Idaho State Board of Medicine

1755 Westgate Drive, Ste 140 • Boise, ID 83704 • http://www.bom.idaho.gov

Instructions for Completing the Online Idaho Licensure Application

No practice is permitted prior to issuance of a license. APPLICANTS ARE ADVISED NOT TO ENTER IRREVOCABLE CONTRACTS, PURCHASE OR SALE AGREEMENTS, ON THE ASSUMPTION THAT LICENSURE WILL BE GRANTED.

An initial license, when approved, will be issued for at least one year. Applicants will be assessed a pro-rated fee to bring their license expiration date into concurrence with the next scheduled expiration date once the application is complete and approved. License and wall certificates will be issued under the name appearing on the application.

Review the following instructions carefully before completing the application. Failure to submit all required information and documentation will result in processing delays. In completing the online application, you will be asked to account for all time since medical school graduation, including employment histories, and information on malpractice claims, if applicable. Having this information on hand before you begin your session will facilitate completing your online application.

Idaho requires the applicant to submit their social security number. If not included in the application, your application will be rejected and this will delay the process.

If you have any questions about the information provided to you, please contact our office at (208) 327-7000. Thank you for applying for licensure in the State of Idaho.

Fees

The Idaho State Board of Medicine application fee is $500.00, to be paid by check or money order. Once you have submitted your application, we will review and send a letter letting you know what will be required to complete your application with a fingerprint card. These will be mailed to the applicant's home mailing address as required by the FBI. Please note that a 3rd party cannot be involved in this process. Attach payment to the completed addendums and any additional documentation that you are submitting to the board.

Licensure by Endorsement – to be determined by the Idaho Board

An applicant, in good standing with no restrictions upon or actions taken against his license to practice medicine and surgery in a state, territory or district of the United States or Canada is eligible for licensure by endorsement to practice medicine in Idaho.

An applicant with any disciplinary action, whether past, pending, public or confidential, by any board of medicine, licensing authority, medical society, professional society, hospital, medical school or institution staff in any state, territory, district or country is not eligible for licensure by endorsement. An eligible applicant for licensure by endorsement (without examination) fulfills all requirements of IDAPA 22.01.01.053.

In brief, simple language, for licensure by endorsement you must:

1. Hold a current license to practice medicine in another U.S. state or Canada that has no disciplinary action, suspension, or restrictions.
2. Be currently ABMS or AOA board certified.
3. Have held an unrestricted license for five years in any U.S. state or Canada.

4. Disclose on the application form any physical or mental impairment that impacts your ability to practice.
5. Disclose any significant (over $50,000) malpractice settlements or judgments in the past 10 years. Any malpractice over $50,000 is not eligible for license by endorsement.
6. Complete an affidavit affirming your eligibility and complete a criminal background (fingerprint) check.

Osteopathic physicians and surgeons receiving degrees after January 1, 1963 and fulfilling applicable requirements may apply for a license by endorsement.

The Florida medical licensing examination, from July 1969 through 1980, and the Puerto Rico medical licensing examination do not meet the requirements for licensure by endorsement.

Eligible applicants for licensure by endorsement will need to complete the following items on the checklist below:

Endorsement Licensure Checklist

Complete an online Uniform Application (UA) and State Addendum Part 1.	☐
Complete State Addendum Part 2 (2.2 and 2.3 do not need to be completed) and mail to the Board.	☐
Application fee of $500.00 mailed to the Board.	☐
Fingerprint Card – obtain from the Board.	☐

The Uniform Application for Physician State Licensure (UA)

The Uniform Application is the licensure application for the Board. After completing the UA for the first time, your application is securely stored and can be sent to another participating board as long as the forms and state-specific requirements are also completed for each board. Updates to the UA can be made as needed.

The Federation Credentials Verification Service (FCVS) can be used for credentials verification as part of the licensure process. Existing FCVS profiles are accepted, provided that your profile is designated to be received by the Board. If you do not have an existing FCVS profile and are considering using FCVS for credentials verification, please note that the Board only recommends the FCVS for International Medical Graduates.

To work on the FCVS application (credentials verification only), visit https://portal.fsmb.org/MyFsmb/ and click on the FCVS graphic, then sign in. You may also visit http://www.fsmb.org/ and click on FCVS in the Licensure menu to access the portal page. For assistance, use the messaging tool within FCVS or call 888-275-3287 with your FCVS ID number.

