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.
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](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](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.*
APPLICATION FOR INITIAL MEDICAL LICENSURE

Dear Applicant:

Attached is an application packet for Initial Medical Licensure. The licensure fee for American Medical Graduates is $790 and $890 for Foreign Medical Graduates.

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 will delay the processing of your application. Please note: Federal Express (FedEx) and UPS do not deliver to post office boxes.

Applications are processed in the order they are received. 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.

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.

Supporting documents must come directly from the source. For example, verification of education must come directly from your school.

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. If the requirements are not met, your application will be closed, and a new application and full licensure 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 learn if a license was issued to you. When you visit the Website, click on Look up a Licensee.

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

Thank you,

The Licensure Division
Maryland Board of Physicians
APPLICATION FOR INITIAL MEDICAL LICENSURE
INSTRUCTIONS AND IMPORTANT INFORMATION

Fees: $790 — American Medical Graduates
$890 — Foreign Medical Graduates

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 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.

3. Non-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.

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. Federation Credentials Verification Service (FCVS): The FCVS can assist applicants with the credentialing process. Maryland is one of many states that accepts credentials verified by FCVS. For further information, contact FCVS at 817-868-5000, 888-275-3287, or www.fsmb.org. Please be aware that the FCVS profile does not include the Record of Scores from the National Board of Medical Examiners (NBME) or the verification of medical licenses in other states. Applicants who use FCVS will need to arrange for these verifications to be sent to the Board. If you plan to use FCVS services, please begin the process at least two months prior to submitting your application to the Board and check the box in Item 9 on the application indicating that you are using the FCVS service.
10. **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.

11. **Verification of Professional Education:** Complete Part 1 of the Verification of Education and English Language Instruction form (IML 2) 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.*

12. **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 (medical) school;
   c. Documentation of a passing score on the USMLE Step 2 Clinical Skills*;
   d. Documentation of receiving a passing score of at least 26 on the “Speaking Section” and 79 on the written part of the Test of English as Foreign Language (TOEFL)*;
   e. Documentation of receiving a passing score of Advanced or higher on the Oral Proficiency Interview (OPI)*.

### *Information about TOEFL, OPI, and Clinical Skills*

**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](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](http://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.*

**Clinical Skills:** The Board will only accept USMLE Step 2 Clinical Skills as demonstration of oral and written competency in English. The Board will not accept the Clinical Skills Assessment administered by the ECFMG or the USMLE Step 2 Clinical Knowledge as demonstration of oral and written competency in English.

13. **Postgraduate Training:** Complete this section and complete Part 1 of the Verification of Postgraduate Medical Education form (IML 3) and send it to each postgraduate training program you attended. American Medical Graduates must have successfully completed at least one year of Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) accredited postgraduate training or equivalent training as determined by the Board. Foreign Medical Graduates must have successfully completed at least two years of ACGME or AOA-accredited postgraduate training or equivalent training as determined by the Board.

**NOTE:** On a case by case basis, the Board may consider full-time teaching in an LCME-accredited medical school in the United States as an alternative to the accredited postgraduate clinical medical education required in the Code of Maryland Regulations (COMAR) 10.32.01.03E. Applicants who intend to request consideration of teaching experience as an alternative to accredited postgraduate clinical education should contact the Board’s Licensure Unit for further information.
14. **Medical Licensing Examination:** Applicants applying for a medical license must provide documentation of having passed a medical licensing examination, e.g., USMLE, NBME, NBOME, COMLEX, FLEX, State Board, or LMCC. Written or electronic documentation of passing a medical licensing exam must be sent directly to the Board, by e-mail or mail, from the agency that administered the examination.

Mail documentation of passage to: P.O. Box 2571, Baltimore, MD 21215. (Do Not send your licensure application to this address.) Electronic verification of passage may be e-mailed to: mdh.nbpergredients@maryland.gov

<table>
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<tr>
<th>Exam</th>
<th>Contact</th>
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<tr>
<td>USMLE, FLEX</td>
<td>Federation of State Medical Boards—<a href="http://www.fsmb.org">www.fsmb.org</a></td>
</tr>
<tr>
<td>NBME</td>
<td>National Board of Medical Examiners—<a href="http://www.nbme.org">www.nbme.org</a></td>
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<tr>
<td>NBOME/COMLEX</td>
<td>National Board of Osteopathic Medical Examiners—<a href="http://www.nbome.org">www.nbome.org</a></td>
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<tr>
<td>LMCC</td>
<td>Medical Council of Canada—<a href="https://mcc.ca/services/file-transfer-and-access-service/">https://mcc.ca/services/file-transfer-and-access-service/</a></td>
</tr>
<tr>
<td>State Board</td>
<td>Contact the appropriate state medical board</td>
</tr>
</tbody>
</table>

