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) 444-5773 • 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

(Please allow 30 days for processing from the date that the Board has a complete routine application.)

Licensure Requirements

- Must be a graduate of a medical school approved by the American Osteopathic Association or the Council for Medical Education of the American Medical Association.
- U.S. graduates must have successfully completed a Board-approved post-graduate residency program.
- Foreign graduates must complete at least 3 years of post-graduate training in an approved program in the United States or Canada or been granted board certification by a specialty board which is approved by AMA or AOA.
- Foreign graduates must have a certificate from the Educational Commission for Foreign Medical Graduates (ECFMG; www.ecfmg.org) and from the Fifth Pathway Program, if applicable.
- Must have passed a licensing exam, approved by the Board, with a score of at least 75% on all portions of the examinations. (Please refer to the Board statutes and rules (ARM 24.156.606) for specific information regarding examination information and limits on attempts.)
- Must be of good moral character.

Application Processing Procedures

- The fee for licensure application is $500. Make checks payable to Montana Board of Medical Examiners.
- 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 15 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.

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 work on the UA, go to [http://www.fsmb.org/](http://www.fsmb.org/) and select Uniform Application from the Licensure menu or Sign In menu. If you have submitted a UA, select the state board in the State Board section to open the UA for editing. Submit your UA to the board when you have finished updating your UA.

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 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/](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 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 $50. Your receipt will be available immediately after submitting your 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/licensure/uniform-application/faq](https://www.fsmb.org/licensure/uniform-application/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) 444-5773 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.**

- Provide both your current home address and current practice/training address, otherwise an error will occur. Do not enter the same address for both home and work.
You are not able to add or edit MD and DO licenses in the UA as all MD and DO license information comes directly into the system from state boards. Email ua@fsmb.org with the correct information if changes are needed.

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.

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.

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.

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/licensure/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 http://www.fsmb.org/licensure/uniform-application/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

<table>
<thead>
<tr>
<th>NOT using FCVS to verify credentials</th>
<th>Using FCVS to verify credentials</th>
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</thead>
<tbody>
<tr>
<td>Completed online uniform application (UA).</td>
<td>□</td>
</tr>
<tr>
<td>Completed state addenda and $500 application fee sent to the Board.</td>
<td>□</td>
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<tr>
<td>Affidavit and Authorization for Release of Information form sent to the Board. Notarization and photo not needed by the Board.</td>
<td>□</td>
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<tr>
<td>State Licensure Verification form (Form #1) sent to the Board from all states in which you have ever held any healthcare license.</td>
<td>□</td>
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<tr>
<td>DD214, Military Discharge Paper (if applicable) sent to the Board.</td>
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<tr>
<td>Notarized copy of birth certificate or current, valid passport sent to the Board.</td>
<td>N/A</td>
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<tr>
<td>Supporting documentation of any legal name change sent to the Board.</td>
<td>□</td>
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<tr>
<td>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).</td>
<td>□</td>
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<tr>
<td>Medical School Transcripts sent to the Board by your medical school(s).</td>
<td>N/A</td>
</tr>
<tr>
<td>Postgraduate Training Verification form (Form #3) sent to the Board from all programs you attended.</td>
<td>□</td>
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<tr>
<td>A copy of your postgraduate training certificate(s) sent to the Board.</td>
<td>□</td>
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<tr>
<td>Examination Transcripts sent to the Board.</td>
<td>□</td>
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<tr>
<td>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).</td>
<td>□</td>
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<tr>
<td>Foreign Graduates: Request for Status Report of ECFMG Certification sent to the Board.</td>
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**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.
**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
Name of Applicant: ____________________________________________

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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: ______

Pre-Medical School:

List all pre-medical schools you have attended, even those from which you did not graduate, in chronological order. Attach an additional sheet if necessary.

<table>
<thead>
<tr>
<th>University/College:</th>
<th>Degree:</th>
<th>Street Address:</th>
<th>City:</th>
<th>State/Province/Territory:</th>
<th>Country:</th>
<th>Dates Attended: From <em><strong><strong>/__<strong>/</strong></strong></strong> to _____/</em><em><strong>/</strong></em>___</th>
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Montana Board of Medical Examiners Uniform Application Addendum 1, Page 1 of 2
Name of Applicant: ________________________________________________________________

**Specialty Certification:**

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

<table>
<thead>
<tr>
<th>Certifying Agency</th>
<th>Specialty</th>
<th>Date Awarded</th>
<th>Date Recertified</th>
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</table>

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.

