New Mexico Medical Board
2055 S. Pacheco Street, Building 400
Santa Fe, NM 87505
505-476-7220
Fax: 505-476-7233

Susana Martinez
Governor

Steven M. Jenkusky, MD
Chair

TO ALL APPLICANTS

Thank you for requesting an application for a license to practice medicine in New Mexico. We look forward to working with you to process your application.

A license to practice medicine in New Mexico is a privilege, not a right. The statutory mandate of the New Mexico Medical Board is to protect the health and safety of the citizens of the state, and the members of the Medical Board take their responsibilities very seriously. Upon completion, your application will be reviewed for quality assurance and reviewed by the medical and executive directors of the board. You may be required to come to the Board office in Santa Fe for an interview as part of the application process. *Please do not assume that licensure is a mere formality or that the granting of a license is automatic.*

PLEASE DO NOT: close your practice and move your family to New Mexico, enroll your children in school, begin construction of a new home, execute contracts with prospective practice partners, schedule patients, or begin practicing until you have received a license.

The application process is outlined in these instruction pages. You may apply for licensure by exam or by endorsement using one of three methods. We will make every effort to complete the application process as quickly as possible but occasionally we encounter unanticipated questions or difficulties that may cause delay or even denial. We will not begin working on your application until we have received a completed Uniform Application and all required fees. Please understand that much of the supporting documentation for your application has to be obtained from third parties, which can add time to the licensing process. In addition, some applications, such as those with a history of disciplinary action, require in-depth investigation that may take extra time and require your cooperation.

To make certain that your application is processed as efficiently as possible, please read the directions carefully, and call or email the Board office if you have any questions. Our staff will be happy to assist you in any way we can.

Again, thank you for your application. *We look forward to working with you to make this process as rapid and painless as possible!*

REQUIREMENTS FOR LICENSURE BY EXAM

Education Requirements: You must have graduated and received a diploma from a New Mexico Board approved school, or present proof of completion of a program substantially equivalent to an United States medical school as determined by an international education credential evaluation service approved by the Board.

Postgraduate Training Requirements: You must have satisfactorily completed twenty-four (24) months of postgraduate medical education in a program approved by the Board. The ACGME *Graduate Medical Education Directory* and the *Directory of Residency Programs of the Royal College of Physicians and Surgeons of Canada* are the official lists approved by the Board.

Examination Requirements: You must have successfully passed one of the following examinations or combination of examinations:

1. All three “steps” of the United States Medical Licensing Examination (USMLE).
2. Two “components” of the Federation Licensing Examination (FLEX).
3. All three “parts” of the National Board of Medical Examiners examination (NBME).
4. Any of the above listed in (1), (2) or (3) in an approved “hybrid” combination, per Board rule 16.10.3.8 NMAC.
5. The Board will accept the results of State Board examinations if taken and passed **before December 1973** (one of the national licensing examinations is required after that date).

6. Medical Council of Canada Qualifying Examination (MCCQE).
7. International medical graduates must have passed the ECFMG exam plus one of the approved combinations listed in Board rule 16.10.3.8 NMAC.

You must have attained a passing score of at least 75 on each required exam. You may attempt to successfully complete any part of a board-approved examination **six times**, as long as the entire examination is successfully completed within **seven years** from the date the first step of the examination is passed. MD/PhD candidates must successfully complete the entire examination within ten years from the date the first step of the examination is passed.

REQUIREMENTS FOR LICENSURE BY ENDORSEMENT

Licensure by endorsement means that the New Mexico Medical Board does not require primary source verification of your medical education, transcripts, postgraduate training and examination history. You may apply in this manner only if you meet ***ALL*** of the following requirements:

1. Hold an unrestricted license in another state and are free of disciplinary history, license restrictions, or pending investigations in all states where holding a license;
2. Graduated from an approved medical school or hold current ECFMG certification;
3. Hold current certification from a medical specialty board recognized by ABMS; and
4. Have been a licensed physician in the United States or Canada and have practiced medicine (not including postgraduate training) in the United States or Canada for at least the three years immediately preceding the application.

A complete copy of the rules may be downloaded from the website at http://www.nmmb.state.nm.us. Part 2 of the rules addresses licensure requirements in detail, and Part 3 addresses examinations approved by the Board.

