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

IMPORTANT INFORMATION FOR THE APPLICANT

Welcome to Massachusetts and thank you for choosing our state to practice medicine. This application is for U.S. and international medical school graduates applying for a full, administrative, or volunteer license in Massachusetts for the first time.

It is extremely important that you read and follow all instructions carefully. Please make a copy of your license application and supplement before you submit them to the Board. When sending your application and supplement, please use one of the tracking services offered by the post office or commercial shippers. **Please note that you must collect all documents listed on the Required Documents Checklist. Documents from primary sources must be collected in sealed envelopes and included in the original sealed envelopes with your license application; otherwise, your license will be significantly delayed. Your application cannot be processed until the Board receives all of the required documents.** After receipt of your license application and all accompanying documents, the Board will notify you about any additional documentation needed--this may take up to eight weeks.

Application processing time is dependent upon receipt of all supporting documents. Under Massachusetts law, you may not practice medicine independently until you have received a full license. The Board strongly recommends that you do not make any commitments such as home purchases, loans, etc. until you have been granted a license to practice medicine in Massachusetts.

If you previously held a Massachusetts full license, you may download the lapsed license application at www.mass.gov/massmedboard, select Physicians, Licensing, Licensing Forms, and Lapsed License.

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HOW FAST CAN I GET A FULL LICENSE?

The most frequently asked question from physicians applying for a full license is "How fast can I get my full license?" The answer depends on two factors: 1) whether the physician has submitted all of the required documentation in accordance with the Board's regulations; and 2) the current volume of applications being processed by the Licensing Division staff.

As part of the application process, a physician seeking a full license is required to provide a number of documents including: primary source verification of completion of medical school training and postgraduate training; examination scores; and satisfactory proof of good moral character. Affirmative responses regarding legal issues necessitate that a physician provide additional primary source documentation including: malpractice complaints; police reports; and other legal documents.

A full license application is complete only after all of the required documentation is received and reviewed by the Licensing Division staff. Timely completion of a full license application is intensive and requires the applicant's cooperation to supply the required documents. Typically, a full license application, received from August through December, can be issued in approximately eight (8) weeks if there are no legal, competency or good moral character issues. License applications with no legal, competency or good moral character issues received between January and July may take approximately twelve (12) weeks to process due to the larger volume of applications received during those months.

Listed below are tips to assist physicians applying for a full license:

<u>Licensing Requirements</u>

- Review the Board's licensing requirements to ensure that you meet the current requirements.

<u>Curriculum Vitae</u>

- Review your curriculum vitae for completeness and accuracy. You must account for all periods of time, by month and year, beginning with entry into medical school.

<u>Adverse Information</u>

- Do not attempt to hide any adverse information from the Board. Making a false statement on an application can be grounds for denial of licensure in Massachusetts.

Active Involvement

- Be actively involved in the licensure process. Follow up with medical schools, training programs, hospitals, and insurers to make sure that requested information is provided promptly.
- Complete the full license application fully and accurately. If you are using a physician licensing service, carefully review your full license application prior to its submission. Inaccurate information causes delays in the application process.
- Review the Board's full application checklist prior to mailing your application to the Board, to ensure that you have answered all of the questions and obtained all of the required documents.
- The Licensing Division staff reviews applications in the order they are received. You will be notified via email of the items needed to complete your application. Questions about your application should be directed to the Licensing Analyst assigned to your application.
- **Your application will not be processed until the Board receives: a completed application; the licensing fee; and all of the required supporting documentation**.

Change of Address

- If you change your address at any time during the licensure process, please remember to update your address with the Board. **Your wallet card will be mailed to the address that the Board has on file.**

General Information

- Typically, the Licensing Committee meets once a month and the Board meets twice a month. The dates of the Board and the committee meetings are posted on the Board's website at www.mass.gov/massmedboard. These dates are subject to change.

Please exercise patience throughout the licensing process. The Board's overriding mission is to serve the public by striving to ensure that only qualified physicians are licensed to practice medicine in the Commonwealth. This requires the Board to take the time to fairly and comprehensively evaluate each application for licensure.

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FULL, ADMINSTRATIVE AND VOLUNTEER LICENSE APPLICATION INSTRUCTIONS

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GENERAL INFORMATION

Previous Medical License in Massachusetts: If you ever held a full license in Massachusetts, do not use this application form. You must complete a lapsed license application to revive your license. The lapsed license application is available on-line at the Board's website at www.mass.gov/massmedboard.

Address Change: The Board's regulations require you to notify the Board in writing within thirty (30) days when you change your address. Your wallet-card will be sent to the mailing address that you provide on your license application.

Practice of Medicine: Please be advised that pursuant to Massachusetts laws and regulations, you may not practice medicine in a training program or in an independent practice until you have received a license. Physicians are responsible for determining that the Board has issued a license prior to practicing medicine.

License Renewal: Renewal of your medical license will occur on your first birthday after the license issuance date, unless your birthday falls within ninety (90) days of obtaining initial licensure. If your first birthday after the issuance date falls within this time frame, you will not be required to renew your license until the following birthday. Renewals thereafter will be on a two-year birthday cycle.

Please notify the Board in writing when you submit your license application if you do not want your application to be presented to the Board until ninety (90) days before your birthdate.

DEA and Controlled Substance Registration: If you wish to prescribe or dispense drugs, you must apply for a Massachusetts Controlled Substance Registration. Go the Department of Public Health website at www.mass.gov/dph/dcp for an application for Massachusetts Controlled Substance Registration and follow the instructions or call (617) 753-8052. For DEA registration go to the DEA website at www.deadiversion.usdoj.gov and follow the instructions or call (617) 557-2468.

