IMPORTANT INFORMATION FOR THE FULL LICENSE 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. When sending your application and supplement, please use one of the tracking services offered by the post office or commercial shippers. After receipt of your license application, the Board will notify you via email about any additional documentation needed--this may take up to eight weeks. The Licensing Division staff reviews applications in the order they are received.

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.

The Board encourages you to 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 licensing service, carefully review your application prior to its submission to ensure its accuracy.
- Questions about your application should be directed to the Licensing Analyst assigned to your application.

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 full license application process, a physician is required to provide a number of primary source documents verifying information including, but not limited to: medical education, postgraduate training, examination scores; malpractice claims history; disciplinary action, criminal history, competency and moral character. Timely completion of a full license application is intensive and requires the applicant’s cooperation to supply all required documents.

A full license application cannot be deemed complete until all of the required documentation is received and reviewed by the Board. Typically, a full license application, received from August through December, can be issued in approximately twelve (12) 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 sixteen (16) weeks to process due to the larger volume of applications received during those months.
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GENERAL INFORMATION

Previous Full 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.

Previous Limited License in Massachusetts: If you ever held a limited license in Massachusetts and are now seeking a full license, you must complete all parts of the full license application except for the Medical Education Verification Form.

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.

DEA and Controlled Substance Registration: If you wish to prescribe or dispense drugs, you must apply for a Massachusetts Controlled Substance Registration. Go to 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) 973-0949. For DEA registration go to the DEA website at www.deadiversion.usdoj.gov and follow the instructions.

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.

Application Processing Time/Review: The application review process is defined by the Board of Registration in Medicine’s statutes, regulations and policies. The Board and its staff must comply with those requirements in processing applications. Applications are processed in the order in which they are received at the Board. After receipt of your full license application, the Board will notify you about any additional documentation needed – this may take up to eight weeks. An application will not be deemed complete until all required application documents and verifications are received and reviewed by the Board and its staff. If any information or documents are missing or incomplete, your full license may be significantly delayed.

Licensing Services/Communication with Third Parties: If you employ a licensing service to assist you with the licensing process, you must provide a letter confirming this representation and directing Board staff to communicate with the licensing service on your behalf.

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).

Interview: During the licensing process, you may be invited for a personal interview with the Board, and/or the Licensing Committee regarding your license application. Unless otherwise indicated, all meetings of the Board or any of its Committees are held at the Board office at 200 Harvard Mill Square, Suite 330, Wakefield, Massachusetts.
**Full License Application Kit:**

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](http://www.mass.gov/massmedboard).

**The Following Documents Must be Submitted to Complete your Application:**

- Full License Application
- Current Curriculum Vitae
- Examination Transcripts (sealed envelope; through FCVS; or electronically through FSMB)
- Electronic Health Records (EHR) Proficiency Form
- 90-Day Form
- Certificate of Moral and Professional Character – (must be notarized and provided in a sealed envelope)
- Authorization for Release of Information, Documents and Records Form
- CORI Acknowledgment Form (must be notarized)
- Application Supplement (All questions must be answered) For any “yes” answers you must submit:
  - Corresponding explanation page for any “yes” answers.
  - Required supporting documentation for any “yes” answer.
- Medical Education Verification Form (sealed envelopes or through FCVS)
- Postgraduate Training Verification Form (sealed envelopes or through FCVS)
- Supervisory Evaluation Form(s) (sealed envelopes)
- Malpractice History Request Form (listing all liability carriers since obtaining your first full license)
- Malpractice history reports from all liability carriers since obtaining your first full license
- National Practitioner Data Bank Report (sealed envelope)
- AMA/AOA Physician Profile (electronically)
- State License Verifications (electronically, Veridoc, sealed envelope)
- ECFMG Certificate (international medical graduates only)
- Medical School Transcripts and notarized copy of Diploma (international medical graduates only)

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.

**Important Notes:**

- Provide a complete and accurate response for every question on the application and application forms.
- All documents should be submitted as one-sided.
- 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.
- The Board requires that many documents be current within 6 months of the date of license approval; therefore, please ensure that the information you provide is current and all documents are signed and dated just prior to submission.

**Documents in a license application that must be updated after 6 months:**

- Full license application
- Application Supplement
- Malpractice History Request form
- Liability reports from all liability carriers
- State license verifications
- NPDB Profile; and
- Supervisory Evaluation form(s) (*expires after 4 months*).
FULL LICENSE APPLICATION INSTRUCTIONS

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.

Type of License
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.

U.S./Canadian Graduate
Graduates of medical schools in the United States, Canada or Puerto Rico, should follow the instructions for U.S. graduates.

International Graduate
Graduates of all medical schools not located in the United States, Canada, or Puerto Rico, should follow the instructions for international medical graduates.

FCVS
The Massachusetts Board of Registration in Medicine accepts the FCVS (Federation Credentials Verification Services) for verification of core credentials which includes medical school, postgraduate training, examination scores and ECFMG verification. If you choose to utilize FCVS, you may obtain information at [www.fsmb.org](http://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 do not need to submit the following Board application forms/primary source documents:**
- Medical Education Verification Form
- Postgraduate Training Verification Form
- Examination Transcripts (USMLE)
- ECFMC Verification

Applicants must complete all additional Board application forms and request all other primary source documentation to complete their application.

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.
Email and Mailing Address
The Board will use your email and mailing address for all correspondence with you.

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

Medical School
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.
List all medical schools attended, regardless of whether a degree was issued.

Timeline of Activities since Graduation from Medical School
Provide a chronological listing by month and year of all activities since graduation from medical school. This would include all postgraduate training, research activities, hospital affiliations, medical staff appointments, faculty appointments, private practices, military assignments, locum tenens and telemedicine assignments and any other employment or volunteer activities. Also include periods of unemployment or any activities outside of the practice of medicine. You must account for any time gaps of 30 days or more since your graduation from medical school. Failure to complete this section or address any time gaps may result in delay of licensure. Attach a separate sheet of paper if necessary. Do not write, “See CV” or “See attached;” you must complete this section AND attach your curriculum vitae. If none, enter “N/A”.

You MUST account for any time gaps of 30 days or more since your graduation from medical school. (For Example: if you graduated from medical school on May 30, 2015 and started residency on July 1, 2015, you must account for this gap of 30 days on your timeline below.)

Examinations Requirements
Please list all the licensing examinations you have completed. Please contact the appropriate examination entity and have the examination scores sent to you in a sealed envelope or sent electronically to the Board.

USMLE/COMLEX Seven-Year Rule: Please note that the Board’s regulations require that all Steps of the USMLE and all levels of the COMLEX must be completed within a seven (7) year time period, beginning with the examination date when the examinee first passes his/her first Step/Level. The Board may grant a waiver of the seven-year examination completion requirement in two types of cases:

1) A waiver may be granted to an applicant who is actively pursuing another advanced doctoral study (i.e.: M.D./Ph.D. joint degree program) and completed all three steps/levels within 10 years; or
2) For all other individuals, 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.

If requesting a waiver of the Board’s seven-year examination rule on the basis of your participation in a joint-degree program (see #1 above) you must submit a written request for a waiver, which confirms your participation in a joint-degree program.

If requesting a non-joint degree waiver of the Board’s seven-year examination rule (see #2 above) you must submit a written request for a waiver, which addresses the three factors (a. – c.) noted above. Additionally, you must arrange for submission of your postgraduate training evaluative files.
USMLE Step 3/COMLEX Level 3 Attempt Limit: 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. An applicant who fails USMLE Step 3 or COMLEX Level 3 on his/her fourth attempt is not eligible for licensure. In very limited and extraordinary circumstances, the Board may grant a case-by-case exception to the Step 3/Level 3 attempt limited 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.

If requesting a waiver of the Board’s Step 3/Level 3 attempt limit you must submit a written request for a waiver, which addresses the three factors (a. – c.) noted above. Additionally, you must request arrange for submission of your postgraduate training evaluative files.

