Rhode Island
Board of Medical Licensure and Discipline
Room 205
3 Capitol Hill
Providence, RI 02908-5097

Instructions and License Application for:

☐ Allopathic Medicine
☐ Osteopathic Medicine
☐ Academic Faculty
  (Limited Medical Registration)

___________________________________________________________
Applicant – Print/Type Name (First/MI/Last)

☐ I am also applying for a RI Uniform Controlled Substance Registration (CSR)
  and I have attached the CSR application to this license application.

Phone: (401) 222-3855  TTY/TDD: (800) 745-5555  Fax: (401) 222-2158
GENERAL INFORMATION

Components of the Application. The following materials and information are part of your application packet:

Instructions
General Information ................................................................. Instructions Pages 1-3
Instructions for Completing Board Application ................................ Instructions Pages 3-5
Checklist .................................................................................. Instructions Page 6

Credentials Verification and Licensure Applications
Federation Credentials Verification Service .................................... Online
Uniform Application ..................................................................... Online
UA Affidavit and Authorization Form ......................................... Page Before Addendum

Addenda
Addendum Instructions ............................................................... Addendum Cover Page
Addendum 1 – Reciprocity Release Form (Licensure Verification) .......... 1 page
Addendum 2 – Additional Physician Information .......................... 5 pages
ABMS Certification Codes ............................................................ Addendum 2, pages 4-5
Addendum 3 – Mandatory Addendum to Licensure App / Verification of SSN... 1 page
Addendum 4 – Uniform Controlled Substances Act Registration (CSR) ......... 1 page
Addendum 5 – Voluntary Race/Ethnicity Questions ........................... 1 page
Addendum 6 – Academic Faculty, Limited Medical Registration Applicants ...... 1 page

Licensure Requirements.

Graduates of Schools Located in the U.S.A., Puerto Rico, and Canada:

- Be of good moral character.
- Graduated from a medical school accredited by the Liaison Committee for Medical Education (LCME).
- Satisfactorily completed two (2) years of progressive postgraduate training, internship, and residency in a program accredited by the Accreditation Council for Graduate Medical Education (ACGME), or satisfactorily completed two (2) years of progressive postgraduate training in a program accredited by the Accreditation Committee of the Federation of the Medical Licensing Authority of Canada or the Royal College of Physicians and Surgeons of Canada.
- Satisfactorily passed a licensure examination approved by the Board.
- Met any other requirement(s) set forth by regulation or established by the Board.

Foreign Medical Graduates:

- Be of good moral character.
- Graduated from a medical school located outside the United States which is recognized by the World Health Organization and the Board.
- Received certification by the Education Commission for Foreign Medical Graduates (ECFMG).
- Satisfactorily completed two (2) years of progressive postgraduate training, internship, and residency or a comparable fellowship in a training program accredited by the Accreditation Council for Graduate Medical Education (ACGME). The Board may grant up to twelve (12) months of credit at the internship level to an applicant with a minimum of three (3) years of progressive international training when advanced standing is also granted by the American Board of Medical Specialties. All or some of this postgraduate training requirement may be waived, at the discretion of the Board, for international medical graduates with advanced international postgraduate training; full and unrestricted medical licensure in another state/jurisdiction; and five (5) years of clinical practice experience in good standing in the alternate jurisdiction.
- Satisfactorily passed an examination approved by the Board.
- Met such other requirements as set forth by regulation or as may be established by the Board.
Osteopathic Physicians:

- Be of good moral character.
- Graduated from an osteopathic medical school located in the United States that is accredited by the American Osteopathic Association.
- Satisfactorily completed two (2) years of progressive postgraduate training, internship, and residency in a program approved by the American Osteopathic Association or the Accreditation Council for Graduate Medical Education.
- Satisfactorily passed an examination approved by the Board.
- Met such other requirements as set forth by regulation or as may be established by the Board.

Academic Faculty–Limited Medical Registration. Academic Faculty–Limited Medical Registration applicants MUST:

- Be recommended by the Medical School Dean.
- Be appointed to Senior Rank at the Medical School.
- Renew yearly and reapply every five (5) years.
- Practice ONLY in hospital and facilities affiliated with the Medical School.

Rules and Regulations. The rules and regulations governing the licensure and discipline of physicians can be obtained at the following web site: http://sos.ri.gov/documents/archives/regdocs/released/pdf/DOH/8700.pdf

Rhode Island General Laws pertaining to the Practice of Medicine can be obtained at the following web sites:

  - Medical Licensure: [http://www.rilin.state.ri.us/statutes/title5/5-37/index.htm](http://www.rilin.state.ri.us/statutes/title5/5-37/index.htm)
  - Controlled Substance Act: [http://www.rilin.state.ri.us/statutes/title21/21-28/index.htm](http://www.rilin.state.ri.us/statutes/title21/21-28/index.htm)

Application Process Overview. The licensure process in the State of Rhode Island is conducted jointly by the Rhode Island Board of Medical Licensure and Discipline (Board) and the Federation of State Medicine Boards (FSMB). The FSMB provides the Federation Credentials Verification Service (FCVS) and the Uniform Application for Physician State Licensure (UA).

All licensure applicants must complete and submit both the FCVS application and the Uniform Application. In addition, required fees must be paid, and state addendum forms and additional information such as the National Practitioner Data Bank (NPDB) Report must sent to the Board. The Board will use all of this information to assess your qualifications for licensure.

