Please Note:

Pages 1-20 are for M.D. /D.O. only. Pages 21-33 are for Physician Assistants only.

Montana Department of LABOR & INDUSTRY

Montana Board of Medical Examiners
PO Box 200513
301 S Park, 4th Floor
Helena, MT 59620-0513
Phone: 406-444-6880
Email: dlibsdhelp@mt.gov Website: www.medicalboard.mt.gov

Licensing Requirements and Application Checklist
Physician

License Requirements for Physician

Below are the minimum requirements you must meet in order to be licensed in the state of Montana.

1. Graduation from an approved medical school – [MCA 37-3-102, 37-3-305]
2. Completion of an approved residency – [MCA 37-3-102, 37-3-305, ARM 24.156.508, ARM 24.156.607]
3. Passage of USMLE or other approved medical licensure exam – [MCA 37-3-305, ARM 24.156.606, ARM 24.156.608]
4. Is of good moral character as determined by the board – [MCA 37-3-305]
5. Is able to communicate in the English language as determined by the board – [MCA 37-3-305]

Checklist of Required Documents to Submit for Application for Physician

The following documents and additional forms are required in addition to the basic application. None of these documents may be submitted directly by the applicant as part of the application. All must be sent to the board directly from either the primary source. The Board of Medical Examiners accepts Federation Credential Evaluation Service (FCVS) profiles and Uniform Applications submitted via the Federation of State Medical Boards. The Board also accepts state Physician license verifications submitted via VeriDoc.

- ☐ License verification. Board staff will verify all U.S. physician licenses via the physician data center. Applicants must request license verifications be sent directly to the Board in the following circumstances: licenses held that are not physician licenses, licenses held in Canada, any license that has ever been disciplined. (Verifications submitted via VeriDoc are accepted.)
- ☐ Verifications from medical school and post-graduate medical educational programs. (Can be in FCVS)
- ☐ Verifications of medical licensure exam(s), including ECFMG if the applicant is a foreign medical graduate. (Can be in FCVS)
- ☐ If you answered yes to discipline questions, include a detailed explanation on the event(s) and documentation from the source (licensing board, federal agencies/programs, or civil/criminal court proceedings such as initiating/charging documents, final disposition/judgement documents, etc.) NOTE: The Montana Board will seek a report from the National Practitioner Data Bank. You do not need to request a self-query from the NBDB. You will be notified if any further information is required as a result of the NPDB report.

Application Fee(s) for Physician

The following fee(s) must be submitted with your application.

- ☐ $375 application fee (payable to the Montana Board of Medical Examiners)

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

P.O. Box 200513 • (301 S Park, 4th Floor – Delivery) • Helena, MT 59620-0513
Phone: (406) 444-6880 • Fax: (406) 841-2305
Email: dlibsdmed@mt.gov • Website: www.medicalboard.mt.gov

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

Application Processing Procedures

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

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

Uniform Application for Physician State Licensure (UA)

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

- To start or update your UA, visit http://www.fsmb.org/uniform-application/ You may also visit http://www.fsmb.org/ and click on Uniform Application in the Licensure menu to access the portal page. Complete the online Uniform Application as instructed in each section.

The Federation Credentials Verification Service (FCVS)

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

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

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

- To begin an initial or subsequent application for creating or updating your profile of primary source verified credentials, visit https://www.fsmb.org/fcvs/ and click on the FCVS graphic, then sign in. You may also visit http://www.fsmb.org/ and click on FCVS in the Licensure menu to access the portal page.

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

Completing the Online Montana Licensure Application

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

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

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

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

- For information with regard to the processing of this application or other concerns, please contact the Board of Medical Examiners' staff at (406) 444-6880 or email us at dlibsdmed@mt.gov.

Please note the following:

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

- If not pre-filled, provide your home address and a separate address for business or postgraduate training. Both Board Contact and Public Access selections must be made but you can use the same address for each. All addresses must be domestic (within the United States).

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

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

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

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

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

- Upon accepting the Terms and Agreement and submitting the UA, first time UA users will be taken to a payment page for the one-time service charge. This charge sustains the UA program and is separate from FCVS and state board licensing fees.