To begin or update your UA (licensure application), visit https://portal.fsmb.org/MyFsmb/ and click on the UA graphic, then sign in. You may also visit http://www.fsmb.org/ and click on Uniform Application in the Licensure menu to access the portal page. Complete as instructed in each section. Use the checklist at the end of these instructions to ensure that you submit all required documentation.

Please note the following:

- If not pre-filled, provide your home address and a separate address for business or postgraduate training. Both Board Contact and Public Access selections must be made but you can use the same address for each selection. All home addresses must be domestic, as fingerprint cards and other background information are mailed there.

- Enter your full social security number and not the USMLE number.

- Enter each training program in the United States and Canada in either the ACGME Training page or the Other Training page. Enter postgraduate programs outside of the United States and Canada on the Chronology page.

- You are not able to add or edit MD or DO license information in the UA because that information is sent directly from the state boards into the FSMB system. If changes are needed, email ua@fsmb.org with the correct information. Depending on volume of license update requests, it may take 1-3 business days for the changes to appear in your UA. Do not enter MD or DO license information under "Other".

- If you hold a medical or osteopathic license or licenses in countries outside of the United States or Canada, provide that information on a separate sheet of paper to the Board.

- Your Chronology of Activities should cover each of your activities (non-working time included) from medical school graduation to present. Previously listed medical school and postgraduate training programs will pre-fill the Chronology. Do not leave gaps. For each entry, use the first day of the month for start and end dates unless you know the exact date. If you have military or locum tenens assignments, list each location separately.

- Clinical time indicates time spent seeing patients and practicing medicine. Administrative time indicates time spent on paperwork, research, or teaching.

- Leave the malpractice liability claims section blank only if you have had no claims. List all pending claims.

- Upon accepting the Terms and Agreement and submitting the UA, first time UA users will be taken to a payment page for the one-time service charge. This charge sustains the UA program and is separate from FCVS and state board licensing fees.

- For a copy of your receipt, click on the "Home" link to return to the portal page, which will now have a Payment link to all FSMB receipts in the upper right corner.

- To open your UA for editing and resubmitting to a board, or for submitting to a new board, sign in and choose the appropriate board in the State Board section. Reselect the US Citizen query on the Identification page (it resets each time a UA is submitted), make changes as needed, then submit or resubmit your UA.

- Refer to the UA FAQ at https://www.fsmb.org/licensure/uniform-application/faq for answers to the most common UA questions. If your issue isn't listed, contact UA customer service at 800-793-7939 or email ua@fsmb.org with your username and a description of your issue. Provide a screenshot for each error you see.

In addition to completing the core UA online, all applicants must:

- Complete both the addendum within the UA and the addendum forms in this packet.

- Submit a UA Affidavit and Authorization for Release of Information form to the Board. The UA Affidavit is separate from the FCVS Affidavit and must be sent directly to the Board. Attach a recent (fewer than 90 days old) two inch by two inch (2" x 2") passport quality, color photograph of yourself in the space provided.

- Have each full, temporary, training, or limited healthcare or profession license or certification you have ever held in the U.S. or Canada verified by the granting board, whether the license or certification is active or inactive. Determine the fees and verification method for each board using the licensure verification resource at http://www.fsmb.org/licensure/uniform-application/. Use the UA Licensure Verification Form for boards that need a written request. If the verifying board uses VeriDoc or another method, use that method instead.

If you are using FCVS for credentials verification,

- Do not complete the UA Medical Education Verification, Postgraduate Training Verification, or Fifth Pathway Verification forms. Do not send any identity documents, transcripts, certificates, or examination scores to the Board. FCVS handles all of this for you.

If you are not using FCVS for credentials verification,

- Send to the Board a certified copy of a legal name change document (marriage certificate, divorce decree, court order) if your name is not the same on all of your submitted documents.

- Contact each appropriate examination entity to have a certified transcript of your scores sent directly from the exam entity to the Board. If you have taken any component of the NBME in conjunction with another exam (USMLE/FLEX), request your transcript of scores from the NBME. For exam entity contact information, see the UA FAQ at http://www.fsmb.org/licensure/uniform-application/faq.

- Complete the UA Medical Education Verification, Postgraduate Training Verification, and Fifth Pathway Verification (if applicable) forms as directed on each form. The UA Medical School Verification form should be accompanied by a copy of your diploma if you graduated from that school.

- If you are an International Medical Graduate, request from ECFMG that your ECFMG certificate, Fifth Pathway Program Certificate, and/or FMGEMS certificate be sent to the Board, as applicable. See the UA FAQ at the link on the previous page for contact information.

