Indiana Professional Licensing Agency - Medical Licensing Board
402 West Washington Street, Room W072
Indianapolis, IN 46204
Email: pla3@pla.IN.gov
(317) 234-2060 (phone) / (317) 233-4236 (fax)

A Note About Licensure & Temporary Permits

Licensure is entirely at the discretion of the Medical Licensing Board of Indiana. Licensure in another state **does not** in any manner assure or guarantee licensure in Indiana. The completion of an application **does not** guarantee licensure in Indiana. The issuance of a temporary permit **does not** in any manner assure or guarantee full licensure in the State of Indiana.

Application Fee

You must submit a copy of your application along with the application fee in the amount of $250.00 made payable to **Professional Licensing Agency**. All fees are **non-refundable** and **non-transferable**. **Please Note: Without the proper fees, the board is unable to begin processing the application.**

Processing Time

Processing time depends on the applicant. The applicant is responsible for the submission of all documents. The sooner the documents are requested and received, the quicker the license can be issued. If you have been named in a malpractice suit, or have answered “yes” to any of the questions 1-12 on “Addendum 2” of the application, the license/temporary cannot be issued until these items have been reviewed by the Board. The Board meets on a monthly basis.

Fair Information Practice Act

In compliance with IC 4-1-6, this agency is notifying you that you must provide the requested information or your application will not be processed. You have the right to challenge, correct, or explain information maintained by this agency. The information you provide will become **public record**. Your examination scores and grade transcripts are confidential except in circumstances where their release is required by law, in which case, you will be notified.

Your social security number is being requested by this state agency in accordance with IC 4-1-8-1. Disclosure is mandatory, and this record cannot be processed without it.

Notarized Copy Information

When submitting a notarized copy of an original document, the notary MUST make a statement to the fact that the notary has seen the original document. If this is not done, the document will NOT be accepted.

Notarized Affidavits

When requested to submit a notarized affidavit, it must indicate that the applicant is attesting/swearing that the information is true and be notarized by someone who specifically indicates that he/she witnessed the applicant signing said affidavit.

Proof of Name Change

When the name on any document differs from the applicant’s name, a notarized or certified copy of a marriage certificate or legal name change must be submitted.

Statutes and Rules

You may view the statutes and rules on our website. For your convenience, you may click on the following link: http://www.in.gov/pla/2482.htm

Examination Requirements

Accepted examinations are National Boards (NBME, NBOME), FLEX, USMLE, State Examinations, LMCC, or a combination of FLEX, USMLE, and National Boards. Applicants who took the USMLE must complete **all** steps within 10 years with a minimum passing score of seventy-five (75) for all steps. If it has taken you more than three (3) attempts to pass a step of the USMLE, you are **not** eligible for licensure in Indiana.

The Medical Licensing Board of Indiana **does not accept the Puerto Rico examination**. All graduates from Puerto Rico must take the English version of the USMLE in order to be considered for licensure in Indiana.

Please note the law regarding the USMLE (effective July 2008):
844 IAC 4-4.5-12 Passing requirements for United States Medical Licensing Examination states:

Sec. 12. The following are the examination passing requirements for licensure:

1. A score of seventy-five (75) is the minimum passing score for all steps of the United States Medical Licensing Examination (USMLE).
2. An applicant may have a maximum of three (3) attempts to pass each step of the USMLE. Therefore, upon the third seating of each step of the exam, the applicant must obtain a passing score.
3. All steps of the USMLE must be taken and successfully passed within a ten (10) year time period. This ten (10) year period begins when the applicant first passes a step, either Step I or Step II. In counting the number of attempts regarding USMLE steps, previous attempts on the National Board of Medical Examination and the examination of the Federation of State Medical Boards of the United States are included.

If you do not meet the ten (10) year period, you may apply for licensure and retake Step 1 and/or Step 2 of the USMLE to put you within the ten (10) year period if it does not put you over the three (3) attempts. You must submit an application and request to retake Step 1 and/or Step 2. Our agency will send out the appropriate letters to the Federation so that you may reapply to take the appropriate steps of the USMLE.