The application process is not considered complete until your Board application (UA), applicable forms, FCVS Physician Information Profile, and NPDB Report are received in a manner satisfactory to the Board. Neither the Board nor the FSMB (FCVS and UA) will accelerate processing of one application at the expense of others for any reason.

Complete all application materials as instructed and arrange them in order as they appear in the application checklist at the end of the instructions. Do not submit an application without all applicable information, documentation and fee. You must respond to all components of the application as instructed. Mail these components of the application to:

Rhode Island Department of Health
Board of Medical Licensure & Discipline
Room 205, Three Capitol Hill
Providence, RI 02908-5097

Please allow a minimum of 8 weeks for the entire licensure process to be completed. If you have malpractice or disciplinary history, it can take an additional 2 or 3 months for all pertinent documentation to be received. Applications are reviewed once a file is complete. Be advised that you may be required to appear for an interview.
After your application is reviewed, you will be contacted in writing. Please allow 2-4 weeks for your wallet size license card and wall certificate to be mailed to you. [Note: You may not practice medicine in Rhode Island until you have received a license number.]

Please continue to review the remaining portions of this application packet for instructions and other materials necessary to complete the Board application. If you have any questions about this process or would like to check on the status of your Board application, please contact us directly at (401) 222-3855.

INSTRUCTIONS FOR COMPLETING THE BOARD APPLICATION

Read the following instructions and those throughout the online application carefully before completing the Board application. Failure to submit all required information and appropriate documentation may result in processing delays. All of the information provided is subject to change.

General Instructions.

1. Type your information or print in blue or black ball-point pen. Board staff will not make assumptions about illegible information. Be sure to print your name in the box provided on the cover page.

2. Provide a response to each section or questions; otherwise, mark “N/A” for Not Applicable.

3. We suggest that you make a copy of your completed application and addenda before submitting it to the Board.

4. It is your responsibility to check on the status of your application.

Completing Your Board Application.

1. **Fees.** Make a check or money order (in U.S. funds only) for the application fee of $1,090.00 (or $1,290.00 if you applying for your Controlled Substance Registration (CSR), payable to “Rhode Island General Treasurer” and staple it to the upper left-hand corner of the first (Top) page of the Application Instructions. These application fees are NON-REFUNDABLE. If you are applying for your CSR, you MUST submit the Board application at the SAME TIME as the CSR application.

   NOTE: These are Board Application Fees. A separate one-time service fee of $50 is charged upon completion of the Uniform Application. Fees for FCVS are located at [http://www.fsmb.org/licensure/fcvs/](http://www.fsmb.org/licensure/fcvs/).

2. **FCVS Application Process.** FCVS uses primary sources to verify core physician credentials as part of the credentialing process and in accordance with established policies and procedures set forth by the Board. FCVS verifies documents for identity, medical education, training, and more. Once your credentials have been verified, they go into a personalized physician profile that can be sent to other entities as needed, saving the time of having each item verified again in the future. After an accuracy review, FCVS will send your non-interpretive Physician Information Profile containing certified photocopies of your credentials to the Board.

   Because the verification process is the most time consuming task, we recommend that you submit your FCVS application as soon as possible. You will deal directly with FCVS for all aspects of this verification. **Do not contact the Board about your FCVS application.** Use the messaging tool within FCVS to contact FCVS.

   For applicants who have an active and unrestricted license in another state, the Board may elect to consider granting licensure pending receipt of FCVS, provided the applicant has submitted documentation of payment to FCVS and a written statement confirming completion of the FCVS application.

   First time FCVS users will need to complete an Initial FCVS Application. If you have already established a profile with FCVS, you will need to complete a Subsequent FCVS Application to update your profile. All applicants must designate the RI board to receive your profile as part of the FCVS application process.
To work on your FCVS application, visit [http://www.fsmb.org/](http://www.fsmb.org/) and select FCVS in the Licensure menu, then sign in as directed. For assistance with FCVS, use the messaging tool within FCVS or call 888-275-3287 with your FCVS ID number between 8am and 5pm CT Monday through Friday.

3. **Uniform Application Process.** The Board was one of the first boards to incorporate the Uniform Application (UA) into its Medical Licensing Application. Much like FCVS, after completing the UA for the first time, you can submit your information to another UA accepting or requiring board, making updates to the UA as needed and completing all board specific requirements for each board applied to.

When completing your UA, you will be asked to account for all time since medical school graduation and provide all information on malpractice claims. We recommend having this information on hand before you begin.

To work on your Uniform Application, visit [http://www.fsmb.org/](http://www.fsmb.org/) and select Uniform Application (UA) in the Licensure menu, then sign in as directed. If you receive an error while working in the UA, email your username, password, and a screenshot of the error or the description to [ua@fsmb.org](mailto:ua@fsmb.org).

In addition to the guidance on each screen, please make special note of the following:

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

- MD and DO license information in the UA cannot be changed, as that information is provided directly from the state boards. If you see incorrect or missing medical license information in your UA, email [ua@fsmb.org](mailto:ua@fsmb.org) with your username or nine-digit Federation ID (FID) plus the correct information. Do not select “Other” to add information unless it is for a non-medical professional license.

