ATTENTION!

Criminal History Record Checks (CHRC) are required for all applicants. The Board may not reinstate or issue a new license to any applicant, physician or allied health practitioner, if the Board has not received criminal history record information.

The Board recommends that you do not submit your fingerprints for a CHRC earlier than 6 weeks before the date you intend to submit your initial license or reinstatement application to the Board.

The Board is only authorized to retain CHRC information for 90 days. If the CHRC is over 90 days, the applicant will be required to complete a new CHRC.

For detailed instructions on submitting your fingerprints for a CHRC, please read and follow the attached instructions.

MARYLAND
Department of Health Board of Physicians
Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

Notice: Criminal History Records Check Required

Dear Applicant for Initial License or Reinstatement of License:

A full Criminal History Records Check (CHRC) is a qualification of licensure. The Board may not reinstate or issue a new license to any applicant, physician, or allied health practitioner, if the Board has not received criminal history record information.

A CHRC will include both a State and national criminal history records check conducted by the Maryland Department of Public Safety and Correctional Services, Criminal Justice Information System (CJIS) and will be maintained in the Maryland and FBI database for further identification purposes. Applicants have the right to challenge their records, which is discussed in more detail in the FBI NonCriminal Justice Applicant's Privacy Rights notice (https://www.mbp.state.md.us/forms/fbi_privacy_rights.pdf). An applicant for initial licensure or reinstatement shall apply to CJIS for a CHRC and the application shall include:

1. Two complete sets of legible fingerprints taken on forms approved by CJIS and the FBI; and
2. Payment of the required fees.

Timing of CHRCs

The Board recommends that applicants do not submit fingerprints earlier than 6 weeks before the date the applicant/licensee intends to complete the initial license or reinstatement application. The Board is only authorized to retain CHRC information for 90 days. If the CHRC is over 90 days, the applicant will be required to complete a new CHRC.

Fingerprints

A. For Initial Applicants and Reinstatements

All applicants for licensure in Maryland will be required to submit fingerprints for the CHRC. In order to be fingerprinted, the fingerprinting entity will need the following Board specific information:

- CJIS Authorization #: 1600000743
- FBI ORI #: MD 920522Z
- Reason Fingerprinted: Professional License
- Type of Check: Governmental Licensing/ Certification

1. Within Maryland

    a. Go to an authorized location to be fingerprinted prior to mailing in your application to the Board. For a list of electronic fingerprinting locations go to the following website: https://www.dpscs.state.md.us/publicservs/fingerprint.shtml. The Board is not responsible for the list. If there are any concerns about a fingerprinting location, please contact CJIS directly.
    b. Provide the fingerprinting entity the CJIS Authorization number and FBI ORI # provided on page 1 of this letter.
    c. Pay the appropriate fee to the fingerprinting entity.

Once the Board receives the results of the CHRCs, the application process will be completed in accordance to Board regulations and policies.

2. Outside of Maryland
    a. Out of state applicants have the option of using a Maryland location for fingerprinting. If a Maryland location is used, follow the instructions above for applicants within Maryland. If a location outside of Maryland is used, follow the instructions below.
    b. Either:
        i. Write to CJIS-Central Repository at P.O Box 32708, Pikesville, Maryland 21282-2708, or
        ii. Call the Central Repository in Baltimore City at 410-764-4501 or toll free number 1-888-795-0011 to request fingerprint cards.
    c. Have CJIS Authorization and FBI ORI Board #'s available to complete your submission.
    d. Mail the fingerprint card and associated fee to CJIS-Central Repository, P.O Box 32708, Pikesville, Maryland 21282-2708, or overnight the fingerprint card to 6776 Reisterstown Road, Suite 102, Baltimore Maryland 21215.
    e. Please include a check or cashier's check made out to "CJIS Central Repository".

Once the Board received the results of the CHRCs, the application process will be completed in accordance to the Board regulations and policies.

Timing of CHRCs

The Board recommends that applicants do not submit fingerprints earlier than 6 weeks before the date the applicant/licensee intends to complete the initial license or reinstatement application. The Board is only authorized to retain CHRC information for 90 days. If the CHRC is over 90 days, the applicant will be required to complete a new CHRC.

Fees:

Fees are required for CJIS to process each criminal background record check request. All fees must be paid by credit card, check or cashier's check in United States currency. The Central Repository cannot accept cash.

