APPLICATION FOR LICENSE TO PRACTICE MEDICINE

Dear Applicant,

Welcome to Maine. We are pleased you’ve chosen to apply for a license to practice medicine here.

This Uniform Application information packet contains licensure application information specific to the Maine Board of Licensure in Medicine. Included are requirements to practice medicine in the state of Maine, checklists for each type of license, Uniform Application (UA) forms, and comprehensive instructions for completing the application process.

We find that it takes on average 90 days to receive responses to all of the inquiries requested in order to have a completed application. In an effort to provide better and faster service you may check the status online at: https://www.pfr.maine.gov/ALMSOnline/ALMSQuery/SearchIndividual.aspx?Board=376 by searching your name.

We will contact you directly with any questions or need for missing information. It is very important that your contact address, email address, and phone number will reach you directly to avoid any delays. We cannot accept email addresses or phone numbers for recruitment agencies, potential employers, etc. The inclusion of those in your application as contact numbers will cause delay, as we would have difficulty reaching you directly.

You must also take and pass an open-book exam covering Maine law and Board rules and regulations during the application process. The review materials and link to the exam are available at http://www.maine.gov/md.

Please read all of the materials in this packet carefully. Deviation from any procedure described herein will result in process delays.

IMPORTANT LICENSING INFORMATION: You will receive an email from noreply@maine.gov with instructions after you submit the online UA on how to proceed with the application process. If you do not receive this important email within 24 hours, contact the Board at (207) 287-3601. Your application will not be processed until you complete the steps outlined in the email.

If you have any questions about the Board’s application process, please feel free to contact the Board Initial Licensure Specialist at the Board’s address, or call Tracy Morrison at (207) 287-3602 for last names starting A-L or Elena Crowley at (207) 287-3782 for last names starting M-Z.

We look forward to serving you.

Sincerely,

State of Maine
Board of Licensure in Medicine
REQUIREMENTS FOR MEDICAL LICENSURE

TO BE CONSIDERED FOR LICENSURE TO PRACTICE MEDICINE IN THE STATE OF MAINE, AN APPLICANT MUST SATISFY EACH OF THE FOLLOWING REQUIREMENTS:

A. U.S.A. OR CANADIAN MEDICAL GRADUATES

1. Graduate from an accredited U.S. or Canadian medical school.

2. Postgraduate training (You must satisfy at least one of these categories):
   a) If you graduated on or after January 1, 1970 but before July 1, 2004 you must have satisfactorily completed at least 24 months in a graduate educational program accredited by the Accreditation Council on Graduate Medical Education (ACGME), the Canadian Medical Association or the Royal College of Physicians and Surgeons of Canada. If you graduated after July 1, 2004 you must have satisfactorily completed 36 months of approved postgraduate training.
   b) If you graduated before January 1, 1970 you must have satisfactorily completed at least 12 months in a graduate educational program accredited by the ACGME, the Canadian Medical Association or the Royal College of Physicians and Surgeons of Canada.
   c) Have satisfactorily graduated from a combined postgraduate training program in which each of the contributing programs is accredited by the ACGME and are eligible for accreditation by the American Board of Medical Specialties (ABMS) in both specialties.
   d) Are currently certified by ABMS.

3. Attain a passing score on one of the following examination sets:
   a) Each individual test of United States Medical Licensing Examination (USMLE), Federation Licensing Examination (FLEX), or National Board of Medical Examiners (NBME), separately or in an approved combination. There is a limit of three attempts for Step 3 and ALL exams must be completed within 7 years.
   b) State Board examination deemed equivalent by the Board to (a) above.*
   c) Licentiate of the Medical Council of Canada (LMCC).*
   d) British Isles Credentialing - General Medical Council of United Kingdom, or Republic of Ireland, or Scotland.*

4. Undergo a background check to verify professional competence, ethics and character.

5. Achieve a passing score on a State of Maine jurisprudence examination administered by the Board.

6. Complete and submit all applicable forms, fees, and documentation as required.

B. INTERNATIONAL MEDICAL GRADUATES


2. Postgraduate training: Satisfactorily completed at least 36 months in an internship/residency/fellowship program(s), which is accredited by the Accreditation Council on Graduate Medical Education (ACGME), the Canadian Medical Association, or the Royal Colleges of Physicians of England, Ireland, or Scotland, or has satisfactorily graduated from a combined postgraduate training program in which each of the contributing programs is accredited by the ACGME and is eligible for accreditation by the American Board Of Medical Specialties (ABMS) in both specialties, or is certified by the ABMS. To apply for a waiver of postgraduate accreditation, see 32 MRSA, §3271(6) at http://janus.state.me.us/legis/statutes/32/title32sec3271.html.