- For a copy of your receipt, click on the "Home" link to return to the portal page, which will now have a Payment link to all FSMB receipts in the upper right corner.

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

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

- Submit a UA Affidavit and Authorization for Release of Information form to the Board. The UA Affidavit is separate from the FCVS Affidavit and must be sent directly to the Board. **The Montana Board of Medical Examiners does not require this form to be notarized, nor does it require a photo.**

- License verification. Board staff will verify all U.S. physician licenses via the Physician Data Center. Applicants must request license verifications be sent directly to the Board in the following circumstances: licenses held that are not physician licenses, licenses held in Canada, any license that has ever been disciplined. Determine the fees and verification method for each board using the licensure verification resource at https://www.fsmb.org/uniform-application/. Use the UA Licensure Verification Form for boards that need a written request. If the verifying board uses VeriDoc or another method, use that method instead.

If you are using FCVS for credentials verification,

- Do not complete the UA Medical Education Verification, Postgraduate Training Verification, or Fifth Pathway Verification forms. Do not send any identity documents, transcripts, certificates, or examination scores to the Board. FCVS handles all of this for you.

If you are not using FCVS for credentials verification,

- Send to the Board a certified copy of a legal name change document (marriage certificate, divorce decree, court order) if your name is not the same on all of your submitted documents.
- Contact each appropriate exam entity to have a certified transcript of your scores sent directly to the Board. If you have taken any component of the NBME in conjunction with another exam (USMLE/FLEX), request your transcript from the NBME. For contact information, see the UA FAQ at https://www.fsmb.org/uniform-application/ua-faq/.
- Complete the UA Medical Education Verification, Postgraduate Training Verification, and Fifth Pathway Verification (if applicable) forms as directed on each form. The UA Medical School Verification form should be accompanied by a copy of your diploma if you graduated from that school. **The Montana Board of Medical Examiners does not require a copy of official medical school transcripts.**
- If you are an International Medical Graduate, request from ECFMG that your ECFMG certificate, Fifth Pathway Program Certificate, and/or FMGEMS certificate be sent to the Board, as applicable. See the UA FAQ at the link on the previous page for contact information.

UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE
CHECK LIST

	NOT using FCVS to verify credentials	Using FCVS to verify credentials
Completed online uniform application (UA).	☐	☐
Completed state addenda and $375 application fee sent to the Board.	☐	☐
Affidavit and Authorization for Release of Information form sent to the Board. Notarization and photo not needed by the Board.	☐	☐
State Licensure Verification form (Form #1) sent to states in which you have discipline or held a non–physician license.	☐	☐
DD214, Military Discharge Paper (if applicable) sent to the Board.	☐	☐
Notarized copy of birth certificate or current, valid passport sent to the Board.	N/A	Completed via FCVS
Supporting documentation of any legal name change sent to the Board.	☐	Completed via FCVS
Medical Education Verification form (Form #2) sent to the Board from all medical schools attended – include a copy of your diploma (must be sealed by your school).	☐	Completed via FCVS
Medical School Transcripts sent to the Board by your medical school(s).	N/A	Completed via FCVS
Postgraduate Training Verification form (Form #3) sent to the Board from all programs you attended.	☐	Completed via FCVS
A copy of your postgraduate training certificate(s) sent to the Board.	☐	Completed via FCVS
Examination Transcripts sent to the Board.	☐	Completed via FCVS
Foreign Graduates: Fifth Pathway form (Form #4) (if applicable) sent to the Board from the medical school and institution - include a copy of your diploma (must be sealed by your school).	☐	Completed via FCVS
Foreign Graduates: Request for Status Report of ECFMG Certification sent to the Board.	☐	Completed via FCVS

Please note:

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

Montana Board of Medical Examiners

Addendum Instructions

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

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

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

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

Please return completed addenda and payment to the:

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

or dlibsdmed@mt.gov

Name of Applicant: _____

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

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ADDENDUM 1

Application for Licensure as:

☐ Medical Doctor ☐ Doctor of Osteopathy

Foreign ID Number _____

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

Which exam did you take for initial licensure?