If you experience difficulties in using or accessing the Uniform Application, visit the Uniform Application FAQ at http://www.fsmb.org/licensure/uniform-application/faq. If your question is not listed, contact UA customer service at 800-793-7939 or ua@fsmb.org. Provide your username and FCVS ID number or nine-digit Federation ID (FID). If you receive an error, send a screenshot of the error or the description to ua@fsmb.org.

Criminal Background Check

Please note: Idaho requires a criminal background check prior to licensure. A fingerprint card and instructions will be mailed to the home address provided on the application. Be aware that fingerprint processing may delay your application. Please make it a **PRIORITY** to complete the fingerprint process upon receipt of the form.

Uniform Application Checklist – Idaho Board of Medicine

	NOT using FCVS to verify credentials	Using FCVS to verify credentials
Completed online application (UA) and State Addendum Part 1. ** Please be sure to enter your full social security number and not the USMLE # in the appropriate field. **	☐	☐
Completed State Addendum Part 2 sent to Board.	☐	☐
Application fee of $500.00 sent to Board.	☐	☐
Completed "Affidavit and Authorization for Release of Information" form submitted to the Board.	☐	☐
Verification of licenses sent to the Board from all states in which you have ever held any healthcare license. You may use VeriDoc or a board's preferred electronic verification in lieu of Form #1.	☐	☐
Fingerprint card (to be obtained from this Board) after your application has been received by the Board.	☐	☐
Supporting documentation of any legal name change sent to the Board.	☐	Completed via FCVS
Medical Education Verification form (Form #2) sent to the Board by all medical schools attended	☐	Completed via FCVS
Medical School Transcripts sent to the Board by your medical school.	☐	Completed via FCVS
A copy of your postgraduate training certificate(s) submitted to the Board.	☐	Completed via FCVS
Postgraduate Training Verification form (Form #3) sent to the Board from all programs you attended.	☐	Completed via FCVS
Fifth Pathway form, if applicable (Form #4), sent to the Board from your medical school and institution	☐	Completed via FCVS
Examination Transcripts sent to the Board.	☐	Completed via FCVS
ECFMG (if applicable) Status Report sent to the Board.	☐	Completed via FCVS

Idaho State Board of Medicine

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State Addendum Part 2 Instructions

Complete the addenda as instructed below. Return the completed forms to the Idaho State Board of Medicine.

Licensure by Endorsement applicants will not need to complete Addendum 2.2 or Addendum 2.3.

☐ **Addendum 2.1 – Additional Physician Information.** To be completed by the applicant.

☐ **Addendum 2.2 – Certification of Recommendation.** Fill in the top section of this form. Duplicate and send this form to two (2) U.S. licensed physician who have at least one (1) full year of current professional knowledge of the applicant (no relatives). The recommendations must be on the form provided or on letterhead addressed to the Board. Names and addresses must be legible.

☐ **Addendum 2.3 – Hospital Affiliation.** Fill in the top section of this form. Send this form to all hospitals that the applicant has physically practiced at for the past five (5) years, including locum tenens. If the applicant has not had any affiliations please write “Not Applicable” on the form and return to the Board.

☐ **Addendum 2.4 – Authorization for Release of Information.** To be completed by the applicant with the name(s) of any other individual(s) or entity(ies), besides the applicant, that the applicant would allow this Board to discuss the status of the pending application, i.e. spouse, staff member, etc., and returned with the application. Without this completed form the Board may only discuss the pending status with the applicant.

Addendum 2.5 - This form is currently not in use.

☐ **Addendum 2.6 - Affidavit for Licensure by Endorsement.** This form will only need to be completed if you are applying for licensure by endorsement. Return the completed form to the Idaho Board.

Idaho State Board of Medicine
Addendum 2.1
Please print clearly

Full Name: ____

Contact Numbers: Telephone: ( ) ___ _____ Cell: ( ) ___ _____

Physician's E-mail: ______________________________

Physical Description: Height:______ feet ____inches

Weight:_______lbs. Hair:__________ Eyes: _________________

Complexion:______ Scars, marks, tattoos, etc.: ______________

Please provide the following information:

Name of Employer: ____

Anticipated practice location and address:

____

Anticipated start date: ____

Type of practice:

___ Locum Tenens
___ Telehealth
___ Hospital
___ Clinic
___ Other: (Please describe)____

Please access the Idaho State Board of Medicine's website at https://bom.idaho.gov/BOMPortal/BoardAdditional.aspx?Board=BOM&BureauLinkID=100 and select the links on the right to review Licensure Laws and Rules.

