MINNESOTA BOARD OF MEDICAL PRACTICE

University Park Plaza • 2829 University Avenue SE Suite 500 • Minneapolis, MN 55414-3246
Telephone (612) 617-2130 • Fax (612) 617-2166 • www.bmp.state.mn.us
MN Relay Service for Hearing Impaired (800) 627-3529

PHYSICIAN INSTRUCTIONS

Please review these materials thoroughly before submitting your application. **DO NOT make commitments to start practicing medicine in Minnesota until you have been issued a license. Any processing fees incurred are your responsibility.** The Board reserves the right to reject any outdated applications submitted; therefore, it is recommended that you use the application in a timely manner. Incomplete applications will be destroyed after six months of inactivity.

The Board **accepts** but does not require the use of the Uniform Application (UA), which is offered as an option. The UA benefits physicians applying for licensure by reducing data entry redundancy on a core licensure application used by other boards using the UA. Board-specific requirements must still be met. UA-specific instructions are located on page 5 of this packet. Physicians have the option of using the Board's Application to Practice Medicine as found on the website http://mn.gov/boards/medical-practice/applicants/apply/ (Physician Application Option 1).

It is your responsibility to make sure your file is complete; i.e. verifications, completed application, recommendations, exam scores, and documentation have been received by our Board.

If any part of this information conflicts with the rules or laws, the rules or laws take precedence. It is your responsibility to comply. Ignorance of the law is not a defense. Call Board offices with any questions.

PHYSICIAN INFORMATION

FEES

The Minnesota Board of Medical Practice application fee of $424 ($200 processing fee, $32 criminal background check fee and $192 annual registration fee) must be submitted with the Minnesota Addendum to Application. *These fees are non-refundable and must be paid in U.S. currency*. Make checks payable to the Minnesota Board of Medical Practice and mail to: Minnesota Board of Medical Practice, University Park Plaza, 2829 University Avenue SE, Suite 500, Minneapolis, MN 55414-3246.

LICENSURE ELIGIBILITY

Domestic Graduate Requirements

1. Graduate of an accredited medical or osteopathic school located in the United States, its territories, or Canada.
2. Successfully complete one year of U.S./Canadian graduate, clinical medical training in a program accredited by the Accreditation Council of Graduate Medical Education (ACGME), the American Osteopathic Association (AOA), the Royal College of Physicians & Surgeons of Canada, the College of Family Physicians of Canada, or other graduate training approved, in advance, by the board as meeting standards similar to those of a national accrediting organization.
3. Successfully complete the USMLE, National Board, LMCC, FLEX or state exam. Applicants licensed in another state must pass the SPEX exam within three attempts if it has been more than 10 years since taking the initial licensing exam unless currently certified by a specialty board of the American Board of Medical Specialties, of the American Osteopathic Association Bureau of Professional Education, of the Royal College of Physicians and Surgeons of Canada, or of the College of Family Physicians of Canada.

International Graduate Requirements

1. Graduate of a medical school listed in the International Medical Education Directory (IMED).
2. Successfully complete two years of U.S./Canadian graduate, clinical medical training in an accredited program unless:
    a) admitted as a permanent immigrant to the United States as a person of exceptional ability in sciences pursuant to rules of the U.S. Department of Labor; or
    b) issued a permanent immigrant visa as a person of extraordinary ability or as an outstanding professor or researcher and has a valid medical license in another country; or
    c) licensed in another state and practiced 5 years without disciplinary action in the US/Canada, completed one year U.S./Canadian accredited training and passed SPEX within three attempts in 24 months prior to licensing. See Minn. Stat. §147.037 Subd. 1(d) for details.
3. ECFMG Certificate
4. Successfully complete the USMLE, FLEX, LMCC or state exam. Applicants licensed in another state must pass the SPEX exam within three attempts if it has been more than 10 years since taking the initial licensing exam unless currently certified by a specialty board of the American Board of Medical Specialties, of the American Osteopathic Association Bureau of Professional Education, of the Royal College of Physicians and Surgeons of Canada, or the College of Family Physicians of Canada.

LICENSURE EXEMPTIONS

Minnesota does not require the following physicians to be licensed while:

1. Practicing at a federal facility providing he/she is licensed elsewhere.
2. In actual consultation here providing he/she is licensed in another state or country.
3. Serving as a camp doctor in Minnesota; however, physicians must register with the board. There is no fee involved.
4. A student practicing under the direct supervision of a preceptor and attending a recognized medical school.
5. Performing the duties of an intern or resident or engaged in postgraduate work approved by the board as meeting standards similar to those of a national accrediting organization provided the student has a residency permit issued by the Board.
6. Employed in a scientific, sanitary or teaching capacity by a bona fide educational institution or state health department while engaged in such duties.
7. Providing medical services at competitive athletic event if physician is registered with the Board and is licensed in another state.

A personal appearance is no longer required for all applicants, but may be required for some applicants to resolve issues during the application review process. A notarized driver's license, legible with a clear photo, is accepted in lieu of the personal appearance.

USMLE EXAMINATION ADMINISTRATION

Applicants are eligible to take the United States Medical Licensing Exam (USMLE) Step 3 providing the following requirements are met by the Step 3 examination date:

1. MD (or equivalent) or DO degree has been conferred;
2. Notice of successful completion of USMLE Step 1 and Step 2 within three attempts has been received;
3. Be currently enrolled in or completed a postgraduate training program accredited by the Accreditation Council for Graduate Medical Education (ACGME), the American Osteopathic Association (AOA), College of Family Physicians of Canada (CFPC), or the Royal College of Physicians and Surgeons of Canada (RCPSC).

