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 BOARD OF PHYSICIANS

Baltimore, Maryland
www.mbp.state.md.us

APPLICATION FOR MEDICAL LICENSURE BY CONCEDED EMINENCE

Dear Applicant:

Attached is an application packet for Medical Licensure by Conceded Eminence. The licensure fee is $1,090.00.

Please make your check or money order payable to: **Maryland Board of Physicians**. Mail your application and payment 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 extra step will delay the processing of your application. **Please note: Federal Express (FedEx) and UPS do not deliver to post office boxes.**

An application that is submitted to the Board without the correct application fee will be returned to the applicant. Incomplete applications and/or failure to submit the required information will delay the processing of your application.

The Board does not confirm receipt of the application and payment. Once the application has been reviewed, applicants will be notified via e-mail with the status of the application. Please do not call the Board to check on the status of your application, as constant interruptions slow down the process.

We look forward to receiving your completed application.

Thank you,
The Licensure Division
Maryland Board of Physicians

Maryland Board of Physicians

APPLICATION FOR IML Conceded Eminence

FOR BANK USE ONLY
Date ___/_____/_____
Check Number _____
Amt Paid _____
Name Code_____
App ID : 20

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 documents.**

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

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

- ☐ Spouse is a Veteran. **Provide supporting documents.**
- ☐ Spouse was a service member who died within one year before the date of submitting the application. **Provide supporting documents.**
- ☐ 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 documents.**

_____

Name of Applicant (PRINT)

MARYLAND BOARD OF PHYSICIANS

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

APPLICATION FOR MEDICAL LICENSURE BY CONCEDED EMINENCE
INSTRUCTIONS AND IMPORTANT INFORMATION

Fee: $1,090.00

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 authorizing the name change. The Board of Physicians (the Board) must be notified of any change in your name on a timely basis.

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

3. **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 by mail.

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

5. **Date of Birth:** Health Occupations Article §14-307(c), Annotated Code of Maryland, requires applicants to be at least 18 years old. Date of birth also will be used for identification and criminal background checks.

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

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

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

   A. Verification of identity with respect to actions related to your license (COMAR 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. §1396a(a)(49); 42 U.S.C. §1396r-2; 42 U.S.C. §1320a-7].

9. **Chronology of Activities:** Beginning with the date you completed medical school and continuing through the present, list chronologically all of your activities, including hospital privileges. Account for all periods of time including each postgraduate training program you attended, regardless of whether or not you completed the program; each job you held, regardless of whether or not it was medically related or you were compensated; and any period of unemployment.

APPLICATION FOR MEDICAL LICENSURE BY CONCEDED EMINENCE
INSTRUCTIONS AND IMPORTANT INFORMATION *(CONTINUED)*

10. **Verification of Professional Education:** Complete Part 1 of the **Verification of Education and English Language Instruction form (CONEM 4)** and forward it to the institution which issued your medical degree. ***The school must return the form directly to the Board at the address listed on the top of the form.***

11. **Oral and Written Competency in English:** Demonstrate verbal and written competency in the English language by any of the following:
    a. Documentation of graduation from an English-speaking high school or undergraduate school after at least three years of enrollment;
    b. Documentation of graduation from an English-speaking professional school;
    c. Documentation of receiving a passing score of at least 26 on the "Speaking Section" of the Test of English as a Foreign Language (TOEFL)*;
    d. Documentation of receiving a passing score of Advanced or higher on the Oral Proficiency Interview (OPI)*.

***Information about TOEFL and OPI**

TOEFL: To schedule the test or obtain score reports for the TOEFL, contact the Educational Testing Services at *http://www.ets.org/toefl/contact/region1.* You will be asked to provide a PDF copy of your score report.

OPI: For information about the OPI, contact Language Testing International (LTI) at *www.languagetesting.com or at 914-963-7110. LTI will provide information, including how to make the payment for testing. LTI can schedule an interview within 24-72 hours after receiving payment. They will arrange a specific date and time for your telephone interview.*

Applicants must have an application on file with the Board before scheduling an interview with LTI.

12. **Licensure in Other States:** If you have ever held a license to practice medicine as a physician in any state or jurisdiction, complete Part 1 of the **State Board Licensure Verification form (CONEM 5)** and send it to the licensing board in each state in which you are or have been licensed/certified/registered. This includes training licenses.