Do not send any payment to the Board, as it does not conduct CHRCs. For additional information contact CJIS at 410-764-4501 or visit https://www.dpscs.state.md.us/publicservs/fingerprint.shtml.

Questions?

Should you have any questions, concerns, or to check the status of a criminal history record information request, please contact the **CJIS Call Center at 410-764-4501 or 1-888-795-0011**, Monday-Friday 8:00 a.m. - 5:00 p.m. The Board cannot assist you in this regard.

***Please do not contact the Board to verify receipt or submit receipts. The Board will receive the electronic CHRC notifications within 3 – 14 days.**

MARYLAND BOARD OF PHYSICIANS

Baltimore, Maryland
410-764-4777
www.mbp.state.md.us

ATHLETIC TRAINER APPLICATION FOR LICENSURE

Dear Applicant:

Attached is an application packet for licensure as an Athletic Trainer in Maryland. The application fee is **$200.00** and is **non-refundable**. Please make your check or money order payable to: **Maryland Board of Physicians.** Mail your application and check to:

Maryland Board of Physicians
P.O. Box 37217
Baltimore, MD 21297

Please **DO NOT** mail or hand deliver your application to the Board office or any other address except the address listed above. Applications mailed or hand delivered to the Board office will be forwarded to the above address. This will delay the processing of your application. **Please note: Federal Express (FEDEX) or UPS do not deliver to post office boxes.**

Applications are processed in order of receipt. **Please allow at least 3 to 6 weeks for the processing of your application.** Board staff will make every effort to process your application as quickly as possible. Incomplete applications and/or failure to submit the required information will delay the processing of your application.

It would be best not to continuously call your analyst to check on the status of your application. Constant interruptions slow down the process. Generally, within 5 - 7 business days from the receipt of your application, your analyst will contact you if additional documentation is required. Please make sure your contact information is current.

Documents submitted to support your application must come directly from the source, e.g., Verification of education must come directly from your school and verification of other licenses must come from the state board that issued your license. Both credentials must be mailed to the address on top of the forms. (**P.O. Box 2571, Baltimore, MD 21215**.) Verification of national certification must be verified by the BOC.

Board staff will not disclose the status of your application to another party unless you have completed the Third Party Option on page 7 of the application or provided documentation allowing staff to disclose the status to another party. Other parties include family members, friends and future employers, etc.

The Board will keep your application open for 120 days from the original date of receipt. All requirements for licensure must be met within the 120 day period. The Board does not grant exemptions from these requirements. If the requirements are not met, your application will be closed and a new application and full application fee will be required.

The Board's website is updated every 24 hours. You may wish to check the website at *www.mbp.state.md.us* before calling the Board to find out if a license was issued to you. When you get to the website, click **Practitioner Profiles**.

We look forward to receiving your completed application and will process it as quickly as possible.

Note: Licensure alone does not permit an Athletic Trainer to practice in Maryland. An Evaluation and Treatment Protocol (ETP) must be completed and filed with the Board. An athletic trainer may assume the duties under an ETP after receiving a written recommendation of approval from the Athletic Trainers Advisory Committee if the ETP does not include specialized tasks or includes previously Board-approved specialized tasks. The fee for the ETP is *$100.00*.

Go to the Board's Website at *http://www.mbp.state.md.us/pages/forms.html* to download this form.

Thank you,
The Allied Health Division
Maryland Board of Physicians

MARYLAND BOARD OF PHYSICIANS

P.O. Box 37217
Baltimore, Maryland 21297
Telephone: 410-764-4775 800-492-6836
www.mbp.state.md.us

APPLICATION FOR LICENSURE OF ATHLETIC TRAINERS

INSTRUCTIONS AND IMPORTANT INFORMATION

1. **Name**: If the name on the application form differs from the name on any of your supporting documentation, you must submit a copy of a marriage license, divorce decree, or a court order explaining the change of name. The Board must be notified of any change in your name on a timely basis.

2. **Non-Public Address:** The non-public (home) address will be the location to which the Board directs all correspondence. If your address changes during the application process, please notify the Board in writing.

3. **Public Address:** The public address (business address) is your address of record and available to the public. However, if no public address is listed, the non-public address will be made available to the public.

4. **Contact Information (Telephones and E-mail Address):** The Board will contact you using the information provided.

5. **Date of Birth**: Health Occupations Article §14-5D-08(b)(2), Annotated Code of Maryland requires applicants to be at least 18 years old. Date of birth will also be used for identification and criminal background checks.

