FOR OFFICE USE ONLY
Receipt #
ID #
Issue Date
License #

Rhode Island
Board of Medical Licensure and Discipline

Room 205
3 Capitol Hill
Providence, RI 02908-5097

Instructions and
License Application for:

☐ Allopathic Medicine

☐ Osteopathic Medicine

☐ Academic Faculty
(Limited Medical Registration)

☐ Temporary Post Graduate – Allopathic Medicine

PGY 2 _____ PGY 3 _____

☐ Temporary Post Graduate – Osteopathic Medicine

PGY 2 _____ PGY 3 _____

_____

Applicant – Print/Type Name (First/MI/Last)

☐ I am also applying for a RI Uniform Controlled Substance Registration (CSR) and I have attached the CSR application to this license application.

Phone: (401) 222-3855 **TTY/TDD: (800) 745-5555** **Fax: (401) 222-2158**

GENERAL INFORMATION

Components of the Application. The following materials and information are part of your application packet:

Instructions

Credentials Verification and Licensure Applications

Addenda

Licensure Requirements.

Graduates of Schools Located in the U.S.A., Puerto Rico, and Canada:

- Be of good moral character.
- Graduated from a medical school accredited by the Liaison Committee for Medical Education (LCME).
- Satisfactorily completed two (2) years of progressive postgraduate training, internship, and residency in a program accredited by the Accreditation Council for Graduate Medical Education (ACGME), or satisfactorily completed two (2) years of progressive postgraduate training in a program accredited by the Accreditation Committee of the Federation of the Medical Licensing Authority of Canada or the Royal College of Physicians and Surgeons of Canada.
- Satisfactorily passed a licensure examination approved by the Board.
- Met any other requirement(s) set forth by regulation or established by the Board.

Foreign Medical Graduates:

- Be of good moral character.
- Graduated from a medical school located outside the United States which is recognized by the World Health Organization and the Board.
- Received certification by the Education Commission for Foreign Medical Graduates (ECFMG).
- Satisfactorily completed two (2) years of progressive postgraduate training, internship, and residency or a comparable fellowship in a training program accredited by the Accreditation Council for Graduate Medical Education (ACGME). The Board may grant up to twelve (12) months of credit at the internship level to an applicant with a minimum of three (3) years of progressive international training when advanced standing is also granted by the American Board of Medical Specialties. All or some of this postgraduate training requirement may be waived, at the discretion of the Board, for international medical graduates with advanced international postgraduate training; full and unrestricted medical licensure in another state/jurisdiction; and five (5) years of clinical practice experience in good standing in the alternate jurisdiction.
- Satisfactorily passed an examination approved by the Board.
- Met such other requirements as set forth by regulation or as may be established by the Board.

Osteopathic Physicians:

- Be of good moral character.
- Graduated from an osteopathic medical school located in the United States that is accredited by the American Osteopathic Association.
- Satisfactorily completed two (2) years of progressive postgraduate training, internship, and residency in a program approved by the American Osteopathic Association or the Accreditation Council for Graduate Medical Education.
- Satisfactorily passed an examination approved by the Board.
- Met such other requirements as set forth by regulation or as may be established by the Board.

Academic Faculty–Limited Medical Registration. Academic Faculty–Limited Medical Registration applicants **MUST:**

- Be recommended by the Medical School Dean.
- Be appointed to Senior Rank at the Medical School.
- Renew yearly and reapply every five (5) years.
- Practice ONLY in hospital and facilities affiliated with the Medical School.

Temporary Post Graduate (Allopathic Physician or Osteopathic Physician

- Universal Application
- Rhode Island Addendum (including Controlled Substance Registration form)
- Payment for Controlled Substance Registration
- FCVS
- One (1) year of post-graduate training in a Rhode Island accredited post-graduate program

Rules and Regulations. The rules and regulations governing the licensure and discipline of physicians can be obtained at the following web site: http://sos.ri.gov/documents/archives/regdocs/released/pdf/DOH/8700.pdf

Rhode Island General Laws pertaining to the Practice of Medicine can be obtained at the following web sites:

Medical Licensure: http://www.rilin.state.ri.us/statutes/title5/5-37/index.htm
Controlled Substance Act: http://www.rilin.state.ri.us/statutes/title21/21-28/index.htm

Application Process Overview. The licensure process in the State of Rhode Island is conducted jointly by the Rhode Island Board of Medical Licensure and Discipline (Board) and the Federation of State Medicine Boards (FSMB). The FSMB provides the Federation Credentials Verification Service (FCVS) and the Uniform Application for Physician State Licensure (UA).

All licensure applicants must complete and submit both the FCVS application and the Uniform Application. In addition, required fees must be paid, and state addendum forms and additional information such as the National Practitioner Data Bank (NPDB) Report must sent to the Board. The Board will use all of this information to assess your qualifications for licensure.

The application process is not considered complete until your Board application (UA), applicable forms, FCVS Physician Information Profile, and NPDB Report are received in a manner satisfactory to the Board. Neither the Board nor the FSMB (FCVS and UA) will accelerate processing of one application at the expense of others for any reason.

Complete all application materials as instructed and arrange them in order as they appear in the application checklist at the end of the instructions. Do not submit an application without all applicable information, documentation and fee. You must respond to all components of the application as instructed. Mail these components of the application to:

Rhode Island Department of Health
Board of Medical Licensure & Discipline
Room 205, Three Capitol Hill
Providence, RI 02908-5097

Please allow a minimum of 8 weeks for the entire licensure process to be completed. If you have malpractice or disciplinary history, it can take an additional 2 or 3 months for all pertinent documentation to be received. Applications are reviewed once a file is complete. Be advised that you may be required to appear for an interview.

After your application is reviewed, you will be contacted in writing. Please allow 2-4 weeks for your wallet size license card and wall certificate to be mailed to you. [Note: You may not practice medicine in Rhode Island until you have received a license number.]

Please continue to review the remaining portions of this application packet for instructions and other materials necessary to complete the Board application. If you have any questions about this process or would like to check on the status of your Board application, please contact us directly at (401) 222-3855.

INSTRUCTIONS FOR COMPLETING THE BOARD APPLICATION

Read the following instructions and those throughout the online application carefully before completing the Board application. Failure to submit all required information and appropriate documentation may result in processing delays. All of the information provided is subject to change.