3. Provide acceptable evidence of one of the following:
a) Educational Commission for Foreign Medical Graduates (ECFMG) examination certification.

b) Certification of Foreign Medical Graduate Examination in the Medical Sciences (FMGEMS).

c) VISA Qualifying Examination (VQE) examination certification.

d) Successful completion of the Fifth Pathway program.

4. Attain a passing score on one of the following examination sets:

a) Each individual test of the United States Medical Licensing Examination (USMLE), the Federation Licensing Examination (FLEX), or the National Board of Medical Examiners (NBME), separately or in an approved combination. There is a limit of three attempts for Step 3 and all exams must be completed within seven years.

b) State Board examination deemed equivalent by the Board to (a) above.*

c) Licentiate of the Medical Council of Canada (LMCC).*

d) British Isles Credentialing - General Medical Council of the United Kingdom, or the Republic of Ireland.*

5. Undergo a background check to verify professional competence, ethics and character.

6. Achieve a passing score on a State of Maine jurisprudence examination administered by the Board.

7. Complete and submit all applicable forms, fees, and documentation as required.

* SUBJECT TO BOARD APPROVAL

PLEASE NOTE

MANDATED REPORTER REQUIREMENTS FOR SUSPECTED CHILD ABUSE

Maine law requires that physicians immediately report or cause a report to be made to the Maine Department of Health and Human Services (DHHS) when the physician knows or has reasonable cause to suspect that a child has been or is likely to be abused or neglected or that a suspicious child death has occurred.

In addition, if a child is under 6 months of age or otherwise non-ambulatory, Maine law requires physicians to immediately report to DHHS if that child exhibits evidence of the following: fracture of a bone; substantial bruising or multiple bruises; subdural hematoma; burns; poisoning; or injury resulting in substantial bleeding, soft tissue swelling or impairment of an organ, except that the reporting of injuries occurring as a result of the delivery of a child attended by a licensed medical practitioner or the reporting of burns or other injuries occurring as a result of medical treatment following the delivery of the child when the child remains hospitalized following the delivery is not required. Please refer to 22 M.R.S. § 4011-A for all reporting requirements.

Mandated Reporter Training and additional information regarding mandated reporting can be found at: http://www.maine.gov/dhhs/ocfs/cps/.

MAINE PRESCRIPTION MONITORING PROGRAM

As of August 1, 2014, Maine law requires all Allopathic Physicians, Osteopathic Physicians, Dentists, Physician Assistants, Podiatrists, and Advanced Practice Registered Nurses who are licensed to prescribe scheduled medications to register with the Prescription Monitoring Program (PMP).

To register, please go to the Prescription Monitoring Program website at http://www.maine.gov/pmp. Download, complete and sign a registration form located within the yellow box. You may mail, scan and email or fax a signed form to the information located on the form. Please note there are two types of registration forms available, 1) Data Requester form for active prescribers with a DEA number and, 2) Sub-Account form for assistants/non-prescribing health professionals.

The Board strongly recommends regular use of the PMP.

**Licensure Application Instructions**

Before you begin your licensure application, please review the previous pages on Requirements for Medical Licensure plus review the other items in this packet. APPLICATION FEES ARE NOT REFUNDABLE. Incomplete applications or those received without the required fee or documents will not be processed. Applications will not be reviewed by the Secretary of the Board until all appropriate materials are received.

**Completing the Federation Credentials Verification Service (FCVS)**

The Federation Credentials Verification Service (FCVS) is a service offered by the Federation of State Medical Boards (FSMB) that uses primary sources to verify a physician’s credentials. FCVS then creates a personalized profile for that physician that can be updated with new verified credentials at any time. The profile eliminates the re-verification of credentials that never change, saving time when applying with boards or other entities accepting FCVS.