_________________________________ Date

Signature of Applicant
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.

<table>
<thead>
<tr>
<th>QUESTIONS</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. If you are a foreign medical graduate, have you satisfied the requirements of the Educational Commission for Foreign Medical Graduates (ECFMG)?</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>2. Do you intend to practice in the State of Montana? If yes, attach a brief explanation.</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>3. Have you ever previously applied for a license to practice in Montana? If yes, give date and results.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>4. Have you ever been denied licensure or the opportunity to take this profession’s licensing examination in any state or country? If yes, attach a detailed explanation.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>5. Have you ever had an application for a professional or occupational license refused or denied? If yes, please attach a detailed explanation and provide supporting documentation from the source.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>6. Have you ever withdrawn an application for licensure prior to the licensing agency’s decision regarding your application? If yes, please attach a detailed explanation and provide supporting documentation from the source.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>7. Have you ever been denied the privilege of taking an examination required for any professional or occupational license? If yes, please attach a detailed explanation and provide supporting documentation from the source.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>8. Have you ever withdrawn or been suspended, placed on probation, expelled or requested to resign from any post-secondary educational program? If yes, please attach a detailed explanation and provide supporting documentation from the source.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>9. Have you ever requested temporary or permanent leave of absence, been placed on probation, restricted, suspended, revoked, allowed to resign, or otherwise acted against by any professional or occupational education program (i.e. residency, internship, apprenticeship, etc.)? If yes, please attach a detailed explanation and provide supporting documentation from the source.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>10. Has a licensing agency initiated or completed disciplinary action against any professional or occupational license you have held? If yes, please provide agency documents including the complaint, initiating documents, orders, final orders, stipulations and consent and/or settlement agreements directly from the source.</td>
<td>☐</td>
<td>☐</td>
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</table>
Name of Applicant: ____________________________________________

<table>
<thead>
<tr>
<th>QUESTIONS</th>
<th>YES</th>
<th>NO</th>
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<tbody>
<tr>
<td>11. Have you ever voluntarily surrendered, cancelled, forfeited, failed</td>
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<td>to renew a professional or occupation license in anticipation of or</td>
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<td>during an investigation or disciplinary proceeding or action? <strong>If yes,</strong></td>
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<td>please attach a detailed explanation and provide supporting documentation</td>
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<td>from the source.</td>
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<td>12. Has a complaint ever been made against you with a professional or</td>
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<td>occupational licensing agency? <strong>If yes,</strong> please attach a detailed</td>
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<td>explanation and provide supporting documentation from the source.</td>
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<td>13. Have you ever been the subject of any sanction or action, denial,</td>
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<td>suspension, revocation, restriction or termination regarding hospital,</td>
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<td>facility or staff privileges; health maintenance organization participation,</td>
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<td>third party provider or Medicare/Medicaid participation; or any other</td>
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<td>privileges? <strong>If yes,</strong> please attach a detailed explanation and provide</td>
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<td>supporting documentation from the source.</td>
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<td>14. Have you ever been censured, expelled, denied membership or asked to</td>
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<td>resign from a professional organization related to your profession or</td>
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<td>occupation? <strong>If yes,</strong> please attach a detailed explanation and provide</td>
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<td>documentation from the source.</td>
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<td>15. Have you ever been the subject of any sanction or action, denial,</td>
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<td>suspension, revocation, restriction or termination regarding your ability</td>
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<td>to prescribe, dispense or administer drugs including controlled</td>
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<td>substances? <strong>If yes,</strong> please attach a detailed explanation and provide</td>
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<td>documentation from the source.</td>
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<td>16. Do you have any initiated or completed action against you by any</td>
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<td>state, federal, tribal, or foreign licensing jurisdiction? (For example:</td>
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<tr>
<td>Drug Enforcement Administration; Alcohol, Tobacco and Firearms;</td>
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<td>Homeland Security; Indian Health Service, etc.) <strong>If yes,</strong> please attach</td>
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<td>a detailed explanation and provide documentation from the source.</td>
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<td>17. Have any civil legal proceedings been filed against you by a patient/</td>
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<td>client, former patient/client or employer/employee? <strong>If yes,</strong> attach a</td>
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<td>detailed explanation and documentation from the source including initiating</td>
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<td>documents and documentation of final disposition. This includes</td>
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<tr>
<td>malpractice claims, settlements, and judgments. This does not include</td>
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<td>filings with the Montana Medical-Legal Panel.</td>
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<td>18. Have you ever been convicted of a misdemeanor or felony crime or do</td>
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<tr>
<td>you have a pending criminal charge? “Convicted” for the purposes of this</td>
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<td>question includes a conviction under appeal, guilty plea, no contest</td>
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<td>plea, and/or forfeiture of bond. “A pending criminal charge” for the</td>
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<td>purposes of this question include a deferred imposition of sentence and/or</td>
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<td>deferred prosecution. <strong>If yes,</strong> please submit a detailed explanation of</td>
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<td>the events AND the charging documents and final judgments or orders of</td>
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<td>dismissal. You must report but may omit documentation for: (1)</td>
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<td>misdemeanor traffic violations older than 10 years ago and that resulted</td>
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<td>in fines of less than $200; and (2) convictions prior to your 18th</td>
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<td>birthday unless you were tried as an adult.</td>
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<td>19. Have you ever been diagnosed with chemical dependency or another</td>
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<td>addiction, or have you participated in a chemical dependency or other</td>
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<td>addiction treatment program? <strong>If yes,</strong> please attach a detailed</td>
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<td>explanation and provide documentation regarding evaluations, diagnosis,</td>
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<td>treatment recommendations and monitoring from the source.</td>
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</tbody>
</table>
Name of Applicant: ________________________________