General Instructions.

1. Type your information or print in blue or black ball-point pen. Board staff will not make assumptions about illegible information. Be sure to print your name in the box provided on the cover page.

2. Provide a response to each section or questions; otherwise, mark "N/A" for Not Applicable.

3. We suggest that you make a copy of your completed application and addenda before submitting it to the Board.

4. **It is your responsibility to check on the status of your application.**

Completing Your Board Application.

1. **Fees**. Make a check or money order (in U.S. funds only) for the application fee of $1,090.00 (or $1,290.00 if you applying for your Controlled Substance Registration (CSR), payable to "Rhode Island General Treasurer" and staple it to the upper left-hand corner of the first (Top) page of the Application Instructions. These application fees are NON-REFUNDABLE. If you are applying for your CSR, you MUST submit the Board application at the SAME TIME as the CSR application.

2. The fee for a temporary post-graduate physician license is $545 but will be waived (for initial license and one renewal) if within nine (9) months of issuance of this license the physician supplies to the Department proof of obtaining a DEA waiver ("X" number) to treat patients with medication-assisted treatment. Physicians who receive a fee waiver who do **not** supply evidence of aforementioned DEA waiver ("X" number) within nine (9) months will be billed for the full license fee. Physicians who do not pay the balance within three (3) months will be referred to the Board for unprofessional conduct.

   NOTE: These are Board Application Fees. A separate one-time service fee of $50 is charged upon completion of the Uniform Application. Fees for FCVS are located at http://www.fsmb.org/licensure/fcvs/.
   The Controlled Substance Registration (CSR) fee is **not** waived and the payment of $100 for the CSR must be included with the CSR application in the Rhode Island addendum.

3. **FCVS Application Process**. FCVS uses primary sources to verify core physician credentials as part of the credentialing process and in accordance with established policies and procedures set forth by the Board. FCVS verifies documents for identity, medical education, training, and more. Once your credentials have been verified, they go into a personalized physician profile that can be sent to other entities as needed, saving the time of having each item verified again in the future. After an accuracy review, FCVS will send your non-interpretive Physician Information Profile containing certified photocopies of your credentials to the Board.

Because the verification process is the most time consuming task, we recommend that you submit your FCVS application as soon as possible. You will deal directly with FCVS for all aspects of this verification. **Do not contact the Board about your FCVS application**. Use the messaging tool within FCVS to contact FCVS.

For applicants who have an active and unrestricted license in another state, the Board may elect to consider granting licensure pending receipt of FCVS, provided the applicant has submitted documentation of payment to FCVS and a written statement confirming completion of the FCVS application.

First time FCVS users will need to complete an Initial FCVS Application. If you have already established a profile with FCVS, you will need to complete a Subsequent FCVS Application to update your profile. All applicants must designate the RI board to receive your profile as part of the FCVS application process.

To work on your FCVS application, visit http://www.fsmb.org/ and select FCVS in the Licensure menu, then sign in as directed. For assistance with FCVS, use the messaging tool within FCVS or call 888-275-3287 with your FCVS ID number between 8am and 5pm CT Monday through Friday.

4. **Uniform Application Process**. The Board was one of the first boards to incorporate the Uniform Application (UA) into its Medical Licensing Application. Much like FCVS, after completing the UA for the first time, you can submit your information to another UA accepting or requiring board, making updates to the UA as needed and completing all board specific requirements for each board applied to.

   When completing your UA, you will be asked to account for all time since medical school graduation and provide all information on malpractice claims. We recommend having this information on hand before you begin.

   To work on your Uniform Application, visit http://www.fsmb.org/ and select Uniform Application (UA) in the Licensure menu, then sign in as directed. If you receive an error while working in the UA, email your username, password, and a screenshot of the error or the description to ua@fsmb.org.

   In addition to the guidance on each screen, please make special note of 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.

   - MD and DO license information in the UA cannot be changed, as that information is provided directly from the state boards. If you see incorrect or missing medical license information in your UA, email ua@fsmb.org with your username or nine-digit Federation ID (FID) plus the correct information. Do not select "Other" to add information unless it is for a non-medical professional license.

   - List ALL professional licenses you have held (Medical, Osteopathic, EMT, PA, nurse, etc.) in the United States and/or Canada, whether active or inactive.

   - On the Chronology of Activities page, if you have military or locum tenens assignments, you must list each location/assignment separately.

   - On the Malpractice page, report all medical malpractice court judgments, medical malpractice arbitration awards, and settlements, within the past ten (10) years, in which payment was made to a complaining party.

     Special Notice about Malpractice Information: Pursuant to R.I.G.L.§ 5-37-9.2, the Rhode Island Board of Medical Licensure and Discipline must collect data regarding your malpractice history. You are required to report to the Board all actual settlement or jury verdict amounts in the past ten (10) years. The Board will not make actual settlement or verdict amount available to the public. I must report the fact that a payment was made and how it compared to other payments made in your specialty. For each incident you report, you must include documentation that verifies the date, place, reason and disposition of the matter.

- For licensure verification, use the Reciprocity Release Form in this packet. To determine verification fees and preferred method of each verifying board, see the Licensure Verification Information resource at http://www.fsmb.org/licensure/uniform-application/. You may use VeriDoc (https://www.veridoc.org/) or a board's preferred electronic verification method in lieu of Addendum 1.

- On the UA Affidavit and Authorization for Release of Information, 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 Affidavit/Authorization form must be notarized and returned to the Rhode Island Board. Do not send the UA Affidavit to FSMB.

- The addenda in the State Addendum section are located in this document after these instructions for your convenience. Each addendum should be completed as instructed. Please type or print all responses. Use the checklist at the end of these instructions to ensure you complete all addenda.

Please review your information before submitting your online UA. We recommend that you print a copy for your records and keep a copy of all forms and documentation sent to the Board.

To update information in your UA, reselect the state board in the State Board area. Make changes as needed and then resubmit your UA.