Permanent, Administrative, Temporary, Youth Camp, and Educational license applicants are required to use FCVS. Applicants for other license types are not required to use FCVS as the Board does not require verification of everything contained in the FCVS profile. These applicants may submit required items directly to the Board. Refer to the checklists in this packet to ensure that you send all required items. Educational Certificate Applicants may ask the medical school to provide a Dean’s letter to expedite the process.

Documentation of your credentials is conducted exclusively by FCVS. Do not attempt to expedite the verification process by requesting information on your behalf. The Board will only accept verification of your credentials (i.e. medical education, postgraduate training, examination history, board action history, ECFMG certification and identity) directly via the FCVS Physician Information Profile.

To use FCVS, visit https://portal.fsmb.org/MyFsmb/ and click on the FCVS graphic, then sign in as directed. If the link doesn’t work, click on the FCVS link listed in the Licensure menu at http://www.fsmb.org/.

- Complete an Initial Application with FCVS if you are using FCVS for the first time.
- Complete a Subsequent Application with FCVS if you need to update an existing FCVS profile.
- For each application, designate your profile to be received by the Maine Board of Licensure in Medicine.
- Profiles with Self designations are not accepted.

For assistance, contact FCVS by using the messaging tool within FCVS or by calling 888-275-3287 with your FCVS ID number between 8am and 5pm CT Monday through Friday. Please do not contact the Board regarding your FCVS Application.

**Completing the Uniform Application for Physician State Licensure (UA)**

Similar to FCVS, the Uniform Application (UA) reduces redundant data entry. Once the core application is completed, it can be updated and used to apply to additional boards for licensure.

To use the UA, visit https://portal.fsmb.org/MyFsmb/ and click on the UA graphic, then sign in as directed. If the link doesn’t work, click on the Uniform Application link listed in the Licensure menu on http://www.fsmb.org/.

First time UA users will be required to pay a one-time service fee of $60. This fee is separate from FCVS fees and board licensing fees. A receipt will be available to print immediately after submitting your UA.

Please note the following:
The Board requires BOTH your HOME and BUSINESS mailing address, email address, and phone number. You may designate which of the two you wish to be used for mailings from the Board, but that default address is the home address, unless you specify otherwise. Your business address will be the address circulated by the Board in listings and publications available to the general public, including the Internet, unless you specify otherwise.

If you currently have no business address and you do not wish for your home address to be on the Internet, you must provide an alternate address, such as a Post Office box, or a mail drop. If, subsequent to this application, your home or business contact information changes, you must immediately notify the Board either in writing or by updating your profile online. **Immediately upon beginning your practice of medicine in Maine, you must provide the Board with your Maine business address, email address, and phone number.**

The following statement is made pursuant to the Privacy Act of 1974, Section 7(b): Disclosure of your social security number is mandatory. Solicitation of your social security number is solely for tax administration purposes pursuant to 36 M.R.S. §175 as authorized by the Tax Reform Act of 1976 (42 U.S.C. §405(c)(2)(c)(I)). Your social security number will be disclosed to the State Tax Assessor or an authorized agent for determining filing obligations and tax liability pursuant to Title 36 of the Maine Revised Statutes. No further use will be made of your social security number, and it shall be treated as confidential tax information pursuant to 36 M.R.S. §191.

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

You are not able to edit or add MD or DO license information in the UA, as that data comes into the system directly from the state boards. If changes are needed, email ua@fsmb.org with the correct information.

If you have held a healthcare license or certification outside of the U.S. Canada, The General Medical Council, or the Ireland Medical Council, you must provide written verification of licensure or registration.

Provide complete addresses for each entry on the Chronology page. In addition, please provide the names and complete addresses, including e-mail and fax, for three peer references who can attest to your clinical and professional skills within the past 12 months. Failure to do so will delay your licensure.

The malpractice section, if applicable, may generate follow up letters from the Board staff and delay your licensure if not answered completely. Report all claims of which you have been noticed, as well as all claims from which you were dismissed as a defendant or for which your insurance company made a settlement of any kind with the plaintiff, or any claim for which a court found you liable in any degree. Claims against a professional corporation are considered a claim against the individual licensee who provided the professional services in dispute.

