RECIPROCITY ELIGIBILITY NOTICE

This application package is for *individuals applying for initial medical licensure in Maryland by reciprocity*.

If you are unable to answer "YES" to all of the following statements, **do not complete this application (IML-R).** Please download and complete the initial medical licensure application (IML). *https://www.mbp.state.md.us/forms/dr_initial.pdf*

Yes No

☐ ☐ I have an active, unrestricted license to practice medicine in another jurisdiction that, at the time of my licensing, had licensure requirements ***substantially equivalent*** to the current licensure requirements of the Maryland Board of Physicians (the Board).

☐ ☐ That same jurisdiction currently offers a similar reciprocal licensure process to physicians licensed by the Board.

☐ ☐ I have demonstrated, in that jurisdiction, verbal and written competency in the English language by one or more of the following:

a. Graduation from an English-speaking high school or undergraduate school after at least three years of enrollment;
b. Graduation from an English-speaking professional school;
c. Received a passing score on the USMLE Step 2 Clinical Skills*;
d. Received 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. Received a passing score of Advanced or higher on the Oral Proficiency Interview (OPI).

** **Clinical Skills:** The Maryland Board of Physicians **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.*

An applicant must contact the jurisdiction of his or her licensure to check on the requirements noted above BEFORE applying in Maryland.

If you proceed with completing this application, you must identify the reciprocal state and provide all citations to the statutes and regulations of the qualifying jurisdiction.

See Item 14 on Page 4 of the application.

MARYLAND BOARD OF PHYSICIANS

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

Complete this application only if you have never been licensed as a physician in Maryland and you meet Maryland requirements for applying for licensure ***by reciprocity****.*

See Health Occupations Article, §14-307(j), Annotated Code of Maryland, and Code of Maryland Regulations (COMAR) 10.32.01.17 for requirements regarding reciprocity in Maryland.
http://mgaleg.maryland.gov/webmga/frmStatutesText.aspx?article=gho&section=14-307&ext=html&session=2018RS&tab=subject5

http://www.dsd.state.md.us/comar/comarhtml/10/10.32.01.17.htm

APPLICATION FOR INITIAL MEDICAL LICENSURE BY RECIPROCITY

Dear Applicant:

Attached is an application packet for Initial Medical Licensure By Reciprocity. Please carefully read all instructions and review the application and checklist before you begin to complete the application.

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.

The Board will keep your application open for 120 days from the original date of receipt. All requirements for licensure by reciprocity 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

MARYLAND BOARD OF PHYSICIANS

P.O. Box 37217
Baltimore, Maryland 21297
Telephone: 410-764-4777 or 800-492-6836
www.mbp.state.md.us

APPLICATION FOR INITIAL MEDICAL LICENSURE BY RECIPROCITY
INSTRUCTIONS AND IMPORTANT INFORMATION

1. **Name:** If the name on the application form differs from the name on any of your supporting documentation, you must submit a copy of a marriage license, divorce decree, or a court order 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 (SSNs) 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.

IMPORTANT REMINDER

Complete this application only if the state in which you have an active, unrestricted license to practice medicine:

- Offers a process for reciprocity to physicians licensed in Maryland; and
- Had, at the time you were licensed in that state, licensure requirements substantially equivalent to the Maryland Board of Physicians' current licensure requirements.

See Health Occupations Article, §14-307(j), Annotated Code of Maryland, and Code of Maryland Regulations (COMAR) 10.32.01.17 for requirements regarding reciprocity in Maryland.

http://mgaleg.maryland.gov/webmga/frmStatutesText.aspx?article=gho&section=14-307&ext=html&session=2018RS&tab=subject5

http://www.dsd.state.md.us/comar/comarhtml/10/10.32.01.17.htm

10. Medical Education: List all medical schools you attended.

11. Postgraduate Training: Complete Item 11 in the application about the postgraduate training program you attended. American Medical Graduates must have successfully completed at least one year (12 consecutive months) 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 (two sets of 12 consecutive months) of ACGME or AOA-accredited postgraduate training or equivalent training as determined by the Board.