5. **National Practitioner Data Bank Self-Query Report**. Submit a "self-query" of the National Practitioner Data Bank (NPDB) by going to https://www.npdb.hrsa.gov/ext/selfquery/SQHome.jsp and following the instructions provided. When you receive your Self-Query, mail the ORIGINAL, UNOPENED response to the Board. The Board must have this response in order to complete your application so you are encouraged to make this request as soon as possible. For questions or assistance, call 800-767-6732 or email help@npdb.hrsa.gov.

Again, the application process is not considered complete until your Board application (UA), applicable forms, FCVS Physician Information Profile, and NPDB Report are received in a manner satisfactory to the Board. Neither the Board nor the FSMB (FCVS and UA) will accelerate processing of one application at the expense of others for any reason.

Complete all application materials as instructed and arrange them in order as they appear in the application checklist at the end of the instructions. Do not submit an application without all applicable information, documentation and fee. You must respond to all components of the application as instructed. Mail these components of the application to:

Rhode Island Department of Health
Board of Medical Licensure & Discipline
Room 205, Three Capitol Hill
Providence, RI 02908-5097

APPLICATION CHECKLIST

Please review the following checklist to ensure you have satisfied all components of the application process.
Some items may not apply.

☐ I have carefully read RIGL 5-37 and R5-37-MD/DO available at:

http://www.rilin.state.ri.us/statutes/title5/5-37/index.htm
http://sos.ri.gov/documents/archives/regdocs/released/pdf/DOH/7669.pdf

☐ I have completed the FCVS application and submitted all required forms, documents, and fees directly to FCVS.

☐ I have a check or money order made payable (in U.S. funds only) to the "Rhode Island General Treasurer" in the amount of $1,090.00 (or $1,290.00 with CSR Application) and have attached it to the upper left-hand corner of the first (Cover/Top) page of the application instructions unless I am applying for Temporary Post Graduate in which case I understand that I owe $100 for the CSR application, the license fee being waived as long as I provide proof to RIDOH that I have completed the DATA Waiver and obtained a DEA X registration number within nine (9) months of issuance.

☐ I have read and understand the "Instructions for Completing the Board Application."

☐ I have read and understand the "Special Notice about Malpractice Information." (Instructions Page 4, Malpractice Liability Claims Information section)

☐ I have completed the Online Rhode Island Board Application (UA) as instructed in each section and submitted it to the Board.

☐ I have completed the UA Affidavit and Authorization for Release of Information Form (located between Instructions and Addendum). I have attached a color photograph of myself and the form has been notarized by a notary public.

☐ I have completed and mailed Addendum 1 (Reciprocity Release Form) with any applicable fees as instructed.

☐ I have completed Addendum 2 (Additional Physician Information) as instructed.

- ☐ I have attached a copy(ies) of my ABMS Certificate(s), if applicable.
- ☐ I have attached complete details of all "Yes" responses to Question #8.

☐ I have completed Addendum 3 (Mandatory Addendum to Licensure Application, Verification of SSN) as instructed.

☐ I have completed Addendum 4 (Rhode Island Uniform Controlled Substances Act Registration (CSR)) as instructed.

☐ I have completed Addendum 5 (Voluntary Race/Ethnicity Questions) as instructed. *(This information is voluntary and will NOT affect your application in any way.)*

☐ I have completed Addendum 6 (Academic Faculty – Limited Medical Registration Applicants Only) as instructed.

☐ I have arranged my Board Application materials in the following order:

1. Fee (Attached as instructed)
2. Completed Top/Cover of Application Instructions
3. Notarized Affidavit and Authorization for Release of Information Form (online Uniform Application)
4. Completed Addendum 2 (Additional Physician Information), followed by a copy(ies) of the ABMS Certificate(s), followed by details of any "Yes" response to Question #8.
5. Completed Addendum 3 (Mandatory Addendum to Licensure Application, Verification of SSN)
6. Completed Addendum 4 (CSR Registration)
7. Completed Addendum 5 (Voluntary Race/Ethnicity Questions)
8. Completed Addendum 6 (Academic Faculty – Limited Medical Registration Applicants Only) if applicable.

Rhode Island
Board of Medical Licensure and Discipline

Room 205
3 Capitol Hill
Providence, RI 02908-5097

ADDENDUM INSTRUCTIONS

Complete the addenda as instructed below. Return the completed addenda to the Board at the address above.

☐ **Addendum 1: Reciprocity Release Form.** Obtain licensure verification from all states where you hold or have ever held a license to practice medicine. Complete the top portion of the Reciprocity Release Form and then mail to each licensing authority in which you are/were licensed. If you are licensed in Canada, send a copy to each province in which you are/were licensed. This form may be duplicated as necessary. This form will be completed in lieu of the Uniform Application Licensure Verification Form (Online Uniform Application, Affidavit and Forms Section).

Also refer to the Licensure Verification Information resource at http://www.fsmb.org/licensure/uniform-application/ to determine if fees need to be sent to the verifying board with Addendum 1. You may use VeriDoc (https://www.veridoc.org/) or a board's preferred electronic verification method in lieu of Addendum 1.

☐ **Addendum 2: Additional Physician Information.** You must complete each question as instructed. Include all requested information and documentation. Please either type or print your responses. If not applicable, please respond with N/A. If you need additional space please attach a separate sheet.

☐ **Addendum 3: Verification of Social Security Number.** This form is mandatory. You must complete this form as instructed.

☐ **Addendum 4: Rhode Island Uniform Controlled Substances Act Registration (CSR).** In order to dispense, prescribe, store, or order controlled substances, you must obtain a Rhode Island Controlled Substance Registration (CSR) and a Drug Enforcement Administration (DEA) Registration. If applying for a CSR you must complete this Registration form and submit it along with your license application. If you are NOT applying for a CSR, please write N/A across the form. After you obtain your Rhode Island CSR, you can apply for a federal DEA Number by using the forms at http://www.deadiversion.usdoj.gov/drugreg/reg_apps/. For federal DEA registration help, email DEA.Registration.Help@usdoj.gov.

☐ **Addendum 5: Voluntary Race/Ethnicity Questions.** The completion of this form is **voluntary** and will **NOT** affect your Application in any way.

☐ **Addendum 6: Academic Faculty – Limited Medical Registration.** This form only needs to be completed if the applicant is applying for Academic Faculty – Limited Medical Registration. Complete the top portion of this form and forward to the Dean of the Medical School. Letters or other forms submitted in lieu of this form will not be accepted. The board must receive this form(s) and attachments directly from the Medical School.