- List ALL professional licenses you have held (Medical, Osteopathic, EMT, PA, nurse, etc.) in the United States and/or Canada, whether active or inactive.

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

- On the Malpractice page, report all medical malpractice court judgments, medical malpractice arbitration awards, and settlements, within the past ten (10) years, in which payment was made to a complaining party.

  **Special Notice about Malpractice Information:** Pursuant to R.I.G.L.§ 5-37-9.2, the Rhode Island Board of Medical Licensure and Discipline must collect data regarding your malpractice history. You are required to report to the Board all actual settlement or jury verdict amounts in the past ten (10) years. The Board will not make actual settlement or verdict amount available to the public. I must report the fact that a payment was made and how it compared to other payments made in your specialty. For each incident you report, you must include documentation that verifies the date, place, reason and disposition of the matter.


- On the UA Affidavit and Authorization for Release of Information, attach a recent (less than 6 months old) two inch by two inch (2” x 2”) passport quality, color photograph of yourself (head and shoulders only) in the space provided. Proof photos, negatives, and digital photos are not acceptable. This Affidavit/Authorization form must be notarized and returned to the Rhode Island Board. Do not send the UA Affidavit to FSMB.

- The addenda in the State Addendum section are located in this document after these instructions for your convenience. Each addendum should be completed as instructed. Please type or print all responses. Use the checklist at the end of these instructions to ensure you complete all addenda.
Please review your information before submitting your online UA. We recommend that you print a copy for your records and keep a copy of all forms and documentation sent to the Board.

To update information in your UA, reselect the state board in the State Board area. Make changes as needed and then resubmit your UA.

4. **National Practitioner Data Bank Self-Query Report.** Submit a “self-query” of the National Practitioner Data Bank (NPDB) by going to [https://www.npdb.hrsa.gov/ext/selfquery/SQHome.jsp](https://www.npdb.hrsa.gov/ext/selfquery/SQHome.jsp) and following the instructions provided. When you receive your Self-Query, mail the ORIGINAL, UNOPENED response to the Board. The Board must have this response in order to complete your application so you are encouraged to make this request as soon as possible. For questions or assistance, call 800-767-6732 or email help@npdb.hrsa.gov.

Again, the application process is not considered complete until your Board application (UA), applicable forms, FCVS Physician Information Profile, and NPDB Report are received in a manner satisfactory to the Board. Neither the Board nor the FSMB (FCVS and UA) will accelerate processing of one application at the expense of others for any reason.

**Complete all application materials as instructed and arrange them in order as they appear in the application checklist at the end of the instructions.** Do not submit an application without all applicable information, documentation and fee. You must respond to all components of the application as instructed. Mail these components of the application to:

| Rhode Island Department of Health  
| Board of Medical Licensure & Discipline  
| Room 205, Three Capitol Hill  
| Providence, RI 02908-5097 |
APPLICATION CHECKLIST

Please review the following checklist to ensure you have satisfied all components of the application process. Some items may not apply.

☐ I have carefully read RIGL 5-37 and R5-37-MD/DO available at:

http://www.rilin.state.ri.us/statutes/title5/5-37/index.htm

☐ I have completed the FCVS application and submitted all required forms, documents, and fees directly to FCVS.

☐ I have a check or money order made payable (in U.S. funds only) to the “Rhode Island General Treasurer” in the amount of $1,090.00 (or $1,290.00 with CSR Application) and have attached it to the upper left-hand corner of the first (Cover/Top) page of the application instructions.

☐ I have read and understand the “Instructions for Completing the Board Application.”

☐ I have read and understand the “Special Notice about Malpractice Information.” (Instructions Page 4, Malpractice Liability Claims Information section)

☐ I have completed the Online Rhode Island Board Application (UA) as instructed in each section and submitted it to the Board.

☐ I have completed the UA Affidavit and Authorization for Release of Information Form (located between Instructions and Addendum). I have attached a color photograph of myself and the form has been notarized by a notary public.

☐ I have completed and mailed Addendum 1 (Reciprocity Release Form) with any applicable fees as instructed.

☐ I have completed Addendum 2 (Additional Physician Information) as instructed.

☐ I have attached a copy(ies) of my ABMS Certificate(s).

☐ I have attached complete details of all “Yes” responses to Question #8.

☐ I have completed Addendum 3 (Mandatory Addendum to Licensure Application, Verification of SSN) as instructed.

☐ I have completed Addendum 4 (Rhode Island Uniform Controlled Substances Act Registration (CSR)) as instructed.

☐ I have completed Addendum 5 (Voluntary Race/Ethnicity Questions) as instructed. (This information is voluntary and will NOT affect your application in any way.)

☐ I have completed Addendum 6 (Academic Faculty – Limited Medical Registration Applicants Only) as instructed.

☐ I have arranged my Board Application materials in the following order:

1. Fee (Attached as instructed)
2. Completed Top/Cover of Application Instructions
3. Notarized Affidavit and Authorization for Release of Information Form (online Uniform Application)
4. Completed Addendum 2 (Additional Physician Information), followed by a copy(ies) of the ABMS Certificate(s), followed by details of any “Yes” response to Question #8.
5. Completed Addendum 3 (Mandatory Addendum to Licensure Application, Verification of SSN)
6. Completed Addendum 4 (CSR Registration)
7. Completed Addendum 5 (Voluntary Race/Ethnicity Questions)
8. Completed Addendum 6 (Academic Faculty – Limited Medical Registration Applicants Only) if applicable.
Rhode Island Board of Medical Licensure and Discipline
Room 205
3 Capitol Hill
Providence, RI 02908-5097

ADDENDUM INSTRUCTIONS

Complete the addenda as instructed below. Return the completed addenda to the Board at the address above.