6. **Gender:** Disclosure of Gender is not a requirement of licensure, but the information provided will be used for identification purposes and for criminal background checks only.

7. **Race and Ethnicity:** Disclosure of race or ethnicity is not a requirement of licensure, but the information provided will be used for identification purposes and for criminal background checks only.

8. **Social Security Number:** Maryland law requires the Board of Physicians to collect Social Security numbers from all persons applying for professional licenses or certificates. Disclosure of your Social Security number is mandatory. The Maryland Board of Physicians is permitted by State or Federal law or regulation to use the Social Security number for the following purposes:

   A. Verification of identity with respect to actions related to your license (Code of Maryland Regulations 10.32.01.);
   B. Administration of the Child Support Enforcement Program (Family Law Article, §10-119.3);
   C. Identification by the Department of Assessments and Taxation of new businesses in Maryland (Health Occupations Article, §1-210);
   D. Verification by the Maryland Medicaid program of licensure and sanctions for providers participating in Medicaid 42 U.S.C. §1396(a)(49); 42 U.S.C. §1396r-2; 42 U.S.C. §1320 a-7).

9. **Employment Activities:** Please complete and include all employment history beginning with the date you graduated from an accredited Athletic Trainer educational program.

INSTRUCTIONS AND IMPORTANT INFORMATION CONTINUED

10. **Verification of Professional Education:** Complete the top portion of the **Verification of Professional Education form (AT 1)** and forward it to the Commission on Accreditation of Athletic Trainers Education (CAATE) accredited Athletic Trainer program from which you graduated with either a bachelor's or master's degree in athletic training. *The school must return the form directly to the Board at the address listed on the top of the form.*

    Note: *The Board will waive the education requirement for applicants who were certified by the Board of Certification before October 1, 2012.*

11. **National Certification:** Applicants for licensure as an Athletic Trainer must be currently certified by the Board of Certification (BOC). To request a verification, go to the BOC's website, www.bocatc.org and request a written or electronic verification of certification be sent directly to the Board. Electronic verifications may be sent to the Board's email address at mbpmail@rcn.com. Written verifications may be sent to: *P.O. Box 2571, Baltimore, MD 21215*. Please do not have the BOC send the verifications to you.

12. **Oral and Written Competency in English:** Demonstrate verbal and written competency in the English language by:

    a. Graduation from an English-speaking high school, undergraduate school, or professional school; **OR**

    Provide evidence that you achieved a passing score on both the Test of Spoken English (TSE) **and** the Test of English as Foreign Language (TOEFL).

    b. Achieving a passing score of at least 26 on the spoken part **and** 79 on the written part of the TOEFL.

13. **Licensure in Other States:** If you have ever held a license, certification or registration to practice as an Athletic Trainer in any state or jurisdiction or in ANY other health care profession in any state, including Maryland, complete the top portion of the **Verification of Other State Licenses form (AT 2)** and send it to the licensing board in each state in which you are or have been licensed/certified/registered. PLEASE check with the applicable state board to see if there is a fee required for this information prior to mailing the form. If you were licensed by the Board of Physicians in another profession, you do not need to complete the **(AT 2**) form. **Please do not send copies of your licenses.**

14. **Character and Fitness Questions:** Answer the Character and Fitness questions "YES" or "NO." If you answer "YES" to any item, please provide a detailed explanation, on a separate sheet of paper, and any supporting documents. If you were discharged from the military, please provide documentation that shows, including, but not limited to, the type of service, date and type of discharge, e.g. DD14. Failure to provide a detailed explanation of a "Yes" response and the required supporting documentation will delay the review process.

15. **Release:** Sign and date the certification. You are giving the Board and Athletic Trainer Advisory Committee permission to request additional information to support your application for licensure.

16. **Optional Third Party Release:** If you wish the Board to release your information to a third party, complete the third party release statement.

17. **Cooperation in an Investigation**: You may be asked to cooperate fully with any request for information related to your practice as an Athletic Trainer.

18. **Certification and Passport Quality Photo:** Sign and date the certification in the presence of a notary public after you have affixed a recent passport quality (2" x 2") photo to the application in the space provided.

INSTRUCTIONS AND IMPORTANT INFORMATION CONTINUED

Supplemental Forms AT1 and AT 2:

Verification of Education (AT 1): Complete this form and send it to the institutions where you completed your CAATE accredited Athletic Trainer educational program.