Please note the law regarding the COMLEX (effective October 2008):
844 IAC 4-4.5-13 Passing requirements for Comprehensive Osteopathic Medical Licensing Examination states:

Sec. 13. The following are the examination passing requirements for licensure:

1. A score of three hundred fifty (350) is the minimum passing score for Step III of the Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA).
2. An applicant may have a maximum of five (5) attempts to pass each step of the COMLEX-USA. Therefore, upon the fifth seating of each step of the exam, the applicant must obtain a passing score.
3. All steps of the COMLEX-USA must be taken and passed in sequential order within a seven (7) year time period. This seven (7) year period begins when the applicant first takes Step I. In counting the number of attempts regarding COMLEX-USA steps, previous attempts on the National Board Osteopathic Medical Examination are included.

Postgraduate Training Requirements

Applicants who have graduated from approved schools in the United States, its possessions or Canada must have at least one (1) year of postgraduate training, in the United States, its possessions or Canada. Those who have graduated from school outside of the United States, its possessions or Canada must have two (2) years of postgraduate training, obtained in an accredited program in the United States, its possessions or Canada.

FOREIGN MEDICAL SCHOOLS
Adopted May 22, 2008
IC 25-22.5-3-1(c)

DISAPPROVED FOREIGN MEDICAL SCHOOLS

- CIFAS School of Medicine, Santo Domingo (closed) as of 10/18/1984
- Universidad Mexico American Del Norte as of 11/15/1984
  (Northern University School of Medicine)
- St. Lucia Health Sciences University, St. Lucia as of 10/18/1984
- Spartan Health Sciences University, St. Lucia as of 10/18/1984
- Clayton University – Osteopathic School as of 06/01/2000
  (American International Open University)
- St. Matthews University, Grand Cayman as of 12/05/2002
- University of Health Sciences Antigua, St. John's as of 12/05/2002
- Grace/St. Kitts/London Medical College as of 12/05/2002
- International University of Health Sciences (IUHS) as of 12/05/2002
- Canadian Academy of Osteopathy and Holistic Health Sciences (Hamilton) as of 8/23/2007
- Osteopathic Health and Wellness Institute (Hamilton) as of 8/23/2007
- Canadian College of Osteopathy (Toronto) as of 8/23/07
- Sutherland Academy of Osteopathy (Oakville) as of 8/23/07
- CETEC University, Santo Domingo (closed) as of 5/22/08
- UTESA University, Santo Domingo as of 5/22/08
- World University, Santo Domingo (closed) as of 5/22/08
- Universidad Federico Henriquez y Carvajal, Dominica Republic as of 5/22/08
- Kigezi International School of Medicine, Cambridge, England & Uganda as of 5/22/08
- Universidad Eugenio Maria de Hostos (UNIREMHOS), Dominica Republic as of 5/22/08

Internet Programs: All schools of medicine whose curriculum and primary requirements are internet based and/or distance learning shall be disapproved. Most specifically, the internet based schools of medicine listed on the Federation Alert are hereby disapproved by the board.

APPROVED FOREIGN MEDICAL SCHOOLS

- American University of the Caribbean School of Medicine as of 12/20/1984
- Ross University of Medicine as of 12/20/1984
- St. George's University School of Medicine as of 12/20/1984
- Saba, Netherlands Antilles (coursework from 1/1/02 to present)

In addition to this list, the Medical Licensing Board of Indiana has recognized the Medical Board of California as having similar standards to those of LCME when considering foreign medical schools. Therefore, in compliance with IAC 844 4-4.5-3, the Board has accepted schools listed on the published, Medical Schools Recognized by the Medical Board of California. A list of their approved and disapproved programs can be found at http://www.in.gov/pla/2799.htm

Those schools that are neither approved by Indiana or California (and not on the disapproved list) are reviewed on a case by case basis. The Board uses IMED FAIMER and ECFMG as tools to determine whether those schools are LCME equivalent.

ONLINE INDIANA LICENSURE APPLICATION INSTRUCTIONS
MEDICAL (MD) AND OSTEOPATHIC (DO)

Uniform Application for Physician State Licensure (UA)

The Medical Licensing Board of Indiana was one of the first medical boards to implement the Uniform Application for Physician State Licensure (UA). The UA benefits physicians by reducing redundancy in filling out multiple applications when applying for licensure in multiple states. The core Uniform Application information can be updated and sent to additional boards as needed, leaving only board-specific requirements to be completed.