**Notice to Applicants Who Failed Any Part, Step, Level, or Component of an Exam Three or More Times**

An applicant who passes any of the required exams after having failed any part, step, level, or component three or more times must meet the requirements in numbers 1-3 or 4 below. If you meet the requirements in numbers 1-3, complete the **Verification of Clinical Practice form (IML 4)**. If you meet the requirements in number 4, the Board will verify your Board certification.

1. No disciplinary action pending and no disciplinary action taken against the applicant that would be grounds for discipline under Health Occupations Article, §14-404, Annotated Code of Maryland; **and**
2. Successful completion of 2 or more years of an ACGME or AOA-accredited residency or fellowship; **and**
3. A minimum of 5 years of clinical medicine experience in the U.S. or in Canada under a full unrestricted medical license with at least 3 of the 5 years having occurred within 5 years of the date* of the application; **or**
4. Board certification.

   * This is the date the Applicant signs the IML application.

15. **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 and Examination Certification form (IML 7)** 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.

16. **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.**
17. Special Purpose Exam (SPEX) or Comprehensive Osteopathic Medical Variable-Purpose Exam (COMVEX): The Board will require an applicant to pass the SPEX or COMVEX if the applicant:

- Passed a medical licensing exam more than 15 years before submitting the application for licensure;
- Never passed a specialty board certification exam or passed a specialty board certification exam given by a member board of the American Board of Medical Specialties or the AOA Bureau of Osteopathic Specialists more than ten years before submitting the application;
- Has not had a full, unrestricted medical license in at least one state of the U.S. or Canada within the ten-year period before submitting the application; and
- Has not actively practiced clinical medicine in the U.S. or Canada for at least seven of the ten years before submitting the application.

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

19. 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 9 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.

20. Cooperation in an Investigation: You are expected to cooperate fully with any request for information related to your application for initial medical licensure.

21. 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.

**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.*

**Please keep a copy of your application.**
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 http://www.mbp.state.md.us/bpqanpo/index.asp.

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 Department of Health and Mental Hygiene, Office of Controlled Substances Administration prior to contacting the Drug Enforcement Administration.

<table>
<thead>
<tr>
<th><strong>CDS Registration</strong></th>
<th><strong>Drug Enforcement Administration</strong></th>
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<tr>
<td>Office of Controlled Substances Administration</td>
<td>Drug Enforcement Administration</td>
</tr>
<tr>
<td>Maryland Department of Health</td>
<td>U.S. Department of Justice</td>
</tr>
<tr>
<td>4201 Patterson Avenue</td>
<td>200 St. Paul Street, Suite 2222</td>
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<tr>
<td>Baltimore, Maryland 21215</td>
<td>Baltimore, Maryland 21202</td>
</tr>
<tr>
<td>410-764-2890</td>
<td>410-244-3509</td>
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<tr>
<td><a href="https://health.maryland.gov/OCSA/Pages/home.ASPX">https://health.maryland.gov/OCSA/Pages/home.ASPX</a></td>
<td><a href="https://www.deadiversion.usdoj.gov/">https://www.deadiversion.usdoj.gov/</a></td>
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**LICENCES**

⇒ **Issuance:** Once you have met the requirements for licensure, the Board will issue a license to you.

⇒ **Expiration:** If your last name begins with the letters A-L, regardless of the date your license is issued, your license will expire on September 30 of the first even year following issuance of the license.

If your last name begins with the letters M-Z, regardless of the date your license is issued, your license will expire on September 30 of the first odd year following issuance of the license.

⇒ **Renewal:** Approximately 60-90 days prior to the expiration date, you should receive a notice to renew your license. The notice will include the renewal fee. The renewal notice will be mailed/e-mailed to the address on file with the Board. Please make sure that your mailing and email addresses current.

*You are required to renew by September 30th of your renewal cycle year whether or not you receive the renewal notice. If you do not renew your license by September 30th of your renewal cycle year, your license will expire and you will be required to reinstate it if you wish to practice medicine in Maryland.*

**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.

**Statutes and Regulations**

The law governing the practice of medicine in Maryland (Health Occupations Article, Title 14, §§14-101 to 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.

