Commonwealth of the Northern Mariana Islands
HEALTH CARE PROFESSIONS LICENSING BOARD
P.O. Box 502078, Bldg., 1242 Pohnpei Court
Capitol Hill, Saipan, MP 96950
Tel No: (670) 664-4809 Fax: (670) 664-4814
Email: cnmi@cnmibpl-hcplb.net
Website: cnmibpl-hcplb.net

Thank you for your interest in serving as a physician in the Commonwealth of Northern Mariana Islands. Applying for licensure can be an overwhelming experience. This packet will outline the process for physician licensure specific to the Commonwealth of the Northern Mariana Islands. Please read each section carefully.

Licensing Requirements

Allopathic Physicians – U.S. or Canada

- MD degree from an LCME-accredited medical school in the U.S. or from a CACMS-accredited medical school in Canada.
- One year of postgraduate training (internship, residency, or fellowship) in an ACGME-accredited program in the U.S. or an accredited program in Canada.
- Satisfactory completion of the NBME, FLEX, USMLE or the Qualifying Exam of LMCC.

Osteopathic Physicians – U.S. or Canada

- DO or DOM degree from an AOA-accredited osteopathic medical school in the U.S.
- One year of postgraduate training (internship, residency, or fellowship) in an AOA-approved program in the U.S.
- Satisfactory completion of the NBOME's COMLEX.

Podiatric Physicians – U.S. or Canada

- DPM degree from a school/college accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association or a school/college approved by the Board.
- One year of postgraduate training approved by the Council on Podiatric Medical Education of the American Podiatric Medical Association or a program approved by the Board.
- Satisfactory completion of the APMLE.

Foreign Physicians / International Medical Graduates

- ECFMG Certificate ("valid indefinitely").
- Three (3) years of postgraduate training (internship, residency, or fellowship) in an ACGME-accredited program in the U.S. or an accredited program in Canada, after earning a medical degree.
- Satisfactory completion of the NBME, COMLEX, FLEX, USMLE or the Qualifying Exam of LMCC.

Licensure by Endorsement

- HCPLB may issue a medical license by endorsement if you hold an active, unrestricted medical license from another U.S. state or territory or from Canada and the jurisdictional requirements in the other location are at least as stringent as the requirements in the CNMI.

General Information for Physician Applications

Completion of the Application Forms

Help us to do a good job processing your application. Please read the instructions given and give careful thought before answering the questions. Remember, you are certifying that the information is truthful and correct.

Provide all documents requested in the application; incomplete applications will delay processing. Make sure all documents are originals or a certified or notarized true copy of original documents. Application fees must accompany applications before initial review can begin.

Answer each question in the Uniform Application and the Addendum in this packet. Attach separate sheets of paper, labeled with your name and signed by you, for any question for which you provided a "yes" response. Type or print legibly.

Failure to answer all questions completely and accurately, or the omission or falsification of information may be cause for denial of your application or disciplinary action if the board subsequently issues you a license.

Confidentiality

The contents of licensing files are generally considered public records. If you believe that the additional information you are attaching to explain a "yes" answer should be considered confidential, state that in the attachment. A request for confidentiality may or may not be granted.

Documents sent by Fax or Email

Fax copies or documents sent via email are not accepted for documentation or verification in our licensing process. If a copy of a document is sent via fax or email, the original must be sent via U.S. Postal Service to the Board's office.

Foreign Language Documents

All documents submitted in a foreign language shall be accompanied by an accurate translation in English. Each translated document shall bear the affidavit of the translator certifying that the translator is competent in both the language of the document and the English language and that the translation is a true and complete translation of the foreign language original, and sworn to before a notary public. Translation of any document relative to a person's application shall be at the expense of the applicant.

National Practitioner Data Bank (NPDB)

Visit the NPDB website at https://www.npdb.hrsa.gov/ and click on "Self-Query" to order a Self-Query report. This report is required for licensure. If you are unable to go online, call the NPDB at 1-800-767-6732 (1-800-SOS-NPDB) for assistance.