☐ NBME ☐ NBOME ☐ FLEX ☐ USMLE ☐ LMCC

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

Most recent test date: _____ Number of Attempts: _____

Name of Applicant: _____

Specialty Certification:

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

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

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

If so, by whom? _____

Reason for denial? _____ Number of times failed: _____

AFFIDAVIT:

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

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

_____ _____

Signature of Applicant Date

Name of Applicant: _____

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ADDENDUM 2

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

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

QUESTIONS		YES	NO
1.	If you are a foreign medical graduate, have you satisfied the requirements of the Educational Commission for Foreign Medical Graduates (ECFMG)?	☐	☐
2.	Do you intend to practice in the State of Montana? **If yes,** attach a brief explanation.	☐	☐
3.	Have you ever previously applied for a license to practice in Montana? **If yes,** give date and results.	☐	☐
4.	Have you ever had any license, certificate, registration, or other privilege to serve as a volunteer or practice a profession denied, revoked, suspended, or restricted by a public or private local, state, federal, tribal, religious, or foreign authority?	☐	☐
5.	Have you ever surrendered a credential like those listed in number 4, in connection with or to avoid action by a public or private local, state, federal, tribal, religious, or foreign authority?	☐	☐
6.	Have you ever resigned to avoid discipline, been suspended, or been terminated from a volunteer or employment position?	☐	☐
7.	Have you ever been required to participate in a behavioral modification or assistance program in lieu of suspension or termination from a volunteer or employment position?	☐	☐
8.	Have you ever withdrawn an application for any professional license?	☐	☐
9.	As of the date of this application, are you aware of any pending complaint, investigation, or disciplinary action related to any professional license you hold?	☐	☐
10.	Are you under a current order that remains unsatisfied (e.g., fines unpaid, probation not concluded, conditions unmet?)	☐	☐

Note on Questions 10 and 11: Applicants who disclose medical, physiological, mental, or psychological conditions or chemical substance use in Question 10 or 11 may qualify for participation in the Montana Recovery Program. Please visit the board website for more information about this program. "Chemical substances" include alcohol, drugs, or medications, whether taken legally or illegally.

Name of Applicant: _____

QUESTIONS		**YES**	**NO**
11.	Do you have any medical, physiological, mental, or psychological condition which in any way currently (within the last 6 months) impairs or limits your ability to practice your profession or occupation with reasonable skill and safety?	☐	☐
12.	Do you currently (within the last 6 months) use one or more chemical substances in any way which impairs or limits your ability to practice your profession or occupation with reasonable skill and safety?	☐	☐
13.	A criminal conviction may not automatically bar you from receiving a license. For more information about how a criminal conviction may impact your application, consult the board or program website. Have you ever been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or sentence deferred or suspended as an adult or "juvenile convicted as an adult" in any state, federal, tribal, or foreign jurisdiction?	☐	☐
14.	Are you now subject to criminal prosecution or pending criminal charges?	☐	☐
15.	Have you ever been disciplined, censured, expelled, denied membership or asked to resign from a professional society or organization?	☐	☐
16.	Have you ever had a civil judgment entered against you in a lawsuit for incompetence, negligence, or malpractice in practicing any profession?	☐	☐
17.	Have you ever been disqualified from working with children, elderly persons, mentally ill persons, or other vulnerable persons?	☐	☐
18.	Have you ever been placed on probation, restricted, reprimanded, suspended, revoked, resigned in lieu of action against you, or had other action taken against you by any hospital, clinic, health care facility, group medical practice, health maintenance organization, or third-party insurance provider, including Medicare and Medicaid?	☐	☐
19.	Are you currently on an exclusion list by the Office of Inspector General (OIG) for the U.S. Department of Health and Human Services prohibiting you from working in a facility receiving federal funding?	☐	☐

Name of Applicant: _____

QUESTIONS		**YES**	**NO**
20.	Has your authority to prescribe, dispense, or administer drugs, including controlled substances, ever been denied, restricted, suspended, or revoked?	☐	☐
21.	Have you ever voluntarily surrendered or had your U.S. Drug Enforcement Administration registration placed on probation, restricted, suspended, or revoked?	☐	☐