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.
Check One:

- [ ] Initial Licensure
- [ ] Reinstatement

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 ____________________________________________
APPLICATION FOR INITIAL MEDICAL LICENSURE

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 License.
   
   First name and middle name:
   
   (If applicable, please check a box and complete below) □ Complete Maiden Name OR □ Complete Former Name □ Completed 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**
   
   - - - -
   
   Cell/Pager:
   - - - -

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:**
   
   - - - -

9. **Check this box if you are using the FCVS.** ☐

For Board Use Only

License Number:

MBP School Code:

Date Issued:

Licensed By: ________ Licensing Exam: ________

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

FOR BANK USE ONLY

Date __________________________
Check Number ___________________
Amount Paid _____________________
Name Code _______________________
App ID 17 _______________________
Fees: AMG-$790.00 or FMG-$890.00
10. Chronology of Activities: DO NOT ATTACH 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 post-graduate 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: 

Activities after completing medical school: Please type or print.

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<tr>
<th>Month</th>
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<th>Activity</th>
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If you will need more space than page 2 allows, please photocopy page 2 for your use or attach a separate sheet. Please sign and date each sheet that you attach.
### 11. Medical Education

**List all medical schools you have attended.**

- **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 [ ]

---

### Graduates of Foreign Medical Schools (Schools not in the U.S., U.S. territories, Puerto Rico, or Canada)

Attach the following documents to this application:

1. A copy of your valid ECFMG certificate or Fifth Pathway Certificate;
2. A copy of your medical school diploma and a certified translation;
3. If you listed an affiliation above (see * in 11 above), the certificate must include your name, name of the medical school, name of the university, and a certified translation.

If your name is not written the same way on all documents, you must submit documentation to explain how and why your name differs and submit one of the following documents to support the name change: passport, ICE card, birth certificate, court document, marriage license, court decree.

---

### 12. 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)**

- [ ] Documentation of graduation from a recognized English-speaking high school (includes GED) or undergraduate college/university where English was the only language of instruction, after at least three years of enrollment; or
- [ ] Documentation of graduation from a recognized English-speaking professional (medical) school; or
- [ ] Documentation of a passing score on the USMLE Step 2 Clinical Skills**; or
- [ ] Documentation of receiving a score of at least 26 on the Speaking section of the Internet-Based TOEFL (IBT)*; or
- [ ] Documentation of receiving a score of Advanced or higher on the Oral Proficiency Interview (OPI).*

**Are you claiming speech impairment?**

- [ ] NO
- [ ] YES
  
  **If “YES,” please write or call the Board for additional information.**

*See item #11 in the Instructions and Important Information for TOEFL and OPI testing instructions.*

**Clinical Skills:** The Board will only accept USMLE Step 2 Clinical Skills as demonstration of oral and written competency in English. The Board will not accept the Clinical Skills Assessment administered by the ECFMG or the USMLE Step 2 Clinical Knowledge as demonstration of oral and written competency in English.
13. **POSTGRADUATE TRAINING.** (DO NOT ATTACH RESUME OR CURRICULUM VITAE.) List in chronological order **ALL** postgraduate training undertaken in the U.S., its territories or possessions, Puerto Rico, or Canada regardless of whether you did or did not complete the program, and regardless of whether you were or were not compensated.

**NOTE:** On a case by case basis, the Board may consider full time teaching in an LCME-accredited medical school in the U.S. as an alternative to the accredited postgraduate clinical medical education required in the Code of Maryland Regulations 10.32.01.03D. Applicants who intend to request consideration of teaching experience as an alternative to accredited postgraduate clinical medical education should contact the Board’s licensure division for further information.

Applicants who have graduated from a medical school NOT in the U.S., U.S. territories, Puerto Rico, or Canada are required to submit evidence acceptable to the Board of successful completion of 2 years of training in a U.S. postgraduate clinical medical education program accredited by an organization recognized by the Board (ACGME, AOA, or equivalent). If you have not met this requirement, DO NOT submit this application. Contact the Board if your postgraduate medical education is not ACGME or AOA-accredited and you are applying for equivalency.

A Fifth Pathway Program graduate must have been a U.S. citizen during the time of medical education and must have successfully completed two years of ACGME accredited postgraduate clinical medical education after successfully completing a Board approved Fifth Pathway Program. If you have not met these two requirements, DO NOT SUBMIT THIS APPLICATION.