Personal Interviews

Applicants for medical licensure may be required to have a personal interview either with an individual board member or with the full board. Should an interview be required, you will be notified and an interview scheduled. An interview may be required if, during the processing of your application, a question arises for which the board determines it requires additional information from you.

Processing Time

In general, average processing time for a permanent license is 4 - 6 weeks. Processing time for a renewal or other license generally takes less time. The amount of time needed depends to a large extent on the response time from other organizations, our workload, and the volume of applications being processed or the routing of the initial or the renewal application.

License Renewal

All licenses issued by the Board expired every two years following its issuance or renewal and becomes invalid after that date. Notification for license renewal is mailed or emailed to licensees at least sixty (60) days before the expiration date. You are required by regulations to keep your current address on file with the Board.

There is a late fee of $25.00 charged for every 1st of the month after the expiration date.

Licenses, which have expired for failure to renew on or before the date required may be reinstated within one year of the expiration date. Each licensee whose license has expired and lapsed for more than one year by failure to renew must file a new application, meet present day requirements for licensure, and receive board approval.

Continuing Education (CE)

All licensed physicians are required to complete fifty (50) Category I CME hours as a prerequisite to the renewal of their license ***during*** the 24 months prior to the expiration of his/her license. It shall be the responsibility of the licensee to obtain documentation, satisfactory to the Board, from the organization or institution, of his or her participation in the CME, and the number of credits earned.

Licensure renewal shall be denied to any licensee who fails to provide satisfactory evidence of completion of CME requirements, or who falsely certifies attendance at and/or completion of the CME, as required herein.

License Denial

If for any reason your application for renewal of your license is denied you are entitled to a hearing pursuant to the Commonwealth Administrative Procedures Act, 1 CMC §9108-15.

Abandonment of Application

Your application shall be considered abandoned and shall be destroyed if you fail to provide evidence of continued efforts to complete the licensing process for one (1) year. If the application is deemed abandoned the applicant shall be required to reapply for licensure and comply with the licensing requirements in effect at the time of the reapplication.

Schedule of Fees

Application Fee	$100.00
License Fee - Temporary	$100.00
License Fee - Initial	$200.00
License Fee - Renewal	$200.00
Delinquent Fee (each month)	$25.00
Replacement of License	$75.00
Replacement of Card	$25.00
Verification of License	$25.00
Letter of Good Standing	$25.00

Guide to Using FCVS and the Uniform Application

The Federation of State Medical Boards

The Federation of State Medical Boards (FSMB) is a national non-profit organization representing the 70 medical and osteopathic boards of the United States and its territories, serving as the national resource and voice on behalf of these boards in their protection of the public.

Two services provided by FSMB that are often used by physicians when applying for licensure are the Federation Credentials Verification Service (FCVS) and the Uniform Application for Physician State Licensure (UA).

Please be aware that FCVS and the UA are two different services. The FCVS application is only used to establish a profile of credentials verified by primary sources. FCVS is not a licensure application. The UA is used as a licensure application most commonly by physicians applying to multiple state boards. Both services may be used when applying to a board for licensure.

Credentials Verification through the Federation Credentials Verification Service (FCVS)

After a physician completes an initial FCVS application to establish a profile of verified credentials (documents related to identity, medical education, postgraduate training, etc.), FCVS staff contacts the primary source of each credential for verification. Each verified credential is added to a personalized profile created for the physician. Once the profile has been completed, it is sent to each board designated to receive the profile during the initial application process.

To update the profile, a physician completes a subsequent FCVS application. Any new credentials are then verified through primary sources, and the updated profile is sent to each board designated to receive it during the subsequent application process.

Each medical and osteopathic board in the United States and its territories (except for Puerto Rico) accepts or requires FCVS. This Board highly recommends but does not require the use of FCVS.

To begin an initial or subsequent application for credentials verification, visit https://portal.fsmb.org/MyFsmb/ and click on the FCVS graphic, then sign in. If the link doesn't work, visit http://www.fsmb.org/ and click on FCVS in the Licensure menu.

