All documents must be sent directly to your BMC training program's office, NOT to the Mass Board of Registration in Medicine. Anything sent directly to the Board will need to be duplicated and sent to BMC.

US Medical School Graduate Checklist

1. Name Printed on Top of EACH PAGE
2. Every Question is answered (n/a is unacceptable)
3. Signed & Dated Page 6 of application
4. Signed & Dated Authorization for Release
5. Provided explanation if you attended medical school for more than 4 years
6. Attached an up-to-date CV in Month/Year format
    a. All 30 day+ gaps will require a separate letter of explanation
7. Completed Medical Education Verification Form, include Medical School transcripts
8. Request Exam Score Transcripts (USMLE, COMPLEX, LMCC)
9. Only If Applicable:
    a. Supplemental Form
        i. Submit if you answered YES to any questions from 16 through 35
    b. Letter from the director of your most recent training program if you did not complete the program
    c. Evaluation Form; Completed by your most recent Program Director
    d. License Verification Form; submit one form for each state you have held a Full Medical License in
    e. Medical Education Verification Form B; Applicable only to those who will graduate Medical School after submission of this application
    f. Change of Name Form; Submit if you have ever changed your name

FAQs

1) How do I request my "Exam Score Transcripts"?
    a. USMLE: https://s1.fsmb.org/trol/ Have transcripts sent your program office to include with your application
    b. COMLPEX: http://www.nbome.org/
    c. MCCQE: www.mcc.ca

DON'TS

- ✓ **Do not** print this application double sided, single sided only
- ✓ **Do not** include the $100.00 fee with your application; BMC covers the cost of limited licenses for all unionized housestaff
- ✓ **Do not** submit any of these pages as pdf scans with electronic signatures; the Mass Board will not accept, it must be original documents with original handwritten signatures

Application #: ______________________
For Board Use Only

Commonwealth of Massachusetts
Board of Registration in Medicine
200 Harvard Mill Square, Suite 330, Wakefield, MA 01880
Telephone: (781) 876-8210 Fax: (781) 876-8383
www.mass.gov/massmedboard

INITIAL LIMITED LICENSE APPLICATION

IMPORTANT:

- **Read the accompanying instructions.**
- **Print legibly or type your answers.**
- **Enclose a $100.00 check or money order payable to the Commonwealth of Massachusetts. This fee is non-refundable.**

Full Disclosure: Please review each question carefully to ensure your answers are accurate prior to submitting your application. You are personally responsible for all information disclosed on your application, including any responses that may have been completed on your behalf by others. It is imperative that you honestly and fully answer all questions, regardless of whether you believe the information requested is relevant. Your responses on your application are evaluated as evidence of your candor and honesty. An honest "yes" answer to a question on your application is not definitive as to the Board's assessment of your present moral character and fitness to practice, but a dishonest "no" answer may be evidence of a lack of candor and honesty, which may be definitive on the character and fitness to practice issue. **Please be advised that a false response to any of these questions may be grounds for denial of licensure and reported to the appropriate data banks.**

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

Are you submitting primary source documents (medical education, previous postgraduate training, etc.) for licensure through the Federation Credentials Verification Service (FCVS)? ☐ Yes ☐ No

SECTION A: Sworn Statement to be completed by applicant

1-A. ____
(Entire Last Name) (First Name) (Middle Name) (Suffix)

1-B. Other Name(s) Used: List any other name(s) you have used which may appear on your identifying documents, such as medical education and examination records. If not applicable, check here: ☐

____
(Entire Last Name) (First Name) (Middle Name) (Suffix)

2. Current Street Address: ____

City: ______________________ State or Province: ____________________ Zip: __________

Country: ____________________________ Telephone Number: ______________________

3. Date of Birth: _____/_____/____ Place of Birth: ____________________________________
Month Day Year State (or country if not United States)

PRINT NAME ____

E-mail Address ______________________________

4. Sex: ☐ Male ☐ Female

5. U.S. Social Security Number: ______ - _____ - _________

6. Name of Massachusetts Postgraduate Training Program: ______________________

____
Street Address City

Postgraduate Training Specialty:______________________________

PRE-MEDICAL EDUCATION

7. Name of premedical school(s):______________________________

Location:______________________________
(City, State, Country)

MEDICAL EDUCATION

8. Name of medical school(s):______________________________

Location:______________________________
(City, State, Country)

Date of Graduation: ______/_____/________
Month Day Year

Degree: ☐ M. D. ☐ D. O. Other (specify) ______________________

If you answer "yes" to any of the following questions, you must provide a detailed explanation and arrange for the appropriate institution to submit copies of all official documentation and correspondence related to the underlying occurrence or action. Documents should be sent directly to you in a sealed envelope.