**NOTE:** Postgraduate training program cycles usually run 12 consecutive months. If the dates of your postgraduate training fall short of the complete cycle, or extend beyond the usual cycle, please attach a complete explanation of why your training was “off-cycle.”

A. During your years of postgraduate training, did you have a break in training? If “Yes,” please provide an explanation.
   - **YES**  **NO**

B. Did you have any condition or impairment that affected your ability to practice medicine during your training? If “Yes,” please provide an explanation.
   - **YES**  **NO**

C. During your years of postgraduate training, was any action taken against you by any training program, hospital, medical board, licensing authority, or court? Such actions include but are not limited to investigations, limitations of privileges or special conditions, requirements imposed for academic incompetence, disciplinary actions, probationary action, etc. If “Yes,” please provide an explanation.
   - **YES**  **NO**

<table>
<thead>
<tr>
<th>PG Year #s</th>
<th>Place of Training:</th>
<th>Specialty:</th>
<th>Accredited by:</th>
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<td>Address:</td>
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<td>ACGME</td>
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<td>PG Year #s</td>
<td>Place of Training:</td>
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<td>Address:</td>
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<td>PG Year #s</td>
<td>Place of Training:</td>
<td>Specialty:</td>
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<td>Address:</td>
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<td>PG Year #s</td>
<td>Place of Training:</td>
<td>Specialty:</td>
<td>Accredited by:</td>
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<tr>
<td></td>
<td>Address:</td>
<td></td>
<td>ACGME</td>
</tr>
</tbody>
</table>

(ATTACH A SEPARATE SIGNED AND DATED PAGE IF ADDITIONAL SPACE IS NEEDED)
14. Medical Licensing Examinations. (USMLE, NBME, NBOME, FLEX, FLEX-Weighted Average, Medical Council of Canada, and licensing exams given by individual states prior to January 1, 1985) DO NOT SUBMIT THIS APPLICATION until you have received written verification of having passed all parts, steps, or components of your medical licensing examinations.

Identify below ALL the medical licensing examinations that you have ever taken. Written or electronic documentation of passing a medical licensing exam must be sent directly to the Board, by e-mail or mail, from the agency that administered the examination. Mail documentation of passage to: P.O. Box 2571, Baltimore, MD 21215. (Do Not send your licensure application to this address.) Electronic verification of passage may be e-mailed to: mbh.mbpcredentials@maryland.gov.

Failing the Exam three or more times—If you have failed any medical licensing exam (part, step, component, or level), you may qualify for a license only if you meet the requirements in numbers 1-3 or 4. If you meet the requirements in numbers 1-3, complete the attached IML 4 Verification of Clinical Practice. If you meet the requirements in number 4, the Board will verify your Board certification. Please check either 1-3 or 4.

1. ☐ No disciplinary action pending and no disciplinary action taken against the applicant that would be grounds for discipline under Health Occupations Article, §14-404, Annotated Code of Maryland; and

2. ☐ Successful completion of 2 or more years of an ACGME or AOA accredited residency or fellowship; and

3. ☐ A minimum of 5 years of clinical medicine experience in the United States or in Canada under a full unrestricted medical license, with at least 3 of the 5 years having occurred within 5 years of the date* of the application; or

4. ☐ Board-certification.

If you have not met this requirement, you are not eligible for licensure in Maryland at this time. DO NOT submit this application until you have fulfilled this requirement.

* This is the date the Applicant signs this application.

a. State Board Examination List state(s): ______________________________

State Board Exams were licensing exams given by individual states and do not include USMLE Step 3, oral exams, interviews or jurisprudence exams. State Board Exams taken after December 31, 1984 are not accepted for licensure in Maryland. Send a copy of the IML 7 State Board Licensure and Examination Certification form to the state(s) that administered your licensing exam and ask the state(s) to send your exam results directly to the Board of Physicians. NOTE: This section does not relate to National Board Certification.

b. ☐ USMLE Steps 1, 2 and 3

c. ☐ FLEX-Weighted Average: All FLEX-Weighted exams must have been taken prior to 1985 and in one sitting with a passing score of 75; or if taken in more than one sitting, must have a passing score of 75 and be currently certified by a member board of the American Board of Medical Specialties.

d. ☐ FLEX Components 1 and 2: Passing score is 75 on each component.

e. ☐ National Board of Medical Examiners (NBME) (See Page 6 if you combined this examination with FLEX or USMLE exams)

