Montana Board of Medical Examiners
Physician Application (MD, DO)

P.O. Box 200513 • (301 S Park, 4th Floor – Delivery) • Helena, MT 59620-0513
Phone: (406) 444-5773 • Fax: (406) 841-2305
Email: dlibsdmed@mt.gov • Website: www.medicalboard.mt.gov

PHYSICIANS ARE NOT PERMITTED TO PRACTICE MEDICINE IN MONTANA IN ANY MANNER WITHOUT AN ACTIVE MONTANA LICENSE

(Please allow 30 days for processing from the date that the Board has a complete routine application.)

Licensure Requirements

- Must be a graduate of a medical school approved by the American Osteopathic Association or conforms to The Liaison Committee on Medical Education (LCME).
- U.S. graduates must have successfully completed a Board-approved post-graduate residency program.
- Foreign graduates must complete at least 3 years of post-graduate training in an approved program in the United States or Canada or been granted board certification by a specialty board which is approved by AMA or AOA.
- Foreign graduates must have a certificate from the Educational Commission for Foreign Medical Graduates (ECFMG; www.ecfmg.org) and from the Fifth Pathway Program, if applicable.
- Must have passed a licensing exam, approved by the Board. Please refer to the Board statutes and rules (ARM 24.156.606) for specific information regarding examination information and limits on attempts.
- Must be of good moral character.

Application Processing Procedures

- The fee for licensure application is $500. Make checks payable to **Montana Board of Medical Examiners**.
- When the application file is complete, it will be processed and considered by Board staff for permanent licensure. The applicant may be notified if additional information is required or if required to appear before the Board for an interview. Once a routine application is complete, the application may take up to 30 days to process.
- You will be notified by mail when the application has been successfully processed and you have been licensed to practice medicine in Montana.
- Applicants will be notified in writing of any deficient or missing items from the application file.
- If the application is considered a non-routine application, there will be a delay in processing of the application. You may be requested to provide additional information or make a personal appearance before the Board during a regularly scheduled Board meeting and/or the application may require Board consideration. You will be notified in writing if you are required to appear before the Board.
- **For an application requiring review by the full Board, all materials must be received by the Board office no later than 15 working days prior to the Board's next scheduled meeting. Applications completed after that deadline will not be put on the Board's agenda.** The Board meets six times per year (generally the third Friday of odd-numbered months) beginning in January. Please visit www.medicalboard.mt.gov for exact meeting dates.
- Keep the Board office informed at all times of any address changes, changes in license status and complaints or proposed disciplinary action. This is essential for timely processing of applications and subsequent licensure.

PLEASE BE SURE TO REVIEW THE MONTANA LAWS AND RULES FOR THE PRACTICE OF MEDICINE ON OUR WEBSITE: www.medicalboard.mt.gov.

Uniform Application for Physician State Licensure (UA)

- The Montana Board of Medical Examiners was one of the first medical boards to implement the "Uniform Application for Physician State Licensure" or "UA". The UA benefits physicians applying to more than one participating medical or osteopathic board during the span of their career by reducing data entry redundancy. The core Uniform Application information can be updated and sent to additional boards as needed, leaving only board-specific requirements to be completed.

- To start or update your UA, 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 the online Uniform Application as instructed in each section.

The Federation Credentials Verification Service (FCVS)

- The Board accepts the use of the FCVS as part of the licensure process, but FCVS is not required for licensure. FCVS is for credentials verification only. FCVS staff verifies primary source documents related to your identity, education, training, and more, creating a personalized profile that eliminates the re-verification of items that never change. Your profile can be updated and sent to additional boards as needed.

The FCVS application does not replace the Montana Board of Medical Examiners Application (UA).
If you choose to use FCVS, you will need to complete both applications separately.

- If you do not use FCVS, you must provide your credentials directly to the board for verification. If you use FCVS, you will still need to complete the UA, but you will not need to complete several of the UA verification forms.

- To begin an initial or subsequent application for creating or updating your profile of primary source verified credentials, 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 between 8am and 5pm CT Monday through Friday.

Completing the Online Montana Licensure Application

- Read the following information carefully before completing and submitting your application. You will be asked to account for all time since medical school graduation, including providing your employment history, and asked to provide any information on medical malpractice claims. We recommend having this information on hand before you begin working on your UA.