8-a. While enrolled in college, medical school or graduate school, were you ever the subject of any disciplinary action? ☐ Yes ☐ No
(This includes action that was formal or informal, oral or written, voluntary or involuntary. A confidentiality agreement does not absolve you of your requirement to answer this question.)

8-b. Have you ever been terminated from medical school? ☐ Yes ☐ No

8-c. Have you ever withdrawn or transferred from a medical school? ☐ Yes ☐ No

8-d. Have you ever been granted a leave of absence by a medical school? ☐ Yes ☐ No
(This includes a leave for research, public service, participated in a joint degree program such as an M.D./Ph.D. program, medical leave, or for any other "personal reasons".)

PRINT NAME ____

8-e. Have you ever been placed on probation or remediation by a medical school or graduate school? ☐ Yes ☐ No

8-f. If you are a US or Canadian graduate, did you take more than four (4) years to complete medical school; or if you are an international medical graduate, did you take more than six (6) years to complete medical school? ☐ Yes ☐ No

POSTGRADUATE TRAINING

9. Have you ever or are you currently engaged in postgraduate training in the U.S. or Canada? ☐ Yes ☐ No

Name of U.S. or Canadian Postgraduate Training Program: ______________________________

City: ____ State: _____________

Training Dates: From: _____/_____/_____ To: _____/_____/_____

Postgraduate Training Specialty: ____

(Attach a list of any additional postgraduate training in the United States or Canada.)

NOTE: **If you answered "Yes" to Question 9, please answer Questions 9 a. – i.**
If you answered "No" to Question 9, please go to Question 10.

If you answer "yes" to any of the following questions, you must provide a detailed explanation and arrange for the appropriate institution to submit copies of all official documentation and correspondence related to the underlying occurrence or action. Documents should be sent directly to you in a sealed envelope.

9-a. While enrolled in postgraduate training, were you ever the subject of any disciplinary action? ☐ Yes ☐ No
(This includes action that was formal or informal, oral or written, voluntary or involuntary. A confidentiality agreement does not absolve you of your requirement to answer this question.)

9-b. Have you ever been suspended, terminated, or dismissed from any postgraduate training program? ☐ Yes ☐ No

9-c. Have you ever had to repeat a year of postgraduate training? ☐ Yes ☐ No

9-d. Have you ever withdrawn or transferred from a postgraduate training program? ☐ Yes ☐ No

9-e. Have you ever been granted a leave of absence from a postgraduate training program? ☐ Yes ☐ No
(This includes a leave for research, public service, medical leave, or for any other "personal reasons".)

9-f. Have you ever been placed on probation or remediation by a postgraduate training program? ☐ Yes ☐ No

PRINT NAME ____

9-g. Were any limitations or special requirements imposed on you because of questions of competency or disciplinary problems? ☐ Yes ☐ No

9-h. Did you ever receive partial or no credit for a postgraduate training program? ☐ Yes ☐ No

9-i. Have you ever had a postgraduate training program contract not be renewed? ☐ Yes ☐ No

10. List states (abbreviations) where you ever had a full license to practice medicine. ☐ None

____

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

COMLEX: ☐ Level 1 ☐ Level 2 (CE) ☐ Level 2 (PE) ☐ Level 3

☐ LMCC ☐ Other ______________________________

YES **NO**

12. Have you applied to enroll in MassHealth as a nonbilling provider? ☐ ☐

To apply to enroll as a nonbilling provider, download the materials from the MassHealth website at http://www.mass.gov/eohhs/docs/masshealth/aca/pe-nbp-con.pdf and send the completed and signed Nonbilling Provider Application and Contract by mail to the MassHealth Customer Service Center at:

MassHealth Customer Service Center
Attn: Provider Enrollment and Credentialing
P.O. Box 121205
Boston, MA 02112-1205

If you have any questions, please contact the MassHealth Customer Service Center at 1-800-841-2900.

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? ☐ ☐

NOTE: If you answered "Yes" to Question 13, please complete the attached "*Timeline of Activities since Graduation from Medical School*". This should include a chronological listing by month and year of all activities, both professional and non-professional, such as postgraduate training, research activities, military assignments, and any other employment or volunteer activities. Also include periods of unemployment or any activities outside of the practice of medicine. You must account for any time gaps of 30 days or more since your graduation from medical school.

PRINT NAME ____

TIMELINE OF ACTIVITIES SINCE GRADUATION FROM MEDICAL SCHOOL

You must complete this section if you answered "yes" to Question 13, indicating that *more than one year* has passed between the date of your graduation from medical school and the anticipated start date of your limited licensure in Massachusetts.