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.

Applicants using FCVS to verify their credentials are still required to complete the Online Medical Licensing Board of Indiana Application.

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 work on the initial FCVS application for creating a profile or the subsequent FCVS application for updating an existing profile, visit http://www.fsmb.org/ and select FCVS in the Licensure or Sign In menu, then sign in as directed. 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 Indiana Licensure Application

Read the following information carefully before completing 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. Your receipt will be available immediately after submitting your UA, and you will receive a separate receipt via email.

To work on the UA visit http://www.fsmb.org/uniform-application/ and select Uniform Application (UA) in the Licensure or Sign In menu, then sign in as directed. Complete the online Uniform Application as instructed in each section. Use the checklist at the end of these instructions to ensure that you submit all required documentation.

The UA FAQ at http://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.

If you have any questions about the application process, please feel free to contact our office at (317) 234-2060 or visit our website at www.pla.IN.gov.

Please note the following:

- Provide both your current home address and current business/training address, otherwise an error will occur. Do not enter the same address for both home and work.

- Please note that any address listed for board mailings will be accessible to the public under Indiana public records act. Please do not list an address/phone number that you consider private.

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

- Graduates of foreign medical schools must submit notarized copies of all subjects and grades (mark sheets). Include official translation if not in English. **If original documents are not available, then notarized copies are acceptable.**

- In the Postgraduate Training section, list all postgraduate programs you have attended, even those you did not complete. **Please explain in a sworn, notarized affidavit the reason(s) you did not complete the postgraduate training program(s).**

- You will be unable to edit MD and DO licenses in the UA as all MD and DO license information comes directly into the system from the state boards. If changes are needed, email ua@fsmb.org with the correct information.

- Enter all other health related and professional licenses (nurse, EMT, physician assistant, etc.) you have held in the U.S. or Canada regardless of status. Request verification from these boards.

- 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 page, vacation periods of less than six (6) weeks need not be accounted for. Describe all non-working time as indicated.

- If you have pending or no malpractice claims, leave the Malpractice section blank. Report all medical malpractice court judgments and settlements.

- To open an already submitted UA for editing, select the Board from the State Board section. Update your UA as needed, then submit your UA to the Board.

<u>In addition to completing the core UA online, all applicants must:</u>

- Submit a UA Affidavit and Authorization for Release of Information form to the Board. The UA Affidavit is separate from the FCVS Affidavit and must be sent directly to the Board. Attach a recent (fewer than 90 days old) two inch by two inch (2" x 2") passport quality, color photograph of yourself in the space provided. **The Montana Board of Medical Examiners <u>does not</u> require this form to be notarized.**

- Have each full, temporary, training, or limited healthcare or profession license or certification you have ever held in the U.S. or Canada verified by the granting board, whether the license or certification is active or inactive. Determine the fees and verification method for each board using the licensure verification resource at http://www.fsmb.org/siteassets/ua/x-pdfs/licensure-verification-information.pdf. 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.

<u>If you are using FCVS for credentials verification,</u>

- 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.

<u>If you are not using FCVS for credentials verification,</u>

- Complete the addendum in this packet.

- 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 examination entity to have a certified transcript of your scores sent directly from the exam entity to the Board. If you have taken any component of the NBME in conjunction with another exam (USMLE/FLEX), request your transcript of scores from the NBME. For exam entity contact information, see the UA FAQ at http://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.

- 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.

ADDITIONAL LICENSURE REQUIREMENTS

National Practitioner Data Bank Report - ***This must be requested by all applicants.*** Start the process for a Self-Query at https://www.npdb.hrsa.gov/ext/selfquery/SQHome.jsp. Follow all instructions given. After your Self-Query has been processed by the NPDB, they will mail the report to you. You must then mail the ORIGINAL, UNOPENED response to the Board. The Board must have this response in order to complete your application so you are encouraged to make this request as soon as possible. For questions or assistance, email help@npdb.hrsa.gov or call 800-767-6732.