Name of Applicant: _____

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ADDENDUM 3

AUTHORIZATION FOR RELEASE OF INFORMATION AND RELEASE FROM LIABILITY

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

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

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

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

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

_____ _____

Signature (Applicant/Licensee) Date

UA UNIFORM APPLICATION FOR LICENSURE

For State Board Use Only

Affidavit and Authorization for Release of Information

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

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

Please send this form to: Montana Board of Medical Examiners
P.O. Box 200513
Helena, MT 59620-0513

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

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

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

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

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

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

Applicant Photograph

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

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

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

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

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

NOTARY

State of _____, County of _____,

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

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

Notary Public Signature _____ My Notary Commission Expires _____

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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 https://www.fsmb.org/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 https://www.fsmb.org/contact-a-state-medical-board/ 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 or dlibsdmed@mt.gov.

Board name	Montana Board of Medical Examiners
Mailing address	P.O. Box 200513
City/State/Zip	Helena, MT 59620-0513

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

Title _____ Date _____

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

Phone number _____ Fax number _____

Email _____

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

UA 17 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	Montana Board of Medical Examiners
Mailing address	P.O. Box 200513
City/State/Zip	Helena, MT 59620-0513

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 19

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

Applicant Please Sign Here →

Applicant Signature ________________________________ **Date** ____________

Section 2 :
Program Participation :

Important:

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

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

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

Report Internships, Residencies and Fellowships separately.

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

Specialty/Subspecialty: ________________________________
From: __/__/______ **To:** __/__/______
Successfully Completed?: ☐Yes ☐No ☐In Progress
Accredited by: ☐ACGME ☐AOA ☐LCGME ☐RSC ☐CFPC
☐RCPSC ☐APPAP ☐None of these

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

Specialty/Subspecialty: ________________________________
From: __/__/______ **To:** __/__/______
Successfully Completed?: ☐Yes ☐No ☐In Progress
Accredited by: ☐ACGME ☐AOA ☐LCGME ☐RSC ☐CFPC
☐RCPSC ☐APPAP ☐None of these

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

Specialty/Subspecialty: ________________________________
From: __/__/______ **To:** __/__/______
Successfully Completed?: ☐Yes ☐No ☐In Progress
Accredited by: ☐ACGME ☐AOA ☐LCGME ☐RSC ☐CFPC
☐RCPSC ☐APPAP ☐None of these

Unusual Circumstances:

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

1. Did this individual ever take a leave of absence or break from his/her training? ---------------- ☐Yes ☐No
2. Was this individual ever placed on probation? -- ☐Yes ☐No
3. Was this individual ever disciplined or placed under investigation? -------------------------------- ☐Yes ☐No
4. Were any negative reports for behavioral reasons ever filed by instructors? -------------------- ☐Yes ☐No
5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? ---------------- ☐Yes ☐No

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

I CERTIFY THAT to the best of my knowledge and belief, the foregoing is a true, accurate and complete statement of the record of the individual named on this form. This section MUST be signed by the program director (M.D. or D.O. only). **(Signature by personnel other than an M.D. or D.O. must attach an authorization letter. Applicable only for Nevada State Board of Medical Examiners.)**

Signature: ________________________________

Print name: ________________________________

Title: ________________________________

Email address: ________________________________

Phone Number: ____________________ **Date:** ____________

UA 20 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	Montana Board of Medical Examiners
Mailing address	P.O. Box 200513
City/State/Zip	Helena, MT 59620-0513

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

Title _____ Date _____

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

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.

Application for Physician Assistant License

Please print pages 21-34 only.

Montana Department of LABOR & INDUSTRY

Montana Board of Medical Examiners
PO Box 200513
301 S Park, 4th Floor
Helena, MT 59620-0513
Phone: 406-444-6880
Email: dlibsdhelp@mt.gov Website: www.medicalboard.mt.gov

Licensing Requirements and Application Checklist
Physician Assistant

License Requirements for Physician Assistant

Below are the minimum requirements you must meet in order to be licensed in the state of Montana.