- First time UA users are required to pay a one-time service charge of $60.00. Your receipt will be available immediately after submitting the UA and, you will receive a separate receipt via email.

- Please utilize the checklist in this packet to ensure that you submit all required documentation. **Please note: All documents not in English must be accompanied by certified translations.**

- The UA FAQ at https://www.fsmb.org/licensure/uniform-application/faq answers the most common UA questions. If your question or issue isn't listed, contact UA customer service at 800-793-7939 or email ua@fsmb.org with your username or FCVS ID if applicable, and a description of what you were doing at the time.

- For information with regard to the processing of this application or other concerns, please contact the Board of Medical Examiners' staff at (406) 444-5773 or email us at dlibsdmed@mt.gov.

Please note the following:

- The Montana Board **does not require either a notarized copy of your birth certificate or of your current, valid passport.**

- 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. All addresses must be domestic (within the United States).

- 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".

- Enter all other professional licenses (nurse, EMT, physician assistant, etc.) you have held (including active, inactive, training, temporary, etc.) in the U.S. or Canada. Request verification from these boards as well.

- If you hold licenses in countries outside the U.S. or Canada, please provide that information on a separate sheet of paper to the Board.

- On the Chronology of Activities, in addition to listing **all** activities after medical school, the Montana Board of Medical Examiners requests that on a separate sheet of paper, you list the name of each place of employment/practice and your **reason for leaving**.

- If you have no malpractice claims, you may leave that section blank.

- 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.

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

- 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. **The Montana Board of Medical Examiners does not require this form to be notarized, nor does it require a photo.**

- 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 exam entity to have a certified transcript of your scores sent directly to the Board. If you have taken any component of the NBME in conjunction with another exam (USMLE/FLEX), request your transcript from the NBME. For 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. **The Montana Board of Medical Examiners does not require a copy of official medical school transcripts.**

- 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.

UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE
CHECK LIST

	NOT using FCVS to verify credentials	Using FCVS to verify credentials
Completed online uniform application (UA).	☐	☐
Completed state addenda and $500 application fee sent to the Board.	☐	☐
Affidavit and Authorization for Release of Information form sent to the Board. Notarization and photo not needed by the Board.	☐	☐
State Licensure Verification form (Form #1) sent to the Board from all states in which you have ever held any healthcare license.	☐	☐
DD214, Military Discharge Paper (if applicable) sent to the Board.	☐	☐
Notarized copy of birth certificate or current, valid passport sent to the Board.	N/A	Completed via FCVS
Supporting documentation of any legal name change sent to the Board.	☐	Completed via FCVS
Medical Education Verification form (Form #2) sent to the Board from all medical schools attended – include a copy of your diploma (must be sealed by your school).	☐	Completed via FCVS
Medical School Transcripts sent to the Board by your medical school(s).	N/A	Completed via FCVS
Postgraduate Training Verification form (Form #3) sent to the Board from all programs you attended.	☐	Completed via FCVS
A copy of your postgraduate training certificate(s) sent to the Board.	☐	Completed via FCVS
Examination Transcripts sent to the Board.	☐	Completed via FCVS
Foreign Graduates: Fifth Pathway form (Form #4) (if applicable) sent to the Board from the medical school and institution - include a copy of your diploma (must be sealed by your school).	☐	Completed via FCVS
Foreign Graduates: Request for Status Report of ECFMG Certification sent to the Board.	☐	Completed via FCVS

Please note:

The National Practitioner Data Bank (NPDB) is a national database of Board actions and other information about health care licensees across the United States. The Board requires the NPDB Report for all applicants for physician licensure and will obtain it at the Board's expense during the application review process. The information contained in the NPDB report may require an applicant to submit further information to the Board before a licensing decision can be made.

Montana Board of Medical Examiners

Addendum Instructions

Addendum Instructions: Complete the addenda as instructed below. Please type or print your responses. Return the completed addenda along with any and all supporting documentation to the Montana Board.

___ **Addendum 1**: These questions must be completed by the applicant.

___ **Addendum 2**: Each question must be completed by the applicant. Documentation must be provided for most "yes" answers.

___ **Addendum 3**: This form must be completed by the applicant.

Please return completed addenda and payment to the:

Montana Board of Medical Examiners
P.O. Box 200513
Helena, MT 59620-0513

Name of Applicant: _____

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ADDENDUM 1

Application for Licensure as:

☐ Medical Doctor ☐ Doctor of Osteopathy

Foreign ID Number _____

Licensure Name _____
(State your name as it should appear on the license if granted.)