"I have carefully read all licensure laws and rules pertaining to practicing medicine in Idaho Chapter 18, Title 54, Idaho Code; IDAPA 22.01.01; Rules Relating to Telehealth; and 'Policy for Use of Opioid Analgesics for Chronic Pain.'"

Signed Under Penalty of Perjury, this _____ day of __________, 20___.

____
Signature

Addendum 2.2

Certification of Recommendation

Please complete and return form directly to the Idaho State Board of Medicine at
P.O. Box 83720, Boise, ID 83720-0058 **or**
Express Mail: Westgate Office Plaza, 1755 Westgate Drive, Suite 140, Boise, ID 83704.

The recommendations must be on the form provided or on letterhead addressed to the Board.
All information must be legible. (This form may be duplicated.)

To be completed by the applicant:

Applicant's Name: ______________________________

Applicant's Address: ______________________________

____

Recommending Physician's Name: ______________________________

Recommending Physician's Address: ______________________________

____

Licensed in [State(s)]: ______________ Type of Practice: ______________________________

To be completed by the recommending physician:

Do you request that this information be confidential? ☐ Yes ☐ No

To: Idaho State Board of Medicine:

I have known Dr. ______________________________ for ______ years, from ____________ to ____________, while he/she was studying or practicing medicine. To the best of my knowledge he/she is of good moral and professional character and ethics.

Additional Comments:

____
Signature

____
Title

____
Date

Addendum 2.3

Hospital Affiliation

Please complete and return form directly to the Idaho State Board of Medicine at
P.O. Box 83720, Boise, ID 83720-0058 **or**
Express Mail: Westgate Office Plaza, 1755 Westgate Drive, Suite 140, Boise, ID 83704.

The recommendations must be on the form provided or on letterhead addressed to the Board.
All information must be legible. (This form may be duplicated.)

To be completed by the applicant:

I am applying for a license to practice medicine and surgery in the state of Idaho. The Idaho State Board of Medicine requires clearance from the chief of staff or administrator of each hospital where I have held privileges, consultation of teaching appointments during the past five (5) years. I hereby authorize you to release any information in your files, favorable or otherwise, directly to the Idaho State Board of Medicine at the address indicated above.

Applicant's Name: ____________________
Applicant's Signature: ____________________
Applicant's Address: ____________________
____

To be completed by the chief of staff or administrator: ☐

What privileges were extended to the applicant?
____
____
____

During what time period? ____________________

Were there limitations other than those usual for specialty or situation (i.e. resident)? ☐ Yes ☐ No
Disciplinary Action? ☐ Yes ☐ No
Derogatory Information? ☐ Yes ☐ No

If yes, please specify: ____________________
____
____

Would you consider this physician's application favorably? ☐ Yes ☐ No

Please initial here if you wish to classify this response as confidential. ________

____
Signature

____
Title

____
Date

Hospital Name : ____________________
Hospital Address: ____________________
____

Addendum 2.4

Authorization for Release of Information

This form is to be completed by the applicant with the name(s) of any other individual(s) or entity(s), besides the applicant, that the applicant would allow this Board to discuss the status of the pending application, i.e. spouse, staff member, etc, and returned with the application. **Without this completed form, the Board may only discuss the pending status with the applicant.**

☐ I will be the only individual inquiring about the status of my application. (If you are not authorizing the release of information to a third party, you will **not** need to have this form notarized, just sign and date below.)

☐ I authorize the following individuals to inquire about the status of my application (see below):

1. ____
First Name Last Name Relationship to Applicant
____
Name of Entity (University, Hospital, etc)
______________________ ______________________
Telephone Number Email Address

2. ____
First Name Last Name Relationship to Applicant
____
Name of Entity (University, Hospital, etc)
______________________ ______________________
Telephone Number Email Address

I hereby authorize and direct the Idaho State Board of Medicine, employees, agents, officers, representatives, and attorneys at any time to release information regarding my filed application for an Idaho medical license to practice medicine and surgery with the Idaho State Board of Medicine to the individuals named above.

I further authorize the Idaho State Board of Medicine, employees, agents, officers, representatives, and attorneys who have such information to consult with or discuss such information with any of the individuals named above.

Upon my knowledge and with legal consultation, I understand the nature of this Authorization for Release of Information with regard to my filed application for an Idaho medical license to practice medicine and surgery with the Idaho State Board of Medicine.

I, and my heirs, do hereby release the Idaho State Board of Medicine, Committee on Professional Discipline of the Idaho State Board of Medicine, and its members, employees, agents, officers, representatives, and attorneys, from all liability and all claims of any nature whatsoever pertinent to the information released.

