

Application #: _____

**Board of Registration in Medicine - 200 Harvard Mill Square, Suite 330
Wakefield, MA 01880 Telephone: (781) 876-8210 Fax: (781) 876-8383
Website: www.massmedboard.org**

INITIAL LIMITED LICENSE APPLICATION

IMPORTANT: Read the accompanying instructions before completing this form, and print legibly or type your answers. Please attach a \$100.00 check payable to the Commonwealth of Massachusetts.

CHECK ONE: Graduate of a Medical School in the United States, Canada, or Puerto Rico (USMG)
 Graduate of an International Medical School (IMG)

NOTE: GRADUATES OF INTERNATIONAL MEDICAL SCHOOLS MUST COMPLETE ADDITIONAL FORMS

SECTION A: Sworn Statement To Be Completed by Applicant

1-A. Name: (Last) _____ (First) _____ (MI) _____

1-B. Other Name(s): _____

	<u>YES</u>	<u>NO</u>
1) Have you ever been known under a different name or combination of names?	<input type="checkbox"/>	<input type="checkbox"/>
2) Have you ever been licensed under a different name?	<input type="checkbox"/>	<input type="checkbox"/>
3) Have you ever applied for licensure, or applied to sit for an examination, or taken an examination under a different name?	<input type="checkbox"/>	<input type="checkbox"/>

If you answer **yes**, you must provide additional information. (See instructions.)

2. Current Address: _____ Telephone Number: _____

City: _____ State: _____ Zip: _____

3. Date of Birth: ____/____/____ Place of Birth: _____
Month Day Year

E-mail Address _____

4. Sex: Male Female 5. Social Security Number: _____ - _____ - _____

6. Name of Massachusetts Training Program: _____

Street Address

(City)

PRINT NAME _____

7. Name of premedical school(s): _____
Location: _____
(City, State, Country)

8. Name of medical school(s): _____
Location: _____
(City, State, Country)

Date of Graduation: ____/____/____ Degree: M. D. D. O. Other (specify) _____
(Month) (Day) (Year)

(See Limited Instructions, (page 3), for completing Medical Education forms for fourth year medical school students.)

9. Have you had previous postgraduate training in the United States? No Yes
Name of Postgraduate Training Program _____
City: _____ State: _____
Training Dates: From: ____/____/____ To: ____/____/____ Specialty: _____

Name of Postgraduate Training Program _____
City: _____ State: _____
Training Dates: From: ____/____/____ To: ____/____/____ Specialty: _____
(If additional space is needed, please continue your answer on a separate sheet of paper.)

10. List states (abbreviations) where you *ever* had a license to practice medicine (include residency training licenses).
_____ (Full) _____ (Full) _____ (Full) _____ (Limited) _____ (Limited)

11. Please indicate **all** the licensing examinations that you have have completed with a passing score:
USMLE Step 1 Step 2 (CK) Step 2 (CS) Step 3
NBME Part 1 Part II Part III COMLEX Level 1 Level 2 LMCC

YES NO

12-A. If you are a USMG, have you taken more than 4 years to complete medical school?

12-B. If you are an IMG, have you taken more than 6 years to complete medical school?
If **yes**, you must provide additional information. (See instructions).

13. Has *more than one year* passed between the date of your graduation from medical school and the anticipated start date of your limited licensure in Massachusetts?

If **yes**, you must provide additional information with your curriculum vitae and include the months and dates of any gaps in your professional activities since graduation from medical school. (See instructions.)

SECTION B: TO BE COMPLETED AND SIGNED BY THE DESIGNATED OFFICIAL OF THE TEACHING PROGRAM AT WHICH THE APPLICANT HAS RECEIVED AN APPOINTMENT

This certifies that _____ has been appointed
(Name of Applicant)

to the position of Intern Resident Fellow

in the specialty of _____ as a PGY _____

Department: _____ Subspecialty: _____

at _____
(Name of Healthcare Facility)

beginning ____/____/____ to anticipated completion of training: ____/____/____.
(Month) (Day) (Year) (Month) (Day) (Year)

YES NO

1. Is the program accredited by the ACGME?
2. If **no**, is there an ACGME-approved training program in the applicant's specialty?
3. Have you reviewed Sections A and C of the limited license application?

Designated Official's Signature: _____

Type or Print Name: _____

Official Title: _____

Date: ____/____/____ Telephone Number: _____

SECTION C: PAGES 4-6 MUST BE COMPLETED BY APPLICANT

PRINT NAME: _____

SECTION C: Read the instructions. Check either YES or NO to each question. Do not answer N/A. If you answer YES to any of these questions, you must provide details on the Limited License Supplement. You must answer all questions or your application will be returned to you.