For assistance, use the messaging tool in FCVS or call 888-275-3287 with your FCVS ID or nine-digit Federation ID (FID) between 8am and 5pm Central Time Monday through Friday.

Licensure Application through the Uniform Application for Physician State Licensure (UA)

The Uniform Application is used to apply for licensure only, not for credentials verification. Once the UA has been completed and the one-time service charge of $50 has been paid, it can be updated and sent to other boards as needed. Additional information required by a board, but not covered in the core UA, is gathered by completing a state board specific UA addendum, various board or UA forms, and/or a board's online addendum or separate online application.

Applicants using the UA must account for all time since medical school graduation, including non-working time as well as postgraduate training and employment. Information on malpractice claims is also required. Having this information on hand before starting the UA is highly recommended.

To begin or update your UA, visit https://portal.fsmb.org/MyFsmb/ and click on the UA graphic, then sign in. If the link doesn't work, visit http://www.fsmb.org/ and click on Uniform Application in the Licensure menu.

When completing your UA online, please note the following:

- Provide your current home address and a separate address for business or postgraduate training. Both Board Contact and Public Access selections must be made, but the same address can be used.

- All medical school, ACGME postgraduate training, and non-ACGME postgraduate training entered will pre-fill your Chronology of Activities. Your Chronology should cover all of your activities (non-working time included) from medical school graduation to present. Use the first day of the month for start and end dates unless you know the exact date.

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

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

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

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

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

- First time UA users will be taken to a payment page for a one-time service charge of $50. This is separate from FCVS and state board licensing fees. A receipt will be available immediately after UA submission for printing and a separate receipt will be emailed to you.

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

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

- Submit a notarized 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 to the Board, not to FCVS or FSMB. Follow the instructions on the form, which is included in this packet.

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

If you are using FCVS for credentials verification,

- FCVS handles all verifications for you. Do not complete the verification forms. Do not send any identity documents, transcripts, certificates, or exam scores to the Board.

Refer to the UA FAQ at https://www.fsmb.org/licensure/uniform-application/faq for answers to 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 and a description of your issue. Provide a screenshot for each error you see.

Use the checklist(s) provided on the next page to ensure that you fulfill all other requirements for licensure.

Uniform Application for Physician State Licensure Checklist

After completing the online application, you are responsible for submitting certain documents.
Please use the below checklist(s) to ensure all required materials are sent to the Board.
If you are not using FCVS for credentials verification, complete both checklists.

All Applicants

- ☐ Complete and submit the online Uniform Application to the Board.
- ☐ Complete the Uniform Application Addendum.
- ☐ Request a Self-Query from the NPDB at https://www.npdb.hrsa.gov/. This must be completed within 60 days of your application date.
- ☐ Have the licensing authority for each healthcare and professional license you have ever held send a verification of the license to the Board. To determine fees and preferred verification of each board, refer to the licensure verification resource at http://www.fsmb.org/licensure/uniform-application/.
- ☐ Mail the following items to the Board:
  - ☐ Non-refundable application fee of **$100** (cashier's check or money order payable to **CNMI Treasurer)**.
  - ☐ Notarized UA Affidavit and Authorization for Release of Verification form. The 2"x2" photograph of you must have been taken within the last **6 months**.
  - ☐ State addendum and documentation for addendum question answers requiring explanations.