Please see below for additional information on requesting copies of your examination transcripts.

- **USMLE** - You may access the Federation of State Medical Boards (FSMB) at [www.fsmb.org](http://www.fsmb.org) to request a transcript. If you are using FCVS, your exam transcript will be sent to the Board with your credentials packet.

- **COMLEX** - You may access the National Board of Osteopathic Medical Examiners (NBOME) website at [www.nbome.org](http://www.nbome.org) to request a transcript.

- **MCCQE** - Applicants providing documentation of examination from the Medical Council of Canada (MCC) must request their MCCQE transcripts be released to the Massachusetts Board. The MCC will electronically send this information to the Massachusetts Board. Information regarding file transfer is located at [https://mcc.ca](https://mcc.ca).

- **FLEX** - Contact the Federation of State Medical Boards (FSMB) at [www.fsmb.org](http://www.fsmb.org) to request FLEX transcript. 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.

- **State Board Examination** - A State Board examination taken after June 19, 1970 will not be accepted for licensure. Verification of a State Board examination take prior to June 19, 1970 must be sent to the Board in a sealed envelope.

**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](http://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. Full license applicants must complete the requirement for training prior to submission of an application to the Board. This is a one-time requirement.

Physicians may comply with the training requirement through:

- Receiving training in child abuse or neglect assessment in medical school 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).

Requirement to Complete Training and Education on the Issue of Domestic and Sexual Violence
M.G.L. c. 112, §264 requires a physician to complete training and education on the issue of domestic violence and sexual violence. Full license applicants must complete the requirement for training prior to submission of an application to the Board. This is a one-time requirement. Physicians may comply with the training and education requirement through the completion of the following on-line training program: https://www.mass.gov/service-details/domestic-and-sexual-violence-integration-initiatives

MassHealth Enrollment
Physicians (including interns and residents) are eligible to order, refer or prescribe services for MassHealth members and, under state law, must apply to enroll with MassHealth at least as ordering and referring (nonbilling) providers in order to obtain and maintain state licensure. Providers who are already enrolled with MassHealth have already met the requirement and do not need to take further action.

MassHealth has created a Nonbilling Provider Application for providers in provider types that are not eligible to enroll as fully participating providers. This application can also be used by providers who are eligible to enroll in MassHealth as fully participating providers but who choose not to at this time. Physicians must apply to enroll with MassHealth at least as ordering and referring (nonbilling) providers in order to obtain and maintain state licensure. Providers who are already enrolled with MassHealth have already met the requirement and do not need to take further action.

Providers who wish to apply to enroll as nonbilling providers must download the materials from the MassHealth website at https://www.mass.gov/files/documents/2018/10/09/penbp.pdf and send their completed and signed Nonbilling Provider Application and Nonbilling Provider Contract by mail to the MassHealth Customer Service Center at:

MassHealth Customer Service Center
Attn: Provider Enrollment and Credentialing
P.O. Box 121205
Boston, MA 02112-1205

Providers who have questions, or if eligible, would like to request a fully participating provider application should contact the MassHealth Customer Service Center at 1-800-841-2900 with any questions or, if eligible, to request a fully participating provider application.

Curriculum Vitae (CV)
Please submit a current CV (month and year format) with your application.

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

Board Certification
Please indicate if you are certified by the American Board of Medical Specialties (ABMS) or the American Board of Osteopathic Medicine (AOA) and provide a listing of all ABMS and AOA certifications.

Practice Specialty
Provide a listing of the medical specialty(ies) that you practice. The medical specialties listed will be included on your Physician Profile on the Board’s website to help consumers locate physicians in specific specialties. If you are currently completing a postgraduate training program list the program specialty in this section.

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ELECTRONIC HEALTH RECORD (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.

90-DAY LICENSE RENEWAL FORM

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 indicate on the Board’s 90-Day Form if you do not want your application to be presented to the Board until ninety (90) days before your birthdate.**

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. This form must be sent to the Board in a sealed envelope with the certifying physician’s signature across the seal.

AUTHORIZATION FOR RELEASE OF INFORMATION, DOCUMENTS AND RECORDS FORM

Sign and date the Authorization for Release of Information, Documents and Records form.

CRIMINAL OFFENDER RECORD INFORMATION (CORI) ACKNOWLEDGEMENT FORM

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.
APPLICATION SUPPLEMENT

Every question on the Application Supplement must be answered “yes” or “no.” It is your responsibility to report to the Board immediately if your responses change while your application is pending.

For every “yes” answer you must:
1) provide an explanation on the corresponding explanation page for that question; AND
2) arrange for the appropriate agency or institution to submit copies of all official documentation related to the underlying occurrence or action. Documents should be sent either directly to the Board from the appropriate agency/institution or to you in a sealed envelope. If the documents are sent to you, the sealed envelopes must be included with your full license application or sent directly to the Board unopened.

Please review each question carefully to ensure your answers are accurate prior to submitting your application. You are personally responsible for all information disclosed on your application, including any responses that may have been completed on your behalf by others. It is imperative that you honestly and fully answer all questions, regardless of whether you believe the information requested is relevant. Your responses on your application are evaluated as evidence of your candor and honesty. An honest “yes” answer to a question on your application is not definitive as to the Board’s assessment of your present moral character and fitness to practice, but a dishonest “no” answer may be evidence of a lack of candor and honesty, which may be definitive on the character and fitness to practice issue. Please be advised that a false response to any of these questions may be grounds for denial of licensure and reported to the appropriate data banks.

Post-Secondary Education – College/Graduate/Medical School: (Questions # 1-6)
If you have any concerns on how to answer any of the questions in this section, please confirm with your college/graduate/medical school on how to appropriately answer the question. The Board will confirm all answers with the primary source.

#1. Answer “yes” if you have ever been the subject of any disciplinary action while enrolled in college, medical school or graduate school. 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. If you answered “yes” please use the explanation page provided on page 7.

#2. Answer “yes” if you have ever been terminated from a medical school for any reason. If you answered “yes” please use the explanation page provided on page 7.

#3. Answer “yes” if you have ever withdrawn or transferred from a medical school, regardless of the reason. If you answered “yes” please use the explanation page provided on page 7.

#4. Answer “yes” if you have you ever been granted a leave of absence by a medical school, including a leave for research, public service, participation in a joint degree program such as an M.D./Ph.D. program, medical leave or for any other “personal reasons”. Please provide the dates and circumstances of the leave in your explanation. If you answered “yes” please use the explanation page provided on page 7.

#5. Answer “yes” if you have ever been placed on probation or remediation by a graduate/medical school. If you answered “yes” please use the explanation page provided on page 7.

#6. Answer “yes” if as an US/Canadian graduate you took more than four years to complete medical school. Answer “yes” if as an international graduate you took more than six years to complete medical school. If you answered “yes” please use the explanation page provided on page 7.
Postgraduate Training Section: (Questions #7 – 15)

If you have any concerns on how to answer any of the questions in this section, please confirm with your postgraduate training program on how to appropriately answer the question. The Board will confirm all answers with the primary source. If you answered “yes” please use the explanation page provided on page 7.

#7. Answer “yes” if you have ever been the subject of any disciplinary action or under investigation while enrolled in postgraduate training. 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. If you answered “yes” please use the explanation page provided on page 7.

#8. Answer “yes” if you have ever been suspended, terminated or dismissed from any postgraduate training program for any reason. If you answered “yes” please use the explanation page provided on page 7.

#9. Answer “yes” if you have ever had to repeat a year of postgraduate training for any reason. If you answered “yes” please use the explanation page provided on page 7.

#10. Answer “yes” if you have ever withdrawn or transferred from a postgraduate training program for any reason. If you answered “yes” please use the explanation page provided on page 7.