LICENSURE APPLICATION PROCESS

Step 1: Determine which of the following three methods you will use to apply to the NM Medical Board.

1. **Applying Directly:** *You* request all required documentation verifying your professional recommendations, licenses, work history and hospital and healthcare affiliations, medical education, post-graduate training, and examination history from the sources and have each source send the materials directly to the Board office. If you choose this method you will need to follow essentially the same process next time you apply for a license in another state. In addition, when you begin practicing in New Mexico you may still need to go through HSC for credentialing purposes.

2. **Using HSC:** If you are getting ready to start practice in New Mexico, we suggest you apply through the NM Hospital Services Corporation Credentials Verification Organization (HSC). They will not only provide nearly all of the required documents for your license application, but they will also have the information available to process your application for privileges at most New Mexico hospitals and credentialing for all health plans in the state. It's "one stop" credentialing to help you start practice as soon as possible and is endorsed by the New Mexico Medical Society.

3. **Using FCVS:** If you think that you may apply for licenses in several states over the coming years, consider using the Federation of State Medical Boards (FSMB) Federation Credentials Verification Service (FCVS). FCVS verifies primary source documents related to your identity, medical education, postgraduate training, and more, and then creates an individualized profile that can be sent to any organization accepting FCVS. By eliminating the re-verification of items that never change, physicians benefit from a shortened credentialing process when applying to more than one state board. 97% of state boards accept or require FCVS.

   To work on the initial FCVS application for creating a profile or the subsequent FCVS application for updating an existing profile, visit http://www.fsmb.org/ and select FCVS in the Licensure or Sign In menu, then sign in as directed. Please note that FCVS is for credentials verification only. The Uniform Application (UA) is the licensure application.

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

Regardless of what application method you use, we urge you to retain a copy of your application.

Step 2: Complete the Uniform Application for Physician State Licensure (UA).

The Uniform Application makes the licensure application process easier by eliminating redundancy. After completing the UA online for the first time, your application is securely stored and can be resubmitted to another state board using the UA without reentering the same information. You would only make updates as needed and ensure that you comply with any board-specific requirements.

In the UA, 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.

To work on the UA, go to http://www.fsmb.org/ and select Uniform Application from the Licensure menu or Sign In menu. If you have submitted a UA previously, select the state board in the State Board section to open the UA for editing. Submit your UA to the board when you have finished updating your UA.

First time UA users are required to pay a one-time service charge of $60. Your receipt will be available immediately after submitting your UA, and you will receive a separate receipt via email.

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.

Please note the following:

- Provide both your current home address and current business practice/training address, otherwise an error will occur. Do not enter the same address for both home and work. You can use the same address for both Board Contact and Public Contact.
- You are not able to add or edit MD and DO licenses in the UA as that information comes directly into the system from the state boards. Email ua@fsmb.org with the correct information if changes are needed.
- Enter all other professional licenses (nurse, EMT, physician assistant, etc.) you have held (active or inactive) 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, if "Military Service" is reported, please provide a copy of your discharge or separation documents.
- For all locations where you have had admitting privileges, check the "Staff Privileges" box.
- Providers who do NOT have admitting privileges, please explain on a separate sheet of paper your procedures or the arrangements you make in instances when patients require admission to a hospital. If you are applying with a health plan, should arrangements include admitting coverage by another provider, a signed letter from the covering provider, including their primary admitting facility, is to be included.
- Clinical time indicates time spent with patients. Administrative indicates time spent on paperwork.
- For all malpractice claims, list as much detail as possible in the "specifics" section, including the name, age, sex of patient/claimant, the nature of the allegations in claims/suits (specify whether a suit was ever filed), names of other practitioners and hospital (if any) involved in claims/suits, name of defense attorney.

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. Attach a recent (less than 6 months old) two inch by two inch (2" x 2") passport quality, color photograph of yourself (head and shoulders only) in the space provided. Proof photos, negatives, and digital photos are not acceptable. This form must be notarized and returned to the New Mexico Medical Board.

- 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.

- Complete the three addenda as instructed.

    - Addendum 1 – Additional Physician Information form. Provide all information requested. If you answer YES to any of the Professional Practice Questions, please give details including name, address, and telephone number of significant parties on a separate sheet of paper.