Name of Applicant: ____
First, Middle, Last

Applicant Signature: ______________________________ Date: ______________

STATE OF _________________)
: ss
County of _________________)

On this _____ day of ________________, 20_____, before me, the undersigned, a Notary Public in and for said State, personally appeared ______________________________, M.D./D.O., known or identified to me to be the person whose name is subscribed to the within instrument, and acknowledged to me that he/she executed the same.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal the day and year in this certificate first above written.

____
NOTARY PUBLIC FOR__________________________
Residing at:______________________________
My Commission Expires: ____________________

Addendum 2.6

AFFIDAVIT FOR LICENSURE BY ENDORSEMENT

IF THE ANSWER TO ANY OF THE FOLLOWING QUESTIONS IS **YES**, PLEASE PROVIDE DETAILS ON A SEPARATE, ATTACHED SHEET.

	YES	NO	
1.	☐	☐	Have you ever been charged with or convicted of a felony or misdemeanor other than a minor traffic violation?
2.	☐	☐	Do you currently have or have you had problems with the use of alcohol, stimulants, habit forming and/or illegal drugs in the past five (5) years which in any way impairs or limits your ability to practice medicine with reasonable skill and safety?
3.	☐	☐	Do you now hold a current, valid, unrevoked, unsuspended, undisciplined license to practice medicine and surgery in a state, territory or district of the United States or Canada?
4.	☐	☐	Do you now hold current board certification by a specialty board approved by the American Board of Medical Specialties or AOA?
5.	☐	☐	Have you engaged in five (5) years of contemporaneous active, unrestricted, clinical practice of medicine and surgery as a licensee of a state, territory or district of the United States or Canada?
6.	☐	☐	Have you had any current or past mental and physical condition or any current or previous physical or mental illness which may impact your ability to practice medicine with reasonable skill and safety?
7.	☐	☐	Do you have pending or had medical malpractice actions against you within the last ten (10) years and the judgments or settlements, if any, of such claims exceeded fifty thousand dollars ($50,000)?

I ____, MD/DO, being first fully sworn, depose and say that I am the person herein described and identified; that the answers to the accompanying questions and statements made in this application are true and correct, particularly in regard to licensure by endorsement pursuant to IDAPA 22.01.01.053; that I am the lawful holder of the degrees/credentials listed, and that such degrees/credentials were procured in the regular course of instruction and examination without fraud or misrepresentation.

I hereby authorize all hospitals. institutions or organizations, my references, personal associates, business associations (past and present) and all government agencies and instrumentalities to release to this licensing Board any information, files or records requested by this Board in connection with the processing of this application. I further authorize this Board to release to the organizations, individuals and groups listed above any information which is material to my application or pertinent to my practice of medicine and surgery during the time that I am a licensee of this Board.
I have carefully read the questions in the accompanying application and have answered them completely, without reservation of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information with this application, I hereby agree that such act shall constitute cause for the denial, suspension or revocation of my license to practice medicine and surgery in the State of Idaho.

Applicant's signature: ____MD/DO Date: _______________, 20____.

STATE OF ________________)
: ss
County of ________________)

On this _____ day of _______________, 20_____, before me, the undersigned, a Notary Public in and for said State, personally appeared ____________________________, M.D./D.O., known or identified to me to be the person whose name is sub-scribed to the within instrument, and acknowledged to me that he/she executed the same.
IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal the day and year in this certificate first above written.

____
NOTARY PUBLIC FOR_____________________________
Residing at:___________________________________
My Commission Expires: _________________________

UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

For State Board Use Only

Affidavit and Authorization for Release of Information

Applicant: In the presence of a notary public, sign this form with attached photo. If you are using FCVS for credentials verification, consider having that form notarized at the same time. Send the separate notarized FCVS form to FCVS. **Do not send this form to FCVS** as doing so will delay your licensure.

Send this form to the board you are applying to for licensure. Include all other required materials. A directory of state medical and osteopathic boards is available at http://www.fsmb.org/policy/contacts.

To ____,
Name of state board applied to for licensure

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my application, and that all documents, forms, or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

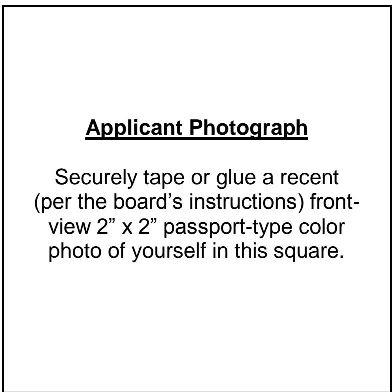
I acknowledge that I have read and understand the Uniform Application for Physician State Licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data, and to permit the Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge, and exonerate the Board, its agents or representatives, and any person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the Board.