#11. Answer “yes” if you have ever been granted a leave of absence from a postgraduate training program, including a leave for research, public service, medical leave or for any other “personal reasons”. Please provide the dates and circumstances of the leave in your explanation. If you answered “yes” please use the explanation page provided on page 7.

#12. Answer “yes” if you have ever been placed on probation or remediation by a postgraduate training program. If you answered “yes” please use the explanation page provided on page 7.

#13. Answer “yes” if any limitations or special requirements were imposed on your because of questions of competency or disciplinary problems during postgraduate training. If you answered “yes” please use the explanation page provided on page 7.

#14. Answer “yes” if you ever received partial or no credit for time spent in a postgraduate training program. If you answered “yes” please use the explanation page provided on page 7.

#15. Answer “yes” if you have ever had a postgraduate training program contract not renewed for any reason. If you answered “yes” please use the explanation page provided on page 7.
Actions by Any Health Care Facility, Employment, Professional Organization, State Board or Any Other Governmental Agency Section: (Questions # 16 – 26)

If you have any concerns on how to answer any of the questions in this section, please confirm with the appropriate facility/organization/agency on how to appropriately answer the question. The Board will confirm all answers with the primary source.

#16. Answer “yes” if you have 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 this would include the time period beginning from college on through your professional career. If you answered “yes” please use the explanation page provided on page 7.

#17. Answer “yes” if you have denied a medical license, whether full, limited, temporary, or have you withdrawn an application for medical licensure for any reason. If you answered “yes” please use the explanation page provided on page 7.

#18. Answer “yes” if you have ever surrendered a license to practice medicine or any professional license or if your license or certificate has ever been revoked. For purposes of this question you do not need to report a lapsed license. If you answered “yes” please use the explanation page provided on page 7.

#19. Answer “yes” if you have been denied American Board of Medical Specialties or American Board of Osteopathic Medicine certification or if your certification ever been suspended or revoked. If you answered “yes” please use the explanation page provided on page 7.

#20. Answer “yes” if you are aware of any pending investigation or inquiry into your professional conduct by any entity or if any disciplinary charges are pending against you. If you answered “yes” please use the explanation page provided on page 7.

#21. Answer “yes” if any disciplinary action has ever been taken against you since completing postgraduate training. A confidentiality agreement does not absolve you of your requirement to answer this question. If you answered “yes” please use the explanation page provided on page 7.

#22. Answer “yes” if your medical staff membership, medical privileges, medical staff status or association with a health care facility have ever been limited, suspended, revoked, not renewed or subject to probationary conditions or if processing toward any of those ends has been instituted or recommended by a medical staff committee, administration or governing board. If you answered “yes” please use the explanation page provided on page 7.

#23. Answer “yes” if you have withdrawn an application for hospital privileges or appointment, or have ever been denied medical staff membership, advancement in medical staff status or association with a health care facility, or if such denial has been recommended by a medical staff committee, administration or governing body. If you answered “yes” please use the explanation page provided on page 7.

#24. Answer “yes” if your privilege to manufacture, distribute, administer, possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted or surrendered, or if you have ever been called before or warned by any state or other jurisdiction including a federal agency regarding such privileges. If you answered “yes” please use the explanation page provided on page 7.

#25. Answer “yes” if your professional liability insurance provider has ever restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition on your coverage or if you have ever voluntarily restricted, limited or terminated your insurance coverage in response to any inquiry by a professional liability insurance provider. If you answered “yes” please use the explanation page provided on page 7.
#26. Answer “yes” if you have ever had an application for membership as a participating provider denied by any third-party payor, Medicare or Medicaid (any state) or if you have ever been the subject of any termination, suspension or probation proceedings instituted by any third-party payor, Medicare or Medicaid (any state) or if you have ever been restricted from receiving payments from any third-party payor, Medicare, Medicaid (any state). If you answered “yes” please use the explanation page provided on page 7.

**Criminal History Section: (Question #27)**

#27. Answer “yes” if you have ever been charged with any criminal offense. This includes being arrested, arraigned, indicted or convicted, even if the charges against you were dropped, filed, dismissed or otherwise discharged. A charge of operating under the influence or its equivalent is reportable. A medical malpractice claim is a civil, not a criminal, matter and need not be reported for purposes of this question. If in doubt as to whether an arrest or criminal offense must be disclosed, it is best to disclose the action on your application.

If you answered “yes” please use the explanation page for question #27 located on page 8. A separate explanation page is to be used for each criminal incident. You must also arrange for the following supporting documentation to be sent directly to the Board or to you in a sealed envelope: 1) **Court Records:** The appropriate court or your lawyer must send certified copies of all court records related to the offense; and 2) **Police Records:** The appropriate arresting/ticketing agency or your lawyer must send certified copies of the arrest/offense/incident report or citation/ticket. If a court, an arresting/ticketing agency or your lawyer is unable to provide copies of the applicable records, request that they furnish a written statement to that effect.

If the criminal charge(s) against you have been formally expunged or sealed the charges, offenses, arrests, tickets or citations need not be disclosed for purposes of this question. However, it is your responsibility to ensure the offense, arrest, ticket or citation has, in fact been expunged or sealed. Failure to reveal an offense, arrest, ticket or citation that is not in fact expunged or sealed, raises questions related to truthfulness in addition to questions regarding the offense itself. **You may have been told your record is expunged or sealed when in fact it is not.**

If, during the course of the application process, information about an offense is discovered which you did not disclose because you believed it to be expunged or sealed, you will be required to provide a copy of the expunction or sealing order.

**Medical Malpractice History Section: (Question #28)**

#28. Answer “yes” if any medical malpractice claim has ever been made against you, whether or not a lawsuit was filed in relation to the claim. This includes any medical malpractice claims that have been made against you, even if the claim against you was dropped, dismissed, settled, adjudicated or otherwise resolved or not pursued.

If you answered “yes” you must complete the explanation pages for question #28 located on pages 9-10. You must complete separate explanation pages for each malpractice claim. You must also arrange for your lawyer or liability carrier to provide the following documents directly to the Board or to you in a sealed envelope: **Pending Claim:** 1) malpractice history report from your liability carrier or letter from your attorney that includes the claimant’s name/initials and confirmation that the claim is open/pending; and 2) a copy of the Complaint, Notice of Intent to File a Claim or other claim letter. **Closed Claim:** 1) malpractice history report from your liability carrier or letter from your attorney that includes the claimant’s name/initials and confirmation that the claim is closed; 2) a copy of the Complaint, Notice of Intent to File a Claim or other claim letter; and 3) a copy of the final judgment, settlement and release or other final disposition of the claim, even if you were dismissed from the case by the court.
Confidential Information Section: (Questions #29-31)

For purposes of answering questions #29 – 31, “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, or within the past two years.

#29. Answer “yes” if you have a medical or physical condition that currently impairs your ability to practice medicine. Your explanation of a “yes” answer should include 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.

#30. Answer “yes” if you engaged in the use of any substance(s) with the result that your ability to practice medicine is currently impaired. Your explanation of a “yes” answer should include the specifics of your treatment, if any, 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.

#31. Answer “yes” if you have ever refused to submit to a test to determine whether you had consumed and/or were under the influence of chemical substances. This would include, but is not limited to, refusal to submit to a breathalyzer test. If you answered “yes” your explanation should include a description of the circumstances leading to your refusal to take the screening test and any resulting criminal or disciplinary consequences.

**Important Note Regarding Physician Wellness**

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

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

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

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.

**FCVS:** If you are using FCVS to verify your medical education, you do **not** need to complete the Board’s Medical Education Verification Form.

**Prior Limited License:** 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 form again.

POSTGRADUATE TRAINING VERIFICATION FORM

To be eligible for a full license, the Board requires completion of the following postgraduate training:

- **U.S. graduates:** Two (2) years of postgraduate training in an ACGME, AOA or Canadian accredited training program.