The USMLE Step 3 must be passed within five years of Step 2 or before the end of residency training. The Board has contracted with the Federation of State Medical Boards (FSMB) to provide application processing and test administration services. Information is available at http://www.fsmb.org/licensure/usmle-step-3/.

Eligibility to sit for USMLE Step 3 does not signify eligibility for a license to practice medicine and surgery in Minnesota. The licensure application process is separate from the exam application process.

EXAMINATION REQUIREMENTS

- USMLE: Applicants must have passed USMLE Steps 1, 2 and 3 within three attempts. Four attempts are allowed if currently licensed in another state and currently certified by a specialty board of ABMS, AOABPE, RCPSC, or CFPC. USMLE Step 3 must be passed within five years of Step 2 or before the end of residency training. Applicants must pass each step with passing scores as recommended by the USMLE program.

  Combinations of FLEX, National Board, and USMLE (as outlined in the USMLE bulletin) may be accepted by the Board as comparable to existing exam sequences, but all exams must be passed within three attempts and completed prior to the year 2000.

- COMLEX EXAM-USA: Applicants must have passed levels one, two and three with passing scores within three attempts.

- FLEX: Eligibility requirements for medical licensure in Minnesota based on the FLEX exam are as follows:

  1. Applicants who took and passed FLEX prior to 1985 must have passed in one sitting within five attempts.
  2. Applicants who took and passed FLEX between 1985 and 1990 may pass in two sittings providing it is within five attempts.
  3. Applicants who have made up to five attempts to pass FLEX (some attempts before 1985 and some between 1985 and 1990, inclusive) may pass in two sittings between 1985 and 1990.
  4. Applicants taking FLEX after 1990 may pass in two sittings within three attempts

  The latest score is the “official score”. Passing score is a weighted average of 75 prior to 1985; thereafter, the passing score is 75 on each component.

CONTINUING MEDICAL EDUCATION

Each licensed physician must obtain 75 hours of continuing medical education (CME) category 1 credit every three years as a condition of licensure renewal. The Board accepts (re)certification or current Maintenance of Competency issued by ABMS, RCPSC, CFPC, or AOA in lieu of CME. Newly licensed physicians commence their three year cycle on their birth month following the initial date of licensure. Physicians under Emeritus registration and licensees in full-time residency or fellowship training at a professionally accredited facility are exempt from the continuing medical education requirement.

RENEWAL CYCLE

Medical licenses must be renewed annually based on birth month. Renewal notices are sent approximately 45 days prior to expiration. It is the physician’s responsibility to keep the Board advised of their current address. The Board is obligated to mail the renewal information to the address on file. Failure to receive the renewal information does not relieve physicians of their renewal obligation. Physicians practicing in Minnesota without a current, valid license are practicing illegally which may result in potential liability or disciplinary action. Physicians not practicing in Minnesota who allow their license to lapse are cancelled after two years due to nonrenewal and must reapply and meet the requirements in place at the time in order to resume practice in Minnesota.

NOTICE

In accordance with Minnesota Statute 147.091, the Board may deny an application or grant a restricted license based on the following conduct:

a) Failure to demonstrate qualifications or satisfy licensure requirements.
b) Obtaining a license by fraud or cheating, or attempting to subvert the licensing examination process
c) Conviction, during the previous five years, of a felony reasonably related to the practice of medicine.
d) Revocation, suspension, restriction, limitation, or other disciplinary action against the person's medical license in another state or jurisdiction, failure to report to the board that charges regarding the person's license have been brought in another state or jurisdiction, or having been refused a license by any other state or jurisdiction.
e) False or misleading advertising.
f) Violating a rule promulgated by the board or an order of the board, a state, or federal law which relates to the practice of medicine or a state or federal narcotics or controlled substance law.
g) Engaging in any unethical conduct; conduct likely to deceive, defraud, or harm the public, or demonstrating a willful or careless disregard for the health, welfare or safety of a patient; or medical practice which is professionally incompetent.
h) Failure to supervise a physician's assistant or failure to supervise a physician under any agreement with the board.
i) Aiding or abetting an unlicensed person in practice of medicine.
j) Adjudication as mentally incompetent, mentally ill or mentally retarded, or as a chemically dependent person, a person dangerous to the public, or a person who has psychopathic personality by a court of competent jurisdiction.
k) Engaging in unprofessional conduct including any departure from or the failure to conform to the minimal standards of acceptable and prevailing medical practice.
l) Inability to practice medicine with reasonable skill and safety to patients by reason of illness, drunkenness, use of drugs, narcotics, chemicals or any other type of material or as a result of any mental or physical condition, including deterioration through the aging process or loss of motor skills.
m) Revealing a privileged communication from or relating to a patient except when otherwise required or permitted by law.
n) Failure by a doctor of osteopath to identify the school of healing.
o) Improper management of medical records.
p) Fee splitting.
q) Engaging in abusive or fraudulent billing practices.
r) Becoming addicted or habituated to a drug or intoxicant.
s) Prescribing a drug or device for other than medically accepted therapeutic purposes.
t) Inappropriate sexual conduct.
u) Failure to fulfill reporting obligation.
v) Knowingly providing false or misleading information directly related to the care of a patient unless done for accepted therapeutic purposes; e.g. administration of placebo.
w) Aiding suicide or aiding attempted suicide.
x) Practicing under lapsed or non-renewed credentials.
y) Failure to repay a state or federal secured student loan in accordance with loan provisions.
z) Providing interstate telemedicine services other than according to section 147.032.

The Board may not grant a license to practice medicine to any person who has been convicted of a felony-level criminal sexual conduct offense. "Conviction" means a plea of guilty, a verdict of guilty by a jury, or a finding of guilty by the court and "criminal sexual conduct offense" means a violation of section 609.342 to 609.345 or a similar statute in another jurisdiction.

