PRINT NAME: _____

Commonwealth of Massachusetts Board of Registration in Medicine
178 Albion Street, Suite 330 – Wakefield, MA 01880
Telephone: (781) 876-8210 Fax: (781) 876-8383
www.mass.gov/massmedboard

LIMITED LICENSE APPLICATION CHECKLIST

Listed below are the minimum application and supporting materials required to obtain a limited license in Massachusetts. This list is not all-inclusive; additional items may be necessary based on responses provided on your Application or information obtained from other sources. For further information please see the *Limited License Application Instructions* posted on the Board's website: www.mass.gov/massmedboard.
Please confirm that documents listed on this checklist are included with your limited license application.

INFORMATION REQUIRED FROM APPLICANT

☐ **Application Fee**	• **Check for $100.00**
	  ○ Must be from a U.S. bank (or a U.S. money order).
	  ○ Made payable to the **Commonwealth of Massachusetts.**
	  ○ Application cannot be processed without the fee.
	  ○ Application fee is non-refundable.

☐ **Limited License Application – Section A**	• All required fields completed and all required questions answered. • Timeline from date of medical school graduation to the present, including all professional and non-professional activities with no gaps of 30 days or more. • "Yes" answers to any Application Question (#14 – 19; 20a-i; & 21-37), requires an explanation on the appropriate Explanation page and submission of supporting documentation, where required. • Please **sign/date your application just prior to submission** to ensure all information is up-to-date. • Complete a Name Change Form (available on website) if any other names appear on your documents such as medical education, exams scores, etc. • **Note:** Send the completed Checklist, Section A (pg 4-17) and any supporting documentation/sealed envelopes directly to your training program. Your training program is responsible for completing Section B of the Application (pg 18) and submitting all documentation to the Board on your behalf.
Personal Interview *(if applicable)*	• You will be notified if a personal interview will be required.

DOCUMENTS REQUIRED FROM THIRD PARTIES

All documents from third parties must be received as indicated below.

☐ **Medical Education Verification** **(sealed envelope or FCVS)**	• Primary source verification is required from ALL medical schools of attendance. • Complete either the Board's Medical Education Verification - Form A (pages 19-20) or submit verification of your medical education through FCVS. • If you are a fourth-year medical student and have not yet been awarded your degree, the Medical Education Verification – Form B is also required.

☐ **Examination Scores** **(Electronically, FCVS or from training program directly through ERAS)**	• Official examination scores must be requested from the appropriate examination agency. Official examination reports may be requested from the following:
	  ○ USMLE – www.fsmb.org
	  ○ COMLEX – www.nbome.org
	  ○ LMCC (Canada) – www.mcc.ca

ADDITIONAL REQUIRED DOCUMENTATION	
Please confirm if any of the following statements applies to your application. If yes, please request submission of the corresponding required documentation, as indicated below.	
☐ **If you have ever participated in Postgraduate Training in the U.S. or Canada**	**Supervisory Evaluation Form** (sealed envelope) • Completed by your Program Director.
☐ **If you ever held a full license in another state**	**License Verifications** (sealed envelopes; electronically from State Board) • License Verifications are required of <u>every</u> active or inactive full medical license issued to you in the U.S., Puerto Rico or Canada. • Do not submit verification of training or temporary licenses.
☐ **If you were ever named in a medical malpractice claim**	**Liability Carrier Request Form** • You must submit with your application the original Liability Carrier Request Form listing your liability carriers, in chronological order. • Provide copies of this Form to each liability carrier listed in order to request that a Claims History Report be sent to the Board. **Liability Carrier Claims History Reports** • Request submission of a Claims History Report/Loss Run Report from your liability carrier providing coverage for you at the time of the claim. • If requesting a Claims History Report from your time in postgraduate training, the training facility's Risk Management Department may assist in providing this documentation. **Copy of the Malpractice Complaint or other Claim Letter** • Documentation must come directly from your liability carrier or from your attorney either in a sealed envelope or electronically. **Copy of the final judgment or other closing papers, if claim is closed** • Documentation must come directly from your liability carrier or from your attorney either in a sealed envelope or electronically.
☐ **If you were ever charged with a criminal offense**	**Copy of the Police Reports** • Documentation must come from the Police Department or from your attorney. **Copy of the Court Documents** • Documentation must come from Court or from your attorney.
☐ **If, <u>during medical school</u>, you were subject to disciplinary action, placed on probation or remediation, or were charged with a criminal offense**	**Medical Student Performance Evaluation Letter** • Documentation must come directly from your medical school in a sealed envelope or from your training program.