Registration of Medical License: Please note that, pursuant to M.G.L. c. 112, §8, you are required to register your medical license with the clerk of the city or town where you practice. Failure to do so could result in a fine of up to $100.00.

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

DOCUMENTS TO BE SUBMITTED WITH YOUR FULL LICENSE APPLICATION

*****ALL DOCUMENTS SHOULD BE SUBMITTED AS ONE-SIDED*****

1. Full License Application – every data field on the full license application must be completed
2. Curriculum vitae
3. Supplement – all questions answered and supplement pages completed for any " yes" answers
4. Authorization for Release
5. CORI Acknowledgment Form
6. Electronic Health Records (EHR) Proficiency Form
7. 90-Day Form
8. Certificate of Moral and Professional Character (sealed envelope)
9. State License Verifications (sealed envelopes)
10. Evaluations (sealed envelopes)
11. Postgraduate Verifications (sealed envelopes)
12. Examination scores (sealed envelope)
13. National Practitioner Data Bank (sealed envelope)

14. Malpractice History Form – listing all liability carriers since postgraduate training
15. Malpractice history reports from all carriers since postgraduate training
16. ECFMG Certificate, notarized copy (international medical graduates only)
17. Medical School Diploma, notarized copy (international medical graduates only)
18. Legal documents, as required

FULL, ADMINSTRATIVE AND VOLUNTEER LICENSE INSTRUCTIONS

The Full License Application Kit consists of the forms required for completing the application process. You may download additional forms at the Board's website at www.mass.gov/massmedboard.

Throughout this application:

- Graduates of medical schools in the United States, Canada or Puerto Rico, should follow the instructions for U.S. graduates.
- Graduates of all medical schools **not** located in the United States, Canada, or Puerto Rico, should follow the instructions for international medical graduates.

Instructions for Completing the Full License Application

- Provide a response for every question on the application and attachments.
- Provide complete names and addresses of medical school(s), postgraduate training program(s), health care affiliation(s) and work site(s).
- Collect all of the documents required for your full license in **sealed envelopes** and send them to the Board with your full license application.
- **If any information or documents are missing or incomplete, your full license will be significantly delayed.**

Application Fee

The application processing fee for a full license is $600.00 and is non-refundable. Please make your check payable to the Commonwealth of Massachusetts. A certified check or money order is preferred, but personal checks are accepted.

License Type

Select one of the following license types listed on the full license application.

- Full License – a full license allows a physician to practice medicine independently in the Commonwealth of Massachusetts.
- Administrative License – an administrative license is for a physician whose primary responsibilities are administrative or academic in nature and does not include authority to diagnose or treat patients, write prescriptions for controlled substances, delegate medical acts or prescriptive authority, or issue opinions regarding medical necessity.
- Volunteer License – a volunteer license is for physicians who practice medicine at work sites pre-approved by the Board, subject to the same conditions and responsibilities as a full licensee. A volunteer licensee may not accept compensation for his or her practice of medicine.

Other Name(s)

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

Social Security Number

Each applicant is required to provide the Board with a United States Social Security Number pursuant to M.G.L. c. 30A, §13A.

Mailing Address

The Board will use your mailing address for all correspondence with you.

Premedical Education

A minimum of two (2) or more academic years at a legally-chartered college or university is required.

Medical Education

Four (4) academic years of instruction of not less than thirty-two (32) weeks in each academic year or courses which in the opinion of the Board of Registration in Medicine are equivalent, in a legally chartered medical school that grants the degree of doctor of medicine or its equivalent.

Qualifying Examinations

Please list all the licensing examinations you have completed.

Postgraduate Training

- U.S. graduates: Two (2) years of postgraduate training in an ACGME accredited or an AOA accredited training program.
- International medical graduates: Effective January 2, 2014, international medical graduates are required to complete three (3) years of ACGME or AOA accredited postgraduate training.
- Full license applicants requesting a waiver for substantial equivalency of medical school training must complete three (3) years of postgraduate training. (See page 8).

Other State Licenses

List all states where you ever had a full license, whether the license is active, inactive or not renewed.

Opioid and Pain Management Training

Physicians who prescribe controlled substances (Schedules II - VI), must have completed at least three (3) credits of Board-approved continuing professional development in effective pain management. Physicians are responsible for determining whether the pain management continuing professional development requirement applies to them, based upon the nature of their practice. A free online resource to obtain the necessary credits is available at www.opioidprescribing.com.

Requirement to Complete Training to Recognize and Report Suspected Child Abuse or Neglect

M.G.L. c. 119, §51A(k) requires all mandated reporters, professionally licensed by the Commonwealth, to complete training to recognize and report suspected child abuse or neglect. Physicians are one category of mandated reporters.

Physicians may comply with the training requirement through:

- Receiving training in child abuse or neglect assessment in medical school education or postgraduate training;
- Completion of a hospital sponsored training program in recognizing the signs of child abuse and neglect;
- Completion of continuing professional development (formerly known as continuing medical education credits) in identifying and reporting child abuse and neglect;
- Completion of an on-line training program (i.e., The Middlesex Children's Advocacy Center's program "51A Online Mandated Reporter Training: Recognizing and Reporting Child Abuse, Neglect, and Exploitation" **www.middlesexcac.org/51A-reporter-training)**; or
- Completion of a specialized certification (i.e., Child Abuse Pediatrics).

Full license applicants must complete the requirement for training prior to submission of an application to the Board. This is a one-time requirement.