<table>
<thead>
<tr>
<th>QUESTIONS</th>
<th>YES</th>
<th>NO</th>
</tr>
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<tbody>
<tr>
<td>20. Have you ever been diagnosed with a physical condition or mental health disorder involving potential health risk to the public? <strong>If yes,</strong> please provide a detailed explanation.</td>
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<tr>
<td>21. Have you ever served in any branch of the armed forces? <strong>If yes,</strong> attach a DD214, Military Discharge Paper, if you have been discharged.</td>
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<tr>
<td>22. Have you ever been court-martialed or discharged other than honorably from any branch of the armed services? <strong>If yes,</strong> attach a detailed explanation and documentation from the source.</td>
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<tr>
<td>23. Have you any physical or mental condition(s) which may have or has adversely affected your ability to practice this profession, including but not limited to a contagious or infectious disease involving serious risk to the public? <strong>If yes,</strong> attach a detailed explanation.</td>
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<td>24. Have you used alcohol or any other mood-altering substance in a manner which may have or has adversely affected your ability to practice this profession? <strong>If yes,</strong> attach a detailed explanation.</td>
<td></td>
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</tr>
</tbody>
</table>
Name of Applicant: ________________________________

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) 444-5773 • Fax: (406) 841-2305
Email: dlibsmed@mt.gov • Website: www.medicalboard.mt.gov

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

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

 Applicant’s printed last name

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

 Date of signature (must correspond to date of notarization)

---fold up---

Notary

(Please note: Notarization of this form is not required by the Montana Board of Medical Examiners.)

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: __________________________

(NOTARY PUBLIC SEAL)
Licensure Verification Form

Applicant: Complete this form as directed in the left sidebar.

Licensing Board: Complete this form as directed. Send the completed verification to the Montana Board of Medical Examiners at the address in Section 1.

Section 1: Applicant Information

Last name: ___________________________ Suffix: _______ Degree Type: ☐ M.D. ☐ D.O.
First name: ___________________________ Middle name: ___________________________
Date of Birth: ________________________ Social Security Number*: ______________________

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

Authorization: I am applying for a license to practice medicine. The Board I am applying to requires that this form be completed by each state or Canadian province in which I hold or have held licenses, whether now current or not. I authorize the licensing agency of the state/province of _______________________ to provide any and all information pertaining to license number _________________ to the following Board:

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

Applicant signature: _______________________________________________ Date: _______________

Section 2: Licensure Verification

Name of Licensee: ______________________________________________________________________

Is issuing State Board: _______________________________ License type: ______________________

License number: ___________________________ Issue date: ______________ Expiration date: ______________

Is this license current? ☐ Yes ☐ No ☐ Cannot answer under state law If not current, please explain: ___________________________________________________________