Rhode Island Board of Medical Licensure and Discipline

Room 205, 3 Capitol Hill
Providence, RI 02908-5097
(401) 222-3855

ADDENDUM 1
Reciprocity Release Form

Substitute forms are not acceptable. This form may be duplicated as needed.

THIS SECTION TO BE COMPLETED BY THE APPLICANT

I am applying for a license to practice medicine in the State of Rhode Island. The Rhode Island Board of Medical Licensure and Discipline requires that the following form be completed by the jurisdiction in which I am now or was previously licensed. This constitutes your authority to release all information in your files, favorable or otherwise, directly to the Rhode Island Board of Medical Licensure and Discipline at the above address.

_____ _____ _____
Print/Type Full Name Signature Date

_____ _____ _____
Previous Names Used Social Security Number Date of Birth

_____ _____
License Number Date Issued

THIS SECTION TO BE COMPLETED BY THE MEDICAL BOARD

Basis for issuing license:

☐ NBME ☐ NBOME ☐ USMLE ☐ LMCC ☐ FLEX _____ State Sponsor ☐ State Exam _____(State)

If a combination of exams were taken, please list the specific combination: _____

License Status: ☐ Active ☐ Inactive ☐ Lapsed	**Original Date Issued**: _____	**Expiration Date**: _____

Questions:

1. Has this physician ever been investigated by your Board? ☐ Yes ☐ No
2. Has this physician incurred any disciplinary proceedings in your state, or is any action pending? ☐ Yes ☐ No
3. Has the applicant's license ever been denied, surrendered, reprimanded, suspended, revoked or placed on probation? ☐ Yes ☐ No
4. Are you aware of any information about this physician submitted to the National Practitioner Data Bank? ☐ Yes ☐ No
5. Do you know of any information that may discredit this person? ☐ Yes ☐ No

If you answer "Yes" to any of the above questions, please provide a written explanation below, and attach a copy of all supporting documentation (e.g. Board order, complaint, etc.). Use a separate sheet if necessary.

_____

_____

_____

_____

Certification:

_____ _____
Signature Date

_____
Type or Print Name

_____
Title

_____
Full Name and of Licensing Board including State

Please Affix
Board Seal Here

Please return directly to the Board at the above address. Thank you for your prompt cooperation.

Rhode Island Board of Medical Licensure and Discipline
Room 205, 3 Capitol Hill
Providence, RI 02908-5097
(401) 222-3855

ADDENDUM 2
Additional Physician Information

Complete each section as instructed.

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1. **Specialty of Practice**: Refer to the ABMS Certification Codes List (pages 4 and 5 of this addendum) when completing this section. You must provide a copy of your ABMS certificate(s). You may report "None", "Other", or "Unknown" if necessary.

_____ Board Certified? ☐ Yes ☐ No
Primary Specialty Code If Yes, Year Certified/Recertified: _____

_____ Board Certified? ☐ Yes ☐ No
Secondary Specialty Code If Yes, Year Certified/Recertified: _____

_____ Board Certified? ☐ Yes ☐ No
Secondary Specialty Code If Yes, Year Certified/Recertified: _____

_____ Board Certified? ☐ Yes ☐ No
Secondary Specialty Code If Yes, Year Certified/Recertified: _____

2. **Practice Information**: Specify where in this State do you intend to practice, and list type of practice using the codes below. (If additional space is needed, attach a separate sheet)

ACD = Academia
ADM = Administration
FTY = Faculty
FEL = Fellowship
GRP = Group
HSP = Hospital
HMO = HMO
OFC = Office
RES = Research
OTH = Other

Location #1: _____
City: _____ Practice Type (See Code): _____

Location #2: _____
City: _____ Practice Type (See Code): _____

Location #3: _____
City: _____ Practice Type (See Code): _____

Identify any translational services that may be available at your primary practice location: _____
_____

3. **Medical School Faculty Appointments**: Identify any appointments to medical school faculties and indicate as to whether you have had responsibility for graduate medical education within the most recent ten (10) years.

_____
_____
_____

4. **Medical Licensure**: List all countries (other than the U.S. and Canada) in which you are now, or ever have been licensed to practice medicine, or any other profession.

_____ ☐ Active ☐ Inactive
Country
_____ ☐ Active ☐ Inactive
Country
_____ ☐ Active ☐ Inactive
Country

5. **Board Discipline**: List any disciplinary actions by licensing boards in other states. Please describe any prior or pending Board action or investigation. Please attach any relevant supplemental materials. If necessary, you may continue on a separate sheet.

☐ Check here if not applicable

Licensing Board (abbreviate) and Nature of Action (e.g. TX – Professional Misconduct):	Month/Year	Type of Discipline:
_____	____/_____	_____
_____	____/_____	_____
_____	____/_____	_____
_____	____/_____	_____
_____	____/_____	_____

6. **Hospital Discipline**: Please explain any disciplinary actions and attach any relevant supplements materials. List any revocation of hospital privileges for reasons related to competence or quality of patient care that have been taken by the hospital's governing body or any other official of the hospital after procedural due process has been afforded. Also, report resignation from or the non-renewal of medical staff privileges or the restriction of privileges at a hospital during the course or threat of investigation. If necessary, you may continue on a separate sheet.

☐ Check here if not applicable

_____
(1) Name of Hospital

_____/ _____/ _____ _____
Month Day Year Type of Action

_____
(2) Name of Hospital

_____/ _____/ _____ _____
Month Day Year Type of Action

_____
(3) Name of Hospital

_____/ _____/ _____ _____
Month Day Year Type of Action

_____
(4) Name of Hospital

_____/ _____/ _____ _____
Month Day Year Type of Action

7. **Criminal Convictions**: Respond to the questions below, then list any criminal convictions(s) in the space provided. If necessary, you may continue on a separate sheet.

Have you ever been convicted of a violation, plead Nolo Contendere, or entered a plea bargain to any federal, state or local statute, or ordinance, or are any formal charges pending; including use of illicit substances or operating a motor vehicle while intoxicated (Please include any offenses which have been expunged from your record)? ☐ Yes ☐ No

Abbreviation of State and Conviction* (e.g.CA – Illegal possession of a controlled substance)	Month/Year
_____	_____/_____
_____	_____/_____
_____	_____/_____
_____	_____/_____

*For purposes of this section, a person shall be deemed to be convicted of a crime if he/she please guilty or if he/she was found or adjudged guilty by a court of competent jurisdiction or has been convicted of a felony by the entry of Nolo Contendere in any state.