Criminal Background Check – ***This must be requested by all applicants.*** Follow the instructions in Addendum 3 to apply for and schedule your fingerprinting appointment. Failure to follow these instructions may delay processing and/or require additional fees to obtain the background check. For more information: http://www.in.gov/pla/3240.htm.

Instructions for Securing a 90 Day Temporary Permit

A ninety (90) day temporary permit may be issued to an applicant who holds and shows proof of holding a valid license to practice medicine in the United States, its possessions or Canada. If you are requesting a ninety (90) day temporary permit, you must also submit to the Medical Licensing Board of Indiana the following items:

--Proof of Current Licensure. You must submit a notarized copy of a license with a current expiration date (pocket card/billfold license).

--You must also submit an additional temporary permit fee of $100.00; payable to Professional Licensing Agency. All fees are non-refundable and non-transferable.

The permit expires ninety (90) days from the date of issuance or when final action is taken on the application for full licensure.

License Renewals / Expiration Date

Expiration Date: Regardless as to when your license is issued, it will expire on the upcoming June 30 of each odd year. For example, a license issued on January 3, 2017 will expire on June 30, 2017, and a license issued on November 3, 2016 will expire on June 30, 2017.

**Licenses issued from May 1 through June 30 of each odd year will be issued through to the next odd year. For example, a license issued on May 25, 2015 will have an expiration date of June 30, 2017.

Renewals: A renewal reminder will be emailed to the email address we have on file around April 30 of each odd year. When you renew your license at this time, it will be for a two (2) year period. Please make sure that the Medical Board of Indiana always has your current email address.

UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE CHECK LIST

After completing the online application, you are responsible for submitting certain documents. Please use the checklist below that applies to you.

	NOT using FCVS to verify credentials	Using FCVS to verify credentials
A copy of your completed online application (UA) mailed to the Board. **Please make sure to include the proper fees to avoid a delay in the processing of your application.**	☐	☐
Completed State Addendums and application fee mailed to the Board.	☐	☐
Apply for and schedule your fingerprinting appointment (Addendum 3)	☐	☐
Completed "Affidavit and Authorization for Release of Information" sent to the Board.	☐	☐
License verifications sent to the Board from all states in which you have ever held any healthcare license. You may use VeriDoc or a board's electronic verification method in lieu of UA Form #1.	☐	☐
Notarized copies of all subjects and grades (mark sheets) including official translation in English for graduates of foreign medical schools.	☐	☐
Sworn, notarized affidavit explaining the reason(s) you did not complete the postgraduate training program(s) - if applicable.	☐	☐
Notarized copy of ECFMG Certificate (if applicable) sent to the Board.	☐	☐
National Practitioner Data Bank Report 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.	☐	Completed via FCVS
Medical School Transcripts sent to the Board by your medical school(s).	☐	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
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
Examination Transcripts sent to the Board.	☐	Completed via FCVS

FOR OFFICE USE ONLY

Application fee	Date fee paid (mo/day/yr)	Receipt number
License number	License issuance date (mo/day/yr)	
Permit fee	Date fee paid (mo/day/yr)	Receipt number
Permit number	Permit issuance date	

MEDICAL LICENSING BOARD OF INDIANA

ADDENDUM INSTRUCTIONS

Addendum Instructions: Complete the addenda as instructed below. Please type or print your responses.

Return the completed addenda, a printed copy of the UA application, payment and all supporting documentation to the Indiana Board.

Medical Licensing Board of Indiana
402 West Washington Street, Room W072
Indianapolis, IN 46204

☐ **Addendum 1**: The completion of this section of the form is **voluntary** and will **not** affect your application in any way.

☐ **Addendum 2**: These questions must be completed by the applicant. Any "yes" responses to questions 1-12 will need additional documentation as explained in the form.

☐ **Addendum 3: *This must be requested by all applicants.*** Follow the instructions to apply for and schedule your fingerprinting appointment. Failure to follow these instructions may delay processing and/or require additional fees to obtain the background check. For more information: http://www.in.gov/pla/3240 htm.