The Board will closely examine any application where applicant has been disciplined in another state.

INSTRUCTIONS FOR COMPLETING THE MINNESOTA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE (UA)

FEDERATION CREDENTIALS VERIFICATION SERVICE (FCVS)

The Board **accepts** but does not require the use of FCVS for credentials verification as part of the licensure process. Using primary source verified credentials, FCVS creates a personalized profile that can be updated and sent to additional boards as needed throughout your career. The profile eliminates the re-verification of items that never change.

If you do not use FCVS, you must complete forms #2 and #3 and provide them directly to the Board for verification.

If you use FCVS, you will still need to complete a license application, but you will not need to complete the medical education and post graduate training verification forms.

To work on the initial FCVS application for creating a profile or the subsequent FCVS application for updating an existing profile, visit https://portal.fsmb.org/MyFsmb/ and click on the FCVS graphic, then sign in as directed. If the link doesn't work, click on the FCVS link listed in the Licensure menu on http://www.fsmb.org/. The Board must be designated to receive your FCVS profile. Self designations are not accepted.

For assistance, use the messaging tool within FCVS or call 888-275-3287 with your FCVS ID number between 8am and 5pm CT Monday through Friday.

UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE (UA)

To work on the Uniform Application to apply for licensure, visit https://portal.fsmb.org/MyFsmb/ and click on the UA graphic, then sign in as directed. If the link doesn't work, click on the Uniform Application link listed in the Licensure menu on http://www.fsmb.org/. Complete as instructed in each section.

To open an already submitted UA for editing, select the appropriate Board from the State Board section. Update your UA as needed, then submit your UA to the Board.

Please note the following:

- The Board will not start the application process until the addendum, Certificate of Ethical and Moral Character, Facilities List, Hospital Privileges Verification Form, and the required fees are received by the Board.

- Minn. Stat. § 147.091 Subd. 7(d) requires all applicants to provide their social security number on their license application for the administration of the state tax code. Your social security number is private. Your social security number is also required to facilitate reporting of The Data Bank and for accurate identification under the federal and state child support enforcement law. The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard and a unique number for covered health care providers.

- ***The name in the UA and on the medical school diploma must be the same. This requirement must be met or your entire application will be returned.*** If there has been a name change, submit a notarized copy of the documentation, e.g. marriage certificate, within 30 days.

- Provide both your current home address and your current business or school address. Do not enter the same address for both home and business/training, otherwise an error will occur. Make sure all contact information is current as it will become public information once your application is approved for license, per Minn. Stat. § 13.41 Subd. 2.

- Applicants that went through a Fifth Pathway should contact ua@fsmb.org for a Fifth Pathway Verification form.

- You are not able to edit or add MD or DO license information in the UA, as that data comes into the system directly from the state boards. If changes are needed, email ua@fsmb.org with the correct information. Licenses held outside of the U.S. and Canada must be listed in the Addendum.

- Enter all other health related and professional licenses (nurse, EMT, physician assistant, etc.) you have held in the U.S. or Canada regardless of status. Request verification from these boards.

- ***All of your time from high school (not medical school graduation) to the date of application must be accounted for on the Chronology of Activities page.*** *Your ACGME and non-ACGME postgraduate training should be pre-filled from your entries on the earlier pages. Use the first day of the month for start dates and use the last day of the month for end dates unless you know the exact date.* ***This requirement must be met or your entire application will be returned.***

- During continuous years of education, periods of three months or less (summer break) need not be accounted for. List as practice references any facility where you are being paid outside of the internship or residency program even if you are practicing at the same facility.

- For each malpractice suit in which you have been named, you must include a detailed clinical explanation of the situation and insurance papers or other formal documentation of the outcome/status.

If you are using FCVS for credentials verification,

- Do not complete the verification forms for Medical Education Verification, Postgraduate Training Verification, or Fifth Pathway. 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,

- Contact each appropriate examination entity (NBME, NBOME/COMLEX-USA, USMLE/FLEX/SPEX, LMCC, State Board) 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 USMLE or FLEX, you must request your transcripts from the NBME. For exam entity contact information, see the UA FAQ at http://www.fsmb.org/licensure/uniform-application/faq. A directory of state medical boards is available at http://www.fsmb.org/policy/contacts.

- Physicians who have not taken USMLE Step 3 should wait until Step 3 has been passed to ensure the score report includes Step 3. The Examination and Board Action History Report (EBAHR) is to be downloaded as well.

- Hard copy requests are required for LMCC verification.

- The SPEX exam is required to be passed within three attempts if you have not passed any of the other licensing examinations listed above during the last ten years and you are not currently certified by the American Board of Medical Specialists, American Osteopathic Association Bureau of Professional Education, Royal College of Physicians and Surgeons of Canada, or College of Family Physicians of Canada. The examination is a computer-based exam administered by the FSMB through Prometric Centers.

- 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, 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 if applicable. If you receive an error, send a screenshot of the error or the description to ua@fsmb.org.

Uniform Application for Physician State Licensure Checklist

All of the following requirements must be met or your entire application will be returned.

Please note: All verification forms must be submitted before your application is complete. It is your responsibility to make sure these forms are completed and received by our office.

The Board must receive separate verification forms completed by medical schools attended, all post graduate internship, residency, fellowship, research or other medical training programs, specialty boards, each hospital where you have held privileges outside a post graduate training program during the last ten years, each state board where you have held a medical license and recommendations from two of the physicians you named as references during your last five years of practice who can testify to your character, personal reputation, background, and professional ability. A verification must be received from every board issuing any type of license to you, including training, locum tenens, and temporary permit. If you are using FCVS for credentials verification, some of the verifications will be completed and sent to the Board on your behalf.