Electronic Health Records (EHR) Proficiency Form

This is a one-time requirement. Complete Section 1 (Demonstrating Proficiency) or Section 2 (Claiming an Exemption). Sign and date the form.

Authorization for Release of Information

Sign and date the Authorization for Release of Information form.

Full Application Supplement

Every question on the Full Application Supplement must be answered "yes" or "no." If a question is answered "yes" you must provide an explanation in the supplement section for that question and provide the additional documents in sealed envelopes.

You will be requesting the following documents to be sent directly to you in sealed envelopes Please request the signature of the endorser or seal of the institution to be placed across the back flap of the envelope. The National Practitioner Data Bank Profile and the USMLE will not have a seal or signature.

Certificate of Moral and Professional Character

The Certificate of Moral and Professional Character must be completed and signed by a physician who has a current medical license in the United States. The designated physician must not be the applicant's relative but should have known the applicant for at least one (1) year. The form must be notarized by a U.S. notary.

Postgraduate Training Verification Form

Submit the Postgraduate Verification form to all health care facilities in the U.S., Puerto Rico or Canada where you have participated in any internship, residency or fellowship training, including training programs that were not completed.

Note: If you are **currently enrolled** in a postgraduate training program, please do not have your postgraduate verification form signed by your program director until you have completed two (2) years of postgraduate training for U.S. graduates and three (3) years for international medical graduates.

Evaluation Form

At least one (1) year of current evaluations are required. The Board's Evaluation form must be completed by a supervising physician, a training program director, department chairperson or a current or former supervising physician who can evaluate your clinical performance.

Physicians who are not affiliated with a healthcare facility must obtain reference letters from three physicians who refer patients to them for clinical care.

Locum tenens physicians must have Evaluation forms completed for the most recent two (2) years by health care facilities where you have had locum tenens assignments.

Note: Evaluation forms must be current within 120 days prior to Board review. If there are any outstanding legal issues relating to your application, the evaluation must be completed within sixty (60) days of Board review. The Board reserves the right to require that Evaluation forms be current within thirty (30) days of Board review.

State License Verifications

You must obtain a written verification of every full license issued to you in the U.S., Puerto Rico or Canada in support of your full license application. The state boards of California, Texas, Indiana, Pennsylvania and Veridoc will only send license verifications directly to the Massachusetts Board of Registration in Medicine. The license verifications will be held in a pending file until your completed full license application is ready to be processed**.**

National Practitioner Data Bank Profile

License applicants must request a self-query profile from the National Practitioner Data Bank (NPDB). You may access the NPDB at www.npdb-hipdb.hrsa.gov and complete the self-query form online. After completing the self-query form, you will be required to verify your identity. In most cases this is an electronic process. If you are unable or unwilling to verify your identity electronically, you must verify your identity offline. The offline process requires you to print out a hard copy of your self-query form, have it notarized and forward it to the Data Bank.

Please note that the NPDB will offer you a pdf and a paper copy of your NPDB profile. You must request a paper copy of your NPDB profile in addition to the pdf.

The self-query fee of $5.00 is payable by credit card (VISA, MasterCard, American Express and Discover) or debit card (with VISA or MasterCard logo on the card). Please remember to include your credit or debit card number and expiration date on your query form.

Once your identity is verified, the Data Bank will process your self-query request. When you profile is available, you will receive an email notification and instructions to view your profile online. In addition to the online profile, you will receive a paper copy of your profile by U.S. mail. When you receive the paper copy of your NPDB profile, **DO NOT OPEN THE ENVELOPE**. You must mail it directly to the Board with your license application. If the envelope is opened, it will be returned to you and a new profile request must be submitted. The NPDB requires up to four weeks to process a new profile. If you have questions, contact the Data Bank at 1-800-767-6732.

Medical Education Verification

Complete the authorization statement at the top of the Medical Education Verification form and send it to your medical school. If more than one medical school was attended, the form must be duplicated and sent to each additional school.

If there were gaps in your medical education, or more than four (4) years of medical school for U.S graduates, or more than six (6) years for international medical school graduates, you must provide an explanation for the additional months or years and the medical school must also provide the dates and reason(s) for the additional months or years.

International medical schools must provide a copy of the medical school transcripts in English. If the transcripts are in a language other than English, the Board will send a copy of the medical school transcripts to you to be translated either by your medical school or a U.S. translation company.

Note: If you were ever issued a limited license in Massachusetts, your medical school verification is on file at the Board and you do not need to provide the medical education verification.

Medical School Diploma

International medical school graduates must provide a notarized copy of their medical school diploma with the full license application. The notarization must be completed b y a U.S. notary and, if it is not in English, it must be translated by a U.S. translation company.

Transfer from Ph.D. or Dental School Program to an M.D. Program

Transfer students who received credit from a Ph.D. or dental school program must submit the Medical Education Verification form with the official transcripts from the Ph.D. or dental school program. A letter of matriculation must also be sent to the Board from the medical school.

Examination Requirements - USMLE and FLEX

Contact the Federation of State Medical Boards (FSMB) at www.fsmb.org to request USMLE and FLEX scores.

Please note that the Board's regulations require that the USMLE Steps 1, 2 and 3 must be completed within a seven (7) year time period, beginning with the examination date when the examinee first passes his/her first Step (either Step 1 or Step 2). The Board may grant a waiver of the seven-year examination completion requirement in the case of an applicant who is actively pursuing another advanced doctoral study. In addition, in very limited and extraordinary circumstances, the Board may grant a case-by-case exception to the seven-year period upon petition by the applicant and demonstration by the applicant of: a. a verifiable and rational explanation for the failure to satisfy the regulation; b. strong academic and post-graduate record; and c. a compelling totality of circumstances. Please review the Board's regulation 243 CMR 2.02(3) (b) and (c) for additional information.