    PLEASE check with the applicable state board to see if there is a fee required for this information prior to mailing the form. **Please do not send copies of your licenses.** ***The state licensing authority must return the form directly to the Board at the address listed on the top of the form.***

13. **Character and Fitness Questions:** Answer the Character and Fitness questions "YES" or "NO." If you answer "YES" to any question, on a separate sheet of paper, please provide a detailed explanation with any supporting documents. If you were dishonorably 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. DD 214. *Failure to provide a detailed explanation of a "YES" response and the required supporting documentation will delay the application process.*

14. **Release:** Sign and date the certification. You are giving the Board permission to request additional information to support your application for licensure.

15. **Optional Third Party Release:** Board staff will not disclose the status of your application to any party unless you have completed the optional Third Party Release on Page 6 of the application. Please complete the third party release if you want the status of your application disclosed to another party, including family members, friends, and future employers, etc.

16. **Cooperation in an Investigation:** You are expected to cooperate fully with any request for information related to your application for medical licensure by conceded eminence.

17. **Affidavit and Passport Quality Photo:** Sign and date the certification in the presence of a notary public after you have affixed a recent **original** passport quality (2" x 2") color photo to the application in the space provided. Both you and the notary should sign the application on the same day. Group photos and copies of photos are not acceptable.

ADDITIONAL INFORMATION AND REQUIREMENTS

In addition to completing the application, the applicant also must meet additional requirements for medical licensure by conceded eminence.

1. **Recommendations:** The dean of a medical school in Maryland or the director of the National Institutes of Health (NIH) shall recommend the applicant to the Board. The dean of the medical school or director of NIH must complete supplemental form **CONEM 1.** The applicant must include the form with the application.
2. **Evidence of Teaching, Research, and Achievement:** The applicant shall demonstrate eminence and authority in the profession by meeting certain qualifications. The applicant must complete supplemental form **CONEM 2** and submit it with the application.
3. **Supervision:** The applicant shall submit the name of the licensed physician who will supervise the medical services the applicant will be providing for the first 6 months of practice and a detailed description of the medical services, duties, and responsibilities the applicant will perform. The supervising physician must complete supplemental form **CONEM 3** for the applicant to submit with the application.
4. **Letter from the Chief of Staff:** The Board may require the applicant to provide a letter from the chief of staff of any hospital where the applicant has practiced within the 5 years preceding the submission of this application, detailing the applicant's competence to practice medicine. Board staff will contact applicants on a case-by-case basis.
5. **Documentation of Speech Impairment:** An applicant wishing to claim speech impairment shall submit documentation of the impairment.
6. **ECFMG Certification:** If applicable, please provide a copy of your ECFMG Certificate.

Controlled Dangerous Substances Registration

For information regarding Controlled Dangerous Substances (CDS) Registration, you may contact the agencies listed below. You must obtain your CDS Registration from the Maryland Department of Health, Office of Controlled Substances Administration prior to contacting the Drug Enforcement Administration.

CDS Registration

Office of Controlled Substances Administration
Maryland Department of Health
4201 Patterson Avenue
Baltimore, Maryland 21215
410-764-2890
https://health.maryland.gov/ocsa/

Drug Enforcement Administration

Drug Enforcement Administration
U.S. Department of Justice
200 St. Paul Street, Suite 2222
Baltimore, Maryland 21202
410-244-3500
https://www.deadiversion.usdoj.gov/

New Physician Orientation Education Program

Maryland Board of Physicians online New Physician Orientation Educational Program: All newly licensed physicians are required to complete this program prior to the first renewal of the license. You may access this program on the Board's Website at *https://www.mbp.state.md.us/bpqanpo/*.

Statutes and Regulations

The law governing the practice of medicine in Maryland (Health Occupations Article, Title 14, (Sections 14-101 through 14-702) and the Board's regulations, Code of Maryland Regulations (COMAR) 10.32.01, *et seq*., may be accessed at the Board's Website at *www.mbp.state.md.us*.

PRACTICING AS A PHYSICIAN: A person may not practice, attempt to practice, or offer to practice as a physician in Maryland unless licensed to practice medicine by the Board. Individuals practicing without a license may be fined up to $50,000.

IMPORTANT: Criminal History Records Check (CHRC)

By law, effective October 1, 2016, a full criminal history records check (CHRC) is a requirement for all applicants applying for licensure. There are NO EXCEPTIONS. A CHRC includes both State and FBI checks. The Department of Public Safety and Correction Services, Criminal Justice Information Services (CJIS), oversees CHRCs, which are conducted using fingerprints. **The Board cannot issue a license until the CHRC information has been received and reviewed.**

Please refer to the information on CHRCs and fingerprinting at the front of this application package.