ADDENDUM 1

VOLUNTARY RACE / ETHNICITY / GENDER QUESTIONS**

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

Gender: ☐ Male ☐ Female Race: ___________________ Ethnicity: ______________________

** Note: This information is being requested for workforce statistical purposes only; disclosure is voluntary.

Applicant Name: ____
Last First Middle

Social Security #: ________________ Email Address: ____

Mailing Address: ____

City/State/Zip:____ Phone#:__________________________

ADDENDUM 2

TEMPORARY PERMIT INFORMATION

Do you desire a temporary permit? ☐ Yes ☐ No **If yes, an additional fee of $100 is required.**

SPECIALITIES / BOARD CERTIFICATION

List specialty: ____

Board certification (list ABMS certification):

ADDITIONAL QUESTIONS

Answer the following questions. If your answer is "Yes" to any of these questions, explain fully in a signed, sworn and notarized affidavit, including all related details. Include the violation, location, date and disposition. If applicable, please submit copies of all court documents and/or arrest records. **If you have malpractice, complete the "Malpractice Claims" section of the Online Uniform Application for each claim.** Letters from attorneys or insurance companies are not accepted in lieu of your statement, but may be submitted with your statement. Falsification of any of the following is grounds for permanent revocation of a license or permit issued pursuant to this application.

☐ Yes ☐ No 1. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit you hold or have held?

☐ Yes ☐ No 2. Have you ever been denied a license, certificate, registration or permit to practice medicine, osteopathic medicine or any regulated health occupation in any state *(including Indiana)* or country, or surrendered your license?

☐ Yes ☐ No 3. Are you now being, or have ever been treated for drug or alcohol abuse or addiction?

☐ Yes ☐ No 4. Have you ever been the subject of an investigation by a regulatory agency concerning your license?

5. Except for minor violations of traffic laws resulting in fines, and arrests or convictions that have been expunged by a court,

☐ Yes ☐ No A. have you ever been arrested;

☐ Yes ☐ No B. have you ever entered into a prosecutorial diversion or deferment agreement regarding any offense, misdemeanor, or felony in any state;

☐ Yes ☐ No C. have you ever been convicted of any offense, misdemeanor, or felony in any state;

☐ Yes ☐ No D. have you ever pled guilty to any offense, misdemeanor, or felony in any state;

☐ Yes ☐ No E. have you ever pled nolo contender to any offense, misdemeanor, or felony in any state?

☐ Yes ☐ No 6. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges revoked, suspended or subjected to any restrictions, probation or other type of discipline or limitations?

☐ Yes ☐ No 7. Have you ever been admonished, censured, reprimanded or requested to withdraw, resign or retire from any hospital or health care facility in which you have trained, held staff membership or privileges or acted as a consultant?

☐ Yes ☐ No 8. Have you ever had a malpractice judgment against you or settled any malpractice action?

☐ Yes ☐ No 9. Have you ever surrendered your DEA registration at any time or had any limitations placed on your DEA registration?

☐ Yes ☐ No 10. Have you ever been terminated or disciplined by your employer while practicing as a physician or resigned in lieu of discipline?

☐ Yes ☐ No 11. Have you ever been excluded from being a Medicare / Medicaid provider?

☐ Yes ☐ No 12. Were there any limitations or special requirements imposed on you because of academic performance, incompetence, disciplinary problems or any other reason during your medical education or post graduate training / residency program?

13. Pursuant to IC 12-32-1-5- and IC 12.32-1.6, I swear under the penalty of perjury that; Please select one of the following:
I am a United State citizen ☐ Yes ☐ No or I am a qualified alien (as defined under 8 USC § 1641) ☐ Yes ☐ No

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

Signature Email Address Phone#

Print Name: Last First Middle

ADDENDUM 3

Fingerprinting in Indiana Professional Licensing Agency

A criminal background check (CBC) completed prior to the submission of an application for licensure will not be considered valid. If an application is not received by IPLA **before** scheduling a CBC, the applicant will be required to submit to another check **resulting in additional fees**.