I will immediately notify the Board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice medicine being granted to me by the Board.

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my license or permit to practice medicine.



Applicant Photograph

Securely tape or glue a recent (per the board's instructions) front-view 2" x 2" passport-type color photo of yourself in this square.

____
Applicant's signature (must be signed in the presence of a notary)

____
Applicant's printed last name, first name, middle initial, and suffix (e.g., Jr.)

____
Date of signature (must correspond to date of notarization)

[Please note: The Notary Public seal should overlap the bottom of the photo to the left.]

NOTARY

State of _____________________, County of _____________________,

I certify that on the date set forth below, the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document.

The statements on this document are subscribed and sworn to before me by the applicant on this _____ day of ___________, 20____.

Notary Public Signature ____ My Notary Commission Expires _________________

UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

For State Board Use Only

Licensure Verification Form (Form #1)

Applicant: Most boards require verification of each professional license ever held. Refer to the licensure verification resource at http://www.fsmb.org/licensure/uniform-application/ to determine fees and preferred verification method(s) for each state medical and osteopathic verifying board. You may use this form for each board that requires a written request for verification. In Section 1, list the board you are applying to for licensure, using the directory at http://www.fsmb.org/policy/contacts to ensure you list the correct name and address. Mail this completed form and any required fee to the verifying board.

Verifying Board: Unless using electronic verification, complete Section 2 below and mail this form to the board at the address listed in Section 1. Use an additional sheet of paper if needed for explanation(s).

Section 1: Applicant Information

First name ______________________ Last name ______________________ Practitioner Type ☐ MD ☐ DO ☐ ____

Middle name ____________________ Suffix ________ SSN* ____________ Birth date (mm/dd/yyyy) ____________

**The social security number is to be used for purposes of identification only and may not be used for any other reason.*

Authorization for Verifying Board: I am applying for a license to practice medicine. The board that I am applying to for licensure requires that this form or an otherwise accepted method of verification be completed by all boards through which I hold or have held licenses, whether now current or not. I authorize the licensing agency of the state/province of ________________ to provide any and all information pertaining to my license number ________________ to the board at the address listed below.

Board name ____

Mailing address ____

City/State/Zip ____

Applicant signature ____ Date _______________

Section 2: Board Verification of Licensure

Name of issuing board or license entity ____

Name of licensee (last, first, middle, suffix) ____

License type ____________ License number _____________ Issue date ____________ Expiration date ____________

1. Is this license current? If not current, please explain: ☐ Yes ☐ No

2. Have formal disciplinary proceedings been initiated against this applicant's license by a disciplinary authority in your state? If yes, please explain on a separate sheet of paper and attach it to this form. ☐ Yes ☐ No ☐ Cannot answer under state law

3. Has the applicant ever been warned, censured, placed on probation, formal consent, reprimand, or in any other manner disciplined, or has the applicant's license ever been revoked, suspended, or, in any other manner, limited by a licensing or disciplinary authority in your state? If yes, please explain on a separate sheet of paper and attach it to this form. ☐ Yes ☐ No ☐ Cannot answer under state law

I CERTIFY THAT to the best of my knowledge and belief, the foregoing is a true, accurate and complete statement of the record of the individual named on this form.

Signature ____

Print name ____

AFFIX INSTITUTIONAL SEAL HERE

(If no seal is available, this form must be notarized.)

Title ____________________________ Date _______________

Phone number __________________ Fax number ____________

Email ____

Please mail this completed form and any other items to the board at the address listed in Section 1. Thank you.

UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

For State Board Use Only

Medical or Osteopathic School Verification Form (Form #2)

Applicant: DO NOT COMPLETE THIS FORM IF YOU ARE USING FCVS. FCVS verifies this data for you. If you are not using FCVS, complete Section 1 below. Send this form and a copy of your medical school diploma to the current dean of your medical or osteopathic school. Copy this form for multiple schools.

Dean or Designated Official: Complete Section 2 of this two-page form and certify the enclosed copy of the diploma by placing your school seal on it. Mail the sealed diploma, an official copy of the physician's transcripts, this completed form, and any other documentation needed to the board at the address listed in Section 1. If transcripts are not in English, an original, certified, and official English translation is required.