YES NO

14. Have you ever been enrolled in a postgraduate training program where you were required to repeat a year of training?

If you answered “yes” to question 14, you must provide an explanation and a letter from the program director is required.

15. Since your enrollment in college, have you been subject to any disciplinary action (see definition) at any academic institution?

- 16-A. Have you ever been terminated or granted a leave of absence, regardless of the reason, by a medical school or any postgraduate training program?

- 16-B. Have you ever voluntarily left, transferred or withdrawn from a medical school or any postgraduate training program?

- 16-C. Have you ever, for any reason, been placed on probation in medical school or any postgraduate training program?

If you answered “yes” to 16-A, B or C, you must provide an explanation and request a letter of explanation from your medical school or postgraduate training program.

17. Since your enrollment in college, have you been denied the privilege of taking or finishing an examination or have you been accused of cheating and/or improper conduct during an examination?

18. Have you ever, for any reason, been denied a medical license, whether full, limited or temporary, or have you withdrawn an application for medical licensure?

19. Have you ever voluntarily surrendered a license to practice medicine or any healing art?

PRINT NAME: _____

- | | <u>YES</u> | <u>NO</u> |
|---|--------------------------|--------------------------|
| 20. Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, health care facility, group practice or professional medical society or association (international, national, state or local)? (See definition). | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Has any disciplinary action ever been taken against you for violation of laws, rules, by-laws or standards of practice by any governmental authority, health care facility, group practice, or professional medical society or association (international, national, state or local)? (See definition). | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Have you ever been denied medical staff membership, or advancement in medical staff status, or has such denial been recommended by a standing medical staff committee or governing body? | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Have you ever, for any reason, withdrawn an application for hospital privileges or appointment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Have you ever voluntarily relinquished any medical staff membership, medical staff privileges or medical staff status? | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Has your medical staff membership, medical privileges or medical staff status at any hospital been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee or governing board? | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Have you ever been charged with any criminal offense, other than a minor traffic offense? | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted or surrendered, or have you ever been called before or warned by any state or other jurisdiction including a federal agency regarding such privileges? | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. In the past ten (10) years, has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim? | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. In the past ten (10) years, has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or has such a suit been settled, adjudicated or otherwise resolved? | <input type="checkbox"/> | <input type="checkbox"/> |

PRINT NAME: _____

CONFIDENTIAL MEDICAL INFORMATION

Before completing the following questions, refer to the instructions for definitions and additional information. If answering “yes” to any of the questions, you must provide details on the Limited License Supplement. For purposes of the following questions, “currently” does not mean on the day of, or even the weeks or months preceding the completion of this application. It means recently enough to have an impact on one’s functioning as a licensee, or within the past two years.

YES NO

- 30. Since becoming a medical student, have you been diagnosed with or treated for a medical condition which in any way currently limits or impairs your ability to practice medicine or function as a physician?
- 31. Do you currently have a medical condition which in any way limits or impairs your ability to practice medicine or to function as a physician?
- 32. Within the past two years, have you engaged in the use of chemical substances with the result that your ability to practice medicine is currently limited or impaired?
- 33. Have you ever refused to submit to a test to determine whether you had consumed and/or were under the influence of chemical substances?
- 34. Are you currently engaged in the illegal use of drugs or misuse of prescription drugs?
- 35. Within the past five years, have you voluntarily modified or otherwise limited your scope of practice of medicine for any reason other than a medical condition?

If your responses to Questions 15-35 change while your application is pending, you must notify the Board of the new information immediately. Please note that your license expires at the end of the academic year and must be renewed. A limited licensee may practice medicine only at the institution or its affiliates. With a limited license you are not allowed to “moonlight” under any circumstances.

CERTIFICATIONS:

- Pursuant to M.G.L. c. 62C, § 49A, I certify under the penalties of perjury that, to the best of my knowledge and belief, I have filed any Massachusetts state tax returns and paid any Massachusetts state taxes that are required under law and that I have complied with all laws of the Commonwealth related to withholding and remitting child support. (Note: This applies even if you reside out of the state or out of the country.)
- Pursuant to G.L. c. 112, § 1A, I will fulfill my obligation to report abuse or neglect of children as required by G.L. c. 119, §51A.
- I will read the Board’s regulations, 243 C.M.R. 1.00 through 3.00. To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.
- Under the penalties of perjury, I declare that I have examined this limited license 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 limited 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.

Applicant’s Signature: _____ **Date:** ____/____/____