Verification of Other State Licenses (AT 2): Complete this form if you were issued a license/certification/ registration as an Athletic Trainer or ANY other health care provider.

Licensure and Renewal: If your application is approved, you will receive an approval letter containing the license number assigned to you, the original date of licensure and expiration, and a license. Regardless of the date of initial licensure, your license will expire on **September 30th* of the first odd year** following the date on which you are initially licensed. You will have to renew your license if you plan to continue practicing in Maryland. A renewal notice will be sent at least 30 - 60 days prior to the expiration of your license to the most current address on file with the Board. **You will be required to renew your license on-line by September 30th of every odd year whether or not you receive the renewal notice.**

EVALUATION AND TREATMENT PROTOCOL

Licensure alone does not permit an Athletic Trainer to practice in Maryland. An Evaluation and Treatment Protocol (ETP) must be completed and filed with the Board. An athletic trainer may assume the duties under an ETP after receiving a written recommendation of approval from the Athletic Trainers Advisory Committee if the ETP does not include specialized tasks or includes previously Board-approved specialized tasks. The fee for the ETP is *$100.00*.

Go to the Board's Website at *http://www.mbp.state.md.us/pages/forms.html* to download this form.

PRACTICING AS AN ATHLETIC TRAINER: A person may not practice, attempt to practice, or offer to practice as an Athletic Trainer in Maryland unless licensed to practice by the Board. A person may not represent or imply to the public by title or by description of services, methods or procedures that the person is an Athletic Trainer unless licensed by the Board to practice as an Athletic Trainer. An Athletic Trainer may not perform or attempt to perform or offer to perform any delegated acts beyond the scope of the license or beyond the scope of an approved evaluation and treatment protocol on file with the Board.

The Maryland Board of Physicians supports the Americans with Disabilities Act and will provide this material in an alternative format to facilitate effective communication with sensory impaired individuals (for example, Braille, large print, audio tape). If you need such accommodation, please notify the Board's ADA designee, Yemisi Koya, at (410)764-4777 or 1-800-492-6836. For the hearing impaired, please contact the Maryland Relay Services TTY/Voice number at 1-800-735-2258. If you have a complaint concerning the Board's compliance with the ADA, please contact Ms. Koya.

Please keep a copy of your application.

Maryland Board of Physicians

Check One:
- ☐ Initial Licensure
- ☐ Reinstatement

Name of Profession: _____

ATTENTION

If You Are a Veteran, Service Member or Military Spouse

PLEASE REVIEW AND COMPLETE BEFORE PROCEEDING

"Veteran" *means a former service member who was discharged from active duty under circumstances other than dishonorable within one year before the date on which the application for license, certificate, or registration is submitted.*

"Veteran" *does not include an individual who has completed active duty and has been discharged for more than one year before the application for a license, certification, or registration is submitted.*

*"**Military Spouse**" means the spouse of a service member or veteran,*

"Military Spouse" includes a surviving spouse of:

* *A veteran; or*
* *A service member who died within one year before the date on which the application for license, certification, or registration is submitted.*

*"**Service Member**" means an individual who is an active duty member of:*

* *The Armed Forces of The United States*
* *A reserve component of the Armed Forces of the United States; or*
* *The National Guards of any state*

Complete ONLY if You Meet the Following Criteria

Check the appropriate box.

☐ Service Member — Currently serving in the U.S. Armed Forces, a reserve component of the Armed Forces or National Guards of any state. **Provide supporting documentation.**.

☐ Veteran — Discharged from active military duty under circumstances other than dishonorable within the one year of submitting the application. **Provide supporting documentation.**

☐ Military Spouse: ***Check the appropriate box***

- ☐ Spouse is a Veteran. **Provide supporting documentation.**
- ☐ Spouse was a service member who died within one year before the date of submitting the application. **Provide supporting documentation.**
- ☐ Spouse is a Service Member currently serving in the U.S. Armed Forces, a reserve component of the Armed Forces or National Guards of any state. **Provide supporting documentation.**

_____ _____

Name of Applicant (PRINT) Military Branch

ATHLETIC TRAINER
LICENSURE APPLICATION
01/2017

MARYLAND BOARD OF PHYSICIANS
P.O. Box 37217 • Baltimore, MD 21297
Telephone: 410-764-4777 Fax: 410-358-0404 Toll Free: 800-492-6836

FOR BANK USE ONLY
Date _____
Check Number _____
Amt Paid _____
Name Code _____
App ID: 58
Fee: $200

ATHLETIC TRAINER APPLICATION FOR LICENSURE

Please print legibly or type the required information. Do not leave any item unanswered.