Do not write, "See CV" or "See attached"

Start Date (mm/yyyy)	**End Date** (mm/yyyy)	**Institution/Place of Employment**	**Address** (City, State/Country)	**Position Held** (Resident, Attending, Research Fellow, etc.)
___/____	___/____			
___/____	___/____			
___/____	___/____			
___/____	___/____			
___/____	___/____			
___/____	___/____			
___/____	___/____			
___/____	___/____			
___/____	___/____			
___/____	___/____			

PRINT NAME ____

ACTIONS BY ANY HEALTH CARE FACILITY, EMPLOYMENT, PROFESSIONAL ORGANIZATION, STATE BOARD OR ANY OTHER GOVERNMENTAL AGENCY

If you answer "yes" to any of these questions, you must provide a detailed explanation and arrange for the appropriate agency or institution to submit copies of all official documentation and correspondence related to the underlying occurrence or action. Documents should be sent directly to you in a sealed envelope.

		YES	NO
14.	Have you been denied the privilege of taking or finishing an examination or been accused of or found to have cheated or engaged in improper conduct during an examination?	☐	☐
15.	Have you ever been denied a medical license, whether full, limited, temporary, or have you withdrawn an application for medical licensure?	☐	☐
16.	Have you ever surrendered a license to practice medicine or any professional license or has your license or certificate ever been revoked? (You do not need to report a lapsed license.)	☐	☐
17.	Have you been denied American Board of Medical Specialties or American Board of Osteopathic Medicine certification or has your certification ever been suspended or revoked?	☐	☐
18.	Are you aware of any pending investigation or inquiry into your professional conduct by any entity or are any disciplinary charges pending against you?	☐	☐
19.	Since your completion of postgraduate training, has any disciplinary action ever been taken against you? (A confidentiality agreement does not absolve you of your requirement to answer this question.)	☐	☐
20.	Has your medical staff membership, medical privileges, medical staff status or association with a health care facility ever 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, administration or governing board?	☐	☐
21.	Have you ever withdrawn an application for hospital privileges or appointment, or have you ever been denied medical staff membership, advancement in medical staff status or association with a health care facility, or has such denial been recommended by a medical staff committee, administration or governing body?	☐	☐
22.	Has your privilege to manufacture, distribute, administer, 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?	☐	☐
23.	Has any professional liability insurance provider ever restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition on your coverage or have you ever voluntarily restricted, limited or terminated your insurance coverage in response to any inquiry by a professional liability insurance provider?	☐	☐

PRINT NAME ____

24. Have you ever had an application for membership as a participating provider denied by any third-party payor, Medicare or Medicaid (any state) or have you ever been the subject of any termination, suspension or probation proceedings instituted by any third-party payor, Medicare or Medicaid (any state) or have you ever been restricted from receiving payments from any third-party payor, Medicare, Medicaid (any state)? ☐ ☐

CRIMINAL HISTORY

YES **NO**

25. Have you ever been charged with any criminal offense?

IMPORTANT NOTE: You must report being arrested, arraigned, indicted or convicted, even if the charges against you were dropped, filed, dismissed or otherwise discharged. A charge of operating under the influence or its equivalent is reportable. A medical malpractice claim is a civil, not a criminal, matter and need not be reported for purposes of this question. If in doubt as to whether an arrest or criminal offense must be disclosed, it is best to disclose the action on your application. ☐ ☐

Expunged/Sealed Offenses: While expunged offenses, arrests, tickets or citations need not be disclosed, it is your responsibility to ensure the offense, arrest, ticket or citation has, in fact been expunged or sealed. Failure to reveal an offense, arrest, ticket or citation that is not in fact expunged or sealed, raises questions related to truthfulness in addition to questions regarding the offense itself. **You may have been told your record is expunged or sealed when in fact it is not.** If, during the course of the application process, information about an offense is discovered which you did not disclose because you believed it to be expunged or sealed, you will be required to provide a copy of the expunction or sealing order.

MEDICAL MALPRACTICE HISTORY

YES **NO**

26. Has any medical malpractice claim ever been made against you, whether or not a lawsuit was filed in relation to the claim? ☐ ☐

(You must report any medical malpractice claims that have been made against you, even if the claim against you was dropped, dismissed, settled, adjudicated or otherwise resolved.)

PRINT NAME ____

CONFIDENTIAL 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
27.	Do you have a medical or physical condition that currently impairs your ability to practice medicine?	☐	☐
28.	Have you engaged in the use of any substance(s) with the result that your ability to practice medicine is currently impaired?	☐	☐
29.	Have you ever refused to submit to a test to determine whether you had consumed and/or were under the influence of chemical substances?	☐	☐

If you have a substance use disorder or mental or physical health diagnosis that impacts your ability to practice medicine, the Board encourages you to seek assistance voluntarily and to abide by any recommendations of your health care provider.

When the Board receives notice of a substance use disorder, its primary mission is to protect the public; however, the Board also seeks to ensure successful rehabilitation through the physician's participation in approved treatment programs and supervised structured aftercare. Similarly, when the Board receives notice of a mental health or physical health diagnosis that impacts a physician's ability to practice, the Board needs to ensure that the physician can practice medicine safely.