    - Addendum 2 – Professional Recommendation form. Complete the top portion of two copies of this form. The NMBME requires two Professional Recommendation forms sent directly to the Board from physicians, chiefs of staff, department chairs or equivalent with whom you have worked and who have personal knowledge of your character and competence to practice medicine. The recommending physicians must have personally known you and have had the opportunity to personally observe your ability and performance. The completed forms must be sent directly to the New Mexico Medical Board from the recommending physicians.

    - Addendum 3 – Work Experience Verification form. Complete the top portion of the form, including dates. You must have the chief of staff, administrator, or medical staff services of each and every hospital and/or health facility where you have been granted and/or held privileges and/or been employed during the past two (2) years if applying by examination, and past three (3) years if applying by endorsement (not including internship, residency, or fellowship), complete the rest of the form in its entirely and send it directly to the New Mexico Medical Board.

If you are using FCVS for credentials verification,

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

- 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.

Step 3: Prepare your documents and fees and mail to the appropriate locations.

The checklist on the last page of these instructions should be used to ensure that you complete all requirements and send all paperwork to the correct locations. Depending on your method of application and what is applicable to your situation, **you must send the following items directly to the New Mexico Medical Board:**

1. Application fee of **$400 made payable to the New Mexico Medical Board** (or $50 if you are enrolled in a postgraduate training program in New Mexico and are applying for a Public Service License. **Please have your Program Director send the NMMB a letter granting you permission for a Public Service License**). Applications will not be processed until the completed Uniform Application Addenda and application fee have been received. The application fee is payable in U.S. funds by cashier's check, money order, personal check, MasterCard or Visa.

2. **When you provide a check as payment, you authorize the State of New Mexico to either use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction. All fees are non-refundable.**
3. If using HSC, include a check in the amount of **$320 made payable to NMHSC**. A copy of the application and your check will be forwarded to HSC from the Board. HSC will bill the applicant for any add-on costs required to obtain the source documents. These may include license verifications or notarized proof of education.

4. If you are an international medical graduate, include a copy of your ECFMG certificate or Fifth Pathway certificate.

5. If you are not a US citizen, you must provide proof of compliance with immigration laws (copies of naturalization papers, passport, J-1 or H-1 visa).

6. A notarized copy of your birth certificate or a current, valid passport.

7. Supporting documentation of any legal name change.

8. A copy or copies of your examination transcript(s).

9. A copy of your specialty board certificate and re-certification, if applicable.

10. Applicable forms and addenda within the Uniform Application. The Affidavit and Authorization for Release of Information form and the Additional Physician Information form are required for all application methods.

11. Other required documentation as needed (military discharge/separation documents, written arrangements for admitting if lacking privileges, letter from treating physician, details to professional practice questions with "yes" answers, etc.).

Attach your payment to the Board to the front of your application documents. Your payment to the Board must be in U.S. funds and may be in the form of personal check, money order, Visa, or MasterCard. If you are using a Visa or MasterCard, please provide the type of credit card, number and expiration date on a cover letter. Do not send cash. Mail your documents to: New Mexico Medical Board, 2055 S. Pacheco St. Bldg. 400, Santa Fe, NM 87505.

Step 4: Complete a criminal history background check.

Beginning in July 2007, the New Mexico Medical Board began requiring that all applicants for initial licensure submit fingerprints and other information for a state and national background check at their cost. Like other state medical boards around the country, the New Mexico Medical Board conducts criminal background checks in order to fulfill its statutory mandate to protect the health and safety of the New Mexico public. **A background check packet, including blank fingerprint cards and instructions, will be sent to you upon receipt of your Uniform Application Addenda and application fee.** Fingerprint cards cannot be downloaded from the Board's web site.

The criminal background check may or may not slow down your license application. A license will not be issued until the Board has confirmation of your background check. If the background check reveals a felony or a violation of the Medical Practice Act, you will be notified and the Board will determine if you are eligible for licensure or if disciplinary action will be taken against you.