- **Addendum 1: Reciprocity Release Form.** Obtain licensure verification from all states where you hold or have ever held a license to practice medicine. Complete the top portion of the Reciprocity Release Form and then mail to each licensing authority in which you are/were licensed. If you are licensed in Canada, send a copy to each province in which you are/were licensed. This form may be duplicated as necessary. This form will be completed in lieu of the Uniform Application Licensure Verification Form (Online Uniform Application, Affidavit and Forms Section).

  Also refer to the Licensure Verification Information resource at [http://www.fsmb.org/licensure/uniform-application/](http://www.fsmb.org/licensure/uniform-application/) to determine if fees need to be sent to the verifying board with Addendum 1. You may use VeriDoc ([https://www.veridoc.org/](https://www.veridoc.org/)) or a board’s preferred electronic verification method in lieu of Addendum 1.

- **Addendum 2: Additional Physician Information.** You must complete each question as instructed. Include all requested information and documentation. Please either type or print your responses. If not applicable, please respond with N/A. If you need additional space please attach a separate sheet.

- **Addendum 3: Verification of Social Security Number.** This form is mandatory. You must complete this form as instructed.

- **Addendum 4: Rhode Island Uniform Controlled Substances Act Registration (CSR).** In order to dispense, prescribe, store, or order controlled substances, you must obtain a Rhode Island Controlled Substance Registration (CSR) and a Drug Enforcement Administration (DEA) Registration. If applying for a CSR you must complete this Registration form and submit it along with your license application. If you are NOT applying for a CSR, please write N/A across the form. After you obtain your Rhode Island CSR, you can apply for a federal DEA Number by using the forms at [http://www.deadiversion.usdoj.gov/drugreg/reg_apps/](http://www.deadiversion.usdoj.gov/drugreg/reg_apps/). For federal DEA registration help, email DEA.Registration.Help@usdoj.gov.

- **Addendum 5: Voluntary Race/Ethnicity Questions.** The completion of this form is voluntary and will NOT affect your Application in any way.

- **Addendum 6: Academic Faculty – Limited Medical Registration.** This form only needs to be completed if the applicant is applying for Academic Faculty – Limited Medical Registration. Complete the top portion of this form and forward to the Dean of the Medical School. Letters or other forms submitted in lieu of this form will not be accepted. The board must receive this form(s) and attachments directly from the Medical School.
Rhode Island Board of Medical Licensure and Discipline
Room 205, 3 Capitol Hill
Providence, RI 02908-5097
(401) 222-3855

ADDENDUM 1
Reciprocity Release Form

Substitute forms are not acceptable. This form may be duplicated as needed.

<table>
<thead>
<tr>
<th>THIS SECTION TO BE COMPLETED BY THE APPLICANT</th>
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<tbody>
<tr>
<td>I am applying for a license to practice medicine in the State of Rhode Island. The Rhode Island Board of Medical Licensure and Discipline requires that the following form be completed by the jurisdiction in which I am now or was previously licensed. This constitutes your authority to release all information in your files, favorable or otherwise, directly to the Rhode Island Board of Medical Licensure and Discipline at the above address.</td>
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<tr>
<th>Print/Type Full Name</th>
<th>Signature</th>
<th>Date</th>
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<tr>
<th>Previous Names Used</th>
<th>Social Security Number</th>
<th>Date of Birth</th>
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<th>License Number</th>
<th>Date Issued</th>
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<tr>
<th>THIS SECTION TO BE COMPLETED BY THE MEDICAL BOARD</th>
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<tr>
<td><strong>Basis for issuing license:</strong></td>
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<tr>
<td>□ NBME □ NBOME □ USMLE □ LMCC □ FLEX ______ State Sponsor □ State Exam ______(State)</td>
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<tr>
<td>If a combination of exams were taken, please list the specific combination: _________________</td>
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<tr>
<th>License Status: □ Active □ Inactive □ Lapsed</th>
<th>Original Date Issued:</th>
<th>Expiration Date:</th>
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<th>Questions:</th>
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<td>1. Has this physician ever been investigated by your Board?</td>
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<td>2. Has this physician incurred any disciplinary proceedings in your state, or is any action pending?</td>
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<tr>
<td>3. Has the applicant’s license ever been denied, surrendered, reprimanded, suspended, revoked or placed on probation?</td>
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<tr>
<td>4. Are you aware of any information about this physician submitted to the National Practitioner Data Bank?</td>
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<tr>
<td>5. Do you know of any information that may discredit this person?</td>
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If you answer “Yes” to any of the above questions, please provide a written explanation below, and attach a copy of all supporting documentation (e.g. Board order, complaint, etc.). Use a separate sheet if necessary.

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<th>Certification:</th>
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<td>Signature</td>
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<td>Date</td>
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<tr>
<td>Type or Print Name</td>
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<tr>
<td>Full Name and of Licensing Board including State</td>
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</table>

Please return directly to the Board at the above address. Thank you for your prompt cooperation.
1. **Specialty of Practice**: Refer to the ABMS Certification Codes List (pages 4 and 5 of this addendum) when completing this section. You must provide a copy of your ABMS certificate(s). You may report “None”, “Other”, or “Unknown” if necessary.