Mail the following items to the Board.	Not Using FCVS	Using FCVS
- Application fee of $424 ($200 processing fee, $32 criminal background check fee and $192 annual registration fee) sent to the Board. *These fees are not refundable and must be in U.S. currency.* Make checks payable to the **Minnesota Board of Medical Practice.**	☐	☐
- Completed Uniform Application Addendum and all related documentation.	☐	☐
- Notarized copy of driver's license as a true likeness. The copy must be legible with a clear photo.	☐	☐
- Notarized copy of military discharge papers (DD Form 214), if applicable.	☐	n/a
- Supporting documentation of any legal name change (marriage certificate, divorce decree, or court document) sent to the Board.	☐	n/a
- Copy of your postgraduate training certificate(s).	☐	☐
- Notarized "UA Affidavit and Authorization for Release of Information" form. A full face, recent 2"x3" photograph must be affixed as indicated and notarized next to the picture as a true likeness. The notary seal must fall partly on the photograph and partly on the form.	☐	☐
- Facilities List form.	☐	☐
- Form for Treating Physician Statement.	☐	☐
- Form of Moral and Ethical Character.	☐	☐
- U.S. / Canadian Graduates only: An 8 ½" x 11" copy of medical diploma and first year postgraduate training certificate, if issued.		
- International Medical Graduates only: Copies of the following original documents with certified translations.		
a. **Notarized** birth record/passport	☐	n/a
b. **Notarized** medical diploma	☐	n/a
c. U.S./Canadian postgraduate certificates	☐	n/a
d. ECFMG certificate	☐	n/a

(continued on next page)

Uniform Application for Physician State Licensure Checklist (continued)

Complete the following items. Forms are included in this packet.	Not Using FCVS	Using FCVS
- Online Uniform Application. *Please note: The name in the UA and on the medical school diploma must be the same. All of your time from high school (not medical school graduation) to the date of application must be accounted for on the Chronology of Activities page.*	☐	☐
- Request a National Practitioner Data Bank Self-Query to be sent to the Board. Visit http://www.npdb-hipdb.hrsa.gov/pract/hasAReportBeenFiledOnYou.jsp and click on "Start a Self-Query on an Individual (Search on Myself)." Complete the required information on the Self-Query Input screens and generate a **Response to Self Query** online. A PDF will be sent to you by NPDB, for your records and a hard copy envelope will follow in the mail. Alternatively, print a copy of the generated Self-Query, sign the formatted copy (in ink) in the presence of a notary public and mail the notarized form to The Data Bank, requesting a mailed copy so that The Data Bank will mail the Self Query report directly to you. The **Response to Self Query (Response)** must be forwarded directly to this office in one of the following ways: 1. Submit the unopened hard copy **Response** envelope; or 2. If opened, submit a notarized copy of the **Response**. Call 800-767-6732 or email help@npdb-hipdb.hrsa.gov for assistance.	☐	☐
- Contact your examination entity(ies) and request transcripts to be sent to the Board. Contact information is available in the UA FAQ at http://www.fsmb.org/licensure/uniform-application/faq.	☐	n/a
- International Medical Graduates only: Contact ECFMG and request a Status Report to be sent to the Board.	☐	n/a
Form for Certification of Medical Education. Send this form to each medical school attended, even if you did not graduate. Medical schools must send the completed forms **directly** to the Board. Some schools will also provide a copy of your diploma upon request.	☐	n/a
Form for Verification of Postgraduate Training. Send this form to each training program whether or not it was accredited or completed. The training programs must send the completed forms **directly** to the Board.	☐	n/a
Form for Physician Verification of Licensure. Verification must be received from every board issuing any type of medical license, training permit, locum tenens, or temporary permit. Make photocopies as necessary. Use the Licensure Verification Information resource at http://www.fsmb.org/licensure/uniform-application/ to determine a verifying board's preferred method and fees, if applicable. Verifications through VeriDoc are also accepted. Log on to www.veridoc.org and follow the onscreen instructions.	☐	☐
Form for Hospital Privileges Verification. Submit the Hospital Privileges form to each hospital listed on the Facilities list. The Hospital must send the completed forms **directly** to the Board.	☐	☐
Form for Verification of Specialty Board Certification. If it has been ten years since you passed the licensing exam, you must be currently specialty board certified by ABMS, AOA/BOS, RCPSC, or CFPC. Submit this form to the appropriate specialty board. The verification must be sent **directly** to the Board from the specialty board.	☐	☐
Form for Physician Recommendation. Obtain recommendations from two physicians you have known for at least one year and practiced with during the last five years who can testify to your character, personal reputation, background, and professional ability. The physicians must send the completed forms **directly** to the Board.	☐ ☐	☐ ☐

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Addendum to Application Cover Sheet

Basis for Application (Check One):

- ☐ Federation Licensing Examination (FLEX)
- ☐ National Board of Medical Examiners Examination (NBME)
- ☐ National Board of Osteopathic Medical Examiners Examination (NBOME)
- ☐ Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA)
- ☐ Licentiate of Medical Council of Canada Examination (LMCC)
- ☐ State Board Examination (State Board)
- ☐ United States Medical Licensing Exam (USMLE)
- ☐ Combination of FLEX, NBME, USMLE (must be completed by year 2000)

For Board Use Only

Application #: _____

Check/Receipt #: _____

Amount Paid: _____

License #: _____

Account Code	Amount
635009 lic	
635010 app	
635064 cbc	

Instructions

Complete each section of the Addendum as instructed. Please type or print your responses and your identifying info at the bottom of the addendum pages.