To be complete, your supplemental explanation must include, **for each such claim reported**, a full description in the space provided. Your insurance carrier or attorney must also provide an independent detailed explanation of all malpractice claims. This information must be received directly from the insurance company or attorney and is needed in addition to your personal explanation.

Send a notarized UA Affidavit and Authorization for Release of Information form to the Board. The UA form is included in this packet. The notarization must cover a portion of the photograph, but not covering above the neck.
Use the applicable checklist on the following pages to ensure you have completed all Board requirements for licensure. All documents must be notarized or original source. Your application, together with all supporting documents and fee, must be filed with the Board at least thirty days prior to the desired effective date of licensure.

Mail the requested items to:

Maine Board of Licensure in Medicine  
137 State House Station  
Augusta, ME 04333-0137  
(Mailing address)

Maine Board of Licensure in Medicine  
161 Capitol Street  
Augusta, ME 04330-6211  
(Delivery address – FedEx, UPS, etc.)

INTERSTATE PRACTICE OF TELEMEDICINE

NOTE: Mandatory Notification of Restrictions. 32 M.R.S. § 3300-D(4) requires that a physician registered to provide interstate telemedicine services shall immediately notify the board of restrictions placed on the physician's license to practice medicine in any state or jurisdiction. Please review the Requirements for Consultative Telemedicine Registration at http://legislature.maine.gov/statutes/32/title32sec3300-D.html

The board may register a physician to provide consultative services through interstate telemedicine to a patient located in this State if the following conditions are met:

a) The physician is fully licensed without restriction to practice medicine in the state from which the physician provides telemedicine services;

b) The physician has not had a license to practice medicine revoked or restricted in any state or jurisdiction;

c) The physician does not open an office in this State, does not meet with patients in this State, does not receive calls in this State from patients and agrees to provide only consultative services as requested by a physician, advanced practice registered nurse or physician assistant licensed in this State and the physician, advanced practice registered nurse or physician assistant licensed in this State retains ultimate authority over the diagnosis, care and treatment of the patient;

d) The physician registers with the board every 2 years, on a form provided by the board; and

e) The physician pays a registration fee not to exceed $500.

APPLICATION FEES ARE NOT REFUNDABLE. Incomplete applications or those received without the required fee or documents will not be processed. Registrations will not be reviewed until all required information has been received.

OTHER IMPORTANT INFORMATION

Applicants are required to complete a written State Examination covering Maine law and Board rules and regulations. It is an open book exam. Review materials are online at https://www1.maine.gov/cgi-bin/online/licensing/begin.pl?board_number=376 under "Online Exam".

The renewal date of your medical license is determined by your date of birth. Your first license is typically not for a full registration period of 2 years. The initial registration fee will register your license to practice until the first renewal date.

Your Board application, FCVS Profile, scored written exam and supporting documentation will be reviewed when administratively complete.
NOTE: All documents must be notarized or original source. Your application, together with all supporting documents and fee, must be filed with the Board at least thirty days prior to the desired effective date of licensure.

**MAINE APPLICATION CHECKLIST FOR PERMANENT OR ADMINISTRATIVE LICENSE**

*(Permanent License Reference: 32 M.R.S. §3270. Licensure required)*

*(Administrative License Reference: 32 M.R.S. § 3271(7). Special License Categories)*

☐ Complete the FCVS application for credentials verification.

☐ Complete and submit the Uniform Application to the Board. If this is your first time using the UA, you will need to pay the one-time service fee of $60 to FSMB before your UA can be sent.

☐ Mail the following items to the Board:

☐ Non-refundable application fee of $700 via check or postal money order made payable to Maine Board of Licensure in Medicine. You may pay this fee by credit card when you complete the Main Addendum or attach a check to your notarized UA affidavit and Authorization for Release of Information form.

☐ Notarized UA Affidavit and Authorization for Release of Verification form. The notarization must cover a portion of the photograph, but not covering above the neck.

☐ Any documentation needed for answers requiring explanations.

☐ Review the written examination materials covering Maine law and Board rules and regulations at:

☐ Complete the written examination at:
   [https://www1.maine.gov/cgi-bin/online/licensing/begin.pl?board_number=376 under "Online Exam"](https://www1.maine.gov/cgi-bin/online/licensing/begin.pl?board_number=376)
Affidavit and Authorization for Release of Information

Applicant: Complete this form as directed in the left sidebar, then submit it to the Board.