You must have your fingerprints taken by a qualified individual. Qualified individuals include, but are not limited to, a public law enforcement official. Public Law enforcement agencies include county sheriff, state, municipal, campus, military, and tribal police. In some locations it may be possible to find other agencies with staff trained to take fingerprints, including hospitals, medical centers, and local school districts. Some agencies may charge a fee to take fingerprints. You are responsible for any costs associated with obtaining fingerprints.

Step 5 (if needed): Personal Interview.

The New Mexico Medical Board no longer requires every applicant be scheduled for a personal interview. If you are required to schedule an appointment for a personal interview with the Board or the Board's designee, you will be notified after your application and all required documents have been received and are complete in every detail.

APPROVAL OF LICENSURE

Applicants whose applications are approved for licensure will be issued a license to practice in New Mexico. ***Medical licenses shall be renewed on July 1 following the date of issue.*** Initial licenses are valid for a period of not more than 13 months or less than 1 month.

Please use the checklist on the next page to ensure you have completed each part of the licensure process.

Uniform Application for Physician State Licensure Checklists

Please use the checklist that applies to you. Items beginning with a * should be sent directly to the NMMB.

	Applying Directly	Using HSC	Using FCVS
Completed online Uniform Application.	☐	☐	☐
*Sent the Affidavit and Authorization for Release of Information form (within the online UA) to the NMMB.	☐	☐	☐
*Sent Addendum 1 (Additional Physician Information form) to the NMMB.	☐	☐	☐
Sent Addendum 2 (Professional Recommendation form) as instructed.	☐	Completed via HSC	☐
Sent Addendum 3 (Work Experience Verification form) as instructed.	☐	Completed via HSC	☐
*Sent application fee of $400 made payable to New Mexico Medical Board to the NMMB (unless enrolled in a postgraduate training program and applying for a Public Service License, in which case a letter from your Program Director granting you permission for a Public Service License must be sent with a $50 application fee).	☐	☐	☐
*Sent a check in the amount of $320 made payable to NMHSC to the NMMB.	n/a	☐	n/a
*Sent a copy of your specialty board certificate and re-certification to the NMMB (if applicable).	☐	☐	☐
*Sent proof of compliance with immigration laws, e.g. copies of naturalization papers, passport, J-1 or H-1 visa to the NMMB (if applicable).	☐	☐	☐
*Sent notarized copy of birth certificate or current, valid passport to the NMMB.	☐	Completed via HSC	Completed via FCVS
*Sent supporting documentation of any legal name change to the NMMB.	☐	Completed via HSC	Completed via FCVS
Sent Licensure Verification Form (Form #1 within the online UA) to each state board with which you have ever held any health care license **or** used VeriDoc or the board's preferred method of verification.	☐	Completed via HSC	☐
Sent Medical School Verification form (Form #2 within the online UA) and a copy of your diploma to each medical school attended.	☐	Completed via HSC	Completed via FCVS
Sent Postgraduate Training Verification form (Form #3 within the online UA) to all training programs attended.	☐	Completed via HSC	Completed via FCVS
*Sent a copy of your postgraduate training certificate(s) to the NMMB.	☐	Completed via HSC	Completed via FCVS
*Sent all examination transcripts to the NMMB.	☐	☐	Completed via FCVS
Sent Fifth Pathway Verification form (Form #4) to the program director at the medical school/institution (if applicable).	☐	☐	Completed via FCVS
*Sent a copy of your ECFMG certificate (if applicable) to the NMMB.	☐	☐	Completed via FCVS
*Sent all additional required documentation (military discharge/separation documents, written arrangements for admitting if lacking privileges, letter from treating physician, details to professional practice questions with "yes" answers, etc.) to the NMMB.	☐	☐	☐

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ADDENDA INSTRUCTIONS

Addendum 1 – Additional Physician Information form. Provide all information requested. If you answer YES to any of the Professional Practice Questions except for Question 20, please give details including name, address, and telephone number of significant parties on a separate sheet of paper.

Addendum 2 – Professional Recommendation form. Complete the top portion of two copies of this form. The NMMB requires two Professional Recommendation forms sent directly to the Board from physicians, chiefs of staff, department chairs or equivalent with whom you have worked and who have personal knowledge of your character and competence to practice medicine. The recommending physicians must have personally known you and have had the opportunity to personally observe your ability and performance. The completed forms must be sent directly to the New Mexico Medical Board from the recommending physicians.