<table>
<thead>
<tr>
<th>Primary Specialty Code</th>
<th>Board Certified? Yes</th>
<th>No</th>
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<td>If Yes, Year Certified/Recertified: ______________________</td>
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<th>Secondary Specialty Code</th>
<th>Board Certified? Yes</th>
<th>No</th>
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<tr>
<td></td>
<td>If Yes, Year Certified/Recertified: ______________________</td>
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2. **Practice Information**: Specify where in this State do you intend to practice, and list type of practice using the codes below. (If additional space is needed, attach a separate sheet)

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<th>Location #1: __________________________</th>
<th>City: __________________________</th>
<th>Practice Type (See Code): ______</th>
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<tr>
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<td>City: __________________________</td>
<td>Practice Type (See Code): ______</td>
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<td>City: __________________________</td>
<td>Practice Type (See Code): ______</td>
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Identify any translational services that may be available at your primary practice location: ______________________

3. **Medical School Faculty Appointments**: Identify any appointments to medical school faculties and indicate as to whether you have had responsibility for graduate medical education within the most recent ten (10) years.

______________________________________________________________________________

______________________________________________________________________________

4. **Medical Licensure**: List all countries (other than the U.S. and Canada) in which you are now, or ever have been licensed to practice medicine, or any other profession.

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<th>Country</th>
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5. **Board Discipline**: List any disciplinary actions by licensing boards in other states. Please describe any prior or pending Board action or investigation. Please attach any relevant supplemental materials. If necessary, you may continue on a separate sheet.

- **Check here if not applicable**

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<th>Licensing Board (abbreviate) and Nature of Action</th>
<th>Month/Year</th>
<th>Type of Discipline</th>
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6. **Hospital Discipline**: Please explain any disciplinary actions and attach any relevant supplements materials. List any revocation of hospital privileges for reasons related to competence or quality of patient care that have been taken by the hospital’s governing body or any other official of the hospital after procedural due process has been afforded. Also, report resignation from or the non-renewal of medical staff privileges or the restriction of privileges at a hospital during the course or threat of investigation. If necessary, you may continue on a separate sheet.

- **Check here if not applicable**

(1) Name of Hospital

______/______/______  Type of Action

(2) Name of Hospital

______/______/______  Type of Action

(3) Name of Hospital

______/______/______  Type of Action

(4) Name of Hospital

______/______/______  Type of Action

7. **Criminal Convictions**: Respond to the questions below, then list any criminal convictions(s) in the space provided. If necessary, you may continue on a separate sheet.

Have you ever been convicted of a violation, plead Nolo Contendere, or entered a plea bargain to any federal, state or local statute, or ordinance, or are any formal charges pending; including use of illicit substances or operating a motor vehicle while intoxicated (Please include any offenses which have been expunged from your record)?  □ Yes  □ No

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<tr>
<th>Abbreviation of State and Conviction* (e.g.CA – Illegal possession of a controlled substance)</th>
<th>Month/Year</th>
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*For purposes of this section, a person shall be deemed to be convicted of a crime if he/she please guilty or if he/she was found or adjudged guilty by a court of competent jurisdiction or has been convicted of a felony by the entry of Nolo Contendere in any state.
8. **Questions**: Check either “Yes” or “No” for each question below. **Note: if you answer “Yes” to any question**, you are required to furnish complete details, including date, place, reason and disposition of the matter on a separate sheet.

   YES | NO

1. During any Professional/Medical Education, were you ever dismissed, suspended, restricted, put on probation, or otherwise acted against or did you take a leave of absence for medical reasons? ☐ ☐

2. During any Professional/Medical Education, were you ever requested to leave or did you leave, temporarily or permanently, prior to completion of training? ☐ ☐

3. During any Post Graduate Training, were you ever dismissed, suspended, restricted, put on probation, or otherwise acted against or did you take a leave of absence for medical reasons? ☐ ☐

4. During any post graduate training, were you ever requested to leave or did you leave temporarily or permanently, prior to completion of training? (excluding maternity leave) ☐ ☐

5. Are there any charges or investigations pending, in any state, against you? ☐ ☐

6. Have your staff privileges at any hospital, nursing home, or other health care facility or health care provider or HMO ever been reduced, revoked, or suspended or have you voluntarily surrendered your clinical privileges from any such unit or facility while under investigation in any state? ☐ ☐

7. Have you ever had any disciplinary action(s) taken, or is any pending, against your License to practice medicine, DEA permit, State Controlled Substances Registration, Medicare Privileges, Medicaid Privileges, or are any complaints pending in any state? ☐ ☐

8. Have you ever had a membership in a professional society revoked, suspended, or limited in any manner or have you voluntarily withdrawn while under investigation? ☐ ☐

9. Have you ever failed to pass an examination for medical licensure (including National Boards, FLEX, USMLE)? If you have failed to pass any segment of the USMLE within three (3) attempts you do not meet the requirements for licensure. Please contact us at (401) 222-3855 to discuss. ☐ ☐

   9. **Physician Honors and Peer-Reviewed Publications (Optional)**: List any information regarding professional or community service awards and/or information regarding publication in peer-reviewed medical literature within the last ten (10) years. Do not submit your curriculum vitae to satisfy the requirements of this section. If necessary, you may continue on a separate sheet.