Applicants Not Using FCVS for Credentials Verification (complete this checklist as well)

- ☐ Have each medical school you attended send verification of your medical education, including transcripts, to the Board. Follow the instructions on the UA medical education verification form in this packet for this request.
- ☐ Have each postgraduate training program you attended send verification of your training to the Board. Follow the instructions on the UA postgraduate training verification form in this packet for that request.
- ☐ Have each applicable examination entity (USMLE/FLEX/SPEX, NBME/COMLEX, LMCC, state board, etc.) send your examination score transcripts to the Board. For contact and request information, refer to the UA FAQ at http://www.fsmb.org/licensure/uniform-application/faq.
  Please note: This is not needed for applicants choosing Licensure by Endorsement.
- ☐ International Medical Graduates Only: Request that a status report be sent to the Board from ECFMG at http://www.ecfmg.org/cvs/index.html.
- ☐ If you went through a Fifth Pathway program, have your program send verification of your program completion to the Board. Follow the instructions on the UA Fifth Pathway verification form in this packet for that request.
- ☐ Mail the following items to the Board:
  - ☐ A notarized copy of your birth certificate or current, valid passport.
  - ☐ Supporting documentation of any legal name change.
  - ☐ A notarized copy of your medical school diploma.
  - ☐ A notarized copy of your postgraduate training certificate(s).
  - ☐ A notarized copy of evidence of comprehensive licensing examination passed (USMLE, NBME, COMLEX, LMCC, state board, etc.). Request exam score transcripts to be sent to the board using the contact information at http://www.fsmb.org/licensure/uniform-application/faq.
  - ☐ International Medical Graduates Only: A notarized copy of your ECFMG Certificate or a notarized letter showing successful completion of the Fifth Pathway program.

Uniform Application Addendum

Commonwealth of Northern Mariana Islands

Additional Physician Information

Name _____ Hair color _____ Eye color _____ Height _____ Weight _____

Name/address of intended CNMI employment _____

Secondary school name/address (1) _____

Secondary school name/address (2) _____

Attestation Questions

If you answer "yes" for any items, you must attach a detailed explanation on a separate sheet, which includes state or country where action is pending or took place, relevant dates, action taken and reasons for such action. (Include Findings of Fact, Conclusion of Law, Final Order and whether you have been reinstated. If reinstated, list date and conditions of license.)

		YES	NO
1.	Have you ever been charged with, or been found to have committed dishonorable, unprofessional conduct, negligence, incompetence, misconduct, or repeated negligent acts or malpractice by any medical licensing board, other agency, or hospital or healthcare facility?	☐	☐
2.	Has a claim or an action ever been filed against you for the practice of medicine which resulted in a malpractice settlement, judgment, or arbitration award of $25,000 or more?	☐	☐
3.	Has any medical licensing board, other agency, or disciplinary authority refused to issue you a license, renew your license, suspended, revoked, accepted surrender of your license, placed on probation or conditioned your license, held by you now or previously, or ever fined or otherwise disciplined you?	☐	☐
4.	Is there any ongoing or pending investigation against you?	☐	☐
5.	Is there any disciplinary action pending against you?	☐	☐
6.	Has any hospital or healthcare/licensed facility or training program restricted or terminated your professional training, employment, or privileges or have you ever voluntarily or involuntarily resigned or withdrawn from such association to avoid imposition of such measures?	☐	☐
7.	Have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program?	☐	☐
8.	Has your ability to practice medicine in a competent and safe manner ever been impaired or limited by any condition, behavior, impairment, or limitation of a physical, mental, or emotional nature?	☐	☐
9.	Have you used or are you currently using any chemical substance(s), legal or illegal, that in any way impaired or limited, or is currently impairing or limiting, your ability to practice medicine in a safe and competent manner?	☐	☐
10.	Have you been treated for or had a recurrence or a diagnosed addictive disorder?	☐	☐
11.	Have you ever been diagnosed with a neurological or other physical condition that would impair your ability to practice medicine safely?	☐	☐
12.	Do you have any other condition in which in any way impairs or limits your ability to practice medicine safely?	☐	☐
13.	Have you ever been found guilty, pleaded guilty, no contest, or nolo contendere to a crime involving moral turpitude or crime related to the medical profession, or felony in any court?	☐	☐
14.	Is criminal action pending against you in any court?	☐	☐
15.	Are you required to register as a Sex Offender?	☐	☐
16.	Have your DEA or state controlled substance registration ever been denied, suspended, restricted, or terminated?	☐	☐
17.	Have you ever entered into any arrangement or plea or agreement in lieu of a federal prosecution for a drug violation regulated by the DEA?	☐	☐
18.	Have you ever been terminated, sanctioned, and penalized, had to repay monies to or been denied provider participation in any Medicaid, Medicare or other publicly funded healthcare program?	☐	☐

UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

Affidavit and Authorization for Release of Information

Applicant: Follow the instructions in the left sidebar.
Send this to the state board you are applying to for licensure, NOT to FCVS/FSMB.