If additional space is necessary, attach a separate sheet referencing the question number to which you are responding.

If the answer to any question is “yes”, please explain in detail on the addendum, using a separate sheet if necessary. Additional documents may be required.

Return the completed addendum along with this cover page, application fee of $424, forms, and other required documents to the Minnesota Board. Use the checklists to ensure you send all required items.

IMPORTANT NOTICE: Minnesota Statute, Section 214.074 requires that all new applicants for licensure must complete a fingerprint – based criminal background check. Applications received on and after December 1, 2017 must include the $32 criminal background check fee or they will be returned. For more information please visit: https://mn.gov/boards/medical-practice/.

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Addendum to Application

1. Business Address

Effective August 1, 2012, Minn. Stat. §214.073 requires licensees to provide their primary business address at the time of initial application and all subsequent renewals. Your primary business address is public and you are required to submit it for application purposes. Your license will not be issued without it unless you check the box below certifying that you are not currently in the workforce related to your practice.

Facility name: _____

Street Address: _____

City / State or Province / Zip: _____

☐ I certify that I am not currently in workforce related to my practice, and I don't have a business address related to my practice.

2. Military Status

Are you or your spouse returning from active military duty (discharged less than 6 months ago) or still in active military duty? ☐ No ☐ Yes - me. ☐ Yes - spouse. If discharged, provide discharge date: _____

☐ I certify that I have not served any military duty.

☐ I certify that I have served military duty in the following branch of service: _____

Rank at Discharge: _____ Type of Discharge: _____

Entry Date (mm/dd/yyyy): _____ Release Date (mm/dd/yyyy): _____

3. Criminal Conviction(s)

Effective July 1, 2013, Minn. Stat. §214.072 requires the Board to collect and post on its website the names and business address of each regulated individual who has been convicted of a felony or gross misdemeanor occurring on or after July 1, 2013 in any state or jurisdiction. This information shall be posted for new licensees issued a license on or after July 1, 2013 and for current licensees upon license renewal occurring on or after July 1, 2013. This information is public and you are required to submit it for application purposes. You must notify the Board if a previously reported conviction has been expunged and provide written documentation of expungement.

If you have more than two items to report, attach additional sheets as needed.

☐ I certify that I have had no felony or gross misdemeanor on or after July 1, 2013.

☐ I certify that I have had the following felony or gross misdemeanor on or after July 1, 2013:

1. Conviction Date (mm/dd/yyyy): _____ Conviction Type: ☐ Felony ☐ Gross misdemeanor

Crime Description: _____

City: _____ State: _____ County: _____ Country: _____

Sentence: _____

_____

2. Conviction Date (mm/dd/yyyy): _____ Conviction Type: ☐ Felony ☐ Gross misdemeanor

Crime Description: _____

City: _____ State: _____ County: _____ Country: _____

Sentence: _____

_____

4. Malpractice Liability Claims Information

The Board requires all applicants to complete the Malpractice Liability Claims Information page within the online Uniform Application unless there have been no claims. Report all claims that are pending or have been dismissed. If you have had no claims, check the box below certifying that you have not had any claims against you and leave the online UA page blank.

☐ I certify that I have never had a malpractice claim, award, judgment, or settlement against me.

☐ I certify that I have listed all malpractice claims information within the online Uniform Application.

5. Additional Physician Information

Alien Registration Number (if applicable): Number _____

Driver's License*: State _____ Number _____

Identifying Characteristics (if you are using FCVS, you do not need to complete this question):

Height (ft/in.) _____ Weight (lbs) _____ Hair Color _____ Eye Color _____

Identifying marks _____

Your intended street address (if known): _____

City / State or Province / Zip / Country: _____

Effective Date: _____

Proposed practice plans in Minnesota (if any): _____

**Submit a copy of your driver's license notarized as a true likeness to the Board. The copy must be legible with a clear photo.*

6. Countries (other than U.S. and Canada) in which you have ever been licensed

Country: _____ License Number: _____ Date Issued: _____

Country: _____ License Number: _____ Date Issued: _____

Country: _____ License Number: _____ Date Issued: _____

Country: _____ License Number: _____ Date Issued: _____

7. Membership in Professional Societies and Organizations

Organization: _____ From (mm/yy): _____ To (mm/yy): _____

Organization: _____ From (mm/yy): _____ To (mm/yy): _____

Organization: _____ From (mm/yy): _____ To (mm/yy): _____

Organization: _____ From (mm/yy): _____ To (mm/yy): _____

Organization: _____ From (mm/yy): _____ To (mm/yy): _____

8. Attestation Questions

Except for questions 1-4, please answer all questions by selecting Yes or No and provide an explanation when requested. Questions 1-4 do not have "No" as an option for confidentiality reasons.

If you have a condition addressed by questions 1-4 and you are NOT participating in Health Professionals Services Program (HPSP) for monitoring of the condition, you must answer "Yes" to the applicable question(s). If you do not have this condition, OR if you are participating in HPSP for monitoring of this condition, do not answer the applicable question(s).

For questions 1-2, the terms "impaired" and "limited" include but are not limited to impairments or limitations related to physical, psychological, or emotional disorders/conditions, or chemical dependency or chemical abuse.

The purpose and intended use of this information is to enable the Board to determine whether you meet statutory and rule requirements for licensure. This information is classified as private while your application is pending and public after your license is granted. Exception: "Yes" answers are confidential during any investigation and private thereafter. This information will NOT be included in the profiling.

If responses to questions change during the time your application is pending, you must make the board aware of the new information. If additional space is necessary, use the end of page 7. Attach a separate sheet if needed.