In regard to issues of physician impairment, whether the impairment is caused by a substance use disorder, or a mental or physical health diagnosis, the Board works cooperatively with the Massachusetts Medical Society's Physician Health Services (PHS) and encourages physicians to contact PHS to determine what services may be available to them in order to ensure their safe practice of medicine. Please call PHS at (781) 434-7404.

PRINT NAME ____

CERTIFICATIONS

- Pursuant to M.G.L. c. 62C, § 49A, I certify 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. (*Note:* This applies even if you reside out of the state or out of the country.)

- Pursuant to M.G.L. c. 62C, § 49A, I certify that, to the best of my knowledge and belief, I am in compliance with M.G.L. c. 119A relating to withholding and remitting child support.

- Pursuant to M.G.L. c. 112, § 1A, I certify that I will fulfill my obligation to report abuse or neglect of children as required by M.G.L. c. 119, §51A.

- By signing this form, I am providing my consent for the Massachusetts Board of Registration in Medicine and, where relevant, their supervising state agencies and the Massachusetts Executive Office of Health and Human Services and, where relevant, its provider enrollment vendor, to obtain, read, copy, and share with each other information regarding my MassHealth application and enrollment status and Massachusetts licensure status.

- 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.

- I certify under the penalties of perjury that all information on this form, and all attached pages, is true, accurate and complete, to the best of my knowledge and belief.

Applicant's Signature: ____ Date: _____/_____/_____

PRINT NAME ____

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?	☐	☐

If your responses to both Questions 1 and 2 are "No", please contact the Licensing Division to determine whether this applicant is eligible for a limited license in Massachusetts.

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: __________________________

COMMONWEALTH OF MASSACHUSETTS
BOARD OF REGISTRATION IN MEDICINE
200 Harvard Mill Square, Suite 330, Wakefield, MA 01880
www.mass.gov/massmedboard

AUTHORIZATION FOR RELEASE OF INFORMATION, DOCUMENTS AND RECORDS

I, ____
(type or print your complete name)

request and authorize every person, institution, professional licensing board of any state in which I hold or may have held a license to practice my profession, hospital, clinic, government agency (local, state, federal or foreign), law enforcement agency, or other third parties and organizations and their representatives to release information, records, transcripts and other documents concerning my professional qualifications and competency, ethics, character and other information pertaining to me to the Massachusetts Board of Registration in Medicine.

I further request and authorize that the requested information, documents, and records be sent directly to:

Board of Registration in Medicine
200 Harvard Mill Square, Suite 330
Wakefield, MA 01880

Attention: Licensing

Immunity and Release

I hereby extend absolute immunity to and release, discharge, and hold harmless from any and all liability: 1) the Board of Registration in Medicine, its agents, representatives, directors and officers; 2) other agencies, institutions, hospitals and clinics providing information, their representatives, directors and officers; and 3) any third parties and organizations for any acts, communications, reports, records, transcripts, statements, documents, recommendations or disclosures involving me, made in good faith and without malice, requested or received by the Board of Registration in Medicine.

By my signature below, I acknowledge that information, documents and records required to be furnished by another organization, educational institution, hospital, individual or any person or groups of persons has been sent to me directly from the primary source in a sealed envelope and that none of the seals have been broken. I understand that the Board of Registration in Medicine will not accept any such information, records or documents forwarded by me unless they are in sealed envelopes.

A photocopy or facsimile of this authorization shall be as valid as the original and shall be valid up to one year from the date signed.

____ _______________________
Applicant's Signature | Date of Signature

____
Applicant's Printed Last Name, First Name, Middle Initial, Suffix (e.g., Jr.)

____
Applicant's Date of Birth (month/day/year)

Make sure you answered every question.

Is your name printed at the top of each page?

Attach your CV in chronological order with no gaps.

Make sure to tell your Medical School that the following form must be sent directly to Boston Medical Center, and NOT to the Mass Medical Board.

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

MEDICAL EDUCATION VERIFICATION – FORM A

APPLICANT INSTRUCTIONS: Please complete the waiver for release of information and forward this form to your university/medical school(s) or university of graduation for verification. **Please note: Fourth year medical students must include the letter to the medical school registrar and Form B**.

Waiver for Release of Information

I authorize the medical school/university listed below to provide any and all information pertaining to my medical education at your institution**.**

Applicant's Signature: ____ Date of Birth: _____/_____/_____

Name (Please type or print): ____
(Last Name) (First Name) (Middle Initial)

Other Name(s) (Please type or print.): ____

Name of Medical School: ____

Address: _________________________________ City: ______________________ State or Province: ___________

INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL

Please complete Form A. For fourth year medical graduates, please complete Form B after the student completes the degree requirements. Please include a copy of the official transcript (which indicates courses taken, dates and hours of attendance, scores, grades, or evaluations) and return to the applicant in a sealed envelope. Please sign or stamp across the seal on the envelope.