- **International medical graduates:** Three (3) years of ACGME, AOA or Canadian accredited postgraduate training program.

The Board requires applicants to submit primary source verification of all postgraduate training done at facilities located in the U.S., Puerto Rico or Canada, regardless of whether the program was completed or not.

Complete the authorization statement at the top of the Postgraduate Training Verification Form and send 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. The Postgraduate Verification Form must be received by the Board in a sealed envelope.

**Note:** If you have not yet completed the required years of postgraduate training, the Board will require your Postgraduate Training Verification Form to be updated by your program director upon your completion of the required years of training.

**FCVS:** If you are using FCVS to verify your postgraduate training, you do **not** need to complete the Board’s Postgraduate Verification Form.

**Research Fellowship:** If you completed any research fellowships please request a letter from your Fellowship Director or Research Supervisor, which should be on the facility letterhead and confirms your participation in the research fellowship, including the dates of your participation.
SUPERVISORY BOARD EVALUATION FORM

At least one (1) year of current evaluations are required. The Board’s Supervisor Evaluation Form must be completed by a supervising physician, such as a training program director, chief medical officer, department chairperson, chief of service, medical director or other supervising physician who can evaluate your clinical performance. If your most recent clinical practice was while you were enrolled in a training program, the Evaluation must be completed by the training program director. The Evaluator must have no financial interest in your licensure in the State of Massachusetts. The Form must be received by the Board in a sealed envelope with the evaluator’s signature across the seal.

Physicians in private practice who have not had any affiliations with a healthcare facility within the past four (4) years must obtain Supervisory Evaluation forms from three physicians who refer patients to them for clinical care.

Locum tenens physicians must have Supervisory 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. The Board reserves the right to require additional Supervisory Evaluation forms be submitted in connection with your application for licensure.

MALPRACTICE HISTORY REQUEST FORM

Complete the Malpractice History Request Form listing all liability carriers, in chronological order, beginning from the date that your first full license was issued in any state 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 from the date that your first full license was issued, whether or not a claim or suit was filed against you.
- Send the signed original Malpractice History Request Form back to the Board along with your full license application.
- If you were enrolled in a postgraduate training program, 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.

Note: 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 liability carrier that took over in the merger or the Division of Insurance in the state where the liability carrier was registered.
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 and Pennsylvania will only send license verifications directly to the Massachusetts Board of Registration in Medicine. If the other state medical board provides license verifications through Veridoc, your license verification will be sent electronically to the Massachusetts Board. The license verifications will be held in a pending file until your completed full license application is ready to be processed.

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.

NATIONAL PRACTITIONER DATA BANK (NPDB) PROFILE

License applicants must request a self-query profile from the National Practitioner Data Bank (NPDB). You may access the NPDB at www.npdb.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 $4.00 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. DO NOT OPEN THE ENVELOPE when you receive the paper copy of your NPDB profile. 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.

AMA PHYSICIAN PROFILE

The AMA Physician Profile may be requested online at https://commerce.ama-assn.org/amaprofiles/, or you may contact the AMA Unified Service Center for ordering assistance at (800) 665-2882. The AMA Physician Profile will be sent electronically directly to the Board.

AOA 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.
**INTERNATIONAL MEDICAL GRADUATES ONLY**

**Education Commission for Foreign Medical Graduates (ECFMG) Status Report**

An ECFMG Status Report may be requested at [https://cvsonline2.ecfmg.org/ImgGenInfo.asp](https://cvsonline2.ecfmg.org/ImgGenInfo.asp). The ECFMG Status Report will be sent electronically to the Board. If you are using FCVS, your ECFMG verification will be provided to the Board in your FCVS credentials packet.

**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 by a U.S. notary and, if it is not in English, it must be translated by a U.S. translation company.

**J WAIVER FORM – Substantial Equivalency of Medical School Education/Off-Site Clinical Rotations:**

If an applicant completed more than three (3) months of any required or elective clinical rotations during medical school outside of the primary teaching hospital of their medical school of attendance, they must submit the following: J Waiver Form and E-1 Form and E-2 Forms. You must send a copy of the E-1 Form to your medical school and the E-2 Forms must be forwarded to the program director at the facility where you completed each clinical clerkship rotation. E-2’s must be sent to the Board in sealed envelopes.

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 and outlined in the J Waiver Form. If the Board determines that an applicant is not eligible for a waiver of substantial equivalency of medical school education, the Board may preliminarily deny the application for licensure based upon a determination that the applicant does not meet the requirements for licensure set forth in the Board’s statutes and regulations. 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 the following medical schools is substantially equivalent to U.S. medical school training. Graduates of the following medical schools do not have to complete the J Waiver Form or Forms E-1 and E-2:

- St. George’s University School of Medicine;
- SABA University;
- Ross University School of Medicine; and
- The American University of the Caribbean.
TELEPHONE DIRECTORY AND WEBSITE ADDRESSES

American Medical Association ................................................................. (800) 621-8335
www.ama-assn.org

American Osteopathic Association ......................................................... (888) 626-9262
www.osteopathic.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) 973-0949
https://www.mass.gov/orgs/massachusetts-controlled-substances-registration

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.hrsa.gov
FULL LICENSE APPLICATION

Non-refundable Application Fee: A $600.00 check or money order payable to the Commonwealth of Massachusetts must be included with your full license application.

Type of License:  □ Initial Full License  □ Administrative License  □ Volunteer License

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

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

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.)

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.)

Degree Type:  □ M.D.  □ D.O.  □ PhD  □ Other degree____________________________

□ Male  □ Female  Social Security Number: _________/_______/___________

NPI Number: ________________________________________________

Date of Birth: _______/_____/______  Place of Birth: __________________________________

Month  Day  Year  City/State  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
PRINT NAME: ______________________________________________________ DATE: ___/___/____

Business Address: __________________________________________ Telephone: _______________

Number and Street

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

*Email Address: ______________________________ Fax number: ______________________________

* The Board will use your Email and/or Mailing Address for all correspondence

Pre-medical School

From To
Name:_____________________________ Degree: _______________ Year:_______ Year:_______

City:_________________________ State:___________ Country: _________________________________

Name:_____________________________ Degree: _______________ Year:_______ Year:_______

City:_________________________ State:___________ Country: _________________________________

Medical School

Name:_____________________________ Degree:_____________________

Street:_____________________________ City:_______________________ State:________

Name:_____________________________ Degree:_____________________

Street:_____________________________ City:_______________________ State:________

Medical School Graduation Date: ____/______
Month Year

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Timeline of Activities since Graduation from Medical School:

Please provide a chronological listing by month and year of all activities since graduation from medical school. This would include all postgraduate training, research activities, hospital affiliations, medical staff appointments, faculty appointments, private practices, locum tenens and telemedicine assignments and any other employment or volunteer activities. Also include periods of unemployment or any activities outside of the practice of medicine. Failure to complete this section or address any time gaps may result in delay of licensure. Do not write, “See CV” or “See attached”; you must complete this section AND attach your curriculum vitae.

You MUST account for any time gaps of 30 days or more since your graduation from medical school. (For Example: if you graduated from medical school on May 30, 2015 and started residency on July 1, 2015, you must account for this gap of 30 days on your timeline below.)

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<tr>
<th>Start Date (mm/yyyy)</th>
<th>End Date (mm/yyyy)</th>
<th>Institution/Place of Employment</th>
<th>Address (City, State/Country)</th>
<th>Position Held (Resident, Attending, Research Fellow, etc.)</th>
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<th>Start Date (mm/yyyy)</th>
<th>End Date (mm/yyyy)</th>
<th>Institution/Place of Employment</th>
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<th>Position Held (Resident, Attending, Research Fellow, etc.)</th>
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Examination History

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

Please list each medical licensure examination you have taken.