RIGHTS OF SUBJECTS OF DATA

The information on your application is requested by the Minnesota Board of Medical Practice. The purpose and intended use of this information is to enable the Board to determine whether you meet statutory and rule requirements for licensure. The information is classified as private while your application is pending or if your application is denied, and as public if your license is granted. You are required to submit this information. Your application will not be processed without it and the form will be returned to you for completion. This information may be used as the basis for further investigation by the Board into your qualifications. Under some circumstances, the information could become available to other agencies or persons authorized by law to have access. Attach a separate page for detailed explanations, when appropriate. Failure to answer all questions completely and accurately, omission or falsification of material fact, alteration of application may be cause for denial of your application, or disciplinary action if you are subsequently licensed by the Board.

		YES
1.	Is your cognitive, communicative, or physical capability to engage in the practice of medicine or surgery with reasonable skill and safety impaired or limited in any way? Please describe.	☐
1a.	If yes, are the limitations or impairments reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? Please describe.	☐
1b.	If yes, are the limitations or impairments reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? Please describe.	☐
2.	Does your use of alcohol or chemical substance(s), including prescription medications, in any way impair or limit your ability to practice medicine with reasonable skill and safety? Please describe.	☐

		YES	NO
3.	Are you engaged in any illegal use of controlled substances including the use of illegal controlled substances (e.g. heroin, cocaine) or illegal use of legal controlled substances (i.e. not obtained pursuant to a valid prescription of a licensed health care provider)? Please describe.	☐	
3a.	If yes, have you taken any steps (i.e. treatment, psychotherapy, participation in a support group) to discontinue or reduce such use? Please describe.	☐	
3b.	If yes, are you now participating in a supervised rehabilitation program or professional assistance program which has as a component a monitoring regimen designed to assure that you are not currently engaging in the use of illegal controlled substances? Please describe.	☐	
4.	Have you within the past five years been advised by your treating physician that you have a mental, physical, or emotional condition, which, if untreated, would be likely to impair your ability to practice medicine with reasonable skill and safety? If you answer this question "yes", please answer the following:	☐	
4a.	With regard to any condition referenced above, are you being treated so that such impairment is avoided?	☐	
4b.	With regard to any condition referenced above, are you in compliance with the recommended treatment?	☐	
4c.	With regard to any condition referenced above, has your treating physician advised you that you are able to practice medicine with reasonable skill and safety?	☐	
4d.	Please explain.		
4e.	Identify your treating physician.	☐	
5.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism, or other sexual behavior disorders? Please describe.	☐	☐
6.	Have you ever been the subject of an investigation by any Federal, State, or Local agency having jurisdiction over controlled substances? If so, give particulars.	☐	☐

		YES	NO
7.	Have you even been denied a license, or the privilege of taking an examination before any medical examining board, or has a conditioned license been issued to you by any state medical board or licensing authority? If so, give particulars.	☐	☐
8.	Has your license to practice medicine in any state or country been voluntarily or involuntarily (i.e. by Medical Board Order or any other form of disciplinary action) revoked, suspended, restricted, or conditioned by a Medical Board or other licensing authority? If so, give particulars.	☐	☐
9.	Have you ever been notified of any investigation by any state medical board, medical society, or any hospital of any complaints against you relative to the practice of medicine, or have you been reprimanded or censured by any medical society or licensing board? If so, give particulars.	☐	☐
10.	Have you ever been a defendant in any malpractice lawsuits, had any malpractice settlement, or have any pending? If so, complete section 4 of this Addendum and give a detailed clinical explanation of each case in the specifics area of the Malpractice Liability Claims Information page within the Uniform Application as well as documentation of outcome (insurance papers or court documents).	☐	☐
11.	Have your hospital privileges been restricted or revoked? If so, give particulars.	☐	☐
12.	Have there ever been any criminal charges filed against you? This includes charges of disorderly conduct, assault or battery, or domestic abuse, whether the charges were misdemeanor, gross misdemeanor, or felony. This also includes any offenses which have been expunged or otherwise removed from your record by executive pardon. If so, complete section 3 in this Addendum and submit a personal statement below regarding the date of conduct, state and local jurisdiction in which the charges were filed, date of closure, what role you played, and the outcome.	☐	☐

	YES	NO
13. Have there ever been any charges of Driving While Intoxicated (DWI) or Driving Under the Influence (DUI) or other impaired driving offenses involving alcohol or other chemical filed against you? If so, submit a detailed personal statement below regarding the date of conduct, state and local jurisdiction in which the charges were filed, explaining in detail the incident and consequences including whether or not a CD evaluation was done (if so, submit results), and description of current drinking habits.	☐	☐
14. Have you ever voluntarily or involuntarily surrendered your DEA certificate or the right to prescribe controlled substances? If so, give particulars.	☐	☐

Use this space for additional information. Be sure to list the question number you are answering.

MINNESOTA BOARD OF MEDICAL PRACTICE

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MN Relay Service for Hearing Impaired (800) 627-3529

Certificate of Ethical and Moral Character

This certificate must be signed by **two** licensed physicians who are personally acquainted with the applicant.

1. I certify that the photograph attached is a recent one and likeness of Dr. _____

and that he/she is a person of good ethical and moral character.

_____ _____
Signature Print or type name

_____ _____ _____
Date License Number State of Issue

CERTIFICATION OF IDENTIFICATION
Certification of Notary Public is required.

State _____ County _____

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 with the signature on his/her identifying document.

Sworn to before me by the applicant on this ____ day of _____, _____,

Notary Public Signature _____

Expiration Date _____/_____/_____

Paste a recent front-view passport-type 2"x2" photo in this square.