Mailing address: Maine Board of Licensure in Medicine 137 State House Station 161 Capitol Street

Delivery address (FedEx, UPS, etc.): Maine Board of Licensure in Medicine

Applicant: Complete this form as directed in the left sidebar, then submit it to the Board.

Mailing address: Maine Board of Licensure in Medicine 137 State House Station 161 Capitol Street

Delivery address (FedEx, UPS, etc.): Maine Board of Licensure in Medicine

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

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

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

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

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

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

Applicant Photograph

Securely tape or glue a recent (less than 90 days) front-view 2" x 2" passport-type color photo of yourself in this square.

The Notary’s Seal must overlap a portion of this photograph but not covering above the neck.

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

Applicant’s printed last name

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

Date of signature (must correspond to date of notarization)

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

Notary

State of ______________________, County of ______________________.

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

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

Notary Public Signature: ____________________________________________ [Notary Seal must be affixed on photo]

My Notary Commission Expires: ____________________________

Maine Board of Licensure in Medicine

Revised October 2017

UA Affidavit and Authorization for Release of Information
Licensure Verification Form (Form #1)

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

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

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Section 1: Applicant Information

First name ___________________________ Last name ___________________________ Practitioner Type □ MD □ DO □ ___
Middle name ___________________________ Suffix ____ SSN* _______ Birth date (mm/dd/yyyy) _________

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

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

Board name ___________________________
Mailing address __________________________________________________________
City/State/Zip __________________________________________________________________

Applicant signature ___________________________ Date ________________

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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.

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.

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.
Medical or Osteopathic School Verification Form (Form #2)

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

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

Section 1: Applicant Information

First name ___________________________ Last name ___________________________ Practitioner Type □ MD □ DO □ ___
Middle name __________________________ Suffix _______ SSN* ________________ Birth date (mm/dd/yyyy) ____________
Name if different when diploma awarded: __________________________________________
Name of school ____________________________________________________________________________

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

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

Board name _____________________________________________________________________________
Mailing address __________________________________________________________________________
City/State/Zip ____________________________________________________________________________

Applicant signature _____________________________________________________________________ Date ________

Section 2: Medical or Osteopathic School Verification

School name _____________________________________________________________________________
Complete address w/country __________________________________________________________________
School name if different when applicant attended __________________________________________________________________
Hours of undergraduate education required for admission ______ Total weeks of education applicant attended ______
Attendance (mm/yyyy) from ______ to ______ Graduation date ______ Degree awarded __________

Unusual Circumstances

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

1. Do the official records for this individual reflect interruptions or extensions in his/her Yes □ No □ 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.

□ 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 From ________ to ________ □ Approved □ Unapproved
study (e.g., fellowship, intl. experience) □ 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.

☐ 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.

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.

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.

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.
Institution Name: ___________________________ 
Institution Address: ___________________________ 
Affiliated School: ___________________________ 

Section 1: 

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Unusual Circumstances: 

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

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

I CERTIFY THAT to the best of my knowledge and belief, the foregoing is a true, accurate and complete statement of the record of the individual named on this form. This section MUST be signed by the program director (M.D. or D.O. only). Please Note: The Nevada Board of Medical Examiners requires an authorization letter to be attached if this form is completed by someone other than an M.D. or D.O. 

Signature: ___________________________ 
Print name: ___________________________ 
Title: ___________________________ 
Email address: ___________________________ 
Phone Number: ___________________________ 
Date: ___________________________ 

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.
Fifth Pathway Verification Form (Form #4)

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

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

Section 1: Applicant Information

First name ___________________________ Last name ___________________________ Practitioner Type ☐ MD ☐ DO ☐ ___

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

Name if different when diploma was awarded:

Name of medical school

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

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

Board name ____________________________________________

Mailing address ____________________________________________

City/State/Zip ____________________________________________

Applicant signature ____________________________________________ Date ____________

Section 2: Fifth Pathway Verification

Institution name ____________________________________________ Affiliated school ____________________________________________

Institution name if different when applicant attended ____________________________________________

Institution address w/country ____________________________________________

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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 ____________________________________________

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.