<table>
<thead>
<tr>
<th>Examination</th>
<th>Number of attempts</th>
<th>Passed (P) or Failed (F)</th>
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<tbody>
<tr>
<td>USMLE Step I</td>
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<td>☐ P ☐ F</td>
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<tr>
<td>USMLE Step II CK</td>
<td></td>
<td>☐ P ☐ F</td>
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<tr>
<td>USMLE Step II CS</td>
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<tr>
<td>USMLE Step III</td>
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<td>☐ P ☐ F</td>
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<tr>
<td>NBME Part I</td>
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<td>☐ P ☐ F</td>
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<tr>
<td>NBME Part II</td>
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<td>☐ P ☐ F</td>
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<tr>
<td>NBME Part III</td>
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<td>☐ P ☐ F</td>
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<tr>
<td>FLEX Component 1</td>
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<td>FLEX Component 2</td>
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<td>FLEX Pre-1985</td>
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<td>COMLEX Level 1</td>
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<td>COMLEX Level 2</td>
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<td>COMLEX Level 3</td>
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<td>MCCQE – Part I</td>
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<td>MCCQE – Part II</td>
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<td>State Board Exam</td>
<td>State of Examination: __________</td>
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1. **Opioid and Pain Management Training:** (You must check one. See Instructions.)
   - ☐ I completed three (3) credits of Board-approved CPD/CME credit in effective pain management. (i.e., www.opioidprescribing.com)
   - ☐ I do not prescribe controlled substances (Schedules II – VI).

2. **Child Abuse or Neglect Recognition and Reporting Training:** (You must check one. See Instructions.)
   - ☐ I received training in child abuse and neglect assessment in medical school or postgraduate training.
   - ☐ I completed a hospital sponsored training program in recognizing the signs of child abuse and neglect.
   - ☐ I completed a CPD/CME program in identifying and reporting child abuse and neglect.
   - ☐ I completed an online 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).
   - ☐ I completed a specialized certification (i.e., Child Abuse Pediatrics)

3. **Domestic and Sexual Violence Education and Training:** (You must complete. See Instructions.)
   - ☐ I completed the Massachusetts Department of Public Health online training in Domestic and Sexual Violence for licensed healthcare professionals. https://www.mass.gov/service-details/domestic-and-sexual-violence-integration-initiatives

4. **MassHealth Enrollment Requirement:** (You must check one. See Instructions.)
   - ☐ I am enrolled or have applied to enroll in MassHealth as a nonbilling provider.
   - ☐ I am enrolled or have applied to enroll in MassHealth as a billing provider.
     (Billing provider application must be requested through MassHealth at 1-800-841-2900)

5. **Curriculum Vitae:** (Required)
   - ☐ I have enclosed a current curriculum vitae (CV) with my application.

6. **Out-of-State Licensure:** List the state abbreviations where you currently or have ever had a full license:

   __________________________________________________________________________
   __________________________________________________________________________

7. **Board Certification:** (You must complete.)
   a) Are you certified by the American Board of Medical Specialties (ABMS)? ☐ Yes ☐ No
      If yes, list Board Certification(s):

   __________________________________________________________________________

   b) Are you certified by the American Board of Osteopathic Medicine (AOA)? ☐ Yes ☐ No
      If yes, list Board Certification(s):

   __________________________________________________________________________

8. **Practice Specialty:** List the medical specialty(ies) that you practice. The medical specialties listed will be included on your Physician Profile to help consumers locate physicians in specific specialties. (If you are completing postgraduate training, list that specialty here):

   __________________________________________________________________________

   __________________________________________________________________________

Full Lic App – Form 2 (Application), Page 6 of 7, Rev. 12/18
Please answer the following questions.

9. Reason for requesting a Massachusetts medical license:

________________________________________________________________________________________

10. Name of anticipated practice location/facility:

Address:____________________________________ City:____________________________

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

**Declaration and Signature**

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 and evidence or other credentials submitted herewith are true, correct and complete. I understand that any falsification or misrepresentation of any item or response on this application or any attachment hereto may be a sufficient basis for denying or revoking a license.

_________________________________________  _____/_____/_____
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 primary sources must be received as indicated below. If the document must be submitted in a sealed envelope, the facility seal or signature must be on the back of the envelope. DO NOT OPEN THE ENVELOPES.

<table>
<thead>
<tr>
<th>Description of Documents Required</th>
<th>Applicant Document Checklist</th>
<th>For Board use only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check for $600.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Must be from a U.S. bank (or a U.S. money order).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Made payable to the Commonwealth of Massachusetts.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Application cannot be processed without the fee.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Application fee is non-refundable.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full license application</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• All fields completed.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• All questions answered.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Complete timeline from the date of medical school graduation to the present is required (month/year format). Provide the Board with a written chronological description of all your professional and non-professional activities with no gaps.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Application signed and dated.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Current</strong> Curriculum Vitae (medical school graduation to present (month/year format))</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Electronic Health Records (EHR) Proficiency Form</td>
<td></td>
<td></td>
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<tr>
<td>• Questions answered.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Signed and dated.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>90-Day Form</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moral and Professional Character form (sealed envelope)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Must be notarized by a U.S. notary.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Authorization for Release of Information form</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Signed and dated.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CORI Acknowledgment Form</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Must be notarized by a U.S. notary.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• All fields with an asterisk are mandatory.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supplement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• All Questions answered.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Provide explanation for “yes” answers and additional documentation in accordance with instructions.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Supplement signed and dated.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Full Lic App – Form 1 (Checklist), Page 1 of 3, Rev. 1/18
<table>
<thead>
<tr>
<th>Medical Education Verification Form (sealed envelope or through FCVS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Postgraduate Verification Form(s) for ALL postgraduate training years. Form must be completed by postgraduate training program director or authorized agent (sealed envelopes or through FCVS).</td>
</tr>
<tr>
<td>For purely research postgraduate training, please provide a letter from the program/research director detailing the beginning and end date of the research postgraduate training (sealed envelope).</td>
</tr>
<tr>
<td>Supervisory Evaluation Form completed by a supervising physician (i.e. Chief Medical Officer; Department Chair; Program Director or physician who evaluates your clinical activities. The evaluator must confirm that s/he has no financial interest in your licensure in the Commonwealth of Massachusetts (sealed envelope).</td>
</tr>
<tr>
<td>Original Malpractice History Request Form listing ALL liability carriers with dates of coverage and policy numbers <strong>from the time your first full license was issued in any state.</strong></td>
</tr>
<tr>
<td>Malpractice history reports from all liability carriers listed on your Malpractice History form.</td>
</tr>
<tr>
<td>If malpractice claim: 1) malpractice claim report(s) or letter regarding malpractice claim from the attorney or liability carrier(s); 2) copy of the complaint or claim letter; and 3) if claim is closed, a copy of final judgment or other closing papers from the attorney or liability carrier(s). Attorney or liability carrier(s) should send this information directly to the Board (sealed envelope).</td>
</tr>
<tr>
<td>USMLE, NBME, AOA, LMCC or FLEX examination scores (sealed envelope; through FCVS; or electronically from the following websites:</td>
</tr>
<tr>
<td>- USMLE, FLEX - <a href="http://www.fsmb.org">www.fsmb.org</a></td>
</tr>
<tr>
<td>- NBME – <a href="http://www.nbme.org">www.nbme.org</a></td>
</tr>
<tr>
<td>- LMCC (Canada) – <a href="http://www.mcc.ca">www.mcc.ca</a></td>
</tr>
<tr>
<td>State License Verifications from current and past state license boards where you have held a full license (sealed envelopes; electronically from State Board; or Veridoc).</td>
</tr>
<tr>
<td>Either:</td>
</tr>
<tr>
<td>- AMA (American Medical Association) Physician Profile <a href="https://commerce.ama-assn.org/amanprofiles/">https://commerce.ama-assn.org/amanprofiles/</a> (sealed envelope or electronically); or</td>
</tr>
<tr>
<td>- AOA Osteopathic Physician Profile <a href="http://www.osteopathic.org">www.osteopathic.org</a> (sealed envelope or electronically)</td>
</tr>
<tr>
<td>National Practitioner Data Bank profile (sealed envelope) <a href="http://www.npdb-hipdb.hrsa.gov">www.npdb-hipdb.hrsa.gov</a></td>
</tr>
</tbody>
</table>
### International Medical Graduates ONLY:

- ECFMG Status Report (sent electronically) [www.ecfmg.org](http://www.ecfmg.org)
- Medical education transcript (An official medical school transcript prepared on university letterhead affixed with the signature of the dean or registrar. The transcript must be mailed directly from the medical school to the Board to be acceptable. If the medical education transcript is not in English, it must be translated by your medical school. If your transcript is in a language other than English, the Board will send a copy of the transcript to you to be translated by a U.S. translation company).
- Medical school diploma (A notarized (US Notary) copy of your medical school diploma is required. If the medical school diploma is not in English, it must be translated either by your medical school or a U.S. translation company).