Section 1: Applicant Information

First name ______________________ Last name ______________________ Practitioner Type ☐ MD ☐ DO ☐ ____

Middle name ____________________ Suffix ________ SSN* ____________ Birth date (mm/dd/yyyy) ____________

Name if different when diploma awarded ____

Name of school ____

**The social security number is to be used for purposes of identification only and may not be used or any other reason.*

Waiver for Release of Information: I am applying for a license to practice medicine. I authorize the medical/osteopathic school listed above to provide any and all information pertaining to my medical/osteopathic education at that institution to the board at the address listed below. I request that the dean or a designated official complete Section 2 of this form and seal the copy of my diploma (attached) as described in the instructions above, then mail this completed form, the sealed diploma copy, and a copy of my official transcripts to the board listed below at the given address:

Board name ____

Mailing address ____

City/State/Zip ____

Applicant signature ____ Date _______________

Section 2: Medical or Osteopathic School Verification

School name ____

Complete address w/country ____

School name if different when applicant attended ____

Hours of undergraduate education required for admission _______ Total weeks of education applicant attended _______

Attendance (mm/yyyy) from __________ to __________ Graduation date __________ Degree awarded ___________

Unusual Circumstances

The following questions apply to unusual circumstances that occurred during any part of the individual's medical or osteopathic education. Check the appropriate responses and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation attached to this form.

1. Do the official records for this individual reflect interruptions or extensions in his/her medical/osteopathic education? **If yes,** indicate the reasons for each interruption or extension, the dates of each interruption or extension, and whether each interruption or extension was approved or unapproved. Yes ☐ No ☐

   ☐ Personal or family — From __________ to __________ ☐ Approved ☐ Unapproved
   ☐ Academic remediation — From __________ to __________ ☐ Approved ☐ Unapproved
   ☐ Health — From __________ to __________ ☐ Approved ☐ Unapproved
   ☐ Financial — From __________ to __________ ☐ Approved ☐ Unapproved
   ☐ Participation in a joint degree program — From __________ to __________ ☐ Approved ☐ Unapproved
   ☐ Participation in a non-research special study (e.g., fellowship, intl. experience) — From __________ to __________ ☐ Approved ☐ Unapproved
   ☐ Other __________________________ — From __________ to __________ ☐ Approved ☐ Unapproved

2. Do the official records for this individual reflect that he/she was ever placed on academic or disciplinary probation during his/her medical/osteopathic education? **If yes,** indicate below the reasons for each time of probation and the dates of placement on and removal from probation. Also attach documentation or information of each circumstance and outcome. Yes ☐ No ☐

☐ Academic	From __________ to __________	☐ Documentation attached
☐ Unprofessional conduct	From __________ to __________	☐ Documentation attached
☐ Behavioral reasons	From __________ to __________	☐ Documentation attached
☐ Other __________________________	From __________ to __________	☐ Documentation attached

3. Do the official records for this individual reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical/osteopathic school or parent university? **If yes,** explain below and/or attach documentation or information of each circumstance and outcome. Yes ☐ No ☐

4. Do the official records for this individual reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical/osteopathic school or parent university? **If yes,** explain below and/or attach documentation or information of each circumstance and outcome. Yes ☐ No ☐

5. Do the official records for this individual reflect that there were ever any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason? **If yes,** explain below and/or attach documentation or information of each circumstance and outcome. Yes ☐ No ☐

I CERTIFY THAT to the best of my knowledge and belief, the foregoing is a true, accurate and complete statement of the record of the individual named on this form.

Signature ____

Print name ____

AFFIX INSTITUTIONAL SEAL HERE

(If no seal is available, this form must be notarized.)

Title ____________________________ Date _______________

Phone number _________________ Fax number ___________

Email ____

Please mail this completed form and any other items to the board at the address listed in Section 1. Thank you.

UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

For State Board Use Only

Postgraduate Training Verification Form (Form #3)

Applicant: DO NOT COMPLETE THIS FORM IF YOU ARE USING FCVS. FCVS verifies this data for you. If you are not using FCVS, complete Section 1 below. Send this form to the current program director of your postgraduate training program. Copy this form for multiple programs.

Program Director or Designated Official: Complete Section 2 of this form. Report internship, residency, and fellowship years on separate pages. Make copies of this form and attach additional pages as needed. Mail completed pages and any other documentation if needed to the board at the address listed in Section 1.