   **Awards, Honors:**

   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

   **Publications:**

   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

10. **Professional and Community Memberships (Optional)**: List any professional and community memberships. Do not submit your curriculum vitae to satisfy the requirements of this section. If necessary, you may continue on a separate sheet.

   ________________________________________________________________
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   ________________________________________________________________

**ABMS Codes and Abbreviations**
### Certification Codes

<table>
<thead>
<tr>
<th>American Board of</th>
<th>General Certificate</th>
<th>Subspecialty Certificates</th>
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<tr>
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<td>PathR</td>
<td>Pathology Recertification</td>
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### ABMS Codes and Abbreviations

- **Blood Banking**: BB
- **Blood Banking/Transfusion Medicine**: BBTM
- **Chemical Pathology**: ChemP
- **Clinical Pathology**: ClinP
- **Cytopathology**: CytoP
- **Dermatopathology**: DP
- **Forensic Pathology**: FPath
- **Hematology**: Hem
- **Immunopathology**: IP
- **Molecular Genetic Pathology**: MGP
- **Medical Microbiology**: MMB
- **Medical Oncology**: MedOnc
- **Medical Toxicology**: MedTox
- **Nuclear Cardiology**: InCard
- **Pathology-Cardiovascular**: PathCard
- **Pathology-Clinical**: PathClin
- **Pathology-Forensics**: PathForensics
- **Pediatric Pathology**: PediatricPath
- **Pathology-Pediatric**: PathPediatric
- **Pathology: Medical Microbiology**: PathMedMicrobiology
- **Pathology: Radiological**: PathRadiological
- **Pathology: Sleep Medicine**: PathSleep
- **Pathology: Transplant Hepatology**: PathTransplantHepatology
- **Sleep Medicine**: SleepMed
- **Sports Medicine**: SportsMed
- **Surgery of the Hand**: SurgHand
- **Transplant Hepatology**: TransplantHepatology

---

**Applicant Name:**
**Date:**

---

Rhode Island Board of Medical Licensure and Discipline

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Addendum 2, Page 4 of 5
## Certification Codes (continued)

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Copyright © 2011 Elsevier Inc. and the American Board of Medical Specialties. All Rights Reserved.
All persons applying or renewing any license, registration, permit or other authority (herein after called “licensee”) to conduct a business or occupation in the state of Rhode Island are required to file all applicable tax returns and pay all taxes owed to the state prior to receiving a license as mandated by state law (RIGL 5-76) except as noted below.

In order to verify that the state is not owed taxes, licensees are required to provide their Social Security Number or Federal Tax Identification Number (for businesses) as appropriate. These numbers will be transmitted to the Division of Taxation to verify tax status prior to the issuance of a license.

Licensee Declaration

☐ I hereby declare, under penalty of perjury, that I have filed all required state tax returns and have paid all taxes owed.

☐ I have entered a written installment agreement to pay delinquent taxes that is satisfactory to the tax administrator.

☐ I am currently pursuing administrative review of taxes owed to the state.

☐ I am in federal bankruptcy. (Case # ____________________________)

☐ I am in state receivership. (Case # ____________________________)

☐ I have been discharged from bankruptcy. (Case # ____________________________)

Type of Professional License for which you are applying.

Full Name (Please Print or Type) ____________________________

Social Security Number ____________________________

Signature ____________________________________________

Phone Number (______) ________ - ________

Date ____________________________

This form must be completed, signed and attached to your license application for processing.
**Rhode Island Board of Medical Licensure and Discipline**  
Room 205, 3 Capitol Hill  
Providence, RI 02908-5097  
(401) 222-3855

**ADDENDUM 4**  
Rhode Island Uniform Controlled Substances Act Registration (CSR)

IF Applying for CSR, this Application MUST BE SUBMITTED ALONG WITH YOUR LICENSE APPLICATION. Substitute forms are not acceptable.

I am applying for a Rhode Island Uniform Controlled Substance Act Registration (CSR). I understand that this application MUST be submitted along with my Board Application, I also understand that there is an additional $200.00 fee for this Registration and that the check or money order for $1,290.00 (Non-Refundable Board Application fee ($1,090.00) PLUS CSR Application fee ($200.00) must be made out to the “RI General Treasurer.” Note: To be issued a RI Controlled Substance Registration you must have a Rhode Island Business Address.

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<th>Print/Type Full Name</th>
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<table>
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<tr>
<th>Signature</th>
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<th>Date</th>
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</table>

Complete this application for registration to prescribe controlled substances in the State of Rhode Island.

A CSR is not required if there will be no controlled substances prescriptions prescribed in this state.

The CSR is renewed at the same time that the professional license is renewed.

Note: Read important information on the bottom of this application.