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

(This applies only to applicants who 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.)

- Waiver Request (Form J) - All fields completed; signed; and dated.
- E-1 Form (send to medical school).
- E-2 Form (send to each program director where you completed a clinical clerkship. E-2 Forms must be returned directly to the applicant in a sealed envelope. DO NOT OPEN THE ENVELOPE. When all E-2 forms are collected, please forward to the Board).

The Board has determined that the medical education at the following medical schools is substantially equivalent to U.S. medical school training. Graduates of the following medical schools DO NOT need to complete a Waiver Request or Forms E-1 and E-2.

- St. George’s University School of Medicine;
- SABA University;
- Ross University School of Medicine; and
- The American University of the Caribbean.

### Interview – You will be notified if a personal interview will be required.

The following documents expire 6 months after date signed/run:

- Full License Application;
- Supplement;
- Malpractice History Request form;
- Liability reports from all liability carriers;
- State license verifications;
- NPDB Profile; and
- Supervisory Board Evaluation form(s) (**expires after 4 months**)

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: ____________________
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.
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.

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 applicant

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

____________________________________________________________________________________

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.
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)

Full Lic App – Form 6 (Authorization for Release), Page 1 of 1, Rev. 7/14
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

Full Lic App – Form 7 (CORI Acknowledgment Form), Page 2 of 2, Rev. 08/16
**FULL LICENSE APPLICATION SUPPLEMENT**

**SUPPORTING DOCUMENTATION:** If you answer “yes” to any of these questions, you must provide a detailed explanation and arrange for the appropriate agency or institution to submit copies of all official documentation related to the underlying occurrence or action. Documents should be sent either directly to the Board from the appropriate agency/institution or to you in a sealed envelope. If the documents are sent to you, the sealed envelopes must be included with your full license application or sent directly to the Board unopened.

**IMPORTANT NOTE:**
It is your responsibility to report to the Board if your responses to Questions 1-31 change while your application is pending. You must immediately notify the Board of the new information.

Please review each question carefully to ensure your answers are accurate prior to submitting your application. You are personally responsible for all information disclosed on your application, including any responses that may have been completed on your behalf by others. It is imperative that you honestly and fully answer all questions, regardless of whether you believe the information requested is relevant. Your responses on your application are evaluated as evidence of your candor and honesty. An honest “yes” answer to a question on your application is not definitive as to the Board’s assessment of your present moral character and fitness to practice, but a dishonest “no” answer may be evidence of a lack of candor and honesty, which may be definitive on the character and fitness to practice issue. **Please be advised that a false response to any of these questions may be grounds for denial of licensure and reported to the appropriate data banks.**

**POST-SECONDARY EDUCATION – (COLLEGE/GRADUATE /MEDICAL SCHOOL)**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. While enrolled in college, medical school or graduate school were you ever the subject of any disciplinary action? (This includes action that was formal or informal, oral or written, voluntary or involuntary. A confidentiality agreement does not absolve you of your requirement to answer this question.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Have you ever been terminated from a medical school?</td>
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<tr>
<td>3. Have you ever withdrawn or transferred from a medical school?</td>
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<tr>
<td>4. Have you ever been granted a leave of absence by a medical school?</td>
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<tr>
<td>(This includes a leave for research, public service, participated in a joint degree program such as an M.D./Ph.D. program, medical leave or for any other “personal reasons”.)</td>
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</tr>
<tr>
<td>5. Have you ever been placed on probation or remediation by a medical school or graduate school?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. 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?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
POSTGRADUATE TRAINING

7. While enrolled in postgraduate training were you ever the subject of any disciplinary action or under investigation? ☐ ☐
   (This includes action that was formal or informal, oral or written, voluntary or involuntary. A confidentiality agreement does not absolve you of your requirement to answer this question.)

8. Have you ever been suspended, terminated or dismissed from any postgraduate training program? ☐ ☐

9. Have you ever had to repeat a year of postgraduate training? ☐ ☐

10. Have you ever withdrawn or transferred from a postgraduate training program? ☐ ☐

11. Have you ever been granted a leave of absence from a postgraduate training program? ☐ ☐
    (This includes a leave for research, public service, medical leave or for any other “personal reasons”.)

12. Have you ever been placed on probation or remediation by a postgraduate training program? ☐ ☐

13. Were any limitations or special requirements imposed on you because of questions of competency or disciplinary problems? ☐ ☐

14. Did you ever receive partial or no credit for a postgraduate training program? ☐ ☐

15. Have you ever had a postgraduate training program contract not be renewed? ☐ ☐
16. 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?  

   YES  NO

17. Have you ever been denied a medical license, whether full, limited, temporary, or have you withdrawn an application for medical licensure?  

   YES  NO

18. 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.)  

   YES  NO

19. 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?  

   YES  NO

20. Are you aware of any pending investigation or inquiry into your professional conduct by any entity or are any disciplinary charges pending against you?  

   YES  NO

21. Since your completion of postgraduate training, has any disciplinary action ever been taken against you?  
   (A confidentiality agreement does not absolve you of your requirement to answer this question.)  

   YES  NO

22. 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?  

   YES  NO

23. Have you ever withdrawn an application for hospital privileges or appointment, or have you ever been denied medical staff membership, advancement in medical staff status or association with a health care facility, or has such denial been recommended by a medical staff committee, administration or governing body?  

   YES  NO

24. 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?  

   YES  NO

25. 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?  

   YES  NO

26. 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)?  

   YES  NO
CRIMINAL HISTORY

27. Have you ever been charged with any criminal offense?
   (You must report being arrested, arraigned, indicted or convicted, even if the charges against you were dropped, filed, dismissed or otherwise discharged. A charge of operating under the influence or its equivalent is reportable. A medical malpractice claim is a civil, not a criminal, matter and need not be reported for purposes of this question. If in doubt as to whether an arrest or criminal offense must be disclosed, it is best to disclose the action on your application.)

   Expunged/Sealed Offenses: While expunged/sealed offenses, arrests, tickets or citations need not be disclosed, it is your responsibility to ensure the offense, arrest, ticket or citation has, in fact been expunged or sealed. Failure to reveal an offense, arrest, ticket or citation that is not in fact expunged or sealed, raises questions related to truthfulness in addition to questions regarding the offense itself. You may have been told your record is expunged or sealed when in fact it is not. If, during the course of the application process, information about an offense is discovered which you did not disclose because you believed it to be expunged or sealed, you will be required to provide a copy of the expunction or sealing order.

MEDICAL MALPRACTICE HISTORY

28. Has any medical malpractice claim ever been made against you, whether or not a lawsuit was filed in relation to the claim?
   (You must report any medical malpractice claims that have been made against you, even if the claim against you was dropped, dismissed, settled, adjudicated or otherwise resolved.)
CONFIDENTIAL INFORMATION

If answering “yes” to any of the questions, provide details on the supplemental pages for questions 29 - 31. 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, or within the past two years.