1. Graduation from an accredited PA training program – [MCA 37-20-402, ARM 24.156.1617]
2. Passage of an examination administered by the NCCPA (PANCE exam) – [MCA 37-20-402, ARM 24.156.1617]
3. Good moral character – [MCA 37-20-402]

Checklist of Required Documents to Submit for Application for Physician Assistant

The following documents and additional forms are required in addition to the basic application. Educational or exam verifications must be sent to the board directly from the source. As of July 1, 2018, the board will accept Uniform Applications for PAs submitted via the Federation of State Medical Boards. State PA license verifications may be sent via VeriDoc.

- ☐ Official license verification from states and jurisdictions in which the applicant holds or has ever held a professional license of any type. (Verifications submitted via VeriDoc will be accepted.)
- ☐ Primary source verification of education as required by 37-20-402.
- ☐ Primary source verification of passage of examination as required by 37-20-402.
- ☐ Description and/or documentation of education and work experience since completing physician assistant training.
- ☐ If you answered yes to discipline questions, include a detailed explanation on the event(s) and documentation from the source (licensing board, federal agencies/programs, or civil/criminal court proceedings such as initiating/charging documents, final disposition/judgement documents, etc.)

Application Fee(s) for Physician Assistant

The following fee(s) must be submitted with your application. All fees are payable to the Montana Board of Medical Examiners.

- ☐ $375 application fee

Montana Board of Medical Examiners
PO Box 200513
(301 S PARK, 4TH FLOOR – DELIVERY)
Helena, Montana 59620-0513
(406) 444-6880 FAX (406) 841-2305
E-Mail: dlibsdmed@mt.gov WEBSITE: www.medicalboard.mt.gov

APPLICATION FOR PHYSICIAN ASSISTANT LICENSE

IMPORTANT: A physician assistant may not practice medicine in Montana in any manner without the following (both are required):

1) **an Active Montana license.**
2) **a signed Supervision Agreement on file with the board.**

APPLICATION PROCEDURES:

- When the application is complete, it will be processed by Board staff.
- If the application is considered non-routine there may be a delay in the processing of the application. The applicant may be notified to submit additional information or may be required to appear before the Board for a personal interview for consideration of the application during a regularly scheduled Board meeting.
- **For an application requiring review by the full Board, all materials must be received by the Board office no later than 30 working days prior to the Board's next scheduled meeting. Applications completed after that deadline will not be put on the Board's agenda.** The Board meets six times per year. Please visit www.medicalboard.mt.gov for exact meeting dates.
- For license verifications: Please be aware that some states change a fee for verifications. Contact each state board prior to sending the request to get specific information about requesting a license verification.
- Keep the Board office informed at all times of any address changes or changes in license status, complaints or proposed disciplinary action. This is essential for timely processing of your application and subsequent licensure.

PROCESSING PROCEDURES:

- Once a complete routine application is received it may take up to 30 days to process.
- The applicant will be notified in writing of any deficient or missing items from the application file.
- The Board of Medical Examiners will verify your examination through NCCPA online services. You will be notified if there are any irregularities with the verification.
- The Board of Medical Examiners will request a report from the National Practitioner Data Bank (NPDB). You do not have to submit a "self-query" to the NPDB. You will be notified if the Board requires any additional information as a result of receiving the NPDB report.

SUPERVISION AGREEMENT:

A physician assistant has a dependent practice and must be under physician supervision. Under 37-20-101 and 37-20-403, MCA, the supervising physician is professionally and legally responsible for all the care and treatment of the physician assistant's patients.

In accordance with 37-20-401 (5), MCA, a "supervision agreement" means a written agreement between a supervising physician and a physician assistant providing for the supervision of the physician assistant.

In accordance with the Board rules, "supervision" is defined as accepting responsibility for, and overseeing all care and treatment of the physician assistant by telephone, radio or in person as frequently as necessary considering the location, nature of practice and experience of the physician assistant.