APPLICANT'S EDUCATIONAL HISTORY

If name of institution was different from the above-named institution when applicant attended, please enter name below:

____

Premedical Education: Does your school have a premedical school education requirement? ☐ Yes ☐ No

If yes, indicate where the applicant completed premedical school.

Applicant's Undergraduate School: ____

Undergraduate School Address: ____

Enrollment and Participation:

Our records indicate that____
(Print the applicant's name): (Last name) (First name) (Middle Initial)

attended our medical school for a total of ______ weeks (must be included) of continuous medical education on the

following dates from _____/_____/_____ to _____/_____/_____.
month/day/year month/day/year

This applicant:

Check one: ☐ **was awarded the** degree of ____ on _____/_____/_____
month/day/year

☐ **will be awarded** the degree of ____ on _____/_____/_____
(Form B must also be completed and returned directly to the Board.) month/day/year

☐ **was not awarded** a degree because: ____

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. All questions must be answered. **If you answer "YES" to any of the questions below, please enclose an explanation.**

		YES	NO
1.	Was the medical school training more than four (4) years for U.S. graduates or 6 years for international medical graduates, or did the applicant take any leaves of absence (i.e. for research, public service, participation in an M.D./Ph.D. program) or for any "personal reasons"?	☐	☐
2.	Was the applicant ever placed on probation or remediation?	☐	☐
3.	Was the applicant ever disciplined or under investigation?	☐	☐
4.	Were any negative reports ever filed by instructors regarding the applicant?	☐	☐

Please provide a detailed explanation for any of the above questions ____

____

AFFIX INSTITUTIONAL SEAL HERE

(If the institution does not have a seal, this form must be notarized.)

INTERNATIONAL MEDICAL SCHOOLS MUST ATTACH A COPY OF THE MEDICAL SCHOOL DIPLOMA AND A TRANSCRIPT OR PROVIDE AN EXPLANATION.

Signature: ____

Print Name: ____

Title: ____

Date: _____/_____/_____ Telephone: (_____)__________________

E-mail address: ____

This form must be stamped with the institutional seal or notarized. Please return to the applicant with the medical school transcripts in a sealed envelope with the signature of the Dean or the seal of the medical school affixed on the back of the envelope. Thank you.

Complete the following only if you will be graduating from Medical School this year.

COMMONWEALTH OF MASSACHUSETTS
Board of Registration in Medicine
200 Harvard Mill Square, Suite 330, Wakefield, MA 01880
Telephone: (781) 876-8210 Fax: (781) 876-8383
www.mass.gov/massmedboard

Dear Registrar:

The Massachusetts Board of Registration in Medicine (hereinafter "the Board") will not grant a limited license to an applicant unless that applicant has been awarded a medical degree. Since the rationale for the Board's licensing regulations and statutes is to ensure that only qualified applicants are licensed, the Board has determined that an applicant must be awarded a medical degree prior to granting a limited license to practice medicine in Massachusetts.

Previously, a medical school verified either an applicant's graduation from medical school or the applicant's anticipated graduation from medical school. We recognize that there are certain circumstances under which an applicant would not graduate, as expected, from medical school, for example: 1) failure to either take or pass Step 2 of the USMLE; 2) uncorrected failing grades in a preclinical course; 3) uncorrected failing or marginal performance in a clinical clerkship; or 4) failure to meet any other curriculum requirements. Therefore, the Board has initiated a new procedure for the verification of medical school education.

All applicants must have Form A, copy attached, of the Medical School Verification completed by their medical school. An additional form is required for applicants who are fourth year medical school students and who have completed the requirements for the M.D./D.O. degree, but have not yet been awarded the degree. For these applicants, the medical school must complete Form B of the Medical School Verification form, copy attached. Any state medical board to whom you have certified an applicant's graduation would wish to be notified immediately regarding a medical school's determination that the applicant *will not* graduate, as reported on Form B. In addition, fourth year medical school students are required to notify the Board within twenty-four hours of notification by the medical school that they have not met the medical school's graduation requirements. The notification form entitled "Medical School Status Update" is available on the Board's website at www.mass.gov/massmedboard.

The Board appreciates your assistance in making your students aware of these new requirements. Should you have any questions, please contact me at the above listed number.

Sincerely,

Licensing Division

Form B

Medical School Verification Form

Applicants who are fourth year medical school students and who have completed the requirements for the M.D./D.O. degree, but have not yet been awarded the degree are also required to have this form completed by their medical school.

Original signature of the Dean or another medical school official is required to complete the requested information. Signature stamps will not be accepted.

Any state medical board to whom you have certified an applicant's graduation would wish to be notified immediately regarding a medical school's determination that the applicant will not graduate.