An applicant who fails to pass Step 3 of the USMLE or level 3 of the COMLEX within three (3) attempts is required to take an additional year of ACGME or AOA approved postgraduate training prior to attempting the step a fourth time.

National Board of Medical Examiners Diplomate Certification

Contact the National Board of Medical Examiners (NBME) at www.nbme.org to obtain the Endorsement of NBME Certification and under Programs and Services, select "NBME certification and transcripts" and follow the instructions to request examination scores.

National Board of Osteopathic Medical Examiners Diplomate Certification

You may access the National Board of Osteopathic Medical Examiners (NBOME) website at www.nbome.org for a transcript request form and instructions.

LMCC

Applicants providing LMCC results may request a transcript of LMCC Scores by fax at (613) 521- 9417 or send a letter to: The Registrar, Medical Council of Canada, Box 8234, 1867 Alta Vista Drive, Ottawa, KIG 3H7 Canada. A notarized copy of your LMCC Certificate must be sent to the Board with your Full License application.

FLEX Examination/State Board Examination Verification

Verification of a FLEX/State Examination must include the examination dates and scores. Massachusetts requires a FLEX passing score of 75 in each component. For examinations prior to June 1985, a FLEX weighted average score of 75 is required in one sitting. A state Board examination taken after June 19, 1970 will not be accepted for licensure.

AMA Physician Profile

The AMA Physician Profile may be requested online at www.ama-assn.org/AMAProfiles, or you may contact the AMA Customer Service for ordering assistance at (800) 665-2882 or (312) 364-5199. The AMA Physician Profile will be sent electronically directly to the Board.

Osteopathic (D.O.) Physician Profile

The Official Osteopathic Physician Report may be requested at www.osteopathic.org or at the American Osteopathic Information Association Credentials Services, 142 E. Ontario St., Chicago, IL 60611.

Education Commission for Foreign Medical Graduates (ECFMG) Status Report

An ECFMG Status Report may be requested at https://cvsonline2.ecfmg.org/ImgGenInfo.asp. The ECFMG Status Report will be sent electronically to the Board.

Substantial Equivalency of Medical School Education and Off-Site Rotations:

In situations where an international medical graduate cannot comply with 243 CMR 2.03(1)(b), requiring substantial equivalency of medical school education, a Waiver Request may be submitted to the Board. If an applicant completed more than three (3) months of any required or elective clinical rotation outside of the primary teaching hospital of their medical school of attendance, a Waiver Request (Form J) and Forms E-1 and E-2 are required. You must send a copy of Form E-1 to your medical school and Form E-2 must be forwarded to

the program director at the program where you completed each clinical clerkship. E-2's must be returned directly to the applicant in a sealed envelope.

The Board will review the applicant's medical school training and/or off-site clinical rotations to determine whether they are substantially equivalent to U.S. medical school training. In assessing the applicant's equivalency of medical education, the Board relies on the factors detailed in Board Policy 91-001. The Waiver for Substantial Equivalency of Medical School education, Board Policy 91-001 and the E-1 and E-2 forms are available at the Board's website. Requesting a waiver for substantial equivalency of medical school education may result in a delay in processing your full license, as determinations on waiver requests are made by the Board on a case-by-case basis.

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

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

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.
- You do not need to list a liability carrier for the time period when you were in a training program unless you 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.

Criminal History

For each criminal proceeding in which you were named a defendant, certified copies of the com plaint, judgment or other disposition and a copy of the police report must be sent to you in sealed envelopes from your lawyer, the court or other appropriate agency. You must also provide a detailed explanation of the incident, including date, time, place, who was with you and the court action. The sealed envelopes must be included with your full license application.

Current Probation Agreement in Another State

It is the practice of the Licensing Committee, a committee of the Board of Registration in Medicine, to defer action on applications from individuals with a current probation agreement in another state, until that state's licensing board has terminated the probation.

Criminal Offender Record Information (CORI)

Criminal Offender Record Information ("CORI") is part of a general background check for licensing purposes. In order to complete this background check, applicants must submit a notarized CORI Acknowledgment Form. You must sign your name in the presence of a U.S. Notary Public. It is preferred that, for purposes of identification, applicants submit identification issued by the U.S. government (i.e., driver's license, identification card, etc.) If you do not have any identification issued by the U.S. government, an international passport may be used to verify the information on the CORI Acknowledgment Form.

In completing the CORI Acknowledgment Form, you will need to provide the following required information: Last Name; First Name; Date of Birth; Last 6 digits of your Social Security Number ("SSN"). If you do not have an SSN, then you must enter 6 zeros – zeros may only be used for CORI if you do not have a valid SSN. An applicant who has a valid SSN and submits a CORI with zeros for a SSN can be subject to civil and criminal penalties.

FCVS Physician Profile

The Massachusetts Board of Registration in Medicine accepts the FCVS (Federation Credentials Verification Services) for verification of core credentials which includes medical school (from primary source) postgraduate training, examination scores and ECFMG verification. If you choose to utilize FCVS, you m ay obtain information at www.fsmb.org or contact the FCVS at (817) 868-5000 or (888) 275-3287. The FCVS does not verify medical licenses in other states. **Applicants utilizing FCVS for their core documents must also complete the following additional Board forms in accordance with the Board's application instructions:**

- Full License application
- Supplement
- Moral and Professional Character form (sealed envelope)
- State License Verifications (sealed envelopes)
- Evaluation Form (sealed envelope)
- National Practitioner Data Bank Profile (sealed envelope)
- AMA Profile (sealed envelope)
- Malpractice history form – listing all liability carriers since postgraduate training
- Malpractice history reports from all carriers since postgraduate training
- Malpractice documents
- Legal documents, as required

Copy your full application and supplement. You will be required to provide a copy to every health care facility for credentialing and for enrollment in health plans.