NOTE: For further information regarding Physician Assistant Montana Regulations and to read the FAQ's about Physician Assistants, please visit our website at: www.medicalboard.mt.gov

For information with regard to the processing of this application and other concerns, please contact the Department at (406) 444-6880 or email the board at : dlibsmed@mt.gov

Uniform Application Physician Assistant Checklist for Licensure

Send this checklist with all other materials being sent to the Board that you are Appling to.

NOTE: If required items are not submitted, then the application will be considered incomplete and will not be processed until all items requested are received.	**NOT using FCVS to verify credentials**	**Using FCVS to verify credentials**
Completed and submitted online Uniform Application to the Board.	☐	☐
Notarized Affidavit and Authorization for Release of Information form with 2x2 photo taken within the past 3 months sent to the Board.	☐	☐
Verification of licenses sent to the Board from all boards with which you have ever held any healthcare license.	☐	☐
Supporting documentation of any legal name change sent to the Board.	☐	FCVS handles
Sent notarized copy of birth certificate or current, valid passport to the Board.	☐	FCVS handles
Verification of the Physician Assistant Program.	☐	FCVS handles
Sent NCCPA examination transcripts to the Board.	☐	FCVS handles

Montana Board of Medical Examiners
Physician Assistant Addendum

P.O. Box 200513 • (301 S Park, 4th Floor – Delivery) • Helena, MT 59620-0513
Phone: (406) 444-6880 • Fax: (406) 841-2305
Email: dlibsdmed@mt.gov • Website: www.medicalboard.mt.gov

ADDENDUM 1

Please answer each of the following questions by putting a check (✓) in the appropriate box. If you answer yes, give specific details (names of organizations, dates, reasons, and outcome) on a supplemental sheet.

	QUESTIONS	YES	NO
1.	Have you ever had any license, certificate, registration, or other privilege to serve as a volunteer or practice a profession denied, revoked, suspended, or restricted by a public or private local, state, federal, tribal, religious, or foreign authority?	☐	☐
2.	Have you ever surrendered a credential like those listed in number 1, in connection with or to avoid action by a public or private local, state, federal, tribal, religious, or foreign authority?	☐	☐
3.	Have you ever resigned to avoid discipline, been suspended, or been terminated from a volunteer or employment position?	☐	☐
4.	Have you ever been required to participate in a behavioral modification or assistance program in lieu of suspension or termination from a volunteer or employment position?	☐	☐
5.	Have you ever withdrawn an application for any professional license?	☐	☐
6.	As of the date of this application, are you aware of any pending complaint, investigation, or disciplinary action related to any professional license you hold?	☐	☐
7.	Are you under a current order that remains unsatisfied (e.g., fines unpaid, probation not concluded, conditions unmet?)	☐	☐
	Note on Questions 8 and 9: Applicants who disclose medical, physiological, mental, or psychological conditions or chemical substance use in Question 8 or 9 may qualify for participation in the Medical Assistance Program. Please visit the board website for more information about this program. "Chemical substances" include alcohol, drugs, or medications, whether taken legally or illegally.		
8.	Do you have any medical, physiological, mental, or psychological condition which in any way currently (within the last 6 months) impairs or limits your ability to practice your profession or occupation with reasonable skill and safety?	☐	☐
9.	Do you currently (within the last 6 months) use one or more chemical substances in any way which impairs or limits your ability to practice your profession or occupation with reasonable skill and safety?	☐	☐
	The following information is provided for Question 10 below: A criminal conviction may not automatically bar you from receiving a license. For more information about how a criminal conviction may impact your application, consult the board or program website.		
10.	Have you ever been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or sentence deferred or suspended as an adult or "juvenile convicted as an adult" in any state, federal, tribal, or foreign jurisdiction?	☐	☐

11. Are you now subject to criminal prosecution or pending criminal charges? If yes, please attach a detailed explanation and provide supporting documentation from the source. ☐ ☐

12. Have you ever been disciplined, censured, expelled, denied membership, or asked to resign from a professional society or organization? If yes, please attach a detailed explanation and provide supporting document from the source. ☐ ☐

13. Have you ever had a civil judgment entered against you in a lawsuit for incompetence, negligence, or malpractice in practicing any profession? ☐ ☐