Which exam did you take for initial licensure?

☐ NBME ☐ NBOME ☐ FLEX ☐ USMLE ☐ LMCC

☐ State Exam - List state board: _____ ☐ Pass ☐ Fail

Most recent test date: _____ Number of Attempts: _____

Name of Applicant: _____

Specialty Certification:

1. Have you ever been certified by a Specialty Board? ☐ Yes ☐ No

Certifying Agency	Specialty	Date Awarded	Date Recertified
_____	_____	_____	_____
_____	_____	_____	_____

2. Have you ever been denied specialty certification or failed to pass a specialty certification examination or portion thereof? ☐ Yes ☐ No

If so, by whom? _____

Reason for denial? _____ Number of times failed: _____

AFFIDAVIT:

I authorize the release of information concerning my education, training, record, character, license history and competence to practice, by anyone who might possess such information, to the Montana Board of Medical Examiners.

I hereby declare under penalty of perjury the information included in my application to be true and complete to the best of my knowledge. In signing this application, I am aware that a false statement or evasive answer to any question may lead to denial of my application or subsequent revocation of licensure on ethical grounds. I have read and will abide by the current licensure statutes and rules of the State of Montana governing the profession. I will abide by the current laws and rules that govern my practice.

_____ _____

Signature of Applicant Date

Name of Applicant: _____

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ADDENDUM 2

Please answer each of the following questions by putting a check (✓) in the appropriate box.

Please Note: Some "yes" answers will require you to provide additional information on a separate sheet of paper.

QUESTIONS		YES	NO
1.	If you are a foreign medical graduate, have you satisfied the requirements of the Educational Commission for Foreign Medical Graduates (ECFMG)?	☐	☐
2.	Do you intend to practice in the State of Montana? **If yes,** attach a brief explanation.	☐	☐
3.	Have you ever previously applied for a license to practice in Montana? **If yes,** give date and results.	☐	☐
4.	Have you ever been denied licensure or the opportunity to take this profession's licensing examination in any state or country? **If yes,** attach a detailed explanation.	☐	☐
5.	Have you ever had an application for a professional or occupational license refused or denied? **If yes,** please attach a detailed explanation and provide supporting documentation from the source.	☐	☐
6.	Have you ever withdrawn an application for licensure prior to the licensing agency's decision regarding your application? **If yes,** please attach a detailed explanation and provide supporting documentation from the source.	☐	☐
7.	Have you ever been denied the privilege of taking an examination required for any professional or occupational license? **If yes,** please attach a detailed explanation and provide supporting documentation from the source.	☐	☐
8.	Have you ever withdrawn or been suspended, placed on probation, expelled or requested to resign from any post-secondary educational program? **If yes,** please attach a detailed explanation and provide supporting documentation from the source.	☐	☐
9.	Have you ever requested temporary or permanent leave of absence, been placed on probation, restricted, suspended, revoked, allowed to resign, or otherwise acted against by any professional or occupational education program (i.e. residency, internship, apprenticeship, etc.)? **If yes,** please attach a detailed explanation and provide supporting documentation from the source.	☐	☐
10.	Has a licensing agency initiated or completed disciplinary action against any professional or occupational license you have held? **If yes,** please provide agency documents including the complaint, initiating documents, orders, final orders, stipulations and consent and/or settlement agreements directly from the source.	☐	☐