INTERNATIONAL MEDICAL GRADUATES ONLY	
☐ **ECFMG Certification:** **(electronically or FCVS)**	• Request submission of your ECFMG Status Report (www.ecfmg.org)
☐ **Medical School Transcript** **(sealed envelope or FCVS)**	• An official medical school transcript prepared on university letterhead affixed with the signature of the dean or registrar is required. • If the transcript is not in English, it must be translated by your medical school or a U.S. translation company.
☐ **Medical School Diploma** **(provided by applicant, medical school or FCVS)**	• A notarized (U.S. Notary) copy of your medical school diploma is required. • If the diploma is not in English, it must be translated by your medical school or a U.S. translation company.
☐ **Substantial Equivalency of Medical Education and Off-Site Rotations Waiver Request** *(if applicable)*	• **ONLY** applies if you completed **more than three (3) months of clinical clerkships off-site of your medical school's primary teaching hospital.** • To request a waiver, you must submit the following documents: o **Current Curriculum Vitae**; o **Substantial Equivalency Waiver Request Form** (completed by applicant); AND o **Clinical Clerkship Verification Form** (completed by medical school). • The Board has determined that graduates of the following schools **DO NOT** need to request a waiver of substantial equivalency: • **St. George's University School of Medicine;** • **SABA University;** • **Ross University School of Medicine;** • **The American University of the Caribbean; and** • **American University of Antigua College of Medicine.**

**** NOTE TO ALL APPLICANTS ****

Send your completed Limited License Application and any corresponding sealed envelopes and supporting documentation to your training program. The training program will submit your Limited License Application, along with certification of your appointment as a trainee directly to the Board for processing.

Do not send your Application materials directly to the Board.

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LIMITED LICENSE APPLICATION – SECTION A

Non-refundable Application Fee: A $100.00 check or money order payable to the Commonwealth of Massachusetts must be included with your limited license application.

U.S. or CANDIAN MEDICAL GRADUATE

(Check One)

☐ U.S. or Canadian Medical School Graduate ☐ International Medical School Graduate

FCVS	Are you submitting primary source documentation (medical education, previous postgraduate training, etc.) for licensure through FCVS? ☐ Yes ☐ No

PERSONAL INFORMATION

1. Legal Name	**Last** **First** **Middle** **Suffix**		
2. Other Name(s) **List other names that appear on your application documents (medical education, exams, etc.)**			
3. Degree Type	☐ M.D. ☐ D.O. ☐ Other degree: _____		
4. Social Security Number		**5. Gender**	☐ Male ☐ Female
6. Date of Birth	_____ _____ _____ Month Day Year	**7. Place of Birth**	**City/State** **Country if not USA**
8. Mailing Address	**Number and Street** **City** **State/Province/Territory** **Zip (or postal) Code**		
9. Telephone Numbers	**Home #**	**Cell #**	
10. Email Address **Will be used for correspondence**			

MASSACHUSETTS POSTGRADUATE TRAINING PROGRAM INFORMATION

11. Training Facility	
12. Training Facility Address	**Number and Street** **City** **State/Province/Territory** **Zip (or postal) Code**
13. Training Specialty	

PRINT NAME: _____

EXAMINATION HISTORY

Please indicate below each medical licensure examination you have completed with a passing score.

NOTE: Please contact the appropriate entity and have the exam scores sent to you in a sealed envelope or sent electronically to the Board. Your training program may also provide the exam scores to the Board directly from ERAS. If you are using FCVS, your exam scores will be sent to the Board directly.

USMLE: ☐ Step 1 ☐ Step 2 CK ☐ Step 2 CS ☐ Step 3

COMLEX: ☐ Level 1 ☐ Level 2 CE ☐ Level 2 PE ☐ Level 3

LMCC: ☐ MCCQE Part I ☐ MCCQE Part II

MASSHEALTH ENROLLMENT REQUIREMENT

You must complete. Please see Application Instructions or contact your training program for further information.