Please complete Form A and return it to the sender. This Form B must be sent to the Board of Registration in Medicine after the student completes the degree requirements.

My signature below certifies that ____
(Student's Name)

has completed the requirements for the ☐ M.D. degree ☐ D.O. degree

from ____
(Name of Medical School)

and will receive the degree on _____/_____/______.

Signature of Certifying Official: ____
(Original Signature is required – Stamps not accepted)

Printed Name:____

Title:____

Date:____

The completed Form B may be faxed to the Limited License Coordinator at (781) 876-8383 or mailed to the Board of Registration in Medicine. 200 Harvard Mill Square, Suite 330. Wakefield, MA 01880. Telephone: 781-876-8210.

Thank you.

Complete the next 7 pages ONLY if you answered YES to Questions 14-35 on the main application

PRINT NAME ____

EXPLANATION FOR APPLICATION QUESTIONS #8 – 9, 14 - 24

This form must be used to provide a detailed written explanation for a "yes" response to any question (#8 – 9, 14 - 24) on the Application. Please use as many forms as necessary to provide a detailed explanation. Do not write "See attached". You must provide your response on this form.
A separate form is to be used for each question.

In addition to the below explanation, you must arrange for the appropriate agency or institution to submit copies of all official documentation and correspondence related to any "yes" response to a question on the Application. All documents should be sent directly to you in a sealed envelope.

Application Question Number: _________________ (list corresponding question number from the Application)

Name of agency or institution taking action: ____

Date(s): ____/____/____ to ____/____/____

Please provide a detailed explanation:____

PRINT NAME ____

EXPLANATION FOR APPLICATION QUESTION 25 – CRIMINAL HISTORY

This form must be used to provide a detailed written explanation for a "yes" response to question #25 on the Application. Please use as many forms as necessary to provide a detailed explanation.
Do not write "See attached". You must provide your response on this form.
A separate form is to be used for each criminal offense/arrest.

Supporting Documentation: Please arrange for the appropriate court or your lawyer to send certified copies of all records related to the offense to you in a sealed envelope. Please arrange for the appropriate arresting/ticketing agency or your lawyer to send certified copies of the arrest/offense/incident report or citation/ticket to you in a sealed envelope. If a court, an arresting/ticketing agency or your lawyer is unable to provide copies of applicable records, request that they furnish a written statement to that effect which should be sent to you in a sealed envelope.

Incident Date: ____/____/________

Location of Incident (City and State/Country):______________________________

Arresting/Ticketing Agency:______________________________

Court:______________________________

Initial Charge(s):______________________________

_____Misdemeanor ______ Felony

Final Charge(s):______________________________

_____Misdemeanor ______ Felony

Plea:______________________________

Disposition: (if probation, deferred adjudication, or deferred prosecution give summary.)

____

Detailed Summary. Provide a personal statement containing a detailed summary of the events and circumstances leading to this arrest, citation, ticket, criminal charge and/or investigation:______________________________

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PRINT NAME ____

QUESTION 26 – MEDICAL MALPRACTICE HISTORY

For each instance of alleged malpractice, you must provide the following information.

Claimant's name/initials:____

Date of incident:_____/_____/______

Insurer's name:____

Allegation(s):____

REQUISITE DESCRIPTIVE INFORMATION:

1. Patient's condition at point of your involvement:____
____
____

2. Patient's condition at end of treatment:____
____
____

3. The nature and extent of your involvement with the patient:____
____
____
____

4. Your degree of responsibility for the course of treatment leading to the claim:______________________________
____
____
____

5. Patient Outcome. If incident resulted in patient's death, indicate cause of death according to autopsy or patient chart:____
____
____

6. Legal representative's name:____
Address:____Telephone:__________________
City:____ State: ____________________ Zip:_____________

(Question #26 continued on next page)

PRINT NAME ____

QUESTION #26 (continued)

Current status of claim: ☐ Closed ☐ Pending

Was a lawsuit filed in relation to the claim: ☐ Yes ☐ No

If the claim resulted in a lawsuit, what was the final outcome of the suit?
☐ Dismissed before trial ☐ Plaintiff Verdict ☐ Defense Verdict
☐ Other (please specify) ______________________________________

Was the claim settled by you or on your behalf, with or without the filing of a lawsuit? ☐ Yes ☐ No

If a payment was made on your behalf, either as a result of a settlement or an award of damages*:*
Amount allocated to you: $_____________________ Payment Date: _____/_____/________

In addition to the information listed above, you must arrange for your lawyer or liability carrier to submit a copy of the following documents directly to the Board for the following malpractice cases:

Pending Claim

1) a malpractice history report from your malpractice liability carrier or letter from your attorney that include the claimant's name/initials and confirmation that the claim is open/pending; and

2) a copy of the Complaint, Notice of Intent to File a Claim Letter or other claim letter.