29. Do you have a medical or physical condition that currently impairs your ability to practice medicine?

30. Have you engaged in the use of any substance(s) with the result that your ability to practice medicine is currently impaired?

31. 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.
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 M.G.L. c. 62C, § 49A, to the best of my knowledge and belief, I am in compliance with G.L. c. 119A relating to withholding and remitting child support.

- Pursuant to M.G.L. c. 119, § 51A, I certify under the penalties of perjury that I will fulfill my obligation to report abuse or neglect of children.

- By signing this form, I am providing my consent for the Massachusetts Board of Registration in Medicine and, where relevant, their supervising state agencies and the Massachusetts Executive Office of Health and Human Services, and where relevant, its provider enrollment vendor, to obtain, read, copy, and share with each other information regarding your MassHealth application and enrollment status and Massachusetts licensure status.

- 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, accurate and complete, to the best of my knowledge and belief.

Applicant’s Signature:_________________________________________________________ Date:_____/_____/____
EXPLANATION FOR APPLICATION QUESTIONS #1 - 26

This form must be used to provide a detailed written explanation for a “yes” response to any question (#1-26) on the Application. Please use as many forms as necessary to provide a detailed explanation.

Do not write, “See attached;” you must provide your response on this form.

A separate form is to be used for each question.

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

Application Question Number: _______________ (list corresponding question number from the Application)

Name of agency or institution taking action: __________________________________________

Date(s): ______/_____/_______ - ______/_____/_______

Please provide a detailed explanation:

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Full Lic App – Form 8 (Application Supplement), Page 7 of 11, Rev. 12/18
EXPLANATION FOR APPLICATION QUESTION #27
CRIMINAL HISTORY

This form must be used to provide a detailed written explanation for a “yes” response to question #27 on the Application. Please use as many forms as necessary to provide a detailed explanation. Do not write, “See attached;” you must provide your response on this form. A separate form is to be used for each criminal offense/arrest.

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

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

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

Incident Date: _____/_____/_______

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

Arresting/Ticketing Agency: ____________________________________________________________

Court: _________________________________________________________________________________________

Initial Charge(s): ____________________________________________________________

   _____Misdemeanor   _____ Felony

Final Charge(s): ____________________________________________________________

   _____Misdemeanor   _____ Felony

Plea: _________________________________________________________________________________________

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

___________________________________________________________________________________________

Detailed Summary. Provide a personal statement containing a detailed summary of the events and circumstances leading to the criminal offense:

___________________________________________________________________________________________

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EXPLANATION FOR APPLICATION QUESTION #28
MALPRACTICE HISTORY

This form must be used to provide a detailed written explanation for a “yes” response to question #28 on the Application. Please use as many forms as necessary to provide a detailed explanation. Do not write, “See attached;” you must provide your response on this form. A separate form is to be used for each malpractice claim.

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

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

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

GENERAL CLAIM INFORMATION:

Claimant’s name/initials: _____________________________________________________________

Date of incident: _______ / _______ / _______

Professional Liability Carrier: _______________________________________________________

Legal representative’s name: _______________________________________________________________________

STATUS OF CLAIM:

Current status of claim: □ Closed □ Pending

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

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

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

□ Other (please specify) __________________________

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

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

Amount allocated to you: $____________________________

(Question #28 continued on next page)
QUESTION #28 – MALPRACTICE HISTORY CONTINUED

MALPRACTICE CLAIM DESCRIPTIVE INFORMATION:

Allegation(s):
____________________________________________________________________________________________________________________________________________________

Alleged Patient Injury:
____________________________________________________________________________________________________________________________________________________

Condition of Patient When You Began Treatment:
____________________________________________________________________________________________________________________________________________________

Condition of Patient at the End of Treatment:
____________________________________________________________________________________________________________________________________________________

Detailed Summary: Provide a detailed narrative of the clinical course and circumstances leading to the claim, including the nature and extent of your involvement and role in patient the care.
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Full Lic App – Form 8 (Application Supplement), Page 10 of 11, Rev. 12/18
EXPLANATION FOR APPLICATION QUESTIONS # 29 – 31
CONFIDENTIAL INFORMATION

QUESTION #29 – Medical condition.
If you answered “yes” to Question 29, please provide the specifics of your condition and any related treatment, including dates and diagnoses. In addition, provide any adjustments or interventions you may have made or taken to ameliorate or address the impact of your medical condition on your current practice, including a change of specialty or field of practice, or participation in any supervised rehabilitation program, professional assistance or retraining program, or monitoring program.

____________________________________________________________________________________

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QUESTION #30 – 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.

____________________________________________________________________________________

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QUESTION #31 - Refusal to take a screening test for chemical substances.
If you answered “yes” to Question 31, please provide a description of the circumstances leading to your refusal to take the screening test and any resulting criminal or disciplinary consequences.

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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: ________________________________

Full Lic App – Form 9 (Medical Education Verification – Form A), Page 1 of 2, Rev. 8/16
Enrollment and Participation:

Our records indicate that ____________________________ attended our medical school for a total of ________ weeks (must be included) of continuous medical education on the following dates from ___.____/____/_____.

This applicant:

Check one: □ was awarded the degree of ____________________________ on ___.____/____/_____.

□ will be awarded the degree of ____________________________ on ___.____/____/_____.

(Form B must also be completed and returned directly to the Board.)

□ 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.)

Signature: ____________________________

Print Name: ____________________________

Title: ____________________________

Date: _____/_____/______ Telephone: (_____)________________

E-mail address: ____________________________

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

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.
**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)

<table>
<thead>
<tr>
<th>Program Type (Report internships, residencies, and fellowships separately.)</th>
<th>PGY (1,2,3,4, etc.)</th>
<th>Department or Type of Specialty Training (Use one section per department/specialty. If the department/specialty was a &quot;rotating&quot; or “transitional” program, please provide a schedule of rotations.)</th>
<th>Dates Attended (Month/Day/Year)</th>
<th>Completed (Yes/No/In Progress)</th>
<th>Accredited by (ACGME, AOA, RSC, or not accredited)</th>
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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.

---

Full Lic App – Form 10 (Postgraduate Training Verification), Page 1 of 2, Rev. 8/16
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

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.
SUPERVISORY EVALUATION FORM

APPLICANT INSTRUCTIONS: Complete this section and print your name on the top of page 2.

- This form must be completed by a supervising physician who can evaluate your clinical performance.
- At least one year of current evaluations are required. Locum tenens physicians must have evaluations from the most recent two years of assignments. The Board reserves the right to require additional Evaluation forms.
- Evaluation forms must be current within 120 days prior to Board review.
- The Evaluator must have no financial interest in your licensure in the State of Massachusetts.

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 Evaluating Hospital/Workplace: ____________________________________________ State: __

SUPERVISING PHYSICIAN INSTRUCTIONS:

- Please complete items #1-10 below and return to the applicant with your name affixed across the envelope seal.
- The Board may provide a copy of this Form and any attachments to the applicant.

1. Date(s) of applicant’s affiliation at facility (month/year)? From: ______/_____ To: _____/_____

2. In what capacity did you supervise the applicant? □ Department Chair □ Chief of Service
   □ Medical Director □ Training Director □ Supervising Physician □ Chief Medical Officer

3. Applicant's Status: □ Intern □ Resident □ Fellow □ Staff Member □ Other ____________

4. Do you have any conflict of interest, personally, professionally or financially in recommending this applicant for licensure in Massachusetts? □ YES □ NO

5. Please rate the following (if "BELOW AVERAGE or "POOR", explain in detail on a separate sheet).

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<th></th>
<th>Superior</th>
<th>Above Average</th>
<th>Average</th>
<th>Below Average</th>
<th>Poor</th>
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<tr>
<td>Clinical knowledge</td>
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<td>Clinical competency</td>
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<td>Professional judgment</td>
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<td>Character and ethics</td>
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<td>Technical skills</td>
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<td>Relationships with staff</td>
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<td>Relationship with patients</td>
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<td>Cooperativeness/ability to work with others</td>
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(Continued on page 2)
6. Has the applicant’s privileges to admit or treat patients ever been modified, suspended, reduced or revoked?  □ YES  □ NO (if "yes" please explain below)

7. 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.  □ YES  □ NO

8. Please comment on the applicant’s strengths or weaknesses and/or any other information that you may have to assist in this evaluation.