Withdrawal of an Application

An application may not be withdrawn if the applicant is under investigation or charges for reasons that may be grounds under Health Occupations Article, §14-404, Annotated Code of Maryland, if the applicant were licensed in this State. *See COMAR 10.32.13.03I.*

The Maryland Board of Physicians supports the Americans with Disabilities Act (ADA) 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.

Conceded Eminence
PERSONAL INFORMATION
3/2018

MARYLAND BOARD OF PHYSICIANS

P.O. Box 37217 • Baltimore, MD 21297
Telephone: 410-764-4777 or Toll Free: 800-492-6836

APPLICATION FOR MEDICAL LICENSURE BY CONCEDED EMINENCE

FOR BANK USE ONLY
Date _____
Check Number _____
Amount Paid _____
Name Code _____
App ID 20
Fees: $1,090.00

Please print legibly or type the required information. Do not leave any item unanswered. If an item does not apply to you, write "N/A" (Not Applicable) for that item. An incomplete application form will delay the processing of your application.

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.): Complete name you would like to appear on your License.

First name and middle name:

(If applicable, please check a box and complete below) □ Complete Maiden Name OR □ Complete Former Name □ Complete Legal 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. Public Address: Your public address of record. This address, usually your office, is available to the public and will 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

3. 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

4. Telephone(s): Home

Office:

Cell/Pager:

E-mail Address:

5. Date of Birth: Month Day Year

6. Gender: ☐ Male ☐ Female

7. Race: Multiracial applicants may select all applicable categories ☐ 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. U.S. Social Security Number:

For Board Use Only

License Number: Date Issued:

Licensed By: _____

9. Chronology of Activities: DO NOT ATTACH A RESUME OR CURRICULUM VITAE.

Beginning with the date you completed medical school and continuing through the present, list chronologically all of your activities, including hospital privileges. Account for all periods of time, including each postgraduate training program you attended, regardless of whether or not you completed the program; each job you held, regardless of whether or not it was medically related or you were compensated; and any period of unemployment.

Date Medical School was Completed:	month	year

Activities after completing medical school: Please type or print.

month	year	TO	month	year	
					Activity:
					Address:
					Activity:
					Address:
					Activity:
					Address:
					Activity:
					Address:
					Activity:
					Address:
					Activity:
					Address:
					Activity:
					Address:
					Activity:
					Address:

If you will need more space than this page allows, please photocopy it for your use or attach a separate sheet. Please sign and date each sheet that you attach.

10. **MEDICAL EDUCATION: List all medical schools you have attended.** **From: MM/YY To MM/YY**

_____ _____

_____ _____

Medical School From Which You Received Your Medical Degree: _____

Name of University Affiliation (if applicable)**: *** _____

Street Address: _____

City: _____ **State/Province:** _____ **Country of citizenship during medical education:** _____

Language(s) of Instruction: _____

Type of Degree: ☐ M.D. ☐ D.O. ☐ M.D./Ph.D ☐ M.B.B.S. ☐ M.B.B.Ch ☐ **Other:** _____ **(specify)**

***Date Degree Was Conferred:** The date you officially received your degree after all prerequisite obligations, required training, government service, etc. was satisfied.

Month ☐☐ Day ☐☐ Year ☐☐

11. **Oral and Written English Language Competency Requirements.** Applicants must demonstrate oral and written competency in English by at least one of the following: (Check one)

a. ☐ Documentation of graduation from a recognized English-speaking high school (includes GED) or undergraduate college or university where English was the *only* language of instruction, after at least three years of enrollment; **or**

b. ☐ Documentation of graduation from a recognized English-speaking medical school; **or**

c. ☐ Documentation of receiving a score of at least 26 on the "Speaking Section" of the Internet–Based TOEFL(IBT); or

d. ☐ Documentation of receiving a passing score of Advanced or higher on the Oral Proficiency Interview (OPI).

12. **Licensing History:** List all the states or jurisdictions where you have held a license to practice medicine. Please complete and mail the attached State Board Licensure Verification form (**CONEM 5**) and send it to the appropriate state/jurisdiction. If you have never been licensed as a physician, please write N/A here _____. (**If more space is needed, attach an additional signed and dated sheet.)**

STATE/ JURISDICTION	LICENSE NUMBER	CURRENT STATUS			
		Date of Licensure	Expired / Lapsed	Active	Inactive

13. Character and Fitness Questions (Check either **YES** or **NO**) Please answer questions "a" through "q" on pages 4 and 5.