1. **Your Complete Current Legal Name:** As listed on your U.S. birth/marriage certificate, U.S. passport, or most recent document issued by the INS.

Last name and generational indicator (Jr., Sr., II, III, etc.):

First name and middle name:

(If applicable, please check a box and complete below) ☐ Complete Maiden Name OR ☐ Complete Former Name

Stop! If any credential you submit bears a name other than your current legal name as listed above, or if you have been licensed in another state under any name other than your current legal name, sign and date an attachment which includes each different name, an explanation of why the name differs from your current legal name, and a copy of the legal document to support the name change.

2. **Non-Public Address:** This address, usually your home, is for Board use only. However, if no public address is listed, this address will be made public.
Street Address: (Do NOT use a P. O. Box) If you change your address prior to being licensed, immediately notify the Board in writing.

City State Zip Code

3. **Public Address:** Your public address of record. This address, usually your place of employment, is available to the public and may be posted on the Internet.
Street Address: If you change your address prior to being licensed, immediately notify the Board in writing.

City State Zip Code

4. Telephone (s): Home - -
Office: - -
Cell/Pager: - -
E-mail address:

5. Date of Birth: Month Day Year

6. Gender: ☐ Male ☐ Female

7. Race: Check all that apply ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ White

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

8. Social Security Number: - -

For Board Use Only	License Number:		Expiration Date:	
	Date Issued:			
	Licensed By:_____			

Print Your Name: ______________________________ Date:______________

9. Chronology of Employment Activities: Beginning with the date you completed your Athletic Trainer Program, list employment activities as an athletic trainer . Also list any other health related employment. Explain any lapse over 1 year in which you were not employed. Please write N/A below if the statements do not apply to you. Please copy this page if you need more space. Sign and date all additional pages.

Graduation Date from AT Program:
Month: __________ Year: ___________

Employment activities after graduation from Athletic Trainer Program

month	year		month	year	
		TO			Activity/Position:
Name and telephone of Supervisor:					Name and Address of Employer:
month	year		month	year	
		TO			Activity/Position:
Name and telephone of Supervisor:					Name and Address of Employer:
month	year		month	year	
		TO			Activity/Position:
Name and telephone of Supervisor:					Name and Address of Employer:
month	year		month	year	
		TO			Activity/Position:
Name and telephone of Supervisor:					Name and Address of Employer:
month	year		month	year	
		TO			Activity/Position:
Name and telephone of Supervisor:					Name and Address of Employer:
month	year		month	year	
		TO			Activity/Position:
Name and telephone of Supervisor:					Name and Address of Employer:
month	year		month	year	
		TO			Activity/Position:
Name and telephone of Supervisor:					Name and Address of Employer:
month	year		month	year	
		TO			Activity/Position:
Name and telephone of Supervisor:					Name and Address of Employer:

CONTINUED ON PAGE 3: If you will need more space than page 3 allows, please photocopy page 3 for your use or attach a separate sheet. Please sign and date each sheet you attach.

Print Your Name: ______________________________ Date: ______________

Chronology (Cont'd) Please photocopy this page if more space is needed. Sign and date all additional pages.

month	year	TO	month	year	Activity/Position:

Name and telephone of Supervisor:	Name and Address of Employer:

month	year	TO	month	year	Activity/Position:

Name and telephone of Supervisor:	Name and Address of Employer:

month	year	TO	month	year	Activity/Position:

Name and telephone of Supervisor:	Name and Address of Employer:

month	year	TO	month	year	Activity/Position:

Name and telephone of Supervisor:	Name and Address of Employer:

month	year	TO	month	year	Activity/Position:

Name and telephone of Supervisor:	Name and Address of Employer:

month	year	TO	month	year	Activity/Position:

Name and telephone of Supervisor:	Name and Address of Employer:

month	year	TO	month	year	Activity/Position:

Name and telephone of Supervisor:	Name and Address of Employer:

month	year	TO	month	year	Activity/Position:

Name and telephone of Supervisor:	Name and Address of Employer:

month	year	TO	month	year	Activity:

Name and telephone of Supervisor:	Name and Address of Employer:

month	year	TO	month	year	Activity:

Name and telephone of Supervisor:	Name and Address of Employer:

10. EDUCATIONAL PROGRAM: Please complete this section and send the attached Verification of Professional Education (AT 1) to your Athletic Trainer program. (The Board will waive the education requirement for applicants certified by the BOC prior to October 1, 2012 if the applicant has the BOC send verification of certification directly to the Board. See #11)

_____
Name of School/Program accredited by the CAATE, CAHEEP or CAHEA

_____/_____/_____ _____
Graduation Date Degree (Bachelor's, Master's, Certificate)/Area of Study (AT, etc.)

_____
Street Address

_____
City State Zip Code

_____
Telephone Number, including area code

11. National Certification: Please complete all sections. To request a verification, go to the BOC's website, www.bocatc.org and request a written or electronic verification of certification be sent directly to the Board. Electronic verifications may be sent to the Board's email address at mbpmail@rcn.com. Written verifications may be sent to *P.O. Box 2571, Baltimore, MD 21215*. Please do not have the BOC send the verifications to you.

BOC certificate number: _____

Certification Date: _____/_____/_____

Expiration Date: _____/_____/_____

12. ORAL AND WRITTEN COMPETENCY IN ENGLISH (Check one)

_____ I graduated from a recognized English-speaking professional school; OR

_____ I graduated from a recognized English-speaking high school or undergraduate school after at least 3 years of enrollment; OR

I achieved a passing score of at least:

_____ 26 on the spoken part and 79-80 on the written part of the TOEFL.

13 a. Licensure as a Athletic Trainer. List all states or other jurisdictions in which ever held a license/certificate/ registration to practice as a Athletic Trainer. Please complete and mail the attached Verification of Other State Licenses form (AT 2) to the appropriate state board(s). If you have never been licensed as a Athletic Trainer, write N/A here _____.

State	License #	Category (AT)	Year Issued	Expiration Date

13 b. Licensure as another health care practitioner. List all states or other jurisdictions in which ever held a license/ certificate/registration to practice in ANY other health occupation. Please complete and mail the attached Verification of Other State License(s) form (AT 2) to the appropriate state board(s). If you have never been licensed in any other health occupation, write N/A here _____.

State	License #	Category (EMT; Nurse, etc).	Year Issued	Expiration Date

14. Character and Fitness Questions (Check either YES or NO) Please answer questions "a" through "q" on pages 6 and 7.

	YES	NO	
a.	☐	☐	Has a state licensing or disciplinary board (including Maryland), a comparable body in the armed services or the Veterans Administration, ever denied your application for licensure, reinstatement, or renewal?
b.	☐	☐	Has a state licensing or disciplinary board (including Maryland), a comparable body in the armed services or the Veterans Administration, ever taken action against your license? Such actions include, but are not limited to, limitations of practice, required education admonishment or reprimand, suspension, probation or revocation.
c.	☐	☐	Has any licensing or disciplinary board in any jurisdiction (including Maryland), a comparable body in the armed services or the Veterans Administration, ever filed any complaints or charges against you or investigated you for any reason?
d.	☐	☐	Have you ever withdrawn your application for a medical license or other health professional license?
e.	☐	☐	Has a hospital, related health care institution, HMO, or alternative health care system ever investigated you or ever brought charges against you?
f.	☐	☐	Has a hospital, related health care institution, HMO, or alternative health care system ever denied your application; failed to renew your privileges, including your privileges as a resident; or limited, restricted, suspended, or revoked your privileges in any way?
g.	☐	☐	Have you ever pleaded guilty or *nolo contendere* to any criminal charge, been convicted of a crime, or received probation before judgment because of a criminal charge?
h.	☐	☐	Have you ever committed an offense involving alcohol or controlled dangerous substances to which you pled guilty or nolo contendere, or for which you were convicted or received probation before judgment? Such offenses include, but are not limited to, driving while under the influence of alcohol or controlled dangerous substances.
i.	☐	☐	Are there any charges pending against you in any court of law, are you currently under arrest, released pending trial with or without bond, or is there an outstanding warrant for your arrest?
j.	☐	☐	Do you currently have any condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or a physical, mental, emotional, or nervous disorder or condition) that in any way affects your ability to practice your profession in a safe, competent, ethical, and professional manner?