Closed Claim

1) a malpractice history report from your malpractice liability carrier or letter from your attorney that includes the claimant's name/initials, final disposition of the claim, and the amount of the payment, if any, that was made on your behalf;

2) a copy of the Complaint, Notice of Intent to File a Claim Letter or other claim letter**;** and

3) a copy of the final judgment, settlement and release or other final disposition of each claim, even if you were dismissed from the case by the court.

PRINT NAME ____

CONFIDENTIAL MEDICAL INFORMATION

QUESTION #27 – Medical condition.

If you answered "yes" to Question 27, please provide the specifics of your condition and any related treatment, including dates and diagnoses. In addition, provide any adjustments or interventions you may have made or taken to ameliorate or address the impact of your medical condition on your current practice, including a change of specialty or field of practice, or participation in any supervised rehabilitation program, professional assistance or retraining program, or monitoring program.

____

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QUESTION #28 – Substance use.

If you have obtained medical treatment related to your use of substances, please provide the specifics of your treatment, including dates and diagnoses. In addition, provide any adjustments or interventions you may have made or taken to ameliorate or address the impact of your use of substances on your current practice, including participation in any supervised rehabilitation program or monitoring program.

____

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QUESTION #29 - Refusal to take a screening test for chemical substances.

If you answered "yes" to Question 29, please provide a description of the circumstances leading to your refusal to take the screening test and any resulting criminal or disciplinary consequences.

____

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____

____

____

Complete the following Evaluation Form only if you are currently or have previously been in a graduate medical education training program

i.e internship, residency or fellowship

post-doc research positions do not count

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

SUPERVISORY EVALUATION FORM

APPLICANT INSTRUCTIONS:

- *This form must be completed by a supervising physician who can evaluate your clinical performance.*
- *At least one year of current evaluations are required. Locum tenens physicians must have evaluations from the most recent two years of assignments. The Board reserves the right to require additional Evaluation forms.*
- *Evaluation forms must be current within 120 days prior to Board review.*
- *The Evaluator must have no financial interest in your licensure in the State of Massachusetts.*

I hereby authorize the representatives or staff of the facility listed below to provide the *Board of Registration in Medicine* with any and all information requested in this evaluation form, whether such information is favorable or unfavorable, and I hereby release from any and all liability the named facility and/or any person for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice.

Signature of applicant:_______________________________________ Date:_____/________/_________

Please PRINT your name:____

Name of Evaluating Hospital/Workplace:____ State:____

SUPERVISING PHYSICIAN INSTRUCTIONS:

- Please complete items #1-10 below and return to the applicant with your name affixed across the envelope seal.
- The Board may provide a copy of this Form and any attachments to the applicant.

1. **Date(s) of applicant's affiliation at facility (month/year)?** From: _____/_____ To: _____/______

2. **In what capacity did you supervise the applicant?** ☐ Department Chair ☐ Chief of Service ☐ Medical Director ☐ Training Director ☐ Supervising Physician ☐ Chief Medical Officer

3. **Applicant's Status:** ☐ Intern ☐ Resident ☐ Fellow ☐ Staff Member ☐ Other ____________

4. **Do you have any conflict of interest, personally, professionally or financially in recommending this applicant for licensure in Massachusetts?** ☐ YES ☐ NO

5. **Please rate the following (if "BELOW AVERAGE or "POOR", explain in detail on a separate sheet).**

	Superior	Above Average	Average	Below Average	Poor
Clinical knowledge					
Clinical competency					
Professional judgment					
Character and ethics					
Technical skills					
Relationships with staff					
Relationship with patients					
Cooperativeness/ability to work with others					

(Continued on page 2)

6. **Has the applicant's privileges to admit or treat patients <u>ever</u> been modified, suspended, reduced or revoked?** ☐YES ☐ NO (if "yes" please explain below)

____

____

7. **Has this applicant <u>ever</u> been the subject of disciplinary action or had staff privileges, employment or appointment at this hospital or facility voluntarily or involuntarily denied, suspended, revoked or has (s)he resigned from the medical staff in lieu of disciplinary action? If "yes" please explain below.** ☐ YES ☐ NO

____

____

8. **Please comment on the applicant's strengths or weaknesses and/or any other information that you may have to assist in this evaluation.**

____

____

9. **The above comments are based on the following:**

☐ Personal observation ☐ General impression ☐ A composite of evaluations by other physicians

☐ Other____

10. **<u>Recommendations</u>:**

☐ Recommend for licensure in Massachusetts.

☐ Recommend for licensure in Massachusetts, with the following reservations:

____

☐ Do not recommend for the following reason(s):

____

Signature of Evaluator: ____ (*check one)* ☐ M.D. or ☐ D.O.