☐ I am enrolled or have applied to enroll in MassHealth as a nonbilling provider.

(Nonbilling application: https://www.mass.gov/doc/nonbilling-orp-provider-contract-and-application-3/download)

U.S. OR CANADIAN MEDICAL LICENSURE

If you currently or have ever held a full license in the U.S. or Canada list the state/province abbreviation. This includes any active or inactive licenses. Do not report training or temporary licenses.

NOTE: You must provide license verifications for every active or inactive full license issued to you in the U.S. or Canada. Verifications must be received in a sealed envelope, electronically from the licensing authority or through Veridoc.

_____

_____

PRE-MEDICAL SCHOOL

A minimum of two or more academic years at a legally-chartered college or university is required.
For international medical graduates, this education may be incorporated into your medical school training. If not, please indicate the school(s) where you completed this requirement.

Name of School	Degree	Dates of Attendance (Year)
		_____ to _____
	City	State/Country

PRINT NAME: _____

MEDICAL SCHOOL	
List <u>all</u> medical schools of attendance regardless of whether a degree was awarded.	
Medical School Name	**Degree**
Street	**City, State**
Medical School Name	**Degree**
Street	**City, State**

PRE-MEDICAL SCHOOL AND MEDICAL SCHOOL QUESTIONS			
You <u>must</u> answer "yes" or "no" to questions #14 – 19. **NOTE: A "yes" response requires a detailed explanation on the *Explanation for Application Questions* page and submission of documentation related to the underlying occurrence from the appropriate institution.**		**<u>YES</u>**	**<u>NO</u>**
14.	While enrolled in college, medical school or graduate school 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.)	☐	☐
15.	Have you ever been terminated from a medical school?	☐	☐
16.	Have you ever withdrawn or transferred from a medical school?	☐	☐
17.	Have you ever been granted a leave of absence by a medical school? (This includes a leave for research, public service, participated in a joint degree program such as an M.D./Ph.D. program, medical leave or for any other "personal reasons".)	☐	☐
18.	Have you ever been placed on probation or remediation by a medical school or graduate school?	☐	☐
19.	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?	☐	☐

PRINT NAME: _____

TIMELINE OF ACTIVITIES SINCE GRADUATION FROM MEDICAL SCHOOL

Please provide a chronological listing by month and year of ALL activities since graduation from medical school. You must include postgraduate training, research activities, hospital affiliations, medical staff appointments, faculty appointments, private practices, locum tenens and telemedicine assignments and any other employment or volunteer activities. Also include periods of unemployment or any activities outside of the practice of medicine. Do not write, "See CV" or "See attached". If you need additional rows, please print additional copies of this page. **You MUST account for any time gaps of one month (30 days) or more since your graduation from medical school. (*For example, if you graduated from medical school in May 2015 and started postgraduate training in July 2015, you must account for this gap.*)**

Start Date (mm/yyyy)	**End Date** (mm/yyyy)	**Position Held** (Resident, Attending, Research Fellow, etc.)	**Institution/Place of Employment**	**City, State/Country**
_____/_____ Month Year		**Medical School Graduation Date** *(start timeline from this date)*		

PRINT NAME: _____

POSTGRADUATE TRAINING

You must answer "yes" or "no" to question #20.

NOTE: A "yes" response requires that you provide information regarding your postgraduate training below. Attach a separate paper listing any additional U.S. or Canadian postgraduate training.