<table>
<thead>
<tr>
<th>The Rhode Island Uniform Controlled Substances Act can be accessed at the following web site:  <a href="http://www.rilin.state.ri.us/Statutes/Title21/21-28/index.htm">http://www.rilin.state.ri.us/Statutes/Title21/21-28/index.htm</a></th>
</tr>
</thead>
</table>

**Drug Schedule (Check all that apply)**

- Schedule II
- Schedule III
- Schedule IV
- Schedule V

A Copy of the DEA Registration must be provided to the Medical Board within 60 Days of its issuance by the DEA. The DEA Registration must be issued to your Rhode Island Practice Address in order for it to be valid. If you are relocating from another state, you need to apply for a DEA Registration that is specific to Rhode Island. See the bottom of this form for information on how to contact the DEA.*

All Applicants MUST answer the following:

**A.** Has the applicant been convicted of, or entered a plea of nolo contendere to a violation of any state or federal law relating to manufacturing, distributing, possessing, prescribing, administering or dispensing of drugs presently defined as controlled substances under Chapter 21-28, General Laws of Rhode Island?  Yes  No

**B.** Has the registration application or registration of the applicant, corporation, firm, partner, or officer of the applicant been surrendered, revoked, suspended or denied under any law of the United State or of any state relating to drugs presently defined as controlled substances under Chapter 21-28, General Laws of Rhode Island, or is such action pending?  Yes  No

**If you answered “Yes” to question “A” or “B” attach an explanation to this form.**

**Important Information**

Issuance of a Rhode Island Controlled Substances Registration is contingent upon registration by the U.S. Drug Enforcement Administration. If denied a “DEA Registration”, the Rhode Island Controlled Substances Registration becomes “VOID.” Licensed drug facilities and licensed practitioners with prescriptive privileges cannot dispense, possess, store or ship controlled substances in or into the State of Rhode Island without a valid drug facility or professional license. Rhode Island Controlled Substances Registration (CSR), and a federal Drug Enforcement Administration (DEA) Registration. Practitioners may only prescribe, dispense, possess, and store controlled substances within their particular “scope of practice.” “Controlled Substances” for purposes of this application, means a prescription drug in Schedules II through V, pursuant to the Rhode Island Uniform Controlled Substance Act, and 21 CFR 1300 of the Federal Code of Regulations. Schedule I drugs are used by researchers, and require the submission of a protocol.

Without a Rhode Island CSR and federal DEA Registration, licensed drug facilities, and practitioners with prescriptive privileges, may dispense or possess non-controlled prescription medications under its facility or professional license. A CSR will not be granted to an applicant whose BOARD licensure application is “pending” in this state.

A Rhode Island CSR must be obtained prior to applying for DEA Registration. Federal regulations require that applicants comply with individual state requirements prior to issuance of a DEA Registration. Once the CSR is issued, applicants must apply to the U.S. Drug Enforcement Administration for a federal registration using that agency’s DEA Form 224 (New Application for Retail Pharmacy, Hospitals/Clinics, Practitioner, Teaching Institution, or Mid-Level Practitioner). Applicants may apply on-line for the DEA Registration at the following website: www.deadiversion.usdoj.gov/drugreg/reg_apps/index.html

*You can also receive an application, or check the status of a pending DEA Registration by contacting the Drug Enforcement Administration at the following location: Registration Unit, US Drug Enforcement Administration, JFK Federal Bldg., 15 new Sudbury Street, Boston, MA 02203-0131, Telephone (888) 272-5174.

NOTE:
- Schedules II, III, and IV of section 21-28-2.08 will become void unless dispensed within thirty (30) days of the original date of the prescription.
- Prescriptions in schedules III, IV, and V cannot be written for more than one hundred (100) dosage units and not more than one hundred(100) dosage units may be dispensed at one time. For purposes of this section, a dosage unit shall be defined as a single capsule, tablet, or suppository, or not more that one (1) teaspoon of an oral liquid.
- Prescriptions in schedule II may be written for up to a 30-day supply, with a maximum of two hundred and fifty (250) dosage units, as determined by the prescriber’s directions for use of the medication.

Applicant Name: ___________________________  Date: ______________________

Rhode Island Board of Medical Licensure and Discipline  
Addendum 4, Page 1 of 1
Rhode Island Board of Medical Licensure and Discipline
Room 205, 3 Capitol Hill
Providence, RI 02908-5097
(401) 222-3855

ADDENDUM 5
Voluntary Race/Ethnicity Questions

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

Note: This information is voluntary and refusal to provide it will not impact on the renewal of your license. It will be confidential and used only in accordance with Title VI of the Civil Rights Act of 1964.

1. **Ethnicity**: Are you Hispanic or Latino? *(Mark “No” if not Hispanic or Latino)*
   - □ No, not Hispanic or Latino
   - □ Yes, Hispanic or Latino

2. **Race**: What is your race? (Mark one or more)
   - □ American Indian or Alaska Native
   - □ Black or African American
   - □ White
   - □ Asian
   - □ Native Hawaiian or other Pacific Islander

For purposes of the above questions kindly use the “Federal Minimum Data Collection” explanations listed below:

1. **Ethnic Categories**:
   - **Hispanic or Latino** – A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term, “Spanish Origin” can be used in addition to “Hispanic or Latino.”
   - **Not Hispanic or Latino** – A person who is not Hispanic or Latino.