Applicant:

This is a separate form from the FCVS affidavit and release.

If you are using FCVS, you must complete both FCVS and UA affidavits. Send the FCVS affidavit to FCVS.

Sign this form with attached photo in the presence of a notary public.

Send this notarized affidavit to the board you are applying to for licensure. See http://www.fsmb.org/policy/contacts for a directory of state medical boards.

DO NOT SEND THIS FORM TO FCVS/FSMB. Doing so will delay your licensure process.

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-

After folding the bottom portion upward, bring the new bottom edge to the top edge and fold to fit in a standard envelope.

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 PHYSICIAN STATE LICENSURE

Licensure Verification (UA Form #1)

Applicant: Complete this form as instructed in the left sidebar.
Licensing Board: Complete this form and send it to the board listed in Section 1.

Applicant:

Send this form and any applicable fee to each state board you have held a full, temporary, training, or limited license with.

Licensure Verification Information (including fees) is available at http://www.fsmb.org/licensure/uniform-application/.

Copy this form for multiple licenses.

Use the medical board directory located at http://www.fsmb.org/policy/contacts to ensure you list the correct name/address.

Section 1: Applicant Information

Last name: _____ Suffix: _____

First name: _____

Middle name: _____

Date of birth: _____ Social Security number*: _____

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

Authorization: I am applying for a license to practice medicine. The Board I am applying to requires that this form be completed by each state or Canadian province in 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 license number _____ to the following Board:

Board name: _____

Mailing address: _____

City/State/Zip: _____

Applicant signature: _____ **Date**: _____

Licensing Board:

Please complete Section 2 of this form.

Send this form to the state board listed in Section 1.

Alternatively, provide electronic verification of licensure to the state board listed in Section 1.

DO NOT SEND THIS FORM OR ANY VERIFICATIONS TO FCVS/FSMB.

Section 2: Licensure Verification

Name of Licensee: _____
Last First Middle Suffix

Issuing State Board: _____ License type: _____

License number: _____ Issue date: _____ Expiration date: _____

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

1. Have formal disciplinary proceedings been initiated against applicant's license by a disciplinary authority in your state? ☐ Yes ☐ No ☐ Cannot answer under state law

If yes, please explain: _____

2. 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?

☐ Yes ☐ No ☐ Cannot answer under state law

If yes, please explain: _____

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

Signature: _____
Print name: _____
Title: _____
Date: _____
Email: _____

UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

Medical School Verification (UA Form #2)

Applicant: Complete this form as instructed in the left sidebar.
Dean or Designated Med School Official: Complete as instructed in the left sidebar.

Applicant:

This form is not needed if you are using FCVS for credentials verification.

Complete Section 1 and fill in your name at the top of page 2. Type or print legibly.

Send this form and a copy of your medical school diploma to the current Dean of your medical school.

Copy this form for multiple schools.

Use the medical board directory located at http://www.fsmb.org/policy/contacts to ensure you list the correct name/address.

Section 1: Applicant Information

Last name: _____ Suffix: _____

First name: _____

Middle name: _____

Name if different when diploma awarded: _____

Name of medical school: _____

Date of birth: _____ Social Security number*: _____

**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 authorize the medical school listed above to provide any and all information pertaining to my medical education at that institution to the Board 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), then return this 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**: _____

Dean or Designated Official:

Please complete Section 2 of this form and certify the enclosed copy of the above named applicant's diploma by placing your school seal on it.