If you answered "YES" to any question, on a separate sheet of paper, please provide a signed and dated detailed explanation and attach appropriate supporting documents.

Failure to provide documentation and a signed and dated explanation will delay the processing of your application.

Continue to Page 7 for questions "k" through "q"

14a. Character and Fitness Questions Continued (Check either YES or NO)

	YES	NO	
k.	☐	☐	Have any malpractice claims or other claims for money damages ever been filed against you? Include past claims as well as any claim that is now pending, has been dismissed, has been settled, or which has resulted in a damages award against you or your medical practice.
l.	☐	☐	Are you in default of a service obligation that you incurred by receiving State or Federal funds for your medical education?
m.	☐	☐	Have you ever failed to make arrangements to satisfy State or Federal loans that financed your medical education?
n.	☐	☐	Has your employment or contractual relationship with any hospital, HMO, other health care facility, health care provider, institution, armed services, or the Veterans Administration ever been terminated for disciplinary reasons?
o.	☐	☐	Have you ever voluntarily resigned or terminated a contract with any hospital, HMO, other health care facility, health care provider, institution, armed services or the Veterans Administration while under investigation by that institution for disciplinary reasons?
p.	☐	☐	Have you ever surrendered your license or allowed it to lapse while you were under investigation by any licensing or disciplinary board of any jurisdiction, any entity of the armed services or the Veterans Administration?
q.	☐	☐	Have you ever been dishonorably discharged from any military service of the U.S. Government? If so, attach a copy of your military discharge documentation that includes type of service, date of discharge, and type of discharge.

»»» If you answered "YES" to any question, on a separate sheet of paper, please provide a signed and dated detailed explanation and attach appropriate supporting documents.

Failure to provide documentation and a signed and dated explanation will delay the processing of your application.

RELEASE AND CERTIFICATION

15. Release:

I agree that the Maryland Board of Physicians (the Board) and the Athletic Trainer Advisory Committee may request any information necessary to process my application for initial licensure as a Athletic Trainer in Maryland from any person or agency, including but not limited to the BOC, former and current employers, government agencies, the National Practitioners Data Bank, the Healthcare Integrity and Protection Data Bank, Federation of State Medical Boards, hospitals and other licensing bodies, and I agree that any person or agency may release to the Board the information requested. I also agree to sign any subsequent releases for information that may be requested by the Board.

Applicant's Name (Printed) _____ Applicant's Signature _____ Date _____

16. (OPTIONAL) Third Party Release: Although the Board encourages you to complete all aspects of your application on your own, if you plan to use an intermediary to receive information about the status of your application, please complete this release.

The Maryland Board of Physicians may release any information pertaining to the status of my application to the following person:

Name: _____

Phone: _____ Applicant's Signature _____ Date _____

17. Cooperation in an Investigation: I agree that I will cooperate fully with any request for information or with any investigation related to my practice as a licensed Athletic Trainer in the State of Maryland, including the subpoena of documents or records.

During the period in which my application is being processed, I shall inform the Board within 30 days of any change to any answer I originally gave in this application, any arrest or conviction, any change of address or any action that occurs based on accusations that would be grounds for disciplinary action under Md. Code Ann., Health Occ. § 14-5D-14.

Applicant's Signature _____ Date _____

18. Certification: To be completed by the applicant in the presence of a notary public after the applicant's picture has been attached below.

I certify that I have personally reviewed all responses to the items in this application and that the information I have given is true and correct to the best of my knowledge and that any false information provided as part of my application may be cause for the denial of my application. I also certify that I am thoroughly familiar with the Statute (MD. Code Ann., Health Occ. 14-5D-01 et seq.) and Code of Maryland Regulations (COMAR) 10.32.08 which govern the practice of Athletic Trainers in Maryland.

Applicant's Signature _____ Date _____

STATE OF _____

CITY/COUNTY OF _____

I HEREBY CERTIFY that on this _____ day of _____ , 20 _____ , before me, _____,
Name of Notary

a Notary Public of the State and City/County aforesaid, personally appeared the Applicant, _____ whose
(Applicant's Name)

whose likeness is identifiable as that of the person in the photograph attached to this application and who

who has made oath in due form of law that signing the foregoing application was his/her voluntary act and

deed.