	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 5 for questions "k" through "q"

13. 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

14. Release: I agree that the Maryland Board of Physicians (the Board) and the Licensure Practice of Medicine Committee may request any information necessary to process my application for licensure by conceded eminence in Maryland from any person or agency, including but not limited to individual physicians, government agencies, the National Practitioner Data Bank, Federation of State Medical Boards, hospitals, and other licensing bodies. I also agree to sign any subsequent release for information that may be requested by the Board and allow the Board to release information that is not statutorily protected.

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

15. (OPTIONAL) Third Party Release: 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.
I agree that the Maryland Board of Physicians may release any information pertaining to the status of my application to the following person:

Name: _____ **Signature:** _____

Phone: _____ **Date:** _____

E-mail Address: _____

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

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. § 14-404.

_____ _____
Applicant's Signature Date

17. 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 the responses in this application and that the information I have given is true and accurate to the best of my knowledge. I understand and agree that I may not practice, attempt to practice, or offer to practice medicine in Maryland unless licensed by the Board. I also certify that I am thoroughly familiar with Health Occupations Article, Title 14, (Sections 14-101 through 14-702) and the Board's regulations, Code of Maryland Regulations (COMAR) 10.32.01, *et seq,* which govern the practice of medicine in Maryland.

_____ _____
Applicant's Signature Date

STATE OF _____, CITY/COUNTY OF _____, I HEREBY CERTIFY that on this

_____ day of _____, 20_____, before me, a Notary Public of the State and City/County aforesaid, personally

appeared the Applicant, _____, whose likeness is identifiable as that of the individual in the photograph
(print applicant's name)
attached to this application and who has made oath in due form of law to be the individual referenced in the above application for license to practice medicine and surgery in Maryland, and to have stated the truth in all statements made in this application.

AS WITNESS my hand and notarial seal. _____
Notary Public

My Commission expires: _____ SEAL

The date the applicant and the notary sign the application must be the same.

APPLICANT:

PASTE YOUR PASSPORT-QUALITY PHOTO HERE
BEFORE NOTARIZING

COPIES OF PHOTOS OR GROUP PHOTOS ARE NOT ACCEPTABLE

MEDICAL LICENSURE BY CONCEDED EMINENCE

Supplemental Forms

- **CONEM 1 — Recommendation**
- **CONEM 2 — Evidence of Teaching, Research, and Achievement**
- **CONEM 3 — Supervision of Applicant**
- **CONEM 4 — Verification of Education and English Language Instruction**
- **CONEM 5 — State Board Licensure Verification**
- **CONEM 6 — Documentation of Speech Impairment (Part A, B, and C)**

Conceded Eminence Supplemental Form MBP CONEM 1 3/2018

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

RECOMMENDATION

To: Maryland Board of Physicians

From: _____ Dean, Johns Hopkins University School of Medicine
_____ Dean, University of Maryland School of Medicine
_____ Dean, Uniformed Services University of the Health Sciences
_____ Director, National Institutes of Health

Re: Application of _____, M.D.

Date: _____

I recommend Dr. _____ for a medical license by conceded eminence and attest that the applicant will be
Name of Applicant

appointed _____ at the _____, effective _____.
Title Name of Institution Date

The applicant's proposed responsibilities will be as follows:

_____

_____

_____

_____

_____

_____

Cite any reasons for any limitations of those practice responsibilities:

_____

_____

_____

_____

Conceded Eminence
Supplemental Form
MBP CONEM 1
3/2018

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

RECOMMENDATION *(Continued)*

Describe the degree of supervision under which the applicant will function:

_____

_____

Provide a detailed statement describing the applicant's conceded eminence and authority in the profession, e.g. development of a treatment modality or surgical technique or other verified original contributions to the field of medicine:

_____

_____

_____

_____

_____

_____
Dean/Director's Signature

_____
Name in Print and Full Title

_____
Full Name of Institution

_____
E-mail Address

_____
Telephone number (including area code)

_____
Date

SEAL

OF THE

INSTITUTION

Conceded Eminence Supplemental Form MBP CONEM 2 3/2018

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

EVIDENCE OF TEACHING, RESEARCH, AND ACHIEVEMENT

Applicants applying for licensure by conceded eminence must demonstrate eminence and authority in the profession by meeting the following qualifications:

Under penalties of perjury, I attest that I have the following qualifications: (Check each appropriate box.)