Name of Applicant: _____

QUESTIONS		**YES**	**NO**
11.	Have you ever voluntarily surrendered, cancelled, forfeited, failed to renew a professional or occupation license in anticipation of or during an investigation or disciplinary proceeding or action? **If yes,** please attach a detailed explanation and provide supporting documentation from the source.	☐	☐
12.	Is there a pending complaint against you with a professional or occupational licensing agency? If yes, please attach a detailed explanation and provide supporting documentation from the source.	☐	☐
13.	Have you ever been the subject of any sanction or action, denial, suspension, revocation, restriction or termination regarding hospital, facility or staff privileges; health maintenance organization participation, third party provider or Medicare/Medicaid participation; or any other privileges? **If yes,** please attach a detailed explanation and provide supporting documentation from the source.	☐	☐
14.	Have you ever been censured, expelled, denied membership or asked to resign from a professional organization related to your profession or occupation? **If yes,** please attach a detailed explanation and provide documentation from the source.	☐	☐
15.	Have you ever been the subject of any sanction or action, denial, suspension, revocation, restriction or termination regarding your ability to prescribe, dispense or administer drugs including controlled substances? **If yes,** please attach a detailed explanation and provide documentation from the source.	☐	☐
16.	Do you have any initiated or completed action against you by any state, federal, tribal, or foreign licensing jurisdiction? (For example: Drug Enforcement Administration; Alcohol, Tobacco and Firearms; Homeland Security; Indian Health Service, etc.) **If yes,** please attach a detailed explanation and provide documentation from the source.	☐	☐
17.	Have any civil legal proceedings been filed against you by a patient/client, former patient/client or employer/employee? **If yes,** attach a detailed explanation and documentation from the source including initiating documents and documentation of final disposition. This includes malpractice claims, settlements, and judgments. This does not include filings with the Montana Medical-Legal Panel.	☐	☐
18.	Have you ever been convicted of a misdemeanor or felony crime or do you have a pending criminal charge? "Convicted" for the purposes of this question includes a conviction under appeal, guilty plea, no contest plea, and/or forfeiture of bond. "A pending criminal charge" for the purposes of this question include a deferred imposition of sentence and/or deferred prosecution. **If yes,** please submit a detailed explanation of the events AND the charging documents and final judgments or orders of dismissal. You must report but may omit documentation for: (1) misdemeanor traffic violations older than 10 years ago and that resulted in fines of less than $200; and (2) convictions prior to your 18th birthday unless you were tried as an adult.	☐	☐
19.	Have you ever been diagnosed with chemical dependency or another addiction, or have you participated in a chemical dependency or other addiction treatment program? **If yes,** please attach a detailed explanation and provide documentation regarding evaluations, diagnosis, treatment recommendations and monitoring from the source.	☐	☐

Name of Applicant: _____

QUESTIONS		**YES**	**NO**
20.	Have you ever been diagnosed within the past 5 years with a physical condition or mental health disorder involving potential health risk to the public? If yes, please provide a detailed explanation.	☐	☐
21.	Have you ever served in any branch of the armed forces? **If yes,** attach a DD214, Military Discharge Paper, if you have been discharged.	☐	☐
22.	Have you ever been court-martialed or discharged other than honorably from any branch of the armed services? **If yes,** attach a detailed explanation and documentation from the source.	☐	☐
23.	Have you any physical or mental condition(s) which may have or has adversely affected your ability to practice this profession, including but not limited to a contagious or infectious disease involving serious risk to the public? **If yes,** attach a detailed explanation.	☐	☐
24.	Have you used alcohol or any other mood-altering substance in a manner which may have or has adversely affected your ability to practice this profession? **If yes,** attach a detailed explanation.	☐	☐

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ADDENDUM 3

AUTHORIZATION FOR RELEASE OF INFORMATION AND RELEASE FROM LIABILITY

NOTE: This form allows a Physician applicant to designate an individual as an "agent" of the Physician during the application process. The "agent" can receive information about the Physician's application in order to assist the Physician with the application process. Common "agents" include hospital credentialing specialists, locum tenens organization personnel, physician recruiters or personal assistants.

TO THE APPLICANT: If you wish to designate someone as your "agent" to assist in the application process, fill in that person's name in the second blank.

I, _____, am an applicant for licensure as a physician. I authorize the Montana State Board of Medical Examiners (Board) to release information, verbally and in writing, to _____ that includes, but is not limited to, application status, the particulars of missing application information or fees, disciplinary action, and any and all other information provided to the Board as part of my application.

I further expressly release the Board, the Department of Labor and Industry, and the State of Montana from liability for further unauthorized dissemination of this information by the above-named individual or entity.

A photocopy or electronic version of this signed release shall be considered as valid as the original. This authorization shall remain in force for as long as my application is pending, after a license is issued to me, and until revoked by me, in writing and received the Board.

_____ _____

Signature (Applicant/Licensee) Date

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 Montana Board of Medical Examiners, P.O. Box 200513, Helena, MT 59620-0513. Include all other required materials.

To the Montana Board of Medical Examiners,

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 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 _____
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.

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.