20.	Have you ever or are you currently engaged in postgraduate training in the U.S. or Canada?	Yes ☐ No ☐

Postgraduate Training Facility: _____

City: _____ State/Province: _____

Training Specialty: _____

Training Dates: Start: _____ / _____ / _____ End: _____ / _____ / _____

Postgraduate Training Facility: _____

City: _____ State/Province: _____

Training Specialty: _____

Training Dates: Start: _____ / _____ / _____ End: _____ / _____ / _____

POSTGRADUATE TRAINING QUESTIONS

	If you answered "yes" to question #20, you must answer questions #20-a – 20-i. **If you answered "no" to question #20, please go to question #21.** **NOTE: A "yes" response requires a detailed explanation on the *Explanation for Application Questions* page and submission of documentation related to the underlying occurrence from the training facility.**	**YES**	**NO**
20-a.	While enrolled in postgraduate training were you ever the subject of any disciplinary action or under investigation? (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.)	☐	☐
20-b.	Have you ever been suspended, terminated or dismissed from any postgraduate training program?	☐	☐
20-c.	Have you ever had to repeat a year of postgraduate training?	☐	☐
20-d.	Have you ever withdrawn or transferred from a postgraduate training program?	☐	☐
20-e.	Have you ever been granted a leave of absence from a postgraduate training program? (This includes a leave for research, public service, medical leave or for any other "personal reasons".)	☐	☐
20-f.	Have you ever been placed on probation or remediation by a postgraduate training program?	☐	☐
20-g.	Were any limitations or special requirements imposed on you because of questions of competency or disciplinary problems?	☐	☐
20-h.	Did you ever receive partial or no credit for a postgraduate training program?	☐	☐
20-i.	Have you ever had a postgraduate training program contract not be renewed?	☐	☐

PRINT NAME: _____

ACTIONS BY ANY HEALTHCARE FACILITY, EMPLOYMENT, PROFESSIONAL ORGANIZATION, STATE BOARD OR ANY OTHER GOVERNMENTAL AGENCY			
You must answer "yes" or "no" to questions #21 – 32. **NOTE: A "yes" response requires a detailed explanation on the *Explanation for Application Questions* page and submission of documentation related to the underlying occurrence from the appropriate institution.**		**YES**	**NO**
21.	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?	☐	☐
22.	Have you ever been denied a medical license, whether full, limited, temporary, or have you withdrawn an application for medical licensure?	☐	☐
23.	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.)	☐	☐
24.	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?	☐	☐
25.	Are you aware of any open complaint, pending investigation or inquiry into your professional conduct by any entity or are any disciplinary charges pending against you?	☐	☐
26.	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.)	☐	☐
27.	Since your completion of postgraduate training, have you taken a leave of absence from any health care facility, group practice or employer for reasons related to your competency to practice medicine?	☐	☐
28.	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?	☐	☐
29.	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?	☐	☐
30.	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?	☐	☐
31.	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?	☐	☐
32.	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)?	☐	☐

PRINT NAME: _____

MEDICAL MALPRACTICE HISTORY QUESTION			
You <u>must</u> answer "yes" or "no" to question #33. **NOTE: A "yes" response requires a detailed explanation of each malpractice claim. Please use the *Explanation for Malpractice History Question.* You must also arrange for your lawyer or liability carrier to provide the requested supporting documentation.**		**<u>YES</u>**	**<u>NO</u>**
33.	Has any medical malpractice claim ever been made against you, or have you received notice of a claim against the United States or any state, municipality or public employer which is based on care provided or supervised by you, whether or not a lawsuit was filed in relation to the claim? **NOTE:** You must report any medical malpractice claims that have been made against you, even if the claim against you was dropped, dismissed, settled, adjudicated or otherwise resolved.	☐	☐

CRIMINAL HISTORY QUESTION			
You <u>must</u> answer "yes" or "no" to question #34. **NOTE: A "yes" response requires a detailed explanation of each offense/arrest. Please use the *Explanation for Criminal History Question*. You must also arrange for submission of the court and police records directly from the primary source or from your lawyer.**		**<u>YES</u>**	**<u>NO</u>**
34.	Have you ever been charged with any criminal offense? **NOTE:** You must report being arrested, arraigned, indicted or convicted, even if the charges against you were dropped, filed, dismissed or otherwise discharged. Minor traffic or parking violations need not be reported. You must report serious traffic offenses such as reckless driving, hit and run, driving with a suspended license, or operating under the influence or its equivalent. This list is not all-inclusive. If in doubt as to whether an arrest or criminal offense must be disclosed, it is best to disclose the action on your application. A medical malpractice claim is a civil, not a criminal matter and should not be reported on this question. <u>Expunged/Sealed Offenses</u>: While expunged/sealed offenses, arrests, tickets or citations need not be disclosed, it is your responsibility to ensure the offense, arrest, ticket or citation has, in fact been expunged or sealed. Failure to reveal an offense, arrest, ticket or citation that is not in fact expunged or sealed, raises questions related to truthfulness in addition to questions regarding the offense itself. **You may have been told your record is expunged or sealed when in fact it is not.** If, during the course of the application process, information about an offense is discovered which you did not disclose because you believed it to be expunged or sealed, you will be required to provide a copy of the expunction or sealing order.	☐	☐