1. Have formal disciplinary proceedings been initiated against applicant’s license by a disciplinary authority in your state?
   ☐ Yes ☐ No ☐ Cannot answer under state law If yes, please explain: _________________________________

2. Has the applicant ever been warned, censured, placed on probation, formal consent, reprimand, or in any other manner disciplined, or has the applicant’s license ever been revoked, suspended, or, in any other manner, limited by a licensing or disciplinary authority in your state?
   ☐ Yes ☐ No ☐ Cannot answer under state law If yes, please explain: _________________________________

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

Signature: ________________________________
Print name: _______________________________
Title: _________________________________
Date: _________________________________
Email: ________________________________

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

Montana Board of Medical Examiners
May 2016

UA Licensure Verification Form
Page 1 of 1
Medical School Verification Form

Applicant: Complete this form as directed in the left sidebar.

Medical School: Complete this form as directed. Send the completed verification to the Montana Board of Medical Examiners at the address in Section 1.

---

Section 1: Applicant Information

Last name: ___________________________ Suffix: _________ Degree Type: ☐ M.D. ☐ D.O.

First name: ___________________________ Middle name: ___________________________

Date of Birth: ___________________________ Social Security Number*: ______________________

Name if different when diploma 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 authorize the medical school listed above to provide any and all information pertaining to my medical education at that institution to the Board listed below. I request that the Dean or a designated official complete Section 2 of this form and seal the copy of my diploma (attached), then return this form, the sealed diploma copy, and a copy of my official transcripts to the Board listed below at the given address.

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

Applicant signature: ___________________________________ Date: __________________

---

Section 2: Medical School Verification

Medical school name: ________________________________________________________________

School name if different when the above applicant attended: __________________________________

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

____________________________________________________________________________________
____________________________________________________________________________________

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

Total weeks of education applicant attended your school: __________________

Applicant's attendance dates: From ___________________________ to ______________________

Graduation date: ___________________________ Degree: ___________________________

(Indicate N/A if not applicable) (Indicate N/A if not applicable)

The questions on the following page apply to unusual circumstances that occurred during any part of the individual’s medical education. Please check the appropriate response(s) and provide dates and requested information. “Yes” responses to any of these questions require a copy of explanatory records or a written explanation. Attach additional pages as necessary.
1. Do the official records for this individual reflect (an) interruption(s) or extension(s) in his/her medical education?  Yes ☐  No ☐

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

<table>
<thead>
<tr>
<th>Reason</th>
<th>From Month/Year</th>
<th>To Month/Year</th>
<th>Approved</th>
<th>Unapproved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal/Family</td>
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<td>Academic remediation</td>
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<tr>
<td>Health</td>
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<tr>
<td>Financial</td>
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<td>Participation in joint degree program (e.g., MD/PhD)</td>
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<tr>
<td>Participation in non-research special study (e.g., fellowship, international experience)</td>
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<tr>
<td>Other:</td>
<td></td>
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</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th>Reason</th>
<th>From Month/Year</th>
<th>To Month/Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Academic probation</td>
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<tr>
<td>Probation for unprofessional conduct/behavioral reasons</td>
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<td></td>
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<tr>
<td>Probation for other reason(s) (please specify):</td>
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</tbody>
</table>

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

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

4. Do the official records for this individual reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical school or parent university?  Yes ☐  No ☐

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

5. Do the official records for this individual reflect that there were ever any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason?  Yes ☐  No ☐

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

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

Signature: __________________________________________
Print name: __________________________________________

AFFIX INSTITUTIONAL SEAL HERE

Title: __________________________________________
Date: __________________________________________
Phone number: __________________ Fax number: ____________
Email: __________________________________________
Applicant:
Complete section 1.
Send this form to the current Program Director of your postgraduate training program.
Copy this form for multiple training programs.
If you are using FCVS for credentials verification, do not complete this form. FCVS handles this verification for you.

Section 1: Applicant Information

Last name: ________________________________ Suffix: _________ Degree Type: □ M.D. □ D.O.
First name: ________________________________ Middle name: _______________________________
Date of Birth: ______________________________ Social Security Number*: ______________________
Name if different when diploma awarded: ____________________________________________________
Name of postgraduate training program:  _____________________________________________________

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

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

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

Applicant signature: ___________________________________________ Date: ________________

Dean or Designated Official:
Complete section 2. Report incomplete years separately from completed years. Report each Internship, Residency, and Fellowship separately.