Addendum 3 – Work Experience Verification form. Complete the top portion of the form, including dates. You must have the chief of staff, administrator, or medical staff services of each and every hospital and/or health facility where you have been granted and/or held privileges and/or been employed during the past two (2) years if applying by examination, and past three (3) years if applying by endorsement (not including internship, residency, or fellowship), complete the rest of the form in its entirely and send it directly to the New Mexico Medical Board.

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ADDITIONAL PHYSICIAN INFORMATION

Physician Name: _____ _____ _____
Last First Middle

An asterisk (*) indicates that this information will be kept confidential.

Will you be applying by endorsement? Yes ☐ No ☐	**Citizenship:**
Immigration Status:	**INS Certification #:** N/A ☐
***Fed Tax ID#:** Pending ☐ N/A ☐	***NM Tax ID#:** Pending ☐ N/A ☐
***Fed. Drug Enforcement Admin. (DEA) Registration #:** **Exp. Date:** Pending ☐ N/A ☐	
***State Controlled Substance Registration (CSR)#** **State:** **Exp. Date:** Pending ☐ N/A ☐	
***Medicare Unique Physician Identification Number (UPIN):** Pending ☐ N/A ☐	
***State Medicaid Provider Number:** **State:** Pending ☐ N/A ☐	

PRACTICE INFORMATION – Please list all applicable practice information below.

Current Practice Name:	
Street Address:	
City: **State:** **Zip Code:**	
Telephone Number:	**Facsimile Number:**
***Office Manager or Contact Person:**	**Practice Limited to (clinical specialty):**
Foreign Languages (spoken fluently by practitioner):	
Foreign Languages (spoken fluently at Practice):	
What are your immediate or future Practice Plans in New Mexico?	
Practice Associates in NM (if applicable):	
Call Coverage in NM (if applicable):	
Other Practice Locations (if applicable):	
Other Practice Name:	
Street Address:	
City: **State:** **Zip Code:**	
Telephone Number:	**Facsimile Number:**
Answering Service:	**Effective Date:**

Applicant Name: _____

PROFESSIONAL REFERENCES – Please list three professional peers familiar with your professional performance in the past 5 years (not including current or impending partners or associates in practice).

(1) Name and Title:			
Street Address:			
City:		**State:**	**Zip Code:**
Telephone Number:	**Facsimile Number:**		

(2) Name and Title:			
Street Address:			
City:		**State:**	**Zip Code:**
Telephone Number:	**Facsimile Number:**		

(3) Name and Title:			
Street Address:			
City:		**State:**	**Zip Code:**
Telephone Number:	**Facsimile Number:**		

SPECIALTY BOARD CERTIFICATIONS ☐ N/A **Are you Board Certified?** ☐ Yes ☐ No

Note: If you are not Board certified by a Board recognized by the American Board of Medical Specialties, the American Osteopathic Association, the National Commission on Certification of Physician Assistants, the American Nurses' Credentialing Center, or the National Certification Commission, or accepted for examination in your specialty, please give a brief explanation on an attached sheet.

Certified/Recertified by the:		
Date Certified:	**Date Last Recertified:**	**Exp. Date:**
Certified/Recertified by the:		
Date Certified:	**Date Last Recertified:**	**Exp. Date:**
Accepted for Examination by the:		
Until (expiration date):	**If not accepted, have you made application?** ☐ Yes ☐ No	

Certified/Recertified by the Subspecialty Board of:		
Date Certified:	**Date Last Recertified:**	**Exp. Date:**
Certified/Recertified by the Subspecialty Board of:		
Date Certified:	**Date Last Recertified:**	**Exp. Date:**
Accepted for Examination by the Subspecialty Board of:		
Until (expiration date):	**If not accepted, have you made application?** ☐ Yes ☐ No	

PROFESSIONAL LIABILITY INSURANCE*

Do you have current liability insurance? ☐Yes ☐No ☐Pending		**Current Carrier:**
Complete address:		
Dates Insured From: To:	**Policy #:**	**Coverage Limits:**

Applicant Name: _____

PROFESSIONAL PRACTICE QUESTIONS – Please answer all of the following Yes or No questions. If you answer YES to any question, please give details including name, address, and telephone number of significant parties on a separate sheet of paper.

