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:**

# **SUBSTANTIAL EQUIVALENCY OF MEDICAL SCHOOL EDUCATION WAIVER REQUEST**

INSTRUCTIONS: Please complete this form if you are an International Medical Graduate who completed any core/required clinical clerkship rotations, or more than three (3) months of elective clinical clerkship rotations as part of the two (2) year medical school clinical student requirement outside of the primary teaching hospital of your medical school of attendance. If you need more space to complete the information, you may attach additional sheets as needed. Please type your answers or print clearly.

**1. Quality of Basic Science Education:** List all institutions where medical school basic science education was completed (include location of each institution):

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**2. Quality of Clinical Clerkship Experience:** List all institutions where you obtained clinical experience while in medical school; include location of institution, and total number of weeks for each rotation and field of clinical experience.

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| **Clerkship Area of Study** | **Name of Facility** | **Location of Facility (City/State/Country)** | **Number of Weeks** |
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**3. Number of Years and Quality of Postgraduate Training:** List all postgraduate training below. Also, you must have a copy of your Postgraduate Training Evaluative Files from each training program submitted directly to the Licensing Division at the Board of Registration in Medicine. The Board also encourages submission of additional evaluations as well as any letters of recommendation.

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| --- | --- | --- | --- | --- |
| **Program Type**  **(Internship/Residency/ Fellowship)** | **PGY**  **(1, 2, 3, etc.)** | **Specialty** | **Name of Institution** | **Accredited by**  **(ACGME, AOA, etc.)** |
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**4. Licensure in Other States**: List all states in which you have held full licensure (use abbreviations).

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

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

**5. Other Distinctions: Honors, Awards, Publications, Board Certifications:** List honors and awards received, publications, and other distinctions here. To support your request for a waiver, you may attach copies of any honors, awards or publications referenced below.

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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: \_\_\_\_/\_\_\_\_/\_\_\_\_

APPLICANT’S NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**6. Nature and Quality of Anticipated Training Program, Including Degree and Quality of**

**Supervision:** Please provide the following information regarding your anticipated postgraduate training in Massachusetts. The Board also encourages submission of additional information regarding your anticipated training program.

**Anticipated Training Dates: Start:** \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ **End:** \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

**Program Type:** □ Internship □ Residency □ Fellowship

**PGY (1, 2, 3, etc.):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Training Specialty/Subspecialty:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of Facility:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Accredited by:** □ ACGME □ AOA □ Not Accredited

**7. Interview:** During the licensing process, you may be invited for a personal interview with the Licensing Committee, a committee of the Board of Registration in Medicine. All interviews with applicants are conducted in-person during a regularly scheduled Licensing Committee meeting, which are held at the Board office at 200 Harvard Mill Square, Suite 330, Wakefield, Massachusetts. An interview may include, but is not limited to, an inquiry regarding the applicant’s education, and waiver request, professional commitment and assessment of communication skills.

1. **USMLE, FLEX or FMGEMS Results:** Please complete the following for each medical licensure examination you have taken.

**Examination Number of Attempts Final Passing Score**

USMLE Step 1 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

USMLE Step 2 CK \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

USMLE Step 2 CS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

USMLE Step 3 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FLEX Component 1 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FLEX Component 2 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FMGEMS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

APPLICANT’S SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_