Ask the NBME to send to the Board both the Endorsement of Certification and the Record of Scores. If you took NBME exams but were not certified, or you took NBME as part of hybrid exams, ask NBME to send only your Record of Scores. Contact the NBME at www.nbme.org

f. ☐ National Board of Osteopathic Medical Examiners

Certifications issued before January 1, 1971 are not accepted for licensure in Maryland. Contact the NBOME at www.nbome.org

g. ☐ Medical Council of Canada (MCC)—Licentiate of the Medical Council of Canada. Contact the MCC at http://mcc.ca/about/lmcc/

CONTINUED ON PAGE 6
HYBRID EXAMINATIONS

The following combinations are the only hybrid examinations accepted by the Maryland Board of Physicians. **ALL HYBRID EXAMINATIONS MUST HAVE BEEN COMPLETED BEFORE JANUARY 1, 2000.**

<p>| | | | |</p>
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<tbody>
<tr>
<td>h.</td>
<td>USMLE 1 + NBME II + NBME III</td>
<td>n.</td>
<td>FLEX 1 + USMLE 3</td>
</tr>
<tr>
<td>i.</td>
<td>USMLE 1 + USMLE 2 + NBME III</td>
<td>o.</td>
<td>FLEX 2 + USMLE 1 + NBME II</td>
</tr>
<tr>
<td>j.</td>
<td>USMLE 1 + NBME II + USMLE 3</td>
<td>p.</td>
<td>FLEX 2 + USMLE 1 + USMLE 2</td>
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<tr>
<td>k.</td>
<td>NBME I + USMLE 2 + USMLE 3</td>
<td>q.</td>
<td>FLEX 2 + NBME I + USMLE 2</td>
</tr>
<tr>
<td>l.</td>
<td>NBME I + USMLE 2 + NBME III</td>
<td>r.</td>
<td>FLEX 2 + NBME I + NBME II</td>
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<tr>
<td>m.</td>
<td>NBME I + NBME II + USMLE 3</td>
<td>s.</td>
<td>NBOME + USMLE</td>
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</table>

- If your hybrid exams included any part of the NBME examination, contact the NBME at [www.nbme.org](http://www.nbme.org) and request to have your Endorsement of Certification and your Record of Scores sent directly to the Board of Physicians.
- If your hybrid exams included only FLEX and USMLE examinations, request your transcript from the Federation of State Medical Boards at [www.fsmb.org](http://www.fsmb.org).
- If your hybrid exams included any part of the NBOME, ask NBOME to send the verification of certification and the complete history of your medical examinations to the Board. Contact the NBOME at [www.nbome.org](http://www.nbome.org).

15. Licensing History: Please complete all that apply.

a. I have never been licensed (including training licenses) in the U.S., its territories, Puerto Rico, or Canada.

b. I have an application for license (including a training license) pending in the following states: ________, ________, ________, ________, ________.

c. Including training licenses, please list below all licenses ever issued to you by a U.S. state/territory, Puerto Rico, or Canada.

d. Has any disciplinary action ever been taken against your license?  Yes  No  If “Yes,” please enclose an explanation.

<table>
<thead>
<tr>
<th>STATE (Or Puerto Rico or Canadian Province)</th>
<th>LICENSE NUMBER or Registration Number</th>
<th>CURRENT STATUS</th>
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<tbody>
<tr>
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<td>Active</td>
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(If more space is needed, please attach an additional signed and dated sheet.)
16. Character and Fitness Questions (Check either YES or NO) Please answer questions “a” through “q” on pages 7 and 8.

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 facility, 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?

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?

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.
16a. Character and Fitness Questions (Continued) (Check either YES or NO) Please answer questions “m” through “q.”

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>m.</td>
<td>Have you ever failed to make arrangements to satisfy State or Federal loans that financed your medical education?</td>
</tr>
<tr>
<td>n.</td>
<td>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?</td>
</tr>
<tr>
<td>o.</td>
<td>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?</td>
</tr>
<tr>
<td>p.</td>
<td>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?</td>
</tr>
<tr>
<td>q.</td>
<td>Have you ever been dishonorably discharged from any military service of the U.S. Government? Attach a copy of your military discharge documentation that includes type of service, date of discharge, and type of discharge.</td>
</tr>
</tbody>
</table>

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.