1.	Has your professional liability coverage ever been terminated by action of the insurance company except as a result of the company ceasing to offer insurance to physicians?	Yes ☐ No ☐
2.	Have you ever been denied professional liability insurance coverage?	Yes ☐ No ☐
3.	Has your professional liability carrier ever excluded any specific procedures from your coverage?	Yes ☐ No ☐
4.	Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any professional organization?	Yes ☐ No ☐
5.	Have you ever been excluded from or sanctioned by Medicare and/or Medicaid?	Yes ☐ No ☐
6.	Have you ever been arrested? If so explain the circumstance, regardless of the outcome (i.e. expunged, dismissed, sealed, vacated).	Yes ☐ No ☐
7.	Have you ever been named as a defendant in any criminal proceedings?	Yes ☐ No ☐
8.	Have you ever been subject to investigation by a governmental entity or Board that either could have resulted or did result in licensure sanction or other adverse actions, irrespective of the outcome?	Yes ☐ No ☐
9.	Have you ever been named in any formal requests for corrective actions filed by any healthcare entity where you have had an appointment (a request which could result in either formal or informal proceedings).	Yes ☐ No ☐
10.	**a.** Have your privileges at any healthcare entity ever been voluntarily or involuntarily suspended, restricted, diminished, revoked, surrendered, or not renewed, for any reason except for medical records delinquency unrelated to your professional competence or conduct? **b.** Have you ever agreed not to exercise your clinical privileges while under investigation? **c.** Have you ever been investigated and / or terminated by a healthcare entity for cause, or without cause, related to your clinical competence or conduct, which could impact patient safety/care, or allowed to resign in lieu of termination for such reason?	Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐
11.	Have you ever resigned from a healthcare entity to avoid modification, suspension, or termination of privileges, or while under investigation?	Yes ☐ No ☐
12.	**a.** Has your application for licensure or license to practice in any jurisdiction ever been investigated, voluntarily or involuntarily limited, suspended, revoked, surrendered or denied? **b.** Are any currently held licenses pending investigation or being challenged?	Yes ☐ No ☐ Yes ☐ No ☐
13.	Have you ever been notified to appear before any licensing agency for a hearing or complaint of any nature?	Yes ☐ No ☐
14.	Has your federal or state narcotics registration certificate in any jurisdiction ever been investigated, voluntarily or involuntarily limited, suspended, revoked, or restricted?	Yes ☐ No ☐

Applicant Name: _____

15.	Have you ever been involved in a settlement, medical malpractice claim or suit, or have you ever received written notice of intent to file such a suit? **If yes, complete the Malpractice Liability Claims Information page in the online UA. Include the following information in the specifics area:** · Name, age, sex of patient/claimant. · Date(s) and type of treatment and/or surgery, which led to the allegations against you. · Nature of allegations in claims/suits. Specify whether a suit was ever filed. · Names of other practitioners and hospital, if any, involved in claims or suit. · Disposition or current status of claim or suit (be specific). · Name of insurance carrier defending you. · Name of defense attorney.	Yes ☐ No ☐

16.	Have you ever been reported to the National Practitioner Data Bank?	Yes ☐ No ☐
17.	**a.** Are you now, or were you in the past, addicted to, abusive of, or in treatment for abuse of any controlled substances, habit-forming drugs, illegal drugs, prescription medication or alcohol? **b.** Are you being treated with opiates for chronic pain? **If yes, please provide to the Board upon application a current evaluation from your treating pain provider (MD or DO).**	Yes ☐ No ☐ Yes ☐ No ☐
18.	In the five (5) years prior to this application, have you had any physical injury or disease, or mental illness or impairment, which you are currently under treatment for or could reasonably be expected to affect your on-going ability to practice medicine safely and competently? **If yes, please have your treating physician send the NM Medical Board a letter regarding your diagnosis and treatment.**	Yes ☐ No ☐
19.	Have you ever, for any reason: **a.** Resigned from a medical school or postgraduate training (PGT) program? **b.** Withdrawn from a medical school or postgraduate training program? **c.** Been suspended, dismissed, or expelled from a medical school or PGT program? **d.** Been placed on probation or remediation, including academic probation or remediation, by a medical school or PGT program? **e.** Taken a leave of absence or break from, or had any interruptions or extensions in, a medical school or PGT program for any personal or professional reason (including illness or disability, pregnancy or maternity, any academic issue, etc)?	 Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐
20.	I attest that I will limit my practice to areas in which I am competent to practice.	Yes ☐ No ☐
21.	Are you currently in arrears in payments of amounts required to be paid pursuant to an outstanding judgment and order for child support in New Mexico or in any other state?	Yes ☐ No ☐