14. Have you ever been disqualified from working with children, elderly persons, mentally ill persons, or other vulnerable persons? If yes, please attach a detailed explanation and provide documentation from the source. ☐ ☐

15. Have you ever been placed on probation, restricted, reprimanded, suspended, revoked, resigned in lieu of action against you, or had other action taken against you by any hospital, clinic, health care facility, group medical practice, health maintenance organization, or third-party insurance provider, including Medicare or Medicaid? If yes, please attach a detailed explanation and provide documentation from the source. ☐ ☐

16. Are you currently on an exclusion list by the Office of the Inspector General (OIG) for the U.S. Department of Health and Human Services prohibiting you from working in a facility receiving federal funding? ☐ ☐

17. Has your authority to prescribe, dispense, or administer drugs, including controlled substances, ever been denied, restricted, suspended, or revoked? ☐ ☐

18. Have you ever voluntarily surrendered or had your U.S. Drug Enforcement Administration registration placed on probation, restricted, or revoked? ☐ ☐

GENERAL INFORMATION FOR SUPERVISION AGREEMENTS

In order to practice as a Physician Assistant (PA) in Montana the PA must have on file with Board in accordance to MCA: 37-20-301, a supervision agreement. The following outlines general information for a supervision agreement for new applicants to the State of Montana, a new supervising physician and PA practice relationship or a change in supervising physician.

A. Supervising Physician is defined as a medical doctor or doctor of osteopathy licensed by the Board who agrees to a supervision agreement and duties and delegation agreement.

B. Qualification of Supervising Physician:

a. possess a current, active Montana license
b. exercises supervision over the physician assistant in accordance with the rules adopted by the Board
c. retains professional and legal responsibility for the care and treatment of patients by the physician assistant

C. Qualifications for Physician Assistant must have a current active Montana PA license.

D. Supervision Relationship Education:

A supervision physician or physician assistant who is new to supervision relationships in Montana will also be required to submit a certificate of completion for the board-approved online education for physicians and physician assistants in supervision relationships. One can access the education and assessment here: https://dlitraining.mt.gov/login/index.php You will find instructions for setting up/logging into the course on the board website, here.

Upon passage of the quiz, please submit the certificate of completion in one of the following ways:

- email to dlibsdmed@mt.gov
- mail to Board of Medical Examiners, PO Box 200513, Helena, MT 59620-0513
- upload to your online application

MONTANA BOARD OF MEDICAL EXAMINERS
PO Box 200513
(301 S PARK, 4TH FLOOR - Delivery)
Helena, Montana 59620-0513
(406) 444-6880 FAX (406) 841-2305
E-MAIL dlibsdmed@mt.gov **WEBSITE:** www.medicalboard.mt.gov

APPLICATION FOR SUPERVISION AGREEMENT

PHYSICIAN ASSISTANT INFORMATION:

1. FULL NAME: _____
   Last First Middle
2. BUSINESS NAME: _____
3. BUSINESS ADDRESS: _____
   Street or PO Box # City and State Zip
4. HOME ADDRESS: _____
   Street or PO Box # City and State Zip

   PREFERRED MAILING ADDRESS: ◯ Business ◯ Home E-MAIL ADDRESS: _____
5. TELEPHONE (____) _____ (____) _____ (____) _____
   Business Home Fax
6. SOCIAL SECURITY NUMBER: _____ LICENSE NUMBER: _____
7. DEA REG. # _____ START DATE: _____

SUPERVISING PHYSICIAN INFORMATION:

1. FULL NAME: _____
   Last First Middle
2. BUSINESS NAME: _____
3. BUSINESS ADDRESS: _____
   Street or PO Box # City and State Zip
4. HOME ADDRESS: _____
   Street or PO Box # City and State Zip

   PREFERRED MAILING ADDRESS: Business Home E-MAIL ADDRESS: _____
5. TELEPHONE: (____) _____ (____) _____ (____) _____
   Business Home Fax
6. SOCIAL SECURITY NUMBER: _____ LICENSE NUMBER: _____
7. DEA REG. # _____ START DATE: _____

AFFIDAVITS AND SIGNATURES

I hereby declare under penalty of perjury the information included in my supervision agreement application to be true and complete to the best of my knowledge. In signing this application, I am aware that a false statement or evasive answer to any question or request for information may lead to a denial of my application or grounds for subsequent disciplinary action imposed on my licensure. I further affirm that I have read and accepted the licensing statutes and pursuant to my profession, including supervision agreement and duties and delegation agreement, and hereby certify that I will abide by all statues and rules of the Board of Medical Examiners that pertain to my licensure. I acknowledge and understand that I may not practice medicine independently pursuant to 37-20-104(2) and 37-20-301, MCA.