PRINT NAME: _____

CONFIDENTIAL INFORMATION QUESTIONS			
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. You must answer "yes" or "no" to questions #35 - 37. **NOTE: A "yes" response to questions # 35 - 37 requires a detailed explanation. Please use the *Explanation for Confidential Information Questions.***		**YES**	**NO**
35.	Do you have a medical or physical condition that currently impairs your ability to practice medicine? (You may answer "**NO**" if the behavior or condition is known to the *Massachusetts Medical Society's Physician Health Services* (PHS) and you are complying with all PHS requirements for evaluation, treatment and/or monitoring as recommended.)	☐	☐
36.	Have you engaged in the use of any substance(s) with the result that your ability to practice medicine is currently impaired?	☐	☐
37.	Have you ever refused to submit to a test to determine whether you had consumed and/or were under the influence of chemical substances?	☐	☐

**** IMPORTANT NOTE REGARDING PHYSICIAN WELLNESS ****

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.

PHS is a nationally recognized physician health program designed to assist physicians with a variety of health related challenges, including but not limited to alcohol and substance use disorders, behavioral or mental health challenges, and/or physical health concerns that could impact the ability to practice medicine. PHS is also available for consultation and resources around stress and burnout, work-family balance, and other health related challenges. PHS is not a direct care provider but can help assess and identify health related challenges, refer for evaluation and treatment when needed, and provide ongoing supportive monitoring when indicated. PHS is a voluntary program available to all physicians in Massachusetts, whether or not they belong to the Massachusetts Medical Society. For more information, please see https://www.massmed.org/phshome/, or reach out for a confidential consultation at (781) 434-7404.

PRINT NAME: _____

EXPLANATION FOR APPLICATION QUESTIONS

This form must be used to provide a detailed written explanation for a "yes" response to Questions # 14 - 32 on the application. Please use as many forms as necessary to provide a detailed explanation.
Do not write, "See attached;" you must provide your response on this form.
A separate form is to be used for each question.

SUPPORTING DOCUMENTATION: In addition to the below explanation, you must arrange for the appropriate agency or institution to submit copies of all official documentation related to any "yes" response to a question on the Application. Documentation should be sent directly to the Board or to you in a sealed envelope.

Application Question Number: _____ (List the corresponding question number - # 14 - 32)

Name of agency or institution taking action: _____

Date(s): _____ _____ _____ - _____ _____ _____

Please provide a detailed explanation: *(Do not write "see attached")*

PRINT NAME: _____

EXPLANATION FOR MALPRACTICE HISTORY QUESTION

This form must be used to provide a detailed written explanation for a "yes" response to question #33 on the Application. Please use as many forms as necessary to provide a detailed explanation.
Do not write, "See attached;" you must provide your response on this form.
A separate form is to be used for each malpractice claim.

SUPPORTING DOCUMENTATION: In addition to the below explanation, you must arrange for your lawyer or liability carrier to provide the following documents directly to the Board or to you in a sealed envelope:

Pending Claim: 1) Claims history report from your liability carrier or letter from your attorney that includes the claimant's name/initials and confirmation that the claim is open/pending; and 2) a copy of the Complaint, Notice of Intent to File a Claim or other claim letter.

Closed Claim: 1) Claims history report from your liability carrier or letter from your attorney that includes the claimant's name/initials and confirmation that the claim is closed ; 2) a copy of the Complaint, Notice of Intent to File a Claim or other claim letter; and 3) a copy of the final judgment, settlement and release or other final disposition of the claim, even if you were dismissed from the case by the court.

GENERAL CLAIM INFORMATION:

Claimant's name/initials: _____

Date of incident: _____ _____ _____

Professional Liability Carrier: _____

Legal representative's name: _____

STATUS OF CLAIM:

Current status of claim: ☐ Closed ☐ Pending

Was a lawsuit filed in relation to the claim: ☐ Yes ☐ No

If the claim resulted in a lawsuit, what was the final outcome of the suit?