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.ecfmg.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.hrsa.gov

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FULL LICENSE APPLICATION

Application Fee: Please enclose a check or money order in the amount of $600.00 made payable to the Commonwealth of Massachusetts. The application fee is non-refundable.

Type of License ☐ Initial Full License ☐ Administrative License ☐ Volunteer License

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. ☐ PhD ☐ Other degree_____ ☐ Male ☐ Female

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.)

Social Security Number: _____/_____/_____ Date of Birth:_____/_____/_____
Month Day Year

NPI (National Provider Identifier) Number: _____

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

*Mailing Address:_____Telephone:_____
Number and Street

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

Home Address:_____Telephone: _____
Number and Street

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

Business Address:_____ Telephone: _____
Number and Street

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

E-mail Address:_____ Fax number:_____

Are you applying for licensure through FCVS? ☐ Yes ☐ No

*** The Board will use your Mailing Address for all correspondence**

Pre-medical School **From** **To**

Name:_____ Degree: _____ Year:_____ Year:_____

Street:_____ City:_____ State:_____

Name:_____ Degree: _____ Year:_____ Year:_____

Street:_____ City:_____ State:_____

Medical School

Name:_____ Degree:_____

Street:_____ City:_____ State:_____

Name:_____ Degree:_____

Street:_____ City:_____ State:_____

Medical School Graduation Date: _____/_____
Month Year

Postgraduate Education:

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

From **To**

Facility:_____ PGY Year:_____ _____/_____ _____/_____

Specialty:_____ City:_____ State:_____

Facility:_____ PGY Year:_____ _____/_____ _____/_____

Specialty:_____ City:_____ State:_____

Facility:_____ PGY Year:_____ _____/_____ _____/_____

Specialty:_____ City:_____ State:_____

Facility:_____ PGY Year:_____ _____/_____ _____/_____

Specialty:_____ _____ City:_____ State:_____

Facility:_____ PGY Year:_____ _____/_____ _____/_____

Specialty:_____ _____ City:_____ State:_____

Examination History

Please contact the appropriate examination entity and have the examination scores sent to you in a sealed envelope. If you are using FCVS, your examination scores will be sent to the Board with your credentials packet.

List each licensure examination, U.S. or international, you have taken (USMLE, NBME, NBOME, LMCC, FLEX, COMVEX, COMLEX or a state examination.

Examination	Number of attempts	Passed (P) or Failed (F)
USMLE Step I	_____	☐ P ☐ F
USMLE Step II	_____	☐ P ☐ F
USMLE Step III	_____	☐ P ☐ F
NBME Part I	_____	☐ P ☐ F
NBME Part II	_____	☐ P ☐ F
NBME Part III	_____	☐ P ☐ F
FLEX Component 1	_____	☐ P ☐ F
FLEX Component 2	_____	☐ P ☐ F
FLEX Pre-1985	_____	☐ P ☐ F
NBOME Part 1	_____	☐ P ☐ F
NBOME Part II	_____	☐ P ☐ F
NBOME Part III	_____	☐ P ☐ F
COMLEX Level 1	_____	☐ P ☐ F
COMLEX Level 2	_____	☐ P ☐ F
COMLEX Level 3	_____	☐ P ☐ F
COMVEX	_____	☐ P ☐ F
LMCC – Single	_____	☐ P ☐ F
LMCC – Part I	_____	☐ P ☐ F
LMCC – Part II	_____	☐ P ☐ F
State Board Exam	_____ (State of examination and year)	☐ P ☐ F

Hospital Affiliations and Employment

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

From **To**

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 had a full license: _____ _____ _____

2. a) Are you certified by the American Board of Medical Specialties? ☐ Yes ☐ No
   b) Are you certified by the American Board of Osteopathic Medicine? ☐ Yes ☐ No

3. List Board Certification(s):_____

4. List your practice specialt(ies):_____

5. Have you completed the Opioid and Pain Management training? (See Instructions) ☐ Yes ☐ No

6. Have you completed training to recognize and report suspected child abuse or neglect? ☐ Yes ☐ No
   (Your license will not be processed until you complete the required training – see instructions.)

7. Reason for requesting a Massachusetts medical license:_____

   _____

8. Name of Facility:_____

   Address:_____ City:_____

9. Anticipated starting date in Massachusetts: _____/_____/_____

10. Curriculum vitae (CV) listing activities by month and year must be enclosed with your application.

Under the penalties of perjury, I declare that I have examined this full 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 Month Day Year

FULL LICENSE APPLICATION CHECKLIST

Please confirm that all documents listed on this checklist are included with your full license application. All documents from other primary sources must be received in sealed envelopes with the facility seal or signature on the back of the envelope. DO NOT OPEN THE ENVELOPES. Please do not send your full license application to the Board until you have received all of the documents from the primary sources.