AS WITNESS my hand and notorial seal. _____
Notary Public

My Commission expires: _____

SEAL

APPLICANT:

PASTE YOUR PASSPORT-QUALITY PHOTO HERE BEFORE NOTARIZING

STOP! Completed application and check for $200 must be mailed to Maryland Board of Physicians, P.O. Box 37217, Baltimore, Maryland 21297
DON'T FORGET TO COMPLETE THE EVALUATION AND TREATMENT PROTOCOL AND KEEP A COPY OF YOUR APPLICATION!

Athletic Trainers

Supplemental Forms

AT 1—Verification of Professional Education (Accredited AT Educational Program)

AT 2—Verification of Other State Licenses

AT 1
Verification of AT Education Supplemental Form

MARYLAND BOARD OF PHYSICIANS
P.O. Box 2571
Baltimore, Maryland 21215-0095
Telephone: 410-764-4777 800-492-6836
www.mbp.state.md.us

For Board Use Only
Program accredited?
_____ Y _____ N
Date verified _____

VERIFICATION OF PROFESSIONAL EDUCATION FOR ATHLETIC TRAINER LICENSURE

Part 1

APPLICANT: Complete Part 1 and send to the institution where you completed your Athletic Trainer program. *(It is not necessary to complete this form if you were certified by the BOC prior to October 1, 2012)*

Name: _____
Last name and generational indicator (Jr., Sr., II, III, etc.) First name Middle name Maiden Name

Date of Birth: _____/_____/_____ Social Secuity Number: _____- _____ - _____
mm dd yyyy

Professional School of Graduation: _____

Attended from: _____ to _____

Date of Graduation: _____ Degree Received: _____
mm/yyyy

Applicant's Signature: _____ Date: _____

Part 2

REGISTRAR, DEAN, PRINCIPAL or OTHER AUTHORIZED OFFICIAL: Please complete this form and mail it to the above address.

I hereby certify that the above-named individual graduated from this institution on: _____
Date of Graduation (mm/yyyy)

The individual graduated with a(n):

☐ Associate's Degree ☐ Certificate ☐ Bachelor's Degree ☐ Master's Degree ☐ Other:_____
(specify)

in _____. The program was accredited by: _____
Educational Program CAATE, CAAHEP, CAHEA, etc.

_____ _____
Printed Name of Authorized Official Name of Institution

_____ _____ _____
Title of Authorized Official Telephone Number Fax Number

_____ _____
Signature of Authorized Official Date

SEAL OF THE INSTITUTION

AT 2
Verification of Licensure in Other States Supplemental Form

MARYLAND BOARD OF PHYSICIANS
P.O. Box 2571
Baltimore, Maryland 21215-0095
Telephone: 410-764-4777 800-492-6836

VERIFICATION OF OTHER STATE LICENSES

Part 1

APPLICANT: Complete and sign Part 1 and send a copy of this form to each state board that ever issued you a license/certificate/registration to practice as an Athletic Trainer. Also use this form to send to each state board, including Maryland, that ever issued you a license/certification/registration to practice as ANY other health care practitioner. Please copy this form if you need to send it to more than one state board.

License Type: _____

State of Licensure: _____ License Number: _____

Date: _____ Expiration Date: _____

Name: _____
(Print) Last (Generational Indicator, Jr., III) First Middle Maiden

Social Security No. : _____ Date of Birth: _____/_____/_____

Professional School of Graduation: _____ Year: _____

Signature: _____ Date: _____

Part 2

AUTHORIZED OFFICIAL OF STATE MEDICAL BOARD: Please certify the following information regarding the above-listed individual and send this form directly to the Maryland Board of Physicians at the above address.

_____ _____ _____ _____
License type License number Date Issued Expiration Date

Is/was the license in good standing? ☐ Yes ☐ No

If not in good standing is/was it: ☐ reprimanded ☐ suspended ☐ revoked ☐ surrendered ☐ Other

Was the license administratively revoked, suspended, or surrendered because the licensee did not renew? ☐ Yes ☐ No

If yes, please explain: _____

_____

Other Derogatory Information or Pending Charges: _____

_____

_____ _____
Printed Name of Authorized Official Direct Telephone Number

_____ _____
Title of Authorized Official Printed Name of State

_____ _____
Signature of Authorized Official Date

State Board Seal

REMINDER NOTICE FOR ATHLETIC TRAINERS

In order to practice athletic training in Maryland, an athletic trainer must submit an Evaluation and Treatment Protocol. The Protocol must be completed by the athletic trainer and the supervising physician and submitted to the Board for approval.