SEAL

The impression of the seal must be partly upon the photo

_____
Applicant's Signature

2. I certify that the photograph attached is a recent one and likeness of Dr. _____

and that he/she is a person of good ethical and moral character.

_____ _____
Signature Print or type name

_____ _____ _____
Date License Number State of Issue

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FACILITIES LIST

Minnesota Statute 147.162 requires physicians to submit a list of inpatient and outpatient medical care facilities where you have medical privileges. In addition, the Board requests a list of all facilities where you have had medical privileges during the last 10 years. List any facility where you are getting (have been) paid outside a post graduate internship, residency or fellowship training program. Submit a Hospital Privilege Form to each facility listed except those clinics which are strictly outpatient. If you have had no privileges, write **NONE** and sign and date the form.

CURRENT PRIVILEGES

Facility	City and State	Type of Privilege

PAST PRIVILEGES (LAST 10 YEARS)

Facility	City and State	Type of Privilege

I hereby certify that the above is a true and accurate list of inpatient and outpatient facilities at which I have (have had) medical privileges.

Print Name_____

Signature_____ Date_____

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Treating Physician Statement

Applicant: Applicants who have a medical condition during the last five years which, if untreated, would be likely to impair their ability to practice with reasonable skill and safety must have their treating physician complete this form. A treating physician is the physician who diagnosed and provides or provided treatment for the condition and includes the current treating physician. **If not applicable, write "not applicable" on the form and submit with the application.**

Treating Physician: Complete and mail this form directly to the Minnesota Board of Medical Practice. This form is also available on our website.

Applicant's Printed Name_____

Applicant's Date of Birth (Mo/Day/Yr)_____ Health Profession_____

I hereby authorize you, my treating physician, to disclose my medical records to the Minnesota Board of Medical Practice. I hereby release, discharge, and exonerate the Board, its agents, and representatives, and any person furnishing information to the Board from any and all liability of every nature and kind arising out of the furnishing oral information or documents, records, or other information to the Board.

Signed_____ Date_____

Nature of medical condition including diagnosis and significant symptoms

Date first saw patient: _____ **Date last saw patient:** _____

Has the applicant been compliant with treatment? (If no, please explain)
☐ Yes ☐ No

What medications is the applicant taking for this condition?

If this medical condition was untreated, would it be likely to impair the applicant's ability to practice with reasonable skill and safety? (If yes, please explain) ☐ Yes ☐ No

Should the condition be monitored? (If yes, please explain) ☐ Yes ☐ No

Treating Physician (print name)_____

Signature_____ Date_____

Phone_____ Fax_____

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HOSPITAL PRIVILEGES VERIFICATION

As part of the medical license application process, the Minnesota Board of Medical Practice requires that this form be completed by each hospital where the applicant has held formal privileges within the last ten years. This form must be completed by each hospital listed on the Facilities List and mailed directly by each facility to the **Minnesota Board of Medical Practice**. Any processing fees are applicant's responsibility. The applicant's signature authorizes release of information, favorable or otherwise, directly to the Board.

Print Name _____ Birthdate _____ Last 4 digits of SSN _____

Signature _____ Date _____

THE HOSPITAL COMPLETES THE FOLLOWING INFORMATION:

IT IS HEREBY CERTIFIED THAT: (Name of Physician) _____

HAD HOSPITAL PRIVILEGES AT: (Name of Hospital) _____

LOCATED AT: (Address) _____

FROM: (Month, Day, Year) _____ **TO:** (Month, Day, Year) _____

TYPE OF PRIVILEGE: _____

ANY DISCIPLINARY ACTION? Yes* _____ No _____

ANY DEROGATORY INFORMATION ON FILE? Yes* _____ No _____

SEAL**

Print Name _____
Signature _____
Title _____
Date _____
Phone _____
Fax _____

*Please attach letter of explanation.
**If there is no seal, attach letter of explanation on letterhead.

03/14

MINNESOTA BOARD OF MEDICAL PRACTICE

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VERIFICATION OF SPECIALTY BOARD CERTIFICATION

This form is for verification of specialty board certification for applicants who have not taken a licensing exam for 10 years. Applicants are required to pass the SPEX exam if it has been more than 10 years since taking the National Board, FLEX, LMCC, or state exam unless the applicant is currently certified by a specialty board of the American Board of Medical Specialties, the American Osteopathic Association Bureau of Professional Education, the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada. The form must be mailed directly by the specialty board (e.g. American Board of Internal Medicine, **not** American Board of Medical Specialties) to the **Minnesota Board of Medical Practice.** Any fees are applicant's responsibility. The applicant's signature authorizes release of information, favorable or otherwise, directly to the Board.

Print Name _____ Birthdate_____ Last 4 digits of SSN_____

Signature_____ Date_____

THE SPECIALTY BOARD COMPLETES THE FOLLOWING:

IT IS HEREBY CERTIFIED THAT: (Name of Physician)_____

WAS ISSUED A CERTIFICATE ON: (Month, Day, Year)_____

BY: (Name of Specialty Board)_____

A SPECIALTY BOARD OF (CHECK ONE):

_____**The American Board of Medical Specialties**
_____**The American Osteopathic Association/Bureau of Osteopathic Specialists**
_____**The Royal College of Physicians and Surgeons of Canada**
_____**The College of Family Physicians of Canada**

EXPIRATION DATE IS: (Month, Day, Year)_____

SEAL*

Print Name_____
Signature_____
Title_____
Date_____
Phone_____

*If there is no seal, attach letter of explanation on letterhead.