8. **Questions**: Check either "Yes" or "No" for each question below. **Note: if you answer "Yes" to any question**, you are required to furnish complete details, including date, place, reason and disposition of the matter on a separate sheet.

		YES	NO
1.	During any Professional/Medical Education, were you ever dismissed, suspended, restricted, put on probation, or otherwise acted against or did you take a leave of absence for medical reasons?	☐	☐
2.	During any Professional/Medical Education, were you ever requested to leave or did you leave, temporarily or permanently, prior to completion of training?	☐	☐
3.	During any Post Graduate Training, were you ever dismissed, suspended, restricted, put on probation, or otherwise acted against or did you take a leave of absence for medical reasons?	☐	☐
4.	During any post graduate training, were you ever requested to leave or did you leave temporarily or permanently, prior to completion of training? (excluding maternity leave)	☐	☐
5.	Are there any charges or investigations pending, in any state, against you?	☐	☐
6.	Have your staff privileges at any hospital, nursing home, or other health care facility or health care provider or HMO ever been reduced, revoked, or suspended or have you voluntarily surrendered your clinical privileges from any such unit or facility while under investigation in any state?	☐	☐
7.	Have you ever had any disciplinary action(s) taken, or is any pending, against your License to practice medicine, DEA permit, State Controlled Substances Registration, Medicare Privileges, Medicaid Privileges, or are any complaints pending in any state?	☐	☐
8.	Have you ever had a membership in a professional society revoked, suspended, or limited in any manner or have you voluntarily withdrawn while under investigation?	☐	☐
9.	Have you ever failed to pass an examination for medical licensure (including National Boards, FLEX, USMLE)? If you have failed to pass any segment of the USMLE within three (3) attempts you do not meet the requirements for licensure. Please contact us at (401) 222-3855 to discuss.	☐	☐

9. **Physician Honors and Peer-Reviewed Publications (Optional)**: List any information regarding professional or community service awards and/or information regarding publication in peer-reviewed medical literature within the last ten (10) years. Do **not** submit your curriculum vitae to satisfy the requirements of this section. If necessary, you may continue on a separate sheet.

   Awards, Honors:

   _____

   _____

   _____

   Publications:

   _____

   _____

   _____

10. **Professional and Community Memberships (Optional)**: List any professional and community memberships. Do **not** submit your curriculum vitae to satisfy the requirements of this section. If necessary, you may continue on a separate sheet.

    _____

    _____

    _____

ABMS Codes and Abbreviations

Certification Codes

American Board of	General Certificate		Subspecialty Certificates	
Allergy and Immunology	**A&I**	Allergy and Immunology	**CLI**	Clinical & Laboratory Immunology [5]
			DLI	Diagnostic Laboratory Immunology [5]
Anesthesiology	**Anes**	Anesthesiology	**CCM**	Critical Care Medicine
			HPM	Hospice and Palliative Medicine
			PM	Pain Medicine [5]
Colon and Rectal Surgery	**CRS**	Colon and Rectal Surgery		
Dermatology	**D**	Dermatology	**CLDI**	Clinical and Laboratory Dermatological Immunology [4]
			DI	Dermatological Immunology/Diagnostic & Laboratory Immunology
			DP	Dermatopathology
			PedD	Pediatric Dermatology
Emergency Medicine	**EM**	Emergency Medicine	**HPM**	Hospice and Palliative Medicine
			MT	Medical Toxicology
			PEM	Pediatric Emergency Medicine
			SM	Sports Medicine
			UHM	Undersea & Hyperbaric Medicine
Family Medicine	**FM**	Family Medicine	**AM**	Adolescent Medicine
			Ger	Geriatric Medicine
			HPM	Hospice and Palliative Medicine
			SLP	Sleep Medicine
			SM	Sports Medicine
Internal Medicine	**IM**	Internal Medicine	**AI**	Allergy and Immunology
			AM	Adolescent Medicine
			CCEP	Clinical Cardiac Electrophysiology [5]
			CCM	Critical Care Medicine
			CLI	Clinical & Laboratory Immunology [5]
			Cv	Cardiovascular Disease
			DLI	Diagnostic Laboratory Immunology [5]
			EDM	Endocrinology, Diabetes & Metabolism [5]
			En	Endocrinology & Metabolism [5]
			Ge	Gastroenterology
			Ger	Geriatric Medicine
			Hem	Hematology
			HPM	Hospice and Palliative Medicine
			Inf	Infectious Disease
			IntvCd	Interventional Cardiology
			Nep	Nephrology
			Onc	Medical Oncology
			Pul	Pulmonary Disease
			Rhu	Rheumatology
			SLP	Sleep Medicine
			SM	Sports Medicine
			TH	Transplant Hepatology
Medical Genetics	**MG CBCGn**	Clinical Biochemical Genetics	**MBG**	Medical Biochemical Genetics
	MG CBMG	Clinical Biochemical/Molecular Genetics [4]	**MGP**	Molecular Genetic Pathology
	MG CCytG	Clinical Cytogenetics		
	MG CGen	Clinical Genetics (M.D.)		
	MG CMGn	Clinical Molecular Genetics		
	MG PhDMG	Ph.D. Medical Genetics [4]		
Neurological Surgery	**NS**	Neurological Surgery		
Nuclear Medicine	**NuM**	Nuclear Medicine		
Obstetrics & Gynecology	**ObG**	Obstetrics & Gynecology	**CCM**	Critical Care Medicine
			GO	Gynecologic Oncology
			HPM	Hospice and Palliative Medicine
			MF	Maternal and Fetal Medicine
			RE	Reproductive Endocrinology/Infertility
Ophthalmology	**Oph**	Ophthalmology		
Orthopaedic Surgery	**OrS**	Orthopaedic Surgery	**HS**	Surgery of the Hand
			OSM	Orthopaedic Sports Medicine
Otolaryngology	**Oto**	Otolaryngology	**ON**	Neurotology [5]
			PO	Pediatric Otolaryngology
			PSHN	Plastic Surgery within the Head and Neck
			SLP	Sleep Medicine
Pathology	**Path AP**	Anatomic Pathology	**BB**	Blood Banking [5]
	Path AP/CP	Anatomic Pathology and Clinical Pathology	**BBTM**	Blood Banking/Transfusion Medicine [5]
	Path CP	Clinical Pathology	**ChemP**	Chemical Pathology [5]
	PathR	Pathology Recertification	**CytoP**	Cytopathology
			DP	Dermatopathology
			FPath	Forensic Pathology [5]
			Hem	Hematology [5]
			IP	Immunopathology [4]
			MGP	Molecular Genetic Pathology [5]
			MMB	Medical Microbiology [5]
			NPath	Neuropathology
			PathF	Pathology-Forensic [5]
			PChem	Pathology-Chemical [5]
			PdP	Pediatric Pathology [5]
			PHem	Pathology-Hematology [5]
			PMG	Pathology-Molecular Genetic [5]
			PMMB	Pathology-Medical Microbiology [5]
			PPed	Pathology-Pediatric [5]
			RIP	Radioisotopic Pathology [4]