17. SPEX/COMVEX Examinations: Please check all that apply. If none apply, please make N/A here. __________

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>The last time I passed a medical licensing exam was more than 15 years before submitting this application for initial medical licensure.</td>
</tr>
<tr>
<td>b.</td>
<td>I have never had a specialty board certification.</td>
</tr>
<tr>
<td>c.</td>
<td>During the 10 years preceding the submission of this application for initial medical licensure, I did not pass a specialty board certification or recertification examination given by the American Board of Medical Specialties or the American Osteopathic Association Bureau of Osteopathic Specialists.</td>
</tr>
<tr>
<td>d.</td>
<td>I have not had a full, unrestricted medical license in at least one state of the U.S. or Canada within the 10-year period before submitting this application for initial medical licensure.</td>
</tr>
<tr>
<td>e.</td>
<td>I have not actively practiced clinical medicine in the U.S. or Canada for at least 7 of the 10 years before submitting this application for initial medical licensure.</td>
</tr>
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</table>

*The date the application is signed will be used for date of submission.*
18. Release: I agree that the Maryland Board of Physicians (the Board) may request any information necessary to process my application for medical licensure in Maryland from any person or agency, including but not limited to postgraduate program directors, individual physicians, government agencies, the National Practitioner Data Bank, the 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.

Applicant’s Name (Printed)  
Applicant’s Signature  
Date

19. (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: ________________________________________________________________

20. 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

21. 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 to items 1-20 of 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 the Statute (Title 14) and 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 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 notorial seal. _____________________________  Notary Public

My Commission expires: _____________________________  SEAL

The date the applicant and the notary sign the application must be the same.
INITIAL MEDICAL LICENSURE APPLICATION

Supplemental Forms

IML 2—Verification of Education and English Language Instruction

IML 3—Verification of Postgraduate Medical Education

IML 4—Verification of Clinical Practice Instructions and Form

IML 7—State Board Licensure and Examination Certification
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 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:  __________________________      __________________________
Month  Day  Year

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 __________________________

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
Part 1

APPLICANT: Complete Part 1 and sign where indicated in the Part 2 instructions. Print your name on top of the reverse page, and send a form to the director of each postgraduate training program you attended. Be sure to copy both sides.

a. Applicant’s Name: ____________________________________________

   Last Name and Generational Indicator (Jr., Sr., II, III, etc.)  First Name  Middle Name

Address: _______________________________________________________

City: ___________________________ State: ___________________________

Date of Birth: ________ ________ ______  Social Security Number: __________ - ______ - ______ - ______ - ______

b. Name of Institution: __________________________________________

Department and Area of Training: _________________________________

Complete Address: _____________________________________________

City: ___________________________ State: ___________________________

   Month  Day  Year

FROM: ________ ________ TO ________ ________

Part 2

POSTGRADUATE TRAINING AUTHORIZED OFFICIAL: Please complete Part 2 according to the records available and send directly to the Maryland Board of Physicians at the above address. Please do not send original or copies to the applicant.

Applicant’s Signature: __________________________________________

1. Did the applicant participate in postgraduate training in your department during the period listed above?*

   YES     NO  If “No,” please enter exact dates: ___________ to ___________

   Program Specialty: _____________________________________________

*If training was part-time, please explain the training schedule after item 8 of this form.

2. During the time of the applicant’s participation, was the postgraduate training program accredited?  YES  NO

   Accredited by:  ACGME: Program # ___________________________  AOA: ID #: ___________________________  RCPSC

3. Did the applicant participate in all of the components of the training as required by the accrediting body?

   YES     NO  Comments (attach signed and dated additions as needed):

   ________________________________________________________________

4. Did the applicant successfully complete all requirements of each year of training?

   YES     NO  Comments (attach signed and dated additions as needed):

   ________________________________________________________________

(Continued on next page)
5. During the applicant’s year(s) of training, did the applicant have any break in training?

☐ YES ☐ NO Comments (attach signed and dated additions as needed):

6. Did the applicant have any condition or impairment that affected the applicant’s ability to practice medicine during the period of training?

☐ YES ☐ NO If “Yes,” please give a detailed explanation*

7. During the period of training, was any action taken against the applicant by any training program, hospital, medical board, licensing authority, or court? Such actions include, but are not limited to investigations, limitations of privileges or special conditions, requirements imposed for academic incompetence, disciplinary actions, probationary actions, etc.

☐ YES ☐ NO If “Yes,” please give a detailed explanation*

8. In each year of training, did the applicant demonstrate sufficient academic and clinical ability to qualify for advancement without conditional or probationary status to the next year and next progressive level of responsibility in a designated specialty program?