Description of Documents Required	Applicant Document Checklist	For Board use only
Check for $600.00 from a U.S. bank or a U.S. money order made payable to the Commonwealth of Massachusetts (application cannot be processed without the licensing fee)		
Full license application – all questions answered and application signed and dated		
Authorization for Release of Information completed		
Electronic Health Records (EHR) Proficiency Form		
90-Day Information Form		
ECFMG Status Report – you must request it to be sent to the Board electronically		
Questions answered and explanation for "yes" answers or additional documentation in accordance with instructions		
Curriculum vitae listing graduate education, medical school(s), postgraduate training and work history by month and year		
Moral and Professional Character form in sealed envelope		
Medical education verification in sealed envelope		
Postgraduate Verification form(s) completed by postgraduate training program director or authorized agent in sealed envelopes		
Evaluation Form signed by department chairperson, program director or a peer who has supervised or evaluated your clinical activities in sealed envelope		
USMLE, NBME, AOA, LMCC or FLEX examination scores in sealed envelope		
State License Verifications from current and past state license boards where you have held a full license in sealed envelopes (see instructions for Veridoc and state boards that will only send license verifications directly to the Board)		
AMA (American Medical Association) Physician Profile requested to be sent to Board electronically, or the AOA Osteopathic Physician Profile (sent to you in a sealed envelope)		
National Practitioner Data Bank profile in a sealed envelope		
Original Malpractice History form listing liability carriers since postgraduate training with dates of coverage and policy numbers		
Malpractice history reports from all liability carriers since postgraduate training listed on your Malpractice History form		
Malpractice claim report(s) or letter of intent for open or closed malpractice cases from the attorney or liability carrier(s) in sealed envelopes		
Police report from the police department and court documents from the court or an attorney, if applicable, in sealed envelopes		
CORI Acknowledgment Form		
Other documents:		
Other documents:		

Please make a copy of your full license application and supplement before sending it to the Board. You are required to provide a copy to every health care facility for credentialing and for enrollment in health plans.

ELECTRONIC HEALTH RECORDS (EHR) PROFICIENCY FORM

Pursuant to M.G.L. c. 112, § 2, an applicant for licensure must demonstrate proficiency in the use of electronic health records (EHR). This is a one-time requirement.

Complete Section 1 (Demonstrating Proficiency) OR Section 2 (Claiming an Exemption) and Sign in Section 3.

SECTION 1. DEMONSTRATING PROFICIENCY

1. I have demonstrated proficiency in the use of EHR in one of the following ways:

____ Participation in a Meaningful Use program as an eligible professional;
____ Employment with, credentialed to provide patient care at, or in a contractual agreement with an eligible hospital or critical access hospital with a CMS Meaningful Use program;
____ Participation as either a Participant or an Authorized User in the Massachusetts Health Information Highway.
____ Completion of 3 hours of a Category 1 EHR-related CPD course that discusses, at a minimum, the core and menu objectives and the Clinical Quality Measures ("CQMs") for Meaningful Use.

SECTION 2. CLAIMING AN EXEMPTION (Exemptions must be claimed each licensing cycle, if applicable. If you are exempted from the EHR proficiency requirement, please select the appropriate exemption.)

2. I am exempt from the EHR Proficiency requirement because I am an applicant

____ who will not be engaged in the practice of medicine as defined in 243 CMR 2.01(4);
____ for an Administrative License;
____ for a Volunteer License;
____ on active duty as a member of the National Guard or of a uniformed service called into service during a national emergency or crisis; or
____ for an Emergency Restricted License.

SECTION 3. SIGNATURE

I, the undersigned applicant, hereby certify that all information included in this EHR Proficiency Form constitutes a true statement made under penalties of perjury.

NAME:_____DATE: _____

90-Day Form

Dear Doctor,

Renewal of your medical license will occur on your first birthday after your license is issued, unless your birthday falls within ninety (90) days of your license issue date. If your first birthday is within the 90-day time period that your license is issued, you will not be required to renew your license until your following birthday. Example: If your birthday falls on September 1, 2014, and your license is issued on July 1, 2014, your renewal date will be September 1, 2015. However, if your birthday falls on September 1, 2014, and your full license is issued on January 1, 2014, you will be required to renew your full license by your birthday on September 1, 2014. Renewals thereafter will be on a two-year birthday cycle. Please select one of the choices below and return this form with your Full License application.

Thank you.

Please select one of the boxes below:

☐ Do not hold my Full License Application; send it to the Board as soon as it is completed.

☐ Hold my Full License Application until it is within the 90-day time period.

My birthdate is _____/_____/_____
Month Day Year

Signature:_____ Today's Date: _____/_____/_____
Month Day Year

Please return this form with your Full License Application. If you do not submit this form with your Full License Application, your completed Full License Application will be forwarded to the Board for approval at the next Board meeting. Thank you.

Commonwealth of Massachusetts
Board of Registration in Medicine
200 Harvard Mill Square, Suite 330 - Wakefield, MA 01880
Telephone: (781) 876-8210 Fax: (781) 876-8383

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

Attach a recent 2 x 2 color photograph. Black and white photographs will not be accepted.

You must sign your name in the presence of a **U.S. Notary Public**.

_____
Signature of applicant

I certify that the photograph above is a genuine likeness of the maker of the signature above.

_____
Signature of Notary

_____
My commission expires

CERTIFICATION OF MORAL AND PROFESSIONAL CHARACTER

This certifies that I have been personally acquainted with the physician named below:

_____
(name of applicant)

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.

_____
Signature of Certifying Physician

_____ _____
License Number State

_____
Type or print name clearly

Address: _____

_____

City: _____ State: _____ Zip:_____

Telephone: (_____)_____

Date: ____/____/____

***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.*

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)

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

CRIMINAL OFFENDER RECORD INFORMATION (CORI) ACKNOWLEDGMENT FORM

The Board of Registration in Medicine is registered under the provisions of M.G.L. c. 6, § 172 to receive CORI for the purpose of screening license applicants.