ABMS Codes and Abbreviations

Certification Codes (continued)

American Board of	General Certificate		Subspecialty Certificates	
Pediatrics	**Ped**	Pediatrics	**AI**	Allergy and Immunology [4]
			AM	Adolescent Medicine
			CCM	Pediatric Critical Care Medicine
			Cd	Pediatric Cardiology
			CAP	Child Abuse Pediatrics
			CLI	Clinical & Laboratory Immunology [5]
			DBP	Developmental-Behavioral Pediatrics
			DLI	Diagnostic Laboratory Immunology [5]
			HPM	Hospice and Palliative Medicine
			En	Pediatric Endocrinology
			Ge	Pediatric Gastroenterology
			HO	Pediatric Hematology-Oncology
			Inf	Pediatric Infectious Diseases
			MT	Medical Toxicology
			ND	Neurodevelopmental Disabilities
			Ne	Pediatric Nephrology
			NP	Neonatal-Perinatal Medicine
			PEM	Pediatric Emergency Medicine
			Pul	Pediatric Pulmonology
			Rhu	Pediatric Rheumatology
			SLP	Sleep Medicine
			SM	Sports Medicine
			TH	Pediatric Transplant Hepatology
Physical Medicine and Rehabilitation	**PMR**	Physical Medicine and Rehabilitation	**HPM**	Hospice and Palliative Medicine
			NeuroMed	Neuromuscular Medicine
			PedRM	Pediatric Rehabilitation Medicine
			PM	Pain Medicine [5]
			SCInj	Spinal Cord Injury Medicine
			SM	Sports Medicine
Plastic Surgery	**PlS**	Plastic Surgery	**HS**	Surgery of the Hand
			PSHN	Plastic Surgery within the Head and Neck
Preventive Medicine	**PrM AeroM**	Aerospace Medicine	**MT**	Medical Toxicology
	PrM GPM	General Preventive Medicine [5]	**UM**	Undersea Medicine [5]
	PrM OM	Occupational Medicine	**UHM**	Undersea & Hyperbaric Medicine [5]
	PrM PH	Public Health [5]		
	PrM PHGPM	Public Health and General Preventive Medicine [5]		
Psychiatry and Neurology	**ChiN**	Neurology with Special Qualification in Child Neurology	**AdP**	Addiction Psychiatry
	N	Neurology	**ChAP**	Child and Adolescent Psychiatry [5]
	Psyc	Psychiatry	**ChiP**	Child Psychiatry [5]
			C/NPh	Clinical Neurophysiology
			FPsy	Forensic Psychiatry
			GPsyc	Geriatric Psychiatry
			HPM	Hospice and Palliative Medicine
			NeuroMed	Neuromuscular Medicine
			ND	Neurodevelopmental Disabilities
			PM	Pain Medicine [5]
			PsycoMed	Psychosomatic Medicine
			SLP	Sleep Medicine
			VascN	Vascular Neurology
Radiology	**Rad DR**	Diagnostic Radiology	**HPM**	Hospice and Palliative Medicine
	Rad DRnt	Diagnostic Roentgenology[4]	**NR**	Nuclear Radiology
	DRSCNR	Diagnostic Radiology with Special Competence in Nuclear Radiology[4]	**NRad**	Neuroradiology
			PR	Pediatric Radiology
	Rad NM	Nuclear Medicine[4]	**VIR**	Vascular and Interventional Radiology
	Rad NM	Nuclear Medicine Medallion		
	Rad R	Radiology[4]		
	Rad Rnt	Roentgenology[4]		
	Rad RO	Radiation Oncology [5]		
	Rad ROR	Radiation Oncology Recertification		
	Rad RT	Radium Therapy[4]		
	Rad TO	Therapeutic Roentgenology [4]		
	Rad TR	Therapeutic Radiology [5]		
Radiologic Physics	**Rad DRMNP**	Diagnostic & Medical Nuclear Physics[4]		
	Rad DRMNP	Diagnostic Radiology & Medical Nuclear Physics		
	Rad DRP	Diagnostic Radiologic Physics		
	Rad MNP	Medical Nuclear Physics		
	Rad RP	Radiologic Physics[4]		
	Rad RRP	Roentgen & Gamma Physics		
	Rad RRP	Roentgen Ray Physics		
	Rad TDRP	Therapeutic & Diagnostic Radiologic Physics[4]		
	Rad TRNP	Therapeutic & Medical Nuclear Physics[4]		
	Rad TRNP	Therapeutic Radiology & Medical Nuclear Physics		
	Rad TRP	Therapeutic Radiologic Physics		
	Rad XRP	X-Ray and Radium Physics[4]		
Surgery	**S**	Surgery	**HPM**	Hospice and Palliative Medicine
	VascS	Vascular Surgery	**HS**	Surgery of the Hand
			PdS	Pediatric Surgery
			SCC	Surgical Critical Care
Thoracic Surgery	**TS**	Thoracic Surgery	**CCS**	Congenital Cardiac Surgery
Urology	**U**	Urology	**PU**	Pediatric Urology

Rhode Island Board of Medical Licensure and Discipline
Room 205, 3 Capitol Hill
Providence, RI 02908-5097
(401) 222-3855

ADDENDUM 3
Mandatory Addendum to Licensure Application
Verification of Social Security Number
Tax Payer Status Affidavit / Identity Verification

All persons applying or renewing any license, registration, permit or other authority (herein after called "licensee") to conduct a business or occupation in the state of Rhode Island are required to file all applicable tax returns and pay all taxes owed to the state prior to receiving a license as mandated by state law (RIGL 5-76) except as noted below.

