ State: _____ Policy #: _____

Liability Carrier: _____ From: ____/____/____ To: ____/____/____
City: _____ State: _____ Policy #: _____

Liability Carrier: _____ From: ____/____/____ To: ____/____/____
City: _____ State: _____ Policy #: _____

Liability Carrier: _____ From: ____/____/____ To: ____/____/____
City: _____ State: _____ Policy #: _____

Applicant's signature: _____ /____/____
Date

Print Name: _____

Address: _____

City: _____ State: _____ Zip code: _____



Authorization of Information Release

The AMA Physician Masterfile is a data source used by professional health care organizations, universities, medical schools, research institutions, governmental agencies, and other related groups concerned with verifying physician credentials. The use of the AMA Physician Masterfile for this purpose is fundamental to the AMA's mission to strengthen the medical profession and ensure quality health care for the American public. Periodically, these organizations may identify discrepancies contained in the physician's record that require verification. In the event discrepancies are identified, the AMA requires that any modifications to a physician's credentials be verified through the appropriate institution (primary source) before making changes to the AMA Physician Masterfile.

In order to initiate verification of physician credentials, most institutions require written permission by the physician before releasing credentialing information to third parties. International medical graduates who are entering the United States on a temporary basis may need to have an AMA Physician Masterfile established when applying for licensure by a state medical board.

This signed Authorization of Release will authorize the Massachusetts Board of Registration in Medicine to send a copy of your medical school verification and diploma to the AMA.

For identification verification purposes, please complete all requested information below:

Legal Name (Printed): _____

Birth Date: _____/_____/_____

Mailing Address _____

City: _____ State: _____ Zip code: _____

I hereby authorize the Massachusetts Board of Registration in Medicine to release information pertaining to my medical school attendance and/or Visa status to the American Medical Association.

Signature

Date

Return this completed form with your Temporary License application if you are an international graduate applying for a Temporary Faculty license. Thank you.

American Medical Association
Data Verification Unit
515 N State St
Chicago, IL 60654
Ph: 312-464-5759
Fx: 312-464-4880

American Medical Association

Physicians dedicated to the health of America

Telephone: 800-621-8335

Fax: 312 464-5900

AMA Physician Profile Order Form -- Physician Use Only

Complete and send this form to the American Medical Association (AMA). Profiles also can be ordered online through **AMA Physician Profiles** located at <http://www.ama-assn.org/go/AMAProfiles>. AMA Customer Service is available for ordering assistance at 800-621-8335, 24 hours a day, seven days a week.

*****Join or renew your AMA membership today---call 800-AMA-3211*****

Standard Mail Service (within 10 business days)

Indicate AMA Membership Status:

_____ Member Physician No charge

_____ Nonmember Physician \$33 per profile

***Prices are subject to change without advance notice.**

Credit card payment is accepted. Checks should be made payable to the American Medical Association, 75 Remittance Drive Suite #6397, Chicago IL 60675-6397. Orders faxed to the AMA must include credit card information for billing purposes.

___ VISA ___ American Express ___ MasterCard Charge Amount: \$ _____

Credit Card Number _____ Expiration Date: ____/____/____

Name on Credit Card: _____

Billing Address: _____

Approval Signature _____ Daytime Telephone: _____

Part 1: AMA Physician Profile Delivery Information

Please send my profile to the following state licensing board:

Board Name: _____

NOTE: When requesting delivery to a state licensing board, indicate MD or DO profession type.

Part 2: Physician Information

Physician Name (first, middle, last, suffix)

Place of Birth /____/____ _____
Date of Birth Social Security Number

E-mail Address _____
Medical Education Number (optional)

Preferred Mailing Address

City, State, Zip Code (____) _____
Telephone Number

The above address is my OFFICE _____ HOME _____ OTHER _____

If address is home or other, please complete this section.

Primary Office Address

City State Zip Code (____) _____
Office Telephone Number

Part 3: Medical Education and Other Information

Medical School of Graduation _____ Year of Graduation _____

DEA Number _____ ECFMG Number _____

Residency Training

Residency Training (institution/hospital name, location, and years)

Hospital Admitting Privileges

Hospital Name _____ City/State _____

Group Practice Affiliation(s)

Group Practice Name _____ City/State _____

Physician Agreement

Agreement must be signed in order to process your request.

AMA endeavors to maintain its physicians' records with information that is complete, current, and timely; however, because of possible reporting and processing delays, no representations or warranties as to the accuracy or completeness can be or is made. In consideration of the receipt of your physician record provided by AMA, hereby release AMA, its agents and servants from any and all liability whatsoever for inaccurate or incomplete information in such physician record. Submission of this form and payment of fee (if applicable) shall be conclusive evidence of your understanding and agreement to the above stated terms and conditions.

X _____
Signature

_____/_____/_____
Date