03/14

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PHYSICIAN RECOMMENDATION FORM (2)

This form must be completed and mailed directly to the **Minnesota Board of Medical Practice** by two US or Canadian licensed physicians with whom applicant has worked during the last five years, has known applicant for more than one year and who can testify to applicant's character, personal reputation, background and professional ability. This form does not have to be filled out by the same physicians you have listed on page 9 of the application. The applicant's signature authorizes release of information, favorable or otherwise, directly to the Board.

Applicant Print Name_____

Applicant Signature_____ Date_____

THE PHYSICIAN SERVING AS A REFERENCE COMPLETES THE FOLLOWING:

RECOMMENDATION FOR: (Print Name of Applicant)_____

1. How long have you known the applicant?_____
2. What has been the nature of your relationship with the applicant?_____

_____

3. How would you characterize the moral and professional conduct of the applicant?_____

_____

4. Would you recommend that the applicant be approved for licensure for the independent, unrestricted practice of medicine?_____
5. Circle the word(s) which best describes this applicant.

A.	Marginal*	Fully Meets Standards	A. Clinical skills
B.	Yes*	No	B. Any indication of chemical dependency?
C.	Yes*	No	C. Any indication of malprescribing?

*Please attach letter of explanation.

Completed By:

Printed Name_____ Signed_____

Health Profession_____ License #_____ State_____

Date_____ Phone#_____ Fax_____

Email_____

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UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

State Board Use Only

Affidavit and Authorization for Release of Information

Applicant: Complete this form as directed in the left sidebar. When completed, mail to:

Minnesota Board of Medical Practice
2829 University Avenue SE, Suite 500
Minneapolis, MN 55414-3246

Applicant:

Sign this form with attached photo in the presence of a notary public. Send this notarized form with any other required materials to the Board at the address listed above.

If you are using FCVS for credentials verification, send the separate FCVS affidavit to FCVS. Do not send this form to FCVS.

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 (less than 3 months) 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

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

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

-fold up *-fold up-*

To fit this form in a standard envelope, fold the portion under this line up to cover the photograph, and then fold the top edge over to the new bottom edge.

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: _____

(NOTARY PUBLIC SEAL)

My Notary Commission Expires: _____

Applicant's Name _____ Last 4 Digits of SSN _____ Date _____

UA UNIFORM APPLICATION FOR 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 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 LICENSURE

Postgraduate Training Verification Form (Form #3)

Institution Name: ____

Institution Address: ____

____

Affiliated School: ____

Applicant: Do not complete this form for verification of accredited training if you are using FCVS. FCVS does not verify non-accredited training. When using FCVS, use this form only if your licensing board requires verification of non-accredited training.

Program Director or designated Official: Please complete Section 2, and mail this form and any other items to the designated state medical board at the address listed in Section 1. Thank you.

Section 1:
To be completed by the Applicant.

Name: ______________________ **Suffix** _____ **Practitioner type: M.D.** ☐ **D.O.** ☐

Date of birth: ____________ **(mm/dd/yyyy) SSN*** ______________________

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

Name if different when diploma awarded: ______________________

Board Information: To be completed by the applicant.

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

Board Name: ______________________

Mailing address: ______________________

Applicant Please Sign Here →

Applicant Signature ______________________ **Date** ____________

Section 2 :
Program Participation :

Important:

Report Incomplete Training Levels (years) separate from those that were successfully completed.

If the training level (year) is currently in progress report the expected comple ion date in the "To" field.

Use one section per Department/Specialty. If he Department/Specialty is rotating or transitional, please provide a schedule of rotations.

Report Internships, Residencies and Fellowships separately.

Training Level: _____
(e.g., 1, 2, 3, etc.)
☐Internship
☐Residency
☐Chief Residency
☐Fellowship
☐Research

Specialty/Subspecialty: ______________________

From: __/__/____ **To:** __/__/____

Successfully Completed?: ☐Yes ☐No ☐In Progress

Accredited by: ☐ACGME ☐AOA ☐LCGME ☐RSC ☐CFPC ☐RCPSC ☐APPAP ☐None of these

Training Level: _____
(e.g., 1, 2, 3, etc.)
☐Internship
☐Residency
☐Chief Residency
☐Fellowship
☐Research

Specialty/Subspecialty: ______________________

From: __/__/____ **To:** __/__/____

Successfully Completed?: ☐Yes ☐No ☐In Progress

Accredited by: ☐ACGME ☐AOA ☐LCGME ☐RSC ☐CFPC ☐RCPSC ☐APPAP ☐None of these

Training Level: _____
(e.g., 1, 2, 3, etc.)
☐Internship
☐Residency
☐Chief Residency
☐Fellowship
☐Research

Specialty/Subspecialty: ______________________

From: __/__/____ **To:** __/__/____

Successfully Completed?: ☐Yes ☐No ☐In Progress

Accredited by: ☐ACGME ☐AOA ☐LCGME ☐RSC ☐CFPC ☐RCPSC ☐APPAP ☐None of these

Unusual Circumstances:

Check the appropriate responses and explain any "Yes" or omitted response(s) on a separate sheet of paper.
Attach pages as needed.

1. Did this individual ever take a leave of absence or break from his/her 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

Certification: Affix your institutional seal in this space. If no seal is available, you must have this form notarized.

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. This section MUST be signed by the program director (M.D. or D.O. only). **Please Note: The Nevada Board of Medical Examiners requires an authorization letter to be attached if this form is completed by someone other than an M.D. or D.O.**

Signature: ______________________

Print name: ______________________

Title: ______________________

Email address: ______________________

Phone Number: ______________________ **Date:** ______________

UA UNIFORM APPLICATION FOR 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 diploma was 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 _____

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.