In order to verify that the state is not owed taxes, licensees are required to provide their Social Security Number or Federal Tax Identification Number (for businesses) as appropriate. These numbers will be transmitted to the Division of Taxation to verify tax status prior to the issuance of a license.

Licensee Declaration

☐ I hereby declare, under penalty of perjury, that I have filed all required state tax returns and have paid all taxes owed.

☐ I have entered a written installment agreement to pay delinquent taxes that is satisfactory to the tax administrator.

☐ I am currently pursuing administrative review of taxes owed to the state.

☐ I am in federal bankruptcy. (Case # _____)

☐ I am in state receivership. (Case # _____)

☐ I have been discharged from bankruptcy. (Case # _____)

_____
Type of Professional License for which you are applying.

_____ _____
Full Name (Please Print or Type) Social Security Number

_____ (_____) _____ - _____
Signature Phone Number

_____
Date

This form must be completed, signed and attached to your license application for processing.

Rhode Island Board of Medical Licensure and Discipline

Room 205, 3 Capitol Hill
Providence, RI 02908-5097
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ADDENDUM 4

Rhode Island Uniform Controlled Substances Act Registration (CSR)

IF Applying for CSR, this Application **MUST BE SUBMITTED ALONG WITH YOUR LICENSE APPLICATION**. Substitute forms are not acceptable.

I am applying for a Rhode Island Uniform Controlled Substance Act Registration (CSR). **I understand that this application MUST be submitted along with my Board Application. I also understand that there is an additional $200.00 fee for this Registration and that the check or money order for $1,290.00 (Non-Refundable Board Application fee ($1,090.00) PLUS CSR Application fee ($200.00) must be made out to the "RI General Treasurer." Note: To be issued a RI Controlled Substance Registration you must have a Rhode Island Business Address.**

Print/Type Full Name	Business Name
Signature	Business Address
Date	Business Telephone / Business Fax

Complete this application for registration to prescribe controlled substances in the State of Rhode Island.

A CSR is not required if there will be no controlled substances prescriptions prescribed in this state.

The CSR is renewed at the same time that the professional license is renewed.

Note: Read important information on the bottom of this application.

The Rhode Island Uniform Controlled Substances Act can be accessed at the following web site:
http://www.rilin.state.ri.us/Statutes/Title21/21-28/index.htm

Drug Schedule (Check all that apply)

☐ Schedule II ☐ Schedule III ☐ Schedule IV ☐ Schedule V

A Copy of the DEA Registration must be provided to the Medical Board within 60 Days of its issuance by the DEA. The DEA Registration must be issued to your Rhode Island Practice Address in order for it to be valid. If you are relocating from another state, you need to apply for a DEA Registration that is specific to Rhode Island. See the bottom of this form for information on how to contact the DEA. *

All Applicants MUST answer the following:

A. Has the applicant been convicted of, or entered a plea of nolo contedere to a violation of any state or federal law relating to manufacturing, distributing, possessing, prescribing, administering or dispensing of drugs presently defined as controlled substances under Chapter 21-28, General Laws of Rhode Island? ☐ Yes ☐ No

B. Has the registration application or registration of the applicant, corporation, firm, partner, or officer of the applicant been surrendered, revoked, suspended or denied under any law of the United State or of any state relating to drugs presently defined as controlled substances under Chapter 21-28, General Laws of Rhode Island, or is such action pending? ☐ Yes ☐ No

If you answered "Yes" to question "A" or "B" attach an explanation to this form.

Important Information

Issuance of a Rhode Island Controlled Substances Registration is contingent upon registration by the U.S. Drug Enforcement Administration. If denied a "DEA Registration", the Rhode Island Controlled Substances Registration becomes "VOID." Licensed drug facilities and licensed practitioners with prescriptive privileges cannot dispense, possess, store or ship controlled substances in or into the State of Rhode Island without a valid drug facility or professional license. Rhode Island Controlled Substances Registration (CSR), and a federal Drug Enforcement Administration (DEA) Registration. Practitioners may only prescribe, dispense, possess, and store controlled substances within their particular "scope of practice." "Controlled Substances" for purposes of this application, means a prescription drug in Schedules II through V, pursuant to the Rhode Island Uniform Controlled Substances Act, and 21 CFR 1300 of the Federal Code of Regulations. Schedule I drugs are used by researchers, and require the submission of a protocol.

Without a Rhode Island CSR and federal DEA Registration, licensed drug facilities, and practitioners with prescriptive privileges, may dispense or possess non-controlled prescription medications under its facility or professional license. A CSR will not be granted to an applicant whose BOARD licensure application is "pending" in this state.

A Rhode Island CSR must be obtained prior to applying for DEA Registration. Federal regulations require that applicants comply with individual state requirements prior to issuance of a DEA Registration. Once the CSR is issued, applicants must apply to the U.S. Drug Enforcement Administration for a federal registration using that agency's DEA Form 224 (New Application for Retail Pharmacy, Hospitals/Clinics, Practitioner, Teaching Institution, or Mid-Level Practitioner). Applicants may apply on-line for the DEA Registration at the following website: www.deadiversion.usdoj.gov./drugreg/reg_apps/index.html

*You can also receive an application, or check the status of a pending DEA Registration by contacting the Drug Enforcement Administration at the following location: Registration Unit, US Drug Enforcement Administration, JFK Federal Bldg., 15 new Sudbury Street, Boston, MA 02203-0131, Telephone (888) 272-5174.