As a license applicant, I understand that a CORI check will be submitted for my personal information to the DCJIS. I hereby acknowledge and provide permission to the Board of Registration in Medicine to submit a CORI check for my information to the DCJIS. This authorization is valid for one year from the date of my signature. I may withdraw this authorization at any time by providing the Board of Registration in Medicine written notice of my intent to withdraw consent to a CORI check.

The Board of Registration in Medicine may conduct subsequent CORI checks within one year of the date this form was signed by me provided, however, that the Board of Registration in Medicine must first provide me with written notice of this check.

By signing below, I provide my consent to a CORI check and acknowledge that the information provided on Page 2 of this Acknowledgment Form is true and accurate.

Signed under the penalties of perjury, this _____ day of _____, 20 ____.

_____
Signature of Applicant

_____
Print Name

SUBJECT INFORMATION: An asterisk (*) denotes a required field.

_____

*Last Name *First Name Middle Name Suffix

_____

*Maiden Name (or other name(s) by which you have been known)

_____ _____

*Date of Birth Place of Birth

*Last Six Digits of Your Social Security Number: _____ - _____

Sex: _____ Height: _____ft. _____in. Eye Color: _____ Race: _____

Driver's License or ID Number: _____ State of Issue: _____

_____ _____

Mother's Full Maiden Name Father's Full Name

Current and Former Addresses:

_____

Street Number & Name City/Town State Zip

_____

Street Number & Name City/Town State Zip

On this _____ day of _____, 20____, before me, the undersigned notary public, personally appeared _____ (name of document signer), proved to me through satisfactory evidence of identification, which were _____, to be the person whose name is signed on the preceding or attached document, and acknowledged to me that (he) (she) signed it voluntarily for its stated purpose.

_____

Notary Public:

_____

Expires On

PRINT NAME: _____ DATE: _____/_____/_____

FULL LICENSE APPLICATION SUPPLEMENT

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.)	☐	☐
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?	☐	☐
2-B.	Have you ever been placed on probation or remediation by a medical school, graduate school or any postgraduate training program?	☐	☐
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?	☐	☐
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?	☐	☐
5.	Have you ever been denied a medical license, whether full, limited, temporary, or have you withdrawn an application for medical licensure?	☐	☐
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.)	☐	☐
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?	☐	☐
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?	☐	☐
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.)	☐	☐

PRINT NAME: _____ DATE: _____/_____/_____

		YES	NO
9-A.	Have you ever relinquished any medical staff membership or association with a health care facility?	☐	☐
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?	☐	☐
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?	☐	☐
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.)	☐	☐
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?	☐	☐
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?	☐	☐
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)?	☐	☐
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?	☐	☐
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?	☐	☐

PRINT NAME: _____ DATE: _____/_____/_____

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.

		YES	NO
15.	Do you have a medical or physical condition that currently impairs your ability to practice medicine?	☐	☐
16.	Have you engaged in the use of any substance(s) with the result that your ability to practice medicine is currently impaired?	☐	☐
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?	☐	☐

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 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.

Applicant's 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:_____

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

Date of action: ____/____/_____

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: _____/_____/_____

<u>QUESTIONS #12 &13</u>– 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 <u>directly to you in a sealed envelope</u>.

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:_____

PRINT NAME: _____ DATE: _____/_____/_____

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.

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

MEDICAL EDUCATION VERIFICATION – FORM A

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

Waiver for Release of Information

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

Applicant's Signature: _____ Date of Birth: _____/_____/_____

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

Other Name(s) (Please type or print.): _____

Name of Medical School: _____

Address: _____ City: _____ State or Province: _____

INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL

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

APPLICANT'S EDUCATIONAL HISTORY

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

_____

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

If yes, indicate where the applicant completed premedical school.

Applicant's Undergraduate School: _____

Undergraduate School Address: _____

Enrollment and Participation:

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

attended our medical school for a total of _____ weeks (must be included) of continuous medical education on the

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

This applicant:

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

☐ **will be awarded** the degree of _____ on _____/_____/_____
(Form B must also be completed and returned directly to the Board.) month/day/year

☐ **was not awarded** a degree because: _____

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

		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, participation in an 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?	☐	☐

Please provide a detailed explanation for any of the above questions _____

_____

AFFIX INSTITUTIONAL SEAL HERE

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

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

Signature: _____

Print Name: _____

Title: _____

Date: _____/_____/_____ Telephone: (_____)_____

E-mail address: _____

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

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POSTGRADUATE TRAINING VERIFICATION

APPLICANT'S AUTHORIZATION: I authorize the release of information from my postgraduate training program listed below, as requested by the Massachusetts Board of Registration in Medicine.

Applicant's Signature: _____ Date: _____

Print or Type Name: _____

Name and Address of Institution: _____

_____

_____

TO BE COMPLETED BY PROGRAM DIRECTOR

Please complete this form and forward it to the applicant in a **sealed envelope, signed across the seal**.

Name of Institution: _____

Name of Institution, if different when applicant attended: _____

Verification for: _____
(Print applicant's name)

Program Type (Report internships, residencies, and fellowships separately.)	**PGY** (1,2,3,4, etc.)	**Department or Type of Specialty Training** (Use one section per department/specialty. If the department/specialty was a "rotating" or "transitional" program, please provide a schedule of rotations.)	**Dates Attended** (Month/Day/Year) **FROM**	**TO**	**Completed** (Yes/No/In Progress)	**Accredited by** (ACGME, AOA, RSC, or not accredited)
			/ /	/ /		
			/ /	/ /		
			/ /	/ /		
			/ /	/ /		
			/ /	/ /		

Report incomplete training levels (years) separate from those that were successfully completed. If the training level (years) is currently in progress, report the expected completion date in the "TO" field.