Section 1: Applicant Information

First name ______________________ Last name ______________________ Practitioner Type ☐ MD ☐ DO ☐ ____

Middle name ____________________ Suffix ________ SSN* ____________ Birth date (mm/dd/yyyy) ____________

Name if different when diploma awarded ____

Name of postgraduate training program ____

**The social security number is to be used for purposes of identification only and may not be used for any other reason.*

Waiver for Release of Information: I request that the program director or a designated official complete Section 2 of this form as outlined above. I authorize the postgraduate training program listed above to provide any and all information pertaining to my training there to the board listed below:

Board name ______________________________

Mailing address ______________________________

City/State/Zip ______________________________

Applicant signature ______________________________ Date _______________

Section 2: Postgraduate Training Verification

Institution name ______________________________ Affiliated school ______________________________

Institution address w/country ______________________________

Program year(s) _____ Attendance (mm/yyyy) from __________ to __________ Specialty ________________________

Program type ☐ Internship ☐ Residency ☐ Internship/Residency
☐ Transitional ☐ Fellowship ☐ Fellowship/Research ☐ Other ______________________

Training status ☐ Completed ☐ In Training ☐ Not Started ☐ Leave of Absence ☐ Withdrawn ☐ Dismissed

Accredited by ☐ ACGME ☐ AOA ☐ APPAP ☐ CFPC ☐ LCGME ☐ RCPSC ☐ RSC ☐ None

The following questions apply to unusual circumstances that occurred during any part of the individual's training. Check the appropriate responses and explain any "Yes" response on a separate sheet of paper. Attach pages as needed.

1. Did this individual ever take a leave of absence or break from training? Yes ☐ No ☐
2. Was this individual ever placed on probation? Yes ☐ No ☐
3. Was this individual ever disciplined or placed under investigation? Yes ☐ No ☐
4. Were any negative reports for behavioral reasons ever filed by instructors? Yes ☐ No ☐
5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems, or any other reason? Yes ☐ No ☐

I CERTIFY THAT to the best of my knowledge and belief, the foregoing is a true, accurate and complete statement of the record of the individual named on this form.

Signature ______________________________

Print name ______________________________

AFFIX INSTITUTIONAL SEAL HERE

(If no seal is available, this form must be notarized.)

Title ____________________ Date ______________

Phone number ______________ Fax number ___________

Email ______________________________

Please mail this completed form and any other items to the board at the address listed in Section 1. Thank you.

UA | UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

For State Board Use Only

Fifth Pathway Verification Form (Form #4)

Applicant: DO NOT COMPLETE THIS FORM IF YOU ARE USING FCVS. FCVS verifies this data for you. If you are not using FCVS, complete Section 1 below. Send this form to your Fifth Pathway program director.

Program Director or Designated Official: Complete Section 2 of this form. Mail this completed form and any other documentation (if applicable) to the board at the address listed in Section 1.

Section 1: Applicant Information

First name ______________________ Last name ______________________ Practitioner Type ☐ MD ☐ DO ☐ ____
Middle name ____________________ Suffix ________ SSN* ____________ Birth date (mm/dd/yyyy) ____________
Name if different when certificate awarded ____
Name of medical school ____

**The social security number is to be used for purposes of identification only and may not be used for any other reason.*

Waiver for Release of Information: I request that the program director or a designated official complete Section 2 of this form as outlined above. I authorize the designated official to provide any and all information pertaining to my time there to the board listed below:

Board name ________________________________
Mailing address ________________________________
City/State/Zip ________________________________

Applicant signature ____ Date ______________

Section 2: Fifth Pathway Verification

Institution name ______________________________ Affiliated school ______________________________
Institution name if different when applicant attended ______________________________
Institution address w/country ______________________________

Type of Clinical Rotation	From	To	Weeks Credit
______________________	__________	__________	____
______________________	__________	__________	____
______________________	__________	__________	____
______________________	__________	__________	____

Completed? ☐ Yes. Attendance was from ____________ to ____________. Completion date was ____________.
☐ No. Withdrawal* date was ____________. **If the applicant withdrew or was dismissed, please explain below.*
☐ No. Dismissal* date was ____________. **If the applicant withdrew or was dismissed, please explain below.*

I CERTIFY THAT to the best of my knowledge and belief, the foregoing is a true, accurate and complete statement of the record of the individual named on this form.

Signature ______________________________
Print name ______________________________
Title ______________________ Date ______________
Phone number ______________ Fax number ____________
Email ______________________________

AFFIX INSTITUTIONAL SEAL HERE
(If no seal is available, this form must be notarized.)

Please mail this completed form and any other items to the board at the address listed in Section 1. Thank you.