A. I have held an appointment at a medical school at the level of ☐ Associate Professor or ☐ Full Professor at the following medical school:

_____
Name of the medical school

_____
Address of medical school

for at least _____ years, and the medical school is approved by the ☐ Liaison Committee of Medical Education
Number

or is listed in the ☐ World Health Organization (WHO) Directory.

B. I have actively practiced medicine cumulatively for at least 10 years, after completion of postgraduate training including research.

C. I am a member in good standing of the Board of _____ of the American Board of Medical Specialties or other equivalent specialty board. Attached is a copy of the applicable board certificate.

D. I posses a current, active, unrestricted license to practice medicine in another state or country or I am otherwise legally recognized as a medical doctor in another country.

E. Please check one qualification:

☐ 1. Within 10 years prior to this application, I have, as first author or last author, published original results of clinical research in a medical journal listed in the Index Medicus, or in an equivalent scholarly publication acceptable to the Board and hereby submit the attached copies of these articles in English or in a foreign language with verifiable, certified translations in English; **OR**

☐ 2. Within 10 years prior to this application, I have developed a treatment modality, surgical technique, or other verified original contribution to the field of medicine, which is attested to by the dean of a medical school in Maryland or by the director of the National Institutes of Health.

_____ _____
Signature Date

Conceded Eminence
Supplemental Form
MBP CONEM 3
3/2018

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

SUPERVISION OF APPLICANT

To: Maryland Board of Physicians

From: Supervising Physician

Re: Application of _____, M.D.

Date: _____

I am/will be the supervising physician of the applicant. The detailed description of the medical services, duties, and responsibilities that the applicant will perform are listed below:

_____

_____

_____

_____

_____

_____

_____

Under penalties of perjury, I attest that I have the information I have provided on this form are true and correct to the best of my knowledge and belief:

_____
Name and Title of Supervising Physician (Print)

_____ _____
Signature of Supervising Physician Date

_____
Name of Institution where applicant and the supervising physician will work together

_____ _____
Telephone Number, including area code, of supervising physician E-mail Address

Conceded Eminence
Supplemental Form
CONEM 4
3/2018

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

VERIFICATION OF EDUCATION AND ENGLISH LANGUAGE INSTRUCTION

Part 1

APPLICANT: Complete Part 1 and send this form to the institution which issued your medical degree. If you satisfied Maryland's English language competency requirements somewhere other than your medical school, also send a copy of this form to that institution and ask the institution to return the completed form directly to the Board.

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

Date of Birth: Month ☐☐ Day ☐☐ Year ☐☐ **Social Security Number:** ☐☐☐-☐☐-☐☐☐☐

School(s) Attended: _____
Only medical school, undergraduate school, or high school

Affiliated with (if applicable): _____
Name of institution that conferred your degree, if different from medical college attended

Attended from: _____ **to** _____ **Date of Graduation:** _____

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 attended this institution during the inclusive dates from

Month ☐☐ Day ☐☐ Year ☐☐ to Month ☐☐ Day ☐☐ Year ☐☐ ; that all academic studies were taught in the

language(s) of _____ ; that all clinical clerkships were taught in the

language(s) of _____ ; and that he/she was conferred the degree of

☐ M.D. ☐ D.O. ☐ M.D./Ph.D ☐ M.B.B.S. ☐ M.B.B.Ch ☐ Other:_____ (specify)

on Month ☐☐ Day ☐☐ Year ☐☐ after he/she had satisfied all prerequisite obligations.

_____ _____
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

Conceded Eminence
Supplemental Form
MBP CONEM 5
3/2018

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

STATE BOARD LICENSURE VERIFICATION

Part 1 **APPLICANT: Complete Part 1 and send a copy of this form to each medical board in the U.S., U.S. territories, Puerto Rico, or Canada that ever issued you a license or administered to you a state/provincial licensing examination.**

1. _____ State of Licensure
2. _____ License Number
3. _____ Date Issued
4. _____ Last Name Under Which You Were Licensed _____ First Name _____ Middle Name
5. _____ Current Last Name if Different from Above _____ First Name _____ Middle Name
6. Any restrictions, conditions, etc., on your license to practice medicine? ☐ Yes ☐ No

   If yes, explain: _____
7. Present status of Medical license: _____

_____ 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.**

1. _____ License Number
2. _____ Date of Original Licensure
3. _____ Date License Expires/Expired

4. Is the license in good standing or, if expired, was the license in good standing at the time of expiration? ☐ Yes ☐ No

5. Is there, or has there ever been, derogatory information, pending charges, or disciplinary action taken against this license? ☐ Yes ☐ No

   If "Yes": ☐ pending charges ☐ reprimanded ☐ suspended ☐ revoked ☐ surrendered ☐ terms/conditions/probation

   ===> On the back of this form, or as an attachment, please explain any discipline information and include all available documentation.