☐ YES ☐ NO Comments:*
The Verification of Clinical Practice form is required if an otherwise qualified applicant passes the examination required for licensure, after having failed any part, step, level, or component three or more times. Under these circumstances, in accordance with Health Occupations Article, §14-307(g), Annotated Code of Maryland and Code of Maryland Regulations (COMAR) 10.32.01.03G(3), the Board may consider clinical practice experience.

Complete this form only if you have passed any of the required exams after having failed it three or more times and meet the requirements below.

1. No disciplinary action pending and no disciplinary action taken against the applicant that would be grounds for discipline under Health Occupations Article, §14-404, Annotated Code of Maryland; and

2. Successful completion of 2 or more years of an ACGME or AOA-accredited residency or fellowship; and

3. A minimum of 5 years of clinical medicine experience in the U.S. or in Canada under a full unrestricted medical license, with at least 3 of the 5 years having occurred within 5 years of the date of the application.

Instructions for the Applicant:

1. Complete Part I.
2. Parts II, III, and signature section must be completed by an employer/former employer, Departmental Chair, Chief Medical Officer, supervising physician, or professional colleague with knowledge of your clinical practice. Upon completion, the forms must be sent directly to the Board.

   **NOTE:** You may send copies of the form with Section I completed to all individuals necessary to verify that you have a minimum of 5 years clinical practice with at least 3 of the 5 years having occurred within 5 years of the date of the application. The date* in Section I is the date of the application.

Instructions for the Person Completing Parts II, III, and signature section:

1. Parts II and III must be completed by the employer/former employer, Departmental Chair, Chief Medical Officer, supervising physician, or professional colleague with personal knowledge of the applicant's clinical practice.

2. The person completing Parts II and III must send the completed form directly to:

   Maryland Board of Physicians  
   Licensure Unit  
   P.O. Box 2571  
   Baltimore, MD  21215

3. **Do not return the form to the applicant.**
Part 1

APPLICANT: Complete Part 1. Send the form to the employer, former employer, Departmental Chair, Chief Medical Officer, or supervising physician with personal knowledge of the applicant’s clinical practice to complete Parts 2 and 3 and the signature section.

Applicant’s Name: ____________________________________________________________
  Last Name and Generational Indicator (Jr., Sr., II, III, etc.)  First Name  Middle Name

Address: ____________________________________________________________________

City: __________________________ State: ______________ Zip code: ________________

E-mail address: _____________________________________________________________

Date of Birth: ___________ ___________ ___________

Applicant’s signature: ______________________________________________________

Date: ______________________

Part 2

CLINICAL PRACTICE VERIFICATION: To be completed by the current/former employer, Departmental Chair, Chief Medical Officer, or supervising physician with personal knowledge of the applicant’s clinical practice.

Name of Practice or Employer: ____________________________________________________________________________________________

Practice/Employer Address: ____________________________________________________________________________________________

City: __________________________ State: ______________ Zip code: ________________

Telephone Number: _______ - _______ - _______

E-mail Address: _____________________________________________________________

Practice or Employment Dates: From: ____________________________ to: ______________

Job Title/Position Held: ______________________________________________________________________________________________

Check the box that applies: □ Clinical Practice  □ Non-clinical practice

If clinical practice is checked, complete Part 3.

Part 3

DATES OF CLINICAL PRACTICE AND SIGNATURE: To be completed by the current/former employer, Departmental Chair, Chief Medical Officer, or supervising physician with personal knowledge of the applicant’s clinical practice.

Did the applicant have 5 years of clinical practice of medicine? □ YES □ NO Dates: From: ___________ to: ___________

Was the clinical practice of medicine in the United States or Canada? □ YES □ NO

Did at least 3 years of the clinical practice of medicine occur within 5 years of the date* of the application? □ YES □ NO

Dates of 3 years of   clinical practice of medicine occurring within 5 years of the date* of the application? Dates: From: ___________ to: ___________

Additional Comments: _______________________________________________________________________________________________

* This is the date the Applicant signs the IML application, not this form.

