

Pre-medical School

Facility: _____	Degree: _____	<u>From</u>	<u>To</u>
Street: _____	City: _____	___/___/___	___/___/___
			State: _____

Facility: _____	Degree: _____	___/___/___	___/___/___
Street: _____	City: _____		State: _____

Medical School

Facility: _____	Degree: _____	<u>From</u>	<u>To</u>
Street: _____	City: _____	___/___/___	___/___/___
			State: _____

Facility: _____	Degree: _____	___/___/___	___/___/___
Street: _____	City: _____		State: _____

Date of medical school graduation: _____/_____/_____

Month Day Year

Note: U.S. graduates must include a written explanation for the duration of medical education longer than four (4) years, and for any breaks in medical education. International graduates must provide a written explanation for the duration of medical education longer than six (6) years and any breaks in medical education.

Postgraduate Education:

List all postgraduate training in chronological order from medical school to the present. Include the name and address of the facility, your position, e.g. PGY 1, 2, fellow, etc. and dates of affiliation. You must account for all periods of training or postgraduate work from the time you graduated from medical school.

Facility: _____	Position: _____	<u>From</u>	<u>To</u>
Street: _____	City: _____	___/___/___	___/___/___
			State: _____

Facility: _____	Position: _____	___/___/___	___/___/___
Street: _____	City: _____		State: _____

Facility: _____	Position: _____	___/___/___	___/___/___
Street: _____	City: _____		State: _____

Facility: _____	Position: _____	___/___/___	___/___/___
Street: _____	City: _____		State: _____

Facility: _____	Position: _____	___/___/___	___/___/___
Street: _____	City: _____		State: _____

Examination History

Please contact the appropriate examination entity and have certified transcript of your scores sent directly to this Board. If you are using FCVS, your examination scores will be sent to the Board with your credentials packet.

List each licensure examination, U.S. or international, you have taken (USMLE, NBME, NBOME, LMCC, Etc.). If additional space is necessary, please enclose a separate sheet with your application and include all the information below. If you answer "yes" to question #5 on the Full Supplement, you must also complete the required information.

<u>Examination</u>	<u>Most Recent Date taken (Month/Year)</u>	<u>Passed (P) or Failed (F)</u>		<u>Number of attempts</u>
USMLE Step I	_____	<input type="checkbox"/> P	<input type="checkbox"/> F	_____
USMLE Step II	_____	<input type="checkbox"/> P	<input type="checkbox"/> F	_____
USMLE Step III	_____	<input type="checkbox"/> P	<input type="checkbox"/> F	_____
NBME Part I	_____	<input type="checkbox"/> P	<input type="checkbox"/> F	_____
NBME Part II	_____	<input type="checkbox"/> P	<input type="checkbox"/> F	_____
NBME Part III	_____	<input type="checkbox"/> P	<input type="checkbox"/> F	_____
FLEX Component 1	_____	<input type="checkbox"/> P	<input type="checkbox"/> F	_____
FLEX Component 2	_____	<input type="checkbox"/> P	<input type="checkbox"/> F	_____
FLEX Pre-1985	_____	<input type="checkbox"/> P	<input type="checkbox"/> F	_____
NBOME Part 1	_____	<input type="checkbox"/> P	<input type="checkbox"/> F	_____
NBOME Part II	_____	<input type="checkbox"/> P	<input type="checkbox"/> F	_____
NBOME Part III	_____	<input type="checkbox"/> P	<input type="checkbox"/> F	_____
COMLEX Level 1	_____	<input type="checkbox"/> P	<input type="checkbox"/> F	_____
COMLEX Level 2	_____	<input type="checkbox"/> P	<input type="checkbox"/> F	_____
COMLEX Level 3	_____	<input type="checkbox"/> P	<input type="checkbox"/> F	_____
COMVEX	_____	<input type="checkbox"/> P	<input type="checkbox"/> F	_____
LMCC – Single	_____	<input type="checkbox"/> P	<input type="checkbox"/> F	_____
LMCC – Part I	_____	<input type="checkbox"/> P	<input type="checkbox"/> F	_____
LMCC – Part II	_____	<input type="checkbox"/> P	<input type="checkbox"/> F	_____
State Board Exam	_____	<input type="checkbox"/> P	<input type="checkbox"/> F	_____
	(State of examination)			

Hospital Affiliations and Employment

List hospital appointments, in chronological order, where you had active staff privileges. Include the name and address of the facility, your position and dates of affiliation. Also include periods of unemployment or employment outside of medicine. Attach a separate sheet of paper if necessary.

		<u>From</u>	<u>To</u>
Facility: _____	Position: _____	___/___/___	___/___/___
Street: _____	City: _____	State: _____	
Facility: _____	Position: _____	___/___/___	___/___/___
Street: _____	City: _____	State: _____	
Facility: _____	Position: _____	___/___/___	___/___/___
Street: _____	City: _____	State: _____	
Facility: _____	Position: _____	___/___/___	___/___/___
Street: _____	City: _____	State: _____	

1. List other states (abbreviations) where you are currently or have ever had a full license: _____

2. a) Are you certified by the American Board of Medical Specialties? Yes No
 b) Are you certified by the American Board of Osteopathic Medicine? Yes No

3. List Board Certification(s): _____ Certification date: ___/___/___
 _____ Certification date: ___/___/___

4. List your practice specialt(ies) _____

5. Have you attached an up-to-date copy of your curriculum vitae? Yes No

6. Reason for requesting a Massachusetts medical license: _____

7. Name of Facility: _____
 Address: _____ City: _____

8. Anticipated starting date in Massachusetts: ___/___/___

Under the penalties of perjury, I declare that I have examined this full application and all its accompanying instructions, forms and statements, and to the best of my knowledge and belief, the information contained herein is true, correct and complete. As an applicant for a full license to practice medicine, I understand that a criminal record check may be conducted for conviction and pending criminal case information from the Criminal History Systems Board only and that it will not necessarily disqualify me from licensure.

Signature of Applicant

___/___/___
Month Day Year

NATIONAL PROVIDER IDENTIFIER (NPI)

The primary purpose of the NPI is to uniquely identify health care providers as “health care providers” in HIPAA standard transactions. The NPI will replace all other identifiers assigned to health care providers, such as those assigned by health plans, government programs and health care purchasers for purposes of conducting these business transactions. Under the final HIPAA NPI Rule, all individual and organization covered providers **were required to obtain an NPI by May 23, 2007.**

You must supply the Board of Registration in Medicine with your valid NPI. If you do not have an NPI number, you can apply for an NPI directly by using the NPPEs web site at www.NPPEs.cms.hhs.gov.

My current NPI is:

Penalties for Falsifying Information on the National Provider Identifier Application

18 U.S.C. 1001 authorizes criminal penalties against an individual who in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry. Individual offenders are subject to fines of up to \$250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to \$500,000. 18 U.S.C. 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.

Please sign and date to confirm that all of the information on this form is true and accurate.

Signature: _____ Date: ____/____/____