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

7. Was the applicant licensed in your state based on an examination administered by your state rather than an examination administered by the Federation of State Medical Boards, the National Board of Medical Examiners, or the National Board of Osteopathic Medical Examiners? ☐ Yes ☐ No

If the answer to question 7 was "Yes", please attach an official copy of the exam results.

_____ Printed Name of Authorized Official
_____ Direct Telephone Number
_____ Title of Authorized Official
_____ Printed Name of State
_____ Signature of Authorized Official
_____ Date

State Board Seal

Conceded Eminence
Supplemental Form
CONEM 6 Part A
3/2018

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

DOCUMENTATION OF SPEECH IMPAIRMENT

Part A — To be completed by the Applicant

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

Type of speech impairment claimed: _____

Onset of impairment: _____

Status of impairment: _____

Name of treating physician: _____

Name of speech pathologist: _____

Number of times to date applicant took the Test of English as a Foreign Language or equivalent examination approved by the Board: _____

_____
Signature Date

Part B on the next page of this form must be completed.

Conceded Eminence
Supplemental Form
CONEM 6 Part B
3/2018

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

DOCUMENTATION OF SPEECH IMPAIRMENT

Part B — To be completed by the treating physician

History: _____

_____

_____

_____

Diagnosis including results of specific test: _____

_____

_____

_____

Treatment: _____

_____

_____

_____

Current Status: _____

_____

_____

_____

Recommendation: _____

_____

_____

_____

_____ _____
Name of Treating Physician (Print) **Signature of Treating Physician**

_____ _____
Telephone Number (including area code) **E-mail Address**

_____
Date

Part C on the next page of this form must be completed.

Conceded Eminence
Supplemental Form
CONEM 6 Part C
2/2018

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

DOCUMENTATION OF SPEECH IMPAIRMENT

Part C — To be completed by the speech pathologist

History: _____

_____

_____

_____

Diagnosis including results of specific test: _____

_____

_____

_____

Treatment: _____

_____

_____

_____

Current Status: _____

_____

_____

_____

Recommendation: _____

_____

_____

_____

_____ _____
Name of Speech Pathologist (Print) **Signature of Speech Pathologist**

_____ _____
Telephone Number (including area code) **E-mail Address**

_____
Date

CHECKLIST

MARYLAND BOARD OF PHYSICIANS

P.O. Box 2571

Baltimore, Maryland 21215-0095

APPLICATION FOR MEDICAL LICENSURE BY CONCEDED EMINENCE

Checklist for the Applicant

Have you:

☐ Completed the application form?
☐ Enclosed an explanation for different names on your credentials and supporting legal document, if applicable?
☐ Attached additional sheets, with your name and date on each page, listing your activities after graduation, if applicable?
☐ Enclosed a detailed explanation and documentation for each "YES" answer given to any of the questions under Item 13, if applicable? Each additional attached page must bear your name and date.
☐ Sent the Recommendation form, MBP CONEM 1, to a dean of a medical school in Maryland or the director of the National Institutes of Health for completion and submission to the Board?
☐ Completed and submitted the Evidence of Teaching, Research, and Achievement form, MBP CONEM 2?
☐ Attached copies of articles in English or in a foreign language with a verifiable, certified translation, if applicable? The articles must be on original results of your clinical research that have been published in a medical journal listed in the Index Medicus or in an equivalent scholarly publication. You must be either the first author or last author on the publication(s).
☐ Attached a copy/copies of your specialty board certificate(s), if applicable?
☐ Sent the Supervision of Applicant form, MBP CONEM 3, to your supervising physician for completion and submission to the Board?
☐ Completed and submitted the Verification of Education and English Language Instruction form, MBP CONEM 4?
☐ Requested the applicable agencies to submit directly to the Board your scores on the Test of English as a Foreign Language, if applicable?
☐ Completed Part A of the State Board Licensure Verification form, MBP CONEM 5, and sent it to each state medical board that ever issued you a license for completion and submission to the Board, if applicable?
☐ Completed Part A of the Documentation of Speech Impairment, MBP CONEM 6, and sent Part B and Part C to your treating physician and speech pathologist, respectively, for completion and submission to the Board, if applicable?
☐ If applicable, provided a copy of your ECFMG certificate?