☐ Dismissed before trial ☐ Judgment for Defendant ☐ Judgement for Plaintiff

☐ Other (please specify) _____

Was the claim settled by you or on your behalf? ☐ Yes ☐ No

If a payment was made on your behalf, either as a result of a settlement or an award of damages:

Amount allocated to you: $_____

(*Explanation for Malpractice History Question* continued on the next page)

PRINT NAME: _____

MALPRACTICE EXPLANATION CONTINUED

MALPRACTICE CLAIM DESCRIPTIVE INFORMATION:

Allegation(s): _____

_____

Alleged Patient Injury: _____

_____

Condition of Patient When You Began Treatment: _____

_____

Condition of Patient at the End of Treatment: _____

_____

Detailed Summary: Provide a detailed narrative of the clinical course and circumstances leading to the claim, including the nature and extent of your involvement and role in the patient care. (*Do not write "see attached"*)

PRINT NAME: _____

EXPLANATION FOR CRIMINAL HISTORY QUESTION

This form must be used to provide a detailed written explanation for a "yes" response to question #34 on the Application. Please use as many forms as necessary to provide a detailed explanation.
Do not write, "See attached;" you must provide your response on this form.
A separate form is to be used for each criminal offense/arrest.

SUPPORTING DOCUMENTATION: In addition to the below explanation, you must arrange for the following to be sent directly to the Board or to you in a sealed envelope:

1) Court Records: The appropriate court or your lawyer must send certified copies of all court records related to the offense; and **2) Police Records:** The appropriate arresting/ticketing agency or your lawyer must send certified copies of the arrest/offense/incident report or citation/ticket.

*If a court, an arresting/ticketing agency or your lawyer is unable to provide copies of the applicable records, request that they furnish a written statement to that effect.

Incident Date: _____ _____ _____

Location of Incident (City and State/Country): _____

Arresting/Ticketing Agency: _____

Court: _____

Initial Charge(s): _____

☐ Misdemeanor ☐ Felony

Final Charge(s): _____

☐ Misdemeanor ☐ Felony

Plea: _____

Disposition: (if probation, deferred adjudication, or deferred prosecution give summary.)

Detailed Summary. Provide a personal statement containing a detailed summary of the events and circumstances leading to the criminal offense. *(Do not write "see attached")*

PRINT NAME: _____

EXPLANATION FOR CONFIDENTIAL INFORMATION QUESTIONS

QUESTION #35 – Medical or physical condition.

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 #36 – 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 #37 - Refusal to take a screening test for chemical substances.

Please provide a description of the circumstances leading to your refusal to take the screening test and any resulting criminal or disciplinary consequences.

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. (*Note:* This applies even if you reside out of the state or out of the country.)
- Pursuant to M.G.L. c. 62C, § 49A, to the best of my knowledge and belief, I am in compliance with 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.
- By signing this application, I am providing my consent for the Massachusetts Board of Registration in Medicine and, where relevant, their supervising state agencies and the Massachusetts Executive Office of Health and Human Services, and where relevant, its provider enrollment vendor, to obtain, read, copy, and share with each other information regarding my MassHealth application and enrollment status and Massachusetts licensure status.
- I have read the Board's regulations, 243 CMR 1.00 through 3.00.

Certification:

☐ **I confirm I have read and agree to comply with these statutory and regulatory requirements.**

DECLARATION OF APPLICANT

I, _____:

(PRINT LEGAL NAME)

being duly sworn, depose and say that I am the person described and identified in this application. I declare that I have examined this complete application and to the best of my knowledge and belief, the information contained herein and evidence or other credentials submitted herewith are true, correct and complete. **I understand that any falsification or misrepresentation of any item or response on this application or any attachment hereto may be a sufficient basis for denying or revoking a license.** I hereby 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 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. I hereby authorize the Board of Registration in Medicine to transmit any information contained in the application, or information that may otherwise become available to them, to any agency, organization, or individual, who, in the judgement of the Board, has a legitimate interest in such information.