Print Name: __________________________ Title: __________________________

Capacity in which you worked with the applicant: __________________________

E-mail address: ____________________________________________________________

Signature: __________________________ Date: __________________________
**STATE BOARD LICENSURE AND EXAMINATION CERTIFICATION**

**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.

<p>| | | |</p>
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<tr>
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<tbody>
<tr>
<td>1.</td>
<td>State of Licensure</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>License Number</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Date of Birth</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Last Name Under Which You Were Licensed</td>
<td>First Name</td>
</tr>
<tr>
<td>5.</td>
<td>Current Last Name if Different from Above</td>
<td>First Name</td>
</tr>
<tr>
<td>6.</td>
<td>Current Street Address</td>
<td>City</td>
</tr>
<tr>
<td>7.</td>
<td>Social Security Number:</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Telephone Number:</td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>Signature</td>
<td>Date:</td>
</tr>
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</table>

**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.

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<tbody>
<tr>
<td>1.</td>
<td>License Number</td>
<td>Date of Original Licensure</td>
</tr>
<tr>
<td>2.</td>
<td>Date License Expires/Expired</td>
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<tr>
<td>4.</td>
<td>Is the license in good standing or, if expired, was the license in good standing at the time of expiration?</td>
<td>Yes</td>
</tr>
<tr>
<td>5.</td>
<td>Is there, or has there ever been, derogatory information, pending charges, or disciplinary action taken against this license?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>If “Yes”: pending charges</td>
<td>reprimanded</td>
</tr>
<tr>
<td></td>
<td>On the back of this form, or as an attachment, please explain any discipline information and include all available documentation.</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Was the license administratively revoked, suspended, or surrendered because the licensee did not renew?</td>
<td>Yes</td>
</tr>
<tr>
<td>7.</td>
<td>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?</td>
<td>Yes</td>
</tr>
</tbody>
</table>

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

**State Board Seal**
CHECKLIST
Please review the checklist before signing page 9. A few minutes spent in review now may save days or weeks of delay in the processing your application.

☐ I have provided all the personal information requested on this application. (See page 1)

☐ My chronology of activities after graduating medical school is legible, and there are no gaps in time. (See page 2)

☐ (If applicable) I have enclosed additional sheets for my chronology.

☐ I have provided all the information about my medical education. (See Item 11 on page 3)

☐ I have indicated how I have met Maryland’s requirement for English proficiency. (See Item 12 on page 3)

Graduates of Foreign Medical School

☐ My English proficiency requirements were satisfied somewhere other than medical school, so I have requested that documentation of both written and oral proficiency be sent to the Board. (See Item 12 on page 3)

I have also enclosed the following documents:

☐ A copy of my valid ECFMG certificate.

☐ A copy of my medical school diploma and a certified translation.

☐ If applicable, a certificate indicating the name of the medical school, the name of the affiliated university; and a certified translation. (See page 3)

☐ I have completed Part 1 of the IML 2 Verification of Education and English Language Instruction form and sent a copy to the institution from which I received my medical degree, and, if different, to the institution at which I received English instruction that meets the Maryland requirements.

☐ I have listed all postgraduate training I have undertaken in the U.S., U.S. territories, Canada, or Puerto Rico (page 4); completed Part 1 of the IML 3 Verification of Postgraduate Medical Education form; signed Part 2; printed my name on side B; and sent a form IML 3 to the authorized official of each program in which I participated.

☐ I have listed all medical licensing examinations I have ever taken (page 6) and requested transcripts from the appropriate administering authority of each exam (See instructions after exams listed on page 6).

☐ I have listed every license/registration I have ever been issued in the U.S., U.S. territories, Puerto Rico, or Canada (page 6) and have sent a copy of the IML 7 State Board Licensure and Examination Certification form to each medical board/issuing authority.

☐ I do not have to take the Special Purpose Exam. (page 8) ☐ I must take the SPEX and have made arrangements to do so.

☐ I have answered all character and fitness questions (pages 7 and 8), explained all “Yes” answers and, if applicable, enclosed all supporting documents (copies of all complaints, malpractice claims, adverse or disciplinary actions, arrests, pleadings, judgments, final orders, etc.).

☐ I have attached a 2” x 2” passport quality, color photograph to the last page (page 9) of this application.

☐ I have read the statements on page 9 of this application; signed and dated items 18,19 (if applicable), 20, and 21.

☐ I have enclosed my check/money order made out to “Maryland Board of Physicians” (or “MBP”) in the amount of either $790.00 (Graduates of LCME-accredited American and Canadian medical schools) or $890.00 (Graduates of International Medical Schools).

☐ I have attached the following number of pages of documentation to support this application: ____________________.

☐ I have signed the application in the presence of a notary and had the application notarized.

☐ I have applied for a Criminal History Records Check.

STOP! Completed application and check/money order must be mailed to: Maryland Board of Physicians; P.O. Box 37217; Baltimore, Maryland 21297.