Mail the sealed diploma copy and an official copy of the transcripts of the above named physician with this form and any attachments to the state board listed in Section 1.

DO NOT MAIL THIS FORM TO FCVS/FSMB.

If transcripts are not in English, an original, certified, and official English translation is required.

Section 2: Medical School Verification

Medical school name: _____

School name if different when the above applicant attended: _____

Medical school address (including city, state or province, zip code, and country as applicable):

_____

_____

Hours of undergraduate education required for admission into your school: _____

Total weeks of education applicant attended your school: _____

Applicant's attendance dates: From _____ to _____

Graduation date: _____ (indicate N/A if not applicable) Degree: _____ (indicate N/A if not applicable)

The questions on the following page apply to unusual circumstances that occurred during any part of the individual's medical education. Please check the appropriate response(s) and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation. Attach additional pages as necessary.

Applicant Name: _____

1. Do the official records for this individual reflect (an) interruption(s) or extension(s) in his/her medical education? Yes ☐ No ☐

   If yes, please select the reason(s), indicate the dates of the interruption(s) or extension(s), and indicate whether the interruption(s)/ extension(s) was/were approved or unapproved.

		From Month/Year	To Month/Year	Approved	Unapproved
☐	Personal/Family	_____	_____	☐	☐
☐	Academic remediation	_____	_____	☐	☐
☐	Health	_____	_____	☐	☐
☐	Financial	_____	_____	☐	☐
☐	Participation in joint degree program (e.g., MD/PhD)	_____	_____	☐	☐
☐	Participation in non-research special study (e.g., fellowship, international experience)	_____	_____	☐	☐
☐	Other: _____	_____	_____	☐	☐

2. Do the official records for this individual reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? Yes ☐ No ☐

   If yes, please select the reason(s) for the probation, indicate the date(s) of placement on and removal from probation, and attach documentation/information of the circumstances and outcome(s).

		From Month/Year	To Month/Year
☐	Academic probation	_____	_____
☐	Probation for unprofessional conduct/behavioral reasons	_____	_____
☐	Probation for other reason(s) (please specify):	_____	_____

_____

3. Do the official records for this individual reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? Yes ☐ No ☐

   If yes, please attach documentation/information of the circumstances and outcome(s).

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 school or parent university? Yes ☐ No ☐

   If yes, please attach documentation/information of the circumstances and outcome(s).

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? Yes ☐ No ☐

   If yes, please attach documentation/information of the nature of the limitations or special requirements.

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: _____

UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

Postgraduate Training Verification (UA Form #3)

Applicant: Complete this form as instructed in the left sidebar.
Program Director or Designated Official: Complete as instructed in the left sidebar.

Applicant:

This form is not needed if you are using FCVS for credentials verification.

Complete Section 1 and fill in your name at the top of page 2. Type or print legibly.

Send this form to the current Program Director of your postgraduate training program.

Copy this form for multiple training programs.

Use the medical board directory located at http://www.fsmb.org/policy/contacts to ensure you list the correct name/address.

Section 1: Applicant Information

Last name: _____ Suffix: _____

First name: _____

Middle name: _____

Name if different when diploma awarded: _____

Name of postgraduate training program: _____

Date of birth: _____ Social Security number*: _____

**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 authorize the postgraduate training program listed above to provide any and all information pertaining to my medical education at that institution to the Board listed below. I request that the Program Director or a designated official complete Section 2 of this form and send it to the Board listed below at the given address.

Board name: _____

Mailing address: _____

City/State/Zip: _____

Applicant signature: _____ **Date**: _____

Dean or Designated Official:

Please complete Section 2. Report incomplete years separately from those that were completed successfully. Report each Internship, Residency, and Fellowship separately.

Use one section per specialty/subspecialty. Provide a schedule of rotations if the specialty/ subspecialty is rotating/ transitional.

Make copies and attach additional pages if necessary.

Send this form to the board listed in Section 1 with any added documentation, if applicable.

DO NOT MAIL THIS FORM TO FCVS/FSMB.