Follow the simple steps outlined below to complete the fingerprinting process:

1. Using your computer web browser, go to ***www.L1enrollment.com*** and choose Indiana.
2. If you do not have access to the internet, you may call us toll-free at (877) 472-6917 to schedule an appointment. If you call, you will be asked for demographic and personal information instead of completing these steps yourself.
3. Click Online Scheduling and choose the language you wish to use for scheduling (English or Spanish).
4. Enter your first and last name and click "go"
5. Choose your Agency Name **Professional Licensing Agency** and click "go"
6. Choose the correct **Applicant Category** for your license type and click "go"
7. Select the location where you want to be fingerprinted. You may choose a region of the state, by clicking on the map, or entering a zip code to view a list of locations in a specific area. Press "go"
8. Click on the words "Click to Schedule" across from the location you want, under the day you wish to be fingerprinted. If you want a date further in the future, click the "Next Week>>" link to display more dates. Once you select the location/date combination, select the time for your appointment and click "go"
9. Complete the demographic information page. Required fields are indicated by a red asterisk (*). When complete, click "Send Information"
10. Confirm the information by following the on screen directions to make any changes necessary. Once you review and verify the data is correct, click "Send Information"
11. Complete your payment process and click "Send Payment Information"
12. Print your confirmation page. If you provided an email address, you will receive an email confirmation as well.
13. Bring **one** of the following with you to your fingerprinting appointment: valid driver license, valid state issued identification card, valid passport, student identification card with picture and date of birth (DOB), work identification card with picture and DOB, valid alien identification card with picture and DOB. If you do not have the above identification, you will need **both** a valid birth certificate and a social security card.
14. Arrive at the facility at your appointed date and time.
15. The enrollment officer at the site will check your ID, verify your information, verify or collect payment, capture your fingerprints, and submit your data. This normally takes less than five minutes.
16. You will receive a signed receipt at the end of your fingerprinting session, which can be provided to your agency for proof of fingerprinting, if needed.
17. All results will be processed and delivered to the Indiana Professional Licensing Agency. L-1 is never in possession of criminal record data results

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: Medical Licensing Board of Indiana
402 West Washington Street, Room W071
Indianapolis, IN 46204

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 _____________

For State Board Use Only

Licensure Verification Form (Form #1)

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

Board name Medical Licensing Board of Indiana

Mailing address 402 West Washington Street, Room W072

City/State/Zip Indianapolis, IN 46204

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. Thank you.

UA UNIFORM APPLICATION FOR LICENSURE

For State Board Use Only

Medical or Osteopathic School Verification Form (Form #2)

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

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

Section 1: Applicant Information

First name ______________________ Last name ______________________ Practitioner Type ☐ MD ☐ DO ☐ ____
Middle name ____________________ Suffix ________SSN* _____________ Birth date (mm/dd/yyyy) ____________
Name if different when diploma awarded: ____

Name of school ____

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

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

Board name Medical Licensing Board of Indiana
Mailing address 402 West Washington Street, Room W072
City/State/Zip Indianapolis, IN 46204

Applicant signature ____ Date _______________

Section 2: Medical or Osteopathic School Verification

School name ____
Complete address w/country ____
School name if different when applicant attended ______________________________________
Hours of undergraduate education required for admission _______ Total weeks of education applicant attended _______
Attendance (mm/yyyy) from __________to __________Graduation date __________ Degree awarded ___________

Unusual Circumstances

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

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

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

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

☐ Academic	From ____________________ to	☐ Documentation attached
☐ Unprofessional conduct	From ____________________ to	☐ Documentation attached
☐ Behavioral reasons	From ____________________ to	☐ Documentation attached
☐ Other __________________________	From __________ to __________	☐ Documentation attached

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

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

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

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

Signature ____

Print name ____

AFFIX INSTITUTIONAL SEAL HERE

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

Title ___________________________ Date _______________

Phone number ________________ Fax number ___________

Email ____

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

UA UNIFORM APPLICATION FOR LICENSURE

Postgraduate Training Verification Form (Form #3)

Institution Name: ______________________________________

Institution Address: ______________________________________

____

Affiliated School: ______________________________________

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

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

Section 1:
To be completed by the Applicant.

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

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

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

Name if different when diploma awarded: ______________________________

Board Information:
To be completed by the applicant.

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

Board Name: **Medical Licensing Board of Indiana**

Mailing address: **402 West Washington Street, Room W072. Indianapolis, IN 46204**

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 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: Medical Licensing Board of Indiana

Mailing address: 402 West Washington St. Room W072

City/State/Zip: Indianapolis, IN 46204

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.