9. The above comments are based on the following:

□ Personal observation  □ General impression  □ A composite of evaluations by other physicians

□ Other_________________________________________

10. Recommendations:

□ Recommend for licensure in Massachusetts.

□ Recommend for licensure in Massachusetts, with the following reservations:

__________________________________________

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

__________________________________________

Signature of Evaluator: __________________________________________ (check one) □ M.D.  or  □ D.O.

Name of Evaluator (Printed):_________________________________________ Date: _____/_____/_______

Title/Position:________________________________________________________

E-mail address:________________________________ Phone number:________________________________

PLEASE RETURN THE COMPLETED EVALUATION TO THE APPLICANT IN A SEALED ENVELOPE WITH YOUR SIGNATURE AFFIXED ACROSS THE ENVELOPE SEAL.
The Board and its Licensing Committee (Board) undertakes a rigorous and comprehensive process when evaluating the professional qualifications of an Applicant for a limited or initial license in Massachusetts. The honest and impartial assessment of an Applicant by his or her Program Director or Residency Director is a crucial component in the Board’s evaluative process.

All persons who submit Evaluations to the Board shall avoid any actual or perceived conflict of interest so as to ensure that the conflict does not affect patient safety, quality of care or the integrity of the services provided by the Board. A “conflict of interest” is a situation where financial, professional or personal interests (including the interests of immediate family members), may compromise one’s professional judgment or official responsibilities. A conflict of interest exists when an Evaluator may gain financially or professionally from an Applicant’s prospective employment.

All persons who submit an evaluation to the Board shall certify that they have knowledge of the Applicant’s performance and have reviewed the Applicant’s training record; that there is no evidence of any unprofessional behavior or any serious question of clinical competence; that the applicant has demonstrated competency to practice medicine without direct supervision; and that the Evaluator is the supervisor and has no conflict of interest, personally, professionally or financially, in recommending the Applicant for licensure.
MALPRACTICE HISTORY REQUEST FORM

APPLICANT SECTION: (Additional forms available at the Board’s website: www.mass.gov/massmedboard.)

Applicant’s Name (Print):__________________________________________  Date:______/______/______

Applicant’s Instructions: In chronological order, please list your liability carriers below. You must include all of your liability carriers from the time your first full license was issued in any state to the present. Send a copy of this form to each of your liability carriers. Return the original form to the Board with your application.

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 #:__________

LIABILITY CARRIER SECTION:

Liability Carrier’s Instructions: Please provide the following information directly to the Board at the above listed mailing address or via email at: malpractice.reports@MassMail.State.MA.US. If sending documents via email, you must include the physician’s name in the subject line of the email.

Malpractice History Report: Please provide a malpractice history report on letterhead, which includes the following:
1. Policy number
2. Dates of policy coverage;
3. If your company’s name has changed, please provide any former company names.
4. Whether the applicant has any claims history;
5. If the applicant has a claims history, please include:
   a. the name/initials of the claimant(s);
   b. nature and date of claim(s);
   c. whether the claim is pending or closed;
   d. amounts paid on the applicant’s behalf, if any; and
   e. final disposition.

Additional Claim Documentation: If the applicant has a claims history, please provide copies of the following:
1. Complaint, notice of intent to file a claim, or other claim letter; and
2. Final judgment, settlement and release, or other final disposition of each claim.

Malpractice History Form, Page 1 of 1, Rev. 1/19
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
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.

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

Name of Applicant: _________________________________ Medical School: ________________________________

<table>
<thead>
<tr>
<th>Clerkship Area of Study</th>
<th>Name of Clerkship Director/Supervisor</th>
<th>Name and Address of Hospital/Facility</th>
<th>Was this Hospital the primary teaching hospital for the Medical School?</th>
<th>Was this Hospital an affiliated teaching hospital for the Medical School?</th>
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<th>Clerkship Area of Study</th>
<th>Name of Clerkship Director/Supervisor</th>
<th>Name and Address of Hospital/Facility</th>
<th>Was this Hospital the primary teaching hospital for the Medical School?</th>
<th>Was this Hospital an affiliated teaching hospital for the Medical School?</th>
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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 HOSPITAL/TEACHING 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 of Study:______________________________________ Type (Elective or Required):__________________________

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

Name of Hospital/Teaching Institution:___________________________________________________________

Name(s) of medical school(s) affiliated with this Hospital/Teaching Institution:___________________________________________________________________________________________________________

Name of Clerkship Director:__________________________

Name of Instructor or Supervisor:________________________________________________

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

Did the supervisor of this clinical training hold a faculty appointment at a legally chartered medical school? □ YES □ NO
If yes, indicate name of medical school: __________________________________________

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: _____/_____/______

Did the Hospital/Teaching Institution conduct accredited postgraduate training programs? □ YES □ NO
If yes, the postgraduate training programs were accredited by: □ ACGME □ AOA □ RCPSC/CFPC □ other:

Did the Hospital/Teaching Institution conduct a postgraduate training program in the same specialty as the clerkship? □ YES □ NO
If yes, the postgraduate training program was accredited by: □ ACGME □ AOA □ RCPSC/CFPC □ other:

__________________________

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

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) _________________

Form E-2 (Elective Medical School Clinical Study Verification), Page 1 of 1, Rev. 02/18
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-case 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:
SUBSTANTIAL EQUIVALENCY OF MEDICAL SCHOOL EDUCATION WAIVER REQUEST

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

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

________________________________________________________________________________________


________________________________________________________________________________________


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

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<tr>
<th>Clerkship Area of Study</th>
<th>Name of Facility</th>
<th>Location of Facility (City/State/Country)</th>
<th>Number of Weeks</th>
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Full Lic App – Form J (Waiver of Substantial Equivalency Form), Page 2 of 4, Rev. 12/18
4. **Number of Years and Quality of Postgraduate Training:** List all postgraduate training below. Also, you must have a copy of your Postgraduate Training Evaluative Files from each training program submitted directly to the Licensing Division at the Board of Registration in Medicine. The Board also encourages submission of additional evaluations as well as any letters of recommendation.

<table>
<thead>
<tr>
<th>Program Type (Internship/Residency/Fellowship)</th>
<th>PGY (1, 2, 3, etc.)</th>
<th>Specialty</th>
<th>Name of Institution</th>
<th>Accredited by (ACGME, AOA, etc.)</th>
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5. **Number of Years and Quality of Post-training Practice:** 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 Supervisory Evaluation Form completed by a physician supervisor from your most recent clinical practice site(s). You must submit evaluations covering at least the most recent year of clinical practice. The Board also encourages submission of additional evaluations as well as any letters of recommendation.

6. **Licensure in Other States:** List all states in which you have held full licensure (use abbreviations).

NAME OF STATE: __________ __________ __________ __________ __________

LICENSE STATUS (current or inactive): __________ __________ __________ __________ __________
APPLICANT’S NAME _________________________________________________________________

7. **American Specialty Board Certification**: List current certification(s) by American Specialty Boards
   Name of Specialty Board: __________________________________________________________
   Name of Specialty Board: __________________________________________________________

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

   __________________________________________________
   __________________________________________________
   __________________________________________________

9. **Results of SPEX Exam**: Indicate SPEX exam results (if taken):
   ___________________________

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

   APPLICANT’S SIGNATURE ____________________________ DATE: ____/____/____