Name of Evaluator (Printed):____ Date: _____/_____/_______

Title/Position: ____

E-mail address:____Phone number:______________________

PLEASE RETURN THE COMPLETED EVALUATION <u>TO THE APPLICANT</u> IN A SEALED ENVELOPE WITH YOUR SIGNATURE AFFIXED ACROSS THE ENVELOPE SEAL.

Complete the next form only if you have held a **FULL** Medical License in the United States.

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

STATE LICENSE VERIFICATION

Applicant's Instructions: Complete the waiver for release of information and forward this form to every state board where you are currently licensed or were ever licensed in the past. Contact the individual state board(s) for information on verification processing fees before you mail this form.

Applicant's Waiver for Release of Information:

I am applying for licensure in the Commonwealth of Massachusetts and the Board of Registration in Medicine requires that this form be completed by each state where I hold or have ever held licensure. I hereby authorize the release of any information in your files, favorable or otherwise.

Signature of physician:____ Date:____/_____/_____

Print or type name:____

License number:_______________ Status of license: ☐ Active ☐ Inactive ☐Other____________________

TO BE COMPLETED BY STATE BOARD

1. Name of medical school of graduation:____
2. Date of graduation: ____/____/____ License number:_________________ Date of issue: ____/____/_____
3. Basis for licensure:____
   Name(s) of medical licensing examinations(s)
4. Expiration date of license: _____/_____/_____
5. Status of license (*check one*): ☐ good standing ☐ revoked ☐ suspended
6. If revoked or suspended, please explain:____
   ____

	YES	NO
7. Has the licensee ever been on probation?	☐	☐
8. Has the licensee ever been requested to appear before the board?	☐	☐

If "yes," please explain:____
____

Other derogatory information:____

Remarks:____

Signed:____

BOARD SEAL

Print Name:____

Title:____

State Board:__________________________ Date: ____/____/____

PLEASE RETURN THE STATE LICENSE VERIFICATION TO THE APPLICANT IN A SEALED ENVELOPE WITH THE BOARD SEAL OR THE SIGNATURE OF THE PERSON COMPLETING THIS FORM ON THE BACK OF THE ENVELOPE.

Complete the Name Change Form for any name changes since you graduated from high school.

Board of Registration in Medicine
200 Harvard Mill Square, Suite 330 - Wakefield, MA 01880
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www.mass.gov/massmedboard

NAME CHANGE AND DUPLICATE LICENSE REQUEST

Please read the following instructions for requesting a name change as a result of marriage or court order attached to the Notary Public Attestation For Name Change form.

NAME CHANGE AS A RESULT OF MARRIAGE OR BY A COURT ORDER

Please submit the following:

- A notarized copy of the marriage certificate from the jurisdiction in the United States in which the licensee was married (if you were married outside of the United States, you must submit your original marriage certificate with a self-addressed envelope to be returned to you), or a notarized copy of a court order.

- A current passport-sized color photograph (2 x 2) which has been attested to by a notary public or other official authorized to administer oaths. The attestation must identify the individual represented in the photograph and state that the photograph accurately depicts the individual so identified. Please complete the Notary Public Attestation for Name Change form.

- Your original wall certificate and your wallet sized card (full licensees only).

Print Current Name: ____MA License #:______________

Print Previous Name: ____

Mailing Address:____

City:____ State: _____ Zip: ________________

For Office use only

Date Rec: _____/_____/____ ☐ Photograph notarized/dated ☐ Board photograph confirmed

☐ Name changed ☐ Wallet card printed/mailed ☐ Wall Certificate printed/mailed

Date Completed: ____/____/____ Board Staff ____________________________________

Approved by: ____Date:_____/_____/_____

NOTARY PUBLIC ATTESTATION FOR NAME CHANGE

- **INSTRUCTIONS TO THE APPLICANT**: A current passport-sized color photograph (2 x 2) which has been attested to by a notary public or other official authorized to administer oaths. The attestation must identify the individual represented in the photograph and state that the photograph accurately depicts the individual so identified. The photograph must have the signature of the applicant, the date and the signature and seal of a U.S. Notary Public.

IDENTIFICATION PHOTOGRAPH

Attach a recent 2 x 2 color photograph on the left side. Black and white photographs will not be accepted. The photograph must be current within the past six months.

You must sign your name and the date in the presence of a Notary.

I swear or affirm that the contents of this document are truthful and accurate to the best of my knowledge and belief.

____ Date:_____/______/__________
Signature of Applicant:

Print Name:____

NOTARY ATTESTATION

I certify that the photograph above is a genuine likeness of the maker of the signature, who personally appeared before me this day. The maker of the signature provided satisfactory evidence of identification, which was ____

Subscribed and sworn to before me:

____ Date:_____/______/__________
Signature of Notary:

____
Print name of Notary:

My commission expires:______________________

Notary Public Seal or Stamp