NOTE:

- Schedules II, III, and IV of section 21-28-2.08 will become void unless dispensed within thirty (30) days of the original date of the prescription.
- Prescriptions in schedules III, IV, and V cannot be written for more than one hundred (100) dosage units and not more than one hundred(100) dosage units may be dispensed at one time. For purposes of this section, a dosage unit shall be defined as a single capsule, tablet, or suppository, or not more that one (1) teaspoon of an oral liquid.
- Prescriptions in schedule II may be written for up to a 30-day supply, with a maximum of two hundred and fifty (250) dosage units, as determined by the prescriber's directions for use of the medication.

Applicant Name: _____ Date: _____

Rhode Island Board of Medical Licensure and Discipline
Room 205, 3 Capitol Hill
Providence, RI 02908-5097
(401) 222-3855

ADDENDUM 5
Voluntary Race/Ethnicity Questions

This information is completely voluntary and will NOT affect your Application in any way.

Note: This information is voluntary and refusal to provide it will not impact on the renewal of your license. It will be confidential and used only in accordance with Title VI of the Civil Rights Act of 1964.

1. **Ethnicity**: Are you Hispanic or Latino? **(Mark "No" if not Hispanic or Latino)**
   ☐ No, not Hispanic or Latino ☐ Yes, Hispanic or Latino

2. **Race**: What is your race? (Mark one or more)
   ☐ American Indian or Alaska Native ☐ Black or African American ☐ White
   ☐ Asian ☐ Native Hawaiian or other Pacific Islander

For purposes of the above questions kindly use the "Federal Minimum Data Collection" explanations listed below:

1. **Ethnic Categories**:

   Hispanic or Latino – A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term, "Spanish Origin" can be used in addition to "Hispanic or Latino."

   Not Hispanic or Latino – A person who is not Hispanic or Latino.

2. **Racial Categories**:

   American Indian or Alaska Native – A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

   Asian – A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

   Black or African American – A person having origins in any of the Black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or African American."

   Native Hawaiian or other Pacific Islanders – A person having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands.

   White – A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

* This information is being collected in accordance with the Department of Health's policy for Maintaining, Collecting and Presenting Data on Race and Ethnicity. The mission of the Department is to protect and promote the health of the population and to prevent disease through life-style change, environmental change, and health services delivery. A copy of this policy is available upon request.

Rhode Island Board of Medical Licensure and Discipline

Room 205, 3 Capitol Hill
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ADDENDUM 6

Academic Faculty – Limited Medical Registration Applicants ONLY

Substitute forms are not acceptable. This form may be duplicated as needed.

I am applying for an Academic Faculty – Limited Medical Registration in the State of Rhode Island. The Rhode Island Board of Medical Licensure and Discipline requires these questions be answered as part o my application process. This constitutes your authority to provide information about my character and professional abilities, favorable or otherwise, directly to the Rhode Island Board of Medical Licensure and Discipline at the above address.

Print/Type Full Name	Signature	Date
Previous Names Used	Social Security Number	Date of Birth

THESE QUESTIONS ARE TO BE ANSWERED BY THE DEAN OF THE MEDICAL SCHOOL.

Please Note: Information must be typed or printed clearly and submitted under separate cover.

Please provide information pertaining to the following:

1. Describe this candidate's exceptional qualifications that warrant consideration for licensure as an Academic Faculty – Limited Medical Registration.

2. Describe fully the candidate's primary clinical and non-clinical activities.

3. Please state the anticipated faculty rank of the candidate.

4. Please describe the Formal Search/Recruitment efforts that led to the selection of this candidate including the number of candidates interviewed and duration of search.

5. Please describe system academic supervision of candidate's clinical practice.

PLEASE SEND THIS COMPLETED FORM TO
THE RHODE ISLAND BOARD OF MEDICAL LICENSURE AND DISCIPLINE
AT THE ADDRESS ABOVE. THANK YOU.

UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

Affidavit and Authorization for Release of Information

Mail this completed notarized form to:

Rhode Island Board of Medical Licensure and Discipline
Room 205, 3 Capitol Hill; Providence, RI 02908-5097

Applicant:

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

If you are using FCVS for credentials verification, you must also send the separate FCVS affidavit form to FCVS if you have not already done so.

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

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

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

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

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

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

Applicant Photograph

Securely tape or glue a recent (less than 6 month old) front-view 2" x 2" passport-type color photo of yourself in this square.

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

_____
Applicant's printed last name

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

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

-fold up- *-fold up-*

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

Notary

State of _____, County of _____,

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

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

Notary Public Signature: _____

(NOTARY PUBLIC SEAL)

My Notary Commission Expires: _____

UA UNIFORM APPLICATION FOR LICENSURE

For State Board Use Only

Licensure Verification Form (Form #1)

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

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

Section 1: Applicant Information

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

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

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

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

Board name _____

Mailing address _____

City/State/Zip _____

Applicant signature _____ Date _____

Section 2: Board Verification of Licensure

Name of issuing board or license entity _____

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

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

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

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

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

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

Signature _____

Print name _____

AFFIX INSTITUTIONAL SEAL HERE

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

Title _____ Date _____

Phone number _____ Fax number _____

Email _____

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

UA UNIFORM APPLICATION FOR LICENSURE

For State Board Use Only

Medical or Osteopathic School Verification Form (Form #2)

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

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

Section 1: Applicant Information

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

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

Name if different when diploma awarded: _____

Name of school _____

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

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

Board name _____

Mailing address _____

City/State/Zip _____

Applicant signature _____ Date _____

Section 2: Medical or Osteopathic School Verification

School name _____

Complete address w/country _____

School name if different when applicant attended _____

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

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

Unusual Circumstances

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

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

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

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

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

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

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

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

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

Signature _____

Print name _____

AFFIX INSTITUTIONAL SEAL HERE

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

Title _____ Date _____

Phone number _____ Fax number _____

Email _____

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

UA UNIFORM APPLICATION FOR LICENSURE

Postgraduate Training Verification Form (Form #3)

Institution Name: ____

Institution Address: ____

____

Affiliated School: ____

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

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

Section 1: To be completed by the Applicant.

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

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

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

Name if different when diploma awarded: ______________________________________

Board Information: To be completed by the applicant.

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

Board Name: ______________________________________

Mailing address: ______________________________________

Applicant Please Sign Here →

Applicant Signature ______________________________________ **Date** ____________

Section 2 : Program Participation :

Important:

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

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

Use one section per Department/Specialty. If the 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.