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

Send this to the board listed in section 1 with any added materials, if applicable.

DO NOT send this form to FCVS or FSMB. Doing so will delay the applicant’s licensure process.

Section 2: Postgraduate Training Verification

Institution name: ________________________________________________________________
Institution street address: __________________________________________________________
Institution city / state or province / zip code: __________________________________________
Affiliated medical school name: ___________________________________________________
Institution / school name if different when the applicant attended: __________________________

1. Postgraduate year (e.g., 1, 2, 3, etc.): ___ Attendance dates: From __________ to __________
   (mm/yyyy) (mm/yyyy)
   □ Internship □ Residency □ Fellowship □ Research
   □ Chief Residency □ Unspecified □ Other: __________________________
Specialty/Subspecialty: __________________________________________________________________
Successfully completed**? □ Yes □ No □ In progress; expected completion in ______(mm/yyyy)

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

Accredited by: □ ACGME □ AOA □ APPAP □ CFPC
   □ LCME □ RCPSC □ RSC □ None of these
2. Postgraduate year (e.g., 1, 2, 3, etc.): ___ Attendance dates: From ____ to ____ (mm/yyyy)  

☐ Internship  ☐ Residency  ☐ Fellowship  ☐ Research  
☐ Chief Residency ☐ Unspecified  ☐ Other: ___________________________  

Specialty/Subspecialty: ___________________________________________________________  

Successfully completed*?  ☐ Yes  ☐ No  ☐ In progress; expected completion in ____ (mm/yyyy)  

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

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

3. Postgraduate year (e.g., 1, 2, 3, etc.): ___ Attendance dates: From ____ to ____ (mm/yyyy)  

☐ Internship  ☐ Residency  ☐ Fellowship  ☐ Research  
☐ Chief Residency ☐ Unspecified  ☐ Other: ___________________________  

Specialty/Subspecialty: ___________________________________________________________  

Successfully completed*?  ☐ Yes  ☐ No  ☐ In progress; expected completion in ____ (mm/yyyy)  

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

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

Unusual Circumstances  

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

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

Signature: ________________________________________________________________  
Print name: _______________________________________________________________  

AFFIX INSTITUTIONAL SEAL HERE  
Title: ________________________________________________________________  
Date: ________________________________________________________________  
Phone number: __________________ Fax number: __________________  
Email: ____________________________  

(If no seal is available, this form must be notarized.)
Section 1: Applicant Information

Last name: ________________________________ Suffix: _________ Degree Type: ☐ M.D. ☐ D.O.
First name: ________________________________ Middle name: _______________________________
Date of Birth: ______________________________ Social Security Number*: ______________________
Name if different when certificate 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 authorize the Program Director or designated official of the Fifth Pathway program to provide any and all information pertaining to my medical education at that institution to the Board listed below. I request that the Program Director or a designated official complete Section 2 of this form and send it to the Board listed below at the given address.

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: _________________________________________________________________
Institution street address: __________________________________________________________
Institution city / state or province / zip code: __________________________________________
Institution / school name if different when the applicant attended: _________________________

Enrollment dates: From ____________ to ____________

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

If the applicant withdrew or was dismissed, please explain in the space below. Attach additional information if needed.
### Type of Clinical Rotation

<table>
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<tr>
<th>From</th>
<th>To</th>
<th>Number of Weeks</th>
<th>Credit</th>
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</tr>
</tbody>
</table>

### Unusual Circumstances

1. Did this individual ever take a leave of absence or break from his/her training?  
   - [ ] Yes  
   - [ ] No

2. Was this individual ever placed on probation?  
   - [ ] Yes  
   - [ ] No

3. Was this individual ever disciplined or placed under investigation?  
   - [ ] Yes  
   - [ ] No

4. Were any negative reports for behavioral reasons ever filed by instructors?  
   - [ ] Yes  
   - [ ] No

5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems, or any other reason?  
   - [ ] Yes  
   - [ ] No

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

---

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

Signature: ________________________________  
Print name: ________________________________  
Title: ________________________________  
Date: ________________________________  
Phone number: _______________ Fax number: _______________  
Email: ________________________________