If you answer YES to any question except for Question 20,
please give details including name, address, and telephone number
of significant parties on a separate sheet of paper.

Applicant Name: _____

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(505) 476-7220

PROFESSIONAL RECOMMENDATION

The New Mexico Medical Board requires the completion of this Professional Recommendation by a physician or a Chief of Staff or a Department Chief with whom I have worked and who has personal knowledge of my character and competence to practice medicine. This form is required as part of my application for licensure. ***All*** elements in the section below ***must*** be completed. The lower half of the form may be used for narrative comment. This is my authorization to send this completed form and release all information in your files, favorable or otherwise, DIRECTLY to the NMMB, 2055 S. Pacheco St., Bldg. 400, Santa Fe, NM 87505.

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

Applicant' Signature: _____ Date_____

Address: _____ City _____State_____ Zip _____

ALL ELEMENTS IN THIS SECTION MUST BE COMPLETED BY THE RECOMMENDING PHYSICIAN
The information on this form is NOT a public document.

1. Date and type of service: This individual served with me as _____

from _____ to _____ at _____

Month/Year Month/Year Location

2. Please evaluate: (Please indicate with check mark)

	Poor	Fair	Good	Superior
Professional knowledge				
Clinical judgment				
Relationship with patients				
Ethical/professional conduct				
Ability to communicate				
Clinical skills				

3. Recommendation: (please indicate with a check mark)

1. Recommend highly and without reservation _____
2. Recommend as qualified and competent _____
3. Recommend with some reservation (explain) _____
4. Concerns (explain) _____

4. Of particular value in evaluating the candidate is information regarding any notable strengths and weaknesses (including personal demeanor). We would appreciate your comments.

_____

_____

5. The above report is based on: (please indicate with check mark)

1. Close personal observation _____ 3. A composite of evaluations _____
2. General impression _____ 4. Other _____

Name (Please Print): _____Title: _____Phone:_____

Signature: _____ Date: _____

New Mexico Medical Board
2055 S. Pacheco St.
Building 400
Santa Fe, NM 87505
(505) 476-7220

WORK EXPERIENCE VERIFICATION

I am applying for a medical license in the State of New Mexico. The New Mexico Medical Board requires this form to be completed by the Chief of Staff or facility's administrative staff. I hereby authorize release of all information in your files, favorable or otherwise, DIRECTLY to the NMMB, **2055 S. Pacheco St., Bldg. 400, Santa Fe, NM 87505**.

Applicant Name

Applicant Signature

Address

***Dates of Privilege/Employment mm/yy to mm/yy (must be provided)**

City/State/Zip

Telephone Number

The section below should be completed by the chief of staff or facility's administrative staff.
Letters of Recommendation are ***NOT*** accepted in lieu of this form.

Type or Print Name of person completing this form

Title

Name of Institution

Address

City / State / Zip

1. This evaluation is based on: ___Observation of applicant ___Review of personnel file
2. In your estimation, is there any reason why this applicant should not be licensed to practice? ___Yes ___No
3. To your knowledge, is there any mental or physical reason why this applicant should not be licensed? ___Yes ___No
4. To your knowledge, is there any derogatory/disciplinary information regarding this applicant? ___Yes ___No
5. Are the dates of privilege/employment provided by the applicant on this form accurate? * ___Yes ___No

If not, please provide correct dates: Beginning _____ (Month/Year) Ending _____ (Month/Year)

If you answered "YES" to questions 2, 3, and/or 4, please provide a written explanation and/or any supporting documentation that may be relevant.

Please affix hospital or notary seal here

Printed name of person completing this form Signature Date

Signature of Notary (if applicable) Date

My commission expires:_____

Please note on this form if there is no hospital or notary seal available.