SIGNATURE: _____ DATE: _____

Commonwealth of Massachusetts Board of Registration in Medicine
178 Albion Street, Suite 330 – Wakefield, MA 01880
Telephone: (781) 876-8210 Fax: (781) 876-8383
www.mass.gov/massmedboard

LIMITED LICENSE APPLICATION: SECTION B

INSTRUCTIONS: **Section B of the Limited License Application must be completed and signed by the Designated Official of the teaching facility at which the applicant has received an appointment.**

This certifies that _____ has been appointed as follows:
(Name of Applicant)

Position: ☐ Intern (Transitional/Preliminary Year) ☐ Resident ☐ Fellow

Specialty: _____

Department: _____

Subspecialty: _____

Training Facility: _____

Anticipated Training Dates: _____/_____/_____ to _____/_____/_____

Anticipated Postgraduate Training Year(s): PGY: _____ to _____

You must answer "yes" or "no" to question #1. **If you answered "no" to question #1, you must answer question #2.** **Note: If your response to both Questions #1 & 2 are "No", please contact the Licensing Division to determine whether this applicant is eligible for a limited license.**		**YES**	**NO**
1.	Is the program accredited by the ACGME?	☐	☐
2.	If no, is there an ACGME accredited program in the applicant's specialty?	☐	☐

DESIGNATED OFFICIAL SIGNATURE

Completion of the following is certification that you have reviewed Section A of the Limited License Application and that the information above is an accurate account of the applicant's appointment.

Signature: _____

Print Name: _____

Official Title: _____

Date: _____/_____/_____ Phone number:_____

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MEDICAL EDUCATION VERIFICATION – FORM A

APPLICANT INSTRUCTIONS: Primary source verification must be received from ALL medical schools of attendance. Please complete the below Waiver and forward this form to your medical school(s). **Note:** Fourth year medical students must include the letter to the medical school registrar and Form B. This form does not need to be completed if you are submitting verification of your medical education through FCVS or if you ever held a Limited License in Massachusetts.

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 Name: _____

Print Other Name(s): _____

Name of Medical School: _____

Address: _____ City: _____ State/Province: _____

MEDICAL SCHOOL SECTION

INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL:

- Please complete all sections of Form A. For fourth year medical students, please complete Form B after the student completes the degree requirements.
- **International medical schools** must include a copy of the official transcript (indicating courses taken, dates and hours of attendance, scores, grades, or evaluations) and diploma.
- This form must be stamped with the institutional seal or notarized on the second page.
- Return form to the applicant in a sealed envelope. Please sign or stamp across the seal on the envelope.

Name of Medical School:

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

Premedical Education:

Does your school have a premedical school education requirement? ☐ Yes ☐ No

If "yes", indicate where the applicant completed premedical school below:

Applicant's Undergraduate School: _____

Undergraduate School Address: _____

(Continued on next page)

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** of continuous medical education on the following dates

from _____ _____ _____ to _____ _____ _____.
month/day/year month/day/year

Degree Earned:

This applicant: *(Check one of the following)*

☐ **was awarded** the degree of _____ on _____ _____ _____
month/day/year

☐ **is expected to 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. **Please provide an explanation for any "YES" answers in the space below or enclose a separate page.**

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

Explanation for any "YES" answers: _____

_____

_____

CERTIFICATION AND SEAL

SEAL / NOTARY
If the institution does not have a seal, this form must be notarized.

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct.

Signature: _____

Print Name: _____

Title: _____

Date: _____ _____ _____ Telephone: _____

E-mail address: _____

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MEDICAL EDUCATION VERIFICATION – FORM B

The Board will not issue a limited license to practice in Massachusetts until verification has been received directly from the medical school that the applicant has satisfactorily completed all degree requirements.

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 once they have been awarded their degree.

MEDICAL SCHOOL SECTION

INSTRUCTIONS:

- Form B is to be completed after the student has satisfactorily completed all degree requirements.
- Form B should be signed by the appropriate certifying official and returned directly to the Board by mail at the above listed address, via email at: FormB@mass.gov, or by fax at: 781-876-8383.

This certifies that _____
(Name of Student)

Has completed the requirements for the ☐ M.D. degree ☐ D.O. degree

from _____
(Name of Medical School)

and will receive the degree on _____/_____/_____ .

CERTIFYING OFFICIAL SIGNATURE

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct.

Signature: _____

Print Name: _____

Official Title: _____

Date: _____/_____/_____