2. **Racial Categories**:
   - **American Indian or Alaska Native** – A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
   - **Asian** – A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
   - **Black or African American** – A person having origins in any of the Black racial groups of Africa. Terms such as “Haitian” or “Negro” can be used in addition to “Black or African American.”
   - **Native Hawaiian or other Pacific Islander** – A person having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands.
   - **White** – A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

* This information is being collected in accordance with the Department of Health’s policy for Maintaining, Collecting and Presenting Data on Race and Ethnicity. The mission of the Department is to protect and promote the health of the population and to prevent disease through life-style change, environmental change, and health services delivery. A copy of this policy is available upon request.
ADDENDUM 6
Academic Faculty – Limited Medical Registration Applicants ONLY

Substitute forms are not acceptable. This form may be duplicated as needed.

I am applying for an Academic Faculty – Limited Medical Registration in the State of Rhode Island. The Rhode Island Board of Medical Licensure and Discipline requires these questions be answered as part of my application process. This constitutes your authority to provide information about my character and professional abilities, favorable or otherwise, directly to the Rhode Island Board of Medical Licensure and Discipline at the above address.

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<tr>
<th>Print/Type Full Name</th>
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<td>Previous Names Used</td>
<td>Social Security Number</td>
<td>Date of Birth</td>
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THESE QUESTIONS ARE TO BE ANSWERED BY THE DEAN OF THE MEDICAL SCHOOL.

Please Note: Information must be typed or printed clearly and submitted under separate cover.

Please provide information pertaining to the following:

1. Describe this candidate’s exceptional qualifications that warrant consideration for licensure as an Academic Faculty – Limited Medical Registration.

2. Describe fully the candidate’s primary clinical and non-clinical activities.

3. Please state the anticipated faculty rank of the candidate.

4. Please describe the Formal Search/Recruitment efforts that led to the selection of this candidate including the number of candidates interviewed and duration of search.

5. Please describe system academic supervision of candidate’s clinical practice.

PLEASE SEND THIS COMPLETED FORM TO
THE RHODE ISLAND BOARD OF MEDICAL LICENSURE AND DISCIPLINE
AT THE ADDRESS ABOVE. THANK YOU.
Affidavit and Authorization for Release of Information

Mail this completed notarized form to:
Rhode Island Board of Medical Licensure and Discipline
Room 205, 3 Capitol Hill; Providence, RI 02908-5097

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.

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 application are subscribed and sworn to before me by the applicant on this _______ day of ________________, 20____.

Notary Public Signature: ____________________________________________ (NOTARY PUBLIC SEAL)

My Notary Commission Expires: _______________________________________

Applicant Photograph

Securely tape or glue a recent (less than 6 month old) front-view 2” x 2” passport-type color photo of yourself in this square.

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

Applicant’s printed last name

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

Date of signature (must correspond to date of notarization)
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/ 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 to ensure you list the correct name and address. Mail this completed form and any required fee to the verifying board.

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

Section 1: Applicant Information

First name ____________________ Last name ____________________ Practitioner Type □ MD □ DO □ ___
Middle name ____________________ Suffix ___ SSN* ____________ Birth date (mm/dd/yyyy) ____________
*The social security number is to be used for purposes of identification only and may not be used for any other reason.

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

Board name ____________________
Mailing address ____________________
City/State/Zip ____________________

Applicant signature ____________________ Date ________________

Section 2: Board Verification of Licensure

Name of issuing board or license entity ____________________
Name of licensee (last, first, middle, suffix) ____________________
License type __________ License number __________ Issue date __________ Expiration date __________

1. Is this license current? If not current, please explain: □ Yes □ No

2. Have formal disciplinary proceedings been initiated against this applicant’s license by a disciplinary authority in your state? If yes, please explain on a separate sheet of paper and attach it to this form.

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
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.
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 study (e.g., fellowship, intl. experience) From __________ to __________ Approved ☐ Unapproved ☐ 
☐ Other ___________________________ From __________ to __________ Approved ☐ Unapproved ☐
2. Do the official records for this individual reflect that he/she was ever placed on academic or disciplinary probation during his/her medical/osteopathic education? If yes, indicate below the reasons for each time of probation and the dates of placement on and removal from probation. Also attach documentation or information of each circumstance and outcome.

☐ 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:** __________________________

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

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

**Section 1 : To be completed by the Applicant.**

**Name:** ____________________________ **Suffix** ____________________________ **Practitioner type:** M.D. □ D.O. □

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

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

**Name if different when diploma awarded:** ____________________________

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

**Board Name:** ____________________________

**Mailing address:** ____________________________

** Applicant Signature** ____________________________ **Date** ____________

**Section 2 : Program Participation**

**Important:**

- Report Incomplete Training Levels (years) separate from those that were successfully completed.
- If the training level (year) is currently in progress report the expected completion date in the “To” field.
- Use one section per Department/Specialty. If the Department/Specialty is rotating or transitional, please provide a schedule of rotations.
- Report Internships, Residencies and Fellowships separately.

**Unusual Circumstances:**

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

**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** ____________________________ **Date** ____________

**Print name:** ____________________________

**Title:** ____________________________

**Email address:** ____________________________

**Phone Number:** ____________________________ **Date:** ____________

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**Affiliated School:** ____________________________
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/county ____________________________________________

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Completed? □ Yes. Attendance was from _______ to _______. Completion date was _______.
□ No. Withdrawal* date was _______.
□ No. Dismissal* date was _______.
*If the applicant withdrew or was dismissed, please explain below.

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

Signature ____________________________________________
Print name ____________________________________________

AFFIX INSTITUTIONAL SEAL HERE
(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.

Uniform Application for State Licensure

October 2017