Physician Assistant:

(Print Name) (Signature) (Date)

PRIMARY SUPERVISING PHYSICIAN AFFIRMATION

I affirm that I have read and understand the current Board of Medical Examiners statutes and rules, including those pertaining to physician assistant, supervision agreements and duties and delegation and my responsibilities as supervising physician. I acknowledge and agree pursuant to 37-20-101, 37-20-301, 37-20-403, MCA to exercise appropriate supervision over the above named PA in accordance with all statues and rules of the Board of Medical Examiners. I acknowledge and agree that I will retain professional and legal responsibility for the care and treatment of patients by the above named PA. I understand that duties and responsibilities may be delegated, or restrictions imposed, at my discretion, including additional limitations on prescribing and dispensing of drugs above those granted by the Board, pursuant to 37-20-404, MCA, and will be reflected in the duties and delegation agreement.

Supervising Physician:

(Printed name) (Signature) (Date)

MONTANA BOARD OF MEDICAL EXAMINERS
301 South Park Avenue, 4th Floor
PO Box 200513
Helena, Montana 59602-0513

(406) 444-6880 FAX (406) 841-2305

AUTHORIZATION FOR RELEASE OF INFORMATION AND RELEASE FROM LIABILITY

(FOR APPLICANTS FOR PHYSICIAN ASSISTANT)

I, _____, am an applicant for licensure as a physician assistant.

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

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

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

_____

Signature (Applicant/Licensee) Date

AFFIDAVIT

I authorize the release of information concerning my education, training, record, character, license history and competence to practice, by anyone who might possess such information, to the Montana Department of Labor and Industry, Healthcare Licensing Bureau.

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

_____ _____

Legal Signature of Applicant Dated

VERIFICATION OF LICENSURE

THIS IS NOT AN ENDORSEMENT CERTIFICATION

PLEASE COMPLETE THIS SECTION OF THE FORM AND MAIL TO EACH STATE BOARD IN WHICH YOU ARE NOW OR HAVE EVER BEEN LICENSED TO PRACTICE AS A PHYSICIAN. YOU MAY COPY THIS FORM AS MANY TIMES AS NEEDED. SOME BOARDS REQUIRE A FEE FOR THIS SERVICE.

STATE BOARD:_____

I am applying for a license to practice medicine in the State of Montana. The Medical Board requires this form to be completed by each state wherein I hold or ever have held a professional/occupational license. This is your authority to release any information in your files, favorable or otherwise, **DIRECTLY** to the **BOARD OF MEDICAL EXAMINERS, P. O. BOX 200513, 301 SOUTH PARK AVENUE, HELENA, MT 59620-0513 or dlibsdmed@mt.gov**.

_____ Name: _____
(Signature) (Please print)

Address:_____

_____

My License Number is:_____

DO NOT DETACH -- THIS SECTION TO BE COMPLETED BY AN OFFICIAL OF THE STATE BOARD AND RETURNED DIRECTLY TO THE MONTANA STATE BOARD OF MEDICAL EXAMINERS

State of:_____

Full Name of Licensee:_____

License No._____ Issue Date:_____

License is current? YES NO If NO, explain _____

Has license been suspended, revoked, placed on probation or otherwise disciplined? YES ◯ NO ◯

If YES, explain and attach documentation

_____

Has licensee ever been requested to appear before your Board? YES ◯ NO ◯

If YES, explain _____

Derogatory information, if any _____

Comments, if any _____

BOARD SEAL

Signed: _____
Title: _____
State Board:_____ Date:_____