Please return this form directly to the address above
Thank you for your cooperation.

Uniform Application
Revised 8/08

UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

For State Board Use Only

Affidavit and Authorization for Release of Information

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

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

To _____,
Name of state board applied to for licensure

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

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

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

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

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

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

Applicant Photograph

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

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

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

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

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

NOTARY

State of _____, County of _____,

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

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

Notary Public Signature _____ My Notary Commission Expires _____

UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

For State Board Use Only

Licensure Verification Form (Form #1)

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

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

Section 1: Applicant Information

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

Middle name _____ Suffix _____ SSN* _____ Birth date (mm/dd/yyyy) _____

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

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

Board name _____

Mailing address _____

City/State/Zip _____

Applicant signature _____ Date _____

Section 2: Board Verification of Licensure

Name of issuing board or license entity _____

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

License type _____ License number _____ Issue date _____ Expiration date _____

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

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

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

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

Signature _____

Print name _____

AFFIX INSTITUTIONAL SEAL HERE

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

Title _____ Date _____

Phone number _____ Fax number _____

Email _____

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

UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

For State Board Use Only

Medical or Osteopathic School Verification Form (Form #2)

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

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

Section 1: Applicant Information

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

Middle name _____ Suffix _____ SSN* _____ Birth date (mm/dd/yyyy) _____

Name if different when diploma awarded _____

Name of school _____

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

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

Board name _____

Mailing address _____

City/State/Zip _____

Applicant signature _____ Date _____

Section 2: Medical or Osteopathic School Verification

School name _____

Complete address w/country _____

School name if different when applicant attended _____

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

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

Unusual Circumstances

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

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

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

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

☐ Academic	From _____ to _____	☐ Documentation attached
☐ Unprofessional conduct	From _____ to _____	☐ Documentation attached
☐ Behavioral reasons	From _____ to _____	☐ Documentation attached
☐ Other _____	From _____ to _____	☐ Documentation attached

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

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

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

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

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

Signature _____
Print name _____
Title _____ Date _____
Phone number _____ Fax number _____
Email _____

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

UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

Postgraduate Training Verification Form (Form #3)

Institution Name: _____

Institution Address: _____

Affiliated School: _____

Applicant: Do not complete this form if you are using FCVS. FCVS verifies this information for you. Send this form to the current program director of your post graduate trainings.

Program Director or designated Official: Please complete section 2.

Section 1: Applicant Information.

To be completed by the applicant.

Name: _____ **Suffix** _____ **Practitioner type: MD** ☐ **DO** ☐

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:

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 completion date in the "To" field.

Report Internships, Residencies and Fellowships separately.

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

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 correct response. Omitted responses require written explanation.

If necessary, you may continue your explanation on a separate sheet of paper.

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

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

Board Information:

Board Name: _____

Mailing address: _____

Applicant Signature _____ **Date** _____

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). **Signature by personnel other than an M.D. or D.O. must attach an authorization letter. Applicable only for Nevada State Board of Medical Examiners.**

Signature _____

Print name _____

Title _____ **Date** _____

Phone number: _____ **Email address:** _____

UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

For State Board Use Only

Fifth Pathway Verification Form (Form #4)

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

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

Section 1: Applicant Information

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

Middle name _____ Suffix _____ SSN* _____ Birth date (mm/dd/yyyy) _____

Name if different when certificate awarded _____

Name of medical school _____

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

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

Board name _____

Mailing address _____

City/State/Zip _____

Applicant signature _____ Date _____

Section 2: Fifth Pathway Verification

Institution name _____ Affiliated school _____

Institution name if different when applicant attended _____

Institution address w/country _____

Type of Clinical Rotation	From	To	Weeks Credit
_____	_____	_____	____
_____	_____	_____	____
_____	_____	_____	____
_____	_____	_____	____

Completed? ☐ Yes. Attendance was from _____ to _____. Completion date was _____.

☐ No. Withdrawal* date was _____. **If the applicant withdrew or was dismissed, please explain below.*

☐ No. Dismissal* date was _____. **If the applicant withdrew or was dismissed, please explain below.*

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

Signature _____

Print name _____

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.