APPLICANT'S NAME: _____

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

QUESTIONS	**YES**	**NO**
1. Did the applicant take any leaves of absence or breaks from his/her postgraduate training?	☐	☐
2. Was the applicant ever placed on probation?	☐	☐
3. Was the applicant ever disciplined or under investigation?	☐	☐
4. Were any negative reports ever filed by instructors regarding the applicant?	☐	☐
5. Were any limitations or special requirements imposed on the applicant because of questions of academic incompetence or disciplinary problems?	☐	☐

COMMENTS: _____

_____

_____

Certification: I hereby certify that the above information is an accurate account of this individual's record and is true and correct.

AFFIX INSTITUTIONAL SEAL HERE

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

Program Director's Signature: _____

Print Name: _____

Academic Title: _____

Telephone: (_____)_____ Today's Date: ____/_____/_____

E-mail address: _____

PLEASE RETURN THIS COMPLETED FORM TO THE APPLICANT IN A SEALED ENVELOPED WITH YOUR SIGNATURE ACROSS THE SEAL OF THE ENVELOPE.

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EVALUATION FORM

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

Signature of applicant:_____ Date:____/_____/_____

Please PRINT your name:_____

Name of facility:_____ State:_____

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

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

   A. In what capacity? ☐ supervisory ☐ other:_____

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

   C. Applicant's Status: ☐ Intern ☐ Resident ☐ Fellow ☐ Staff Member ☐ Other _____

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

   _____

   _____

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

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

(Continued on page 2)

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

_____

_____

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.

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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: _____

Additional forms available at the Board's website at www.mass.gov/massmedboard.

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NAME CHANGE AND DUPLICATE LICENSE REQUEST

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

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

Please submit the following:

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

Print Name: _____MA License #:_____

Print new name: _____

Mailing Address:_____

City:_____ State: _____ Zip: _____

For Office use only

Date Rec: _____/_____/____ ☐ Photograph notarized/dated ☐ Board photograph confirmed

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

Date Completed: ____/____/____ Board Staff _____

Approved by: _____Date:_____/_____/_____

NOTARY PUBLIC ATTESTATION FOR NAME CHANGE

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

IDENTIFICATION PHOTOGRAPH

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

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

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

_____ Date:_____/_____/_____
Signature of Applicant:

Print Name:_____

NOTARY ATTESTATION

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

Subscribed and sworn to before me:

_____ Date:_____/_____/_____
Signature of Notary:

_____
Print name of Notary:

My commission expires:_____

Notary Public Seal or Stamp

FORM E-1 **Return to: Board of Registration in Medicine, 200 Harvard Mill Square, Suite 330, Wakefield, MA 01880**

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

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

Name of Applicant:_____ Training Institution: _____

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

Signature of Dean or Designated Official: _____ SCHOOL SEAL

Name (please print): _____

Title: _____

Date: _____

Name of Applicant:____

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

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

ELECTIVE MEDICAL SCHOOL CLINICAL STUDY VERIFICATION

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

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

Name of Applicant:_____

Clinical Area:_____ Type (Elective or Required):_____

Dates of Attendance: From _____/_____/_____ To _____/_____/_____ Weeks of Credit:_____

Name of Instructor or Supervisor:_____

Name of Program Director:_____

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

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

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

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

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

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

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

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

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

_____

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

SIGNED:_____ DATE:_____

Name and Title (please print or type):_____

Name and Address of Institution:_____

HOSPITAL SEAL (If no seal, indicate so) _____

COMMONWEALTH OF MASSACHUSETTS

BOARD OF REGISTRATION IN MEDICINE

POLICY 91-01

(Adopted January 9, 1991)

BOARD PROCEDURE REGARDING REQUEST FOR WAIVER OF 243 CMR 2.03(1)(B): FULL LICENSURE

In situations where an 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 M.G.L. c.112, § 2, requires that the Board determine that the applicant's course of medical education is substantially equivalent, in its entirety, to a U.S. medical school graduate's education. In addition, the Board must determine that the licensure of this applicant would not impair the public health, safety, and welfare. It is the applicant's responsibility to demonstrate s/he is qualified under both of these standards.

The Licensing Committee will review each such application on a case-by-basis. The assessment and determination of the applicant's equivalency of complete medical education 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. Number of years and quality of post-training practice (evaluations required)
5. Licensure in other states
6. American Specialty Board Certification
7. Other distinctions: honors, awards, publications
8. Results of SPEX exam (applicable only in certain cases)
9. Licensing Committee recommendation from personal interview with applicant (interview to include, but not be limited to, inquiry regarding the applicant's education, professional commitment and assessment of communication skills).

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.

APPLICANT'S NAME _____

FORM J: WAIVER REQUEST

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

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

_____

_____

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

_____

_____

_____

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

_____

_____

_____

_____

_____

_____

_____

_____

_____

APPLICANT'S NAME _____

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

_____

_____

_____

_____

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

_____

_____

_____

_____

_____

_____

_____

_____

_____

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

NAME OF STATE: _____ _____ _____ _____ _____

LICENSE STATUS (current or inactive): _____ _____ _____ _____ _____

APPLICANT'S NAME _____

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

Name of Specialty Board: _____ Date Certified: ____/____/____

Name of Specialty Board: _____ Date Certified: ____/____/____

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

_____

_____

_____

_____

9. Indicate SPEX exam results (if taken): _____

APPLICANT'S SIGNATURE _____DATE: ____/____/____