Section 2: Postgraduate Training Verification

Institution name: _____

Institution address: _____

Institution city / state or province / zip code: _____

Affiliated medical school name: _____

Institution / school name if different when the applicant attended: _____

_____

Postgraduate year (e.g., 1, 2, 3, etc.): _____ ☐ Internship ☐ Residency ☐ Fellowship

☐ Research ☐ Chief Residency ☐ Other: _____

Specialty/Subspecialty: _____

Attendance dates: From _____ to _____

Successfully completed*? ☐ Yes ☐ No ☐ In progress with expected completion date of _____

**In each year of training, did the applicant demonstrate sufficient academic and clinical ability to qualify for advancement without conditional or probationary status to the next year and next progressive level of responsibility in a designated specialty program?*

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

Applicant Name: _____

Postgraduate year (e.g., 1, 2, 3, etc.): _____ ☐ Internship ☐ Residency ☐ Fellowship

☐ Research ☐ Chief Residency ☐ Other: _____

Specialty/Subspecialty: _____

Attendance dates: From _____ to _____

Successfully completed*? ☐ Yes ☐ No ☐ In progress with expected completion date of _____

**In each year of training, did the applicant demonstrate sufficient academic and clinical ability to qualify for advancement without conditional or probationary status to the next year and next progressive level of responsibility in a designated specialty program?*

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

Postgraduate year (e.g., 1, 2, 3, etc.): _____ ☐ Internship ☐ Residency ☐ Fellowship

☐ Research ☐ Chief Residency ☐ Other: _____

Specialty/Subspecialty: _____

Attendance dates: From _____ to _____

Successfully completed*? ☐ Yes ☐ No ☐ In progress with expected completion date of _____

**In each year of training, did the applicant demonstrate sufficient academic and clinical ability to qualify for advancement without conditional or probationary status to the next year and next progressive level of responsibility in a designated specialty program?*

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

Please explain any "Yes" response on an additional page or in the blank sidebar area above.

Unusual Circumstances

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

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: _____

UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

Fifth Pathway Verification (UA Form #4)

Applicant: Complete this form as instructed in the left sidebar.
Program Director or Designated Official: Complete as instructed in the left sidebar.

Applicant:

This form is not needed if you are using FCVS for credentials verification.

Complete Section 1 and fill in your name at the top of page 2. Type or print legibly.

Send this form to your Fifth Pathway director.

Section 1: Applicant Information

Last name: _____ Suffix: _____

First name: _____

Middle name: _____

Name if different when certificate awarded: _____

Name of medical school: _____

Date of birth: _____ Social Security number*: _____

**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 authorize the Program Director or designated official of the Fifth Pathway program to provide any and all information pertaining to my medical education at that institution to the Board listed below. I request that the Program Director or a designated official complete Section 2 of this form and send it to the Board listed below at the given address.

Use the medical board directory located at http://www.fsmb.org/policy/contacts to ensure you list the correct name/address.

Board name: _____

Mailing address: _____

City/State/Zip: _____

Applicant signature: _____ **Date**: _____

Program Director or Designated Official:

Please complete all of Section 2.

Send this form to the board listed in Section 1 with any added documentation, if applicable.

DO NOT MAIL THIS FORM TO FCVS/FSMB.

Section 2: Fifth Pathway Verification

Institution name: _____

Institution address: _____

Institution city / state or province / zip code: _____

Institution / school name if different when the applicant attended: _____

Enrollment dates: From _____ to _____

Completed?
- ☐ Yes. Certification date: _____
- ☐ No. Withdrawal date: _____
- ☐ No. Dismissal date: _____
- ☐ In progress. Expected completion date: _____

If the applicant withdrew or was dismissed, please explain in the space below. Attach additional information if needed.

Applicant Name: _____

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

Unusual Circumstances

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

Please explain any "Yes" response in the blank space below. Attach additional information if needed.

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

Title: _____

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

Date: _____

Phone number: _____ Fax number: _____

Email: _____