12. 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.

13. Medical Licensing Examination: Complete this section regarding your passage of a medical licensing examination. If you have not taken any of the exams listed (see 13a through 13e on Page 4 of the application), complete the IML application. *https://www.mbp.state.md.us/forms/dr_initial.pdf*

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

An applicant who passed any of the required exams after having failed any part, step, level, or component three or more times is not eligible for licensure by reciprocity in Maryland and must complete an application for Initial Medical Licensure (IML).

14. Licensure in Other States: The Board will make every effort to verify your license from each state board where you have held a license to practice medicine. If the Board cannot verify your license, you will be contacted by Board staff. Be sure to indicate which state is the reciprocal state.

15. 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.*

APPLICATION FOR INITIAL MEDICAL LICENSURE BY RECIPROCITY
INSTRUCTIONS AND IMPORTANT INFORMATION *(CONTINUED)*

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

17. **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.

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

19. **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. The Board does not accept group photos and copies of photos.

IMPORTANT: Criminal History Records Check

By law, effective October 1, 2016, a full criminal history records check (CHRC) is a requirement for all applicants applying to the Board for licensure in Maryland. 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 in 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 in Maryland 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 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 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/Pages/home.ASPX

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

Expiration and Renewal: 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.

Approximately 60-90 days prior to the expiration date, you should receive a notice to renew your license. The renewal notice will be mailed/e-mailed to the current address on file with the Board.

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, Sections 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.

CHECKLIST:
APPLICATION
FOR
INITIAL MEDICAL
LICENSURE
BY RECIPROCITY

Make sure you have read Maryland statute [Health Occupations Article, §14-307(j), Annotated Code of Maryland] and Code of Maryland Regulations 10.32.01.17 to determine if you meet the requirements for licensure by reciprocity in Maryland.

If you do not meet the requirements, you must download and complete the Maryland Board of Physicians' Application for Initial Medical Licensure (IML).

Initial Medical Licensure By Reciprocity CHECKLIST

10/2017

Print Your Name: _____ Date: _____

CHECKLIST

Please review the checklist before signing Page 6. A few minutes spent in review now may save days or weeks of delay in the processing your application.

IMPORTANT REMINDER

Complete this application only if the state in which you have an active, unrestricted license to practice medicine:

- Offers a process for reciprocity to physicians licensed in Maryland; and
- Had, at the time you were licensed in that state, licensure requirements substantially equivalent to the Maryland Board of Physicians' current licensure requirements.

See Health Occupations Article, §14-307(j), Annotated Code of Maryland, and Code of Maryland Regulations (COMAR) 10.32.01.17 for requirements regarding reciprocity in Maryland.

_____ I have read Maryland's requirements for applying for medical licensure by reciprocity.

_____ I have provided all personal information requested on this application. (See Page 1)

_____ I have provided all information about my medical education. (See Page 2)

_____ I have completed the section on postgraduate training, initialing where appropriate. (See Page 2)

_____ (If applicable) I have provided additional information regarding my postgraduate training. (See Page 2)

_____ My chronology of activities after graduating medical school is legible, it includes my postgraduate training, and there are no gaps in time. (See Page 3)

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

_____ I have indicated all medical licensing examinations I have ever taken. (See Page 4)

_____ I have listed every license / registration I have ever been issued in the U.S., U.S. territories, Puerto Rico, or Canada, and I have indicated my reciprocal state where I have an active, unrestricted license. (See Page 4)

_____ I have contacted the reciprocal state so that I can provide all citations of statute and regulations that show that the reciprocal state had substantially equivalent requirements, at the time I was licensed there, to Maryland's requirements for medical licensure.

_____ I have answered all character and fitness questions (Page 5), 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 6) of this application.

_____ I have read the statements on Page 6 of this application; signed and dated items 16,17 (if applicable), 18, and 19.

_____ I have enclosed my check or 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 or money order must be mailed to:

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

Maryland Board of Physicians

Check One:
- ☐ Initial Licensure
- ☐ Reinstatement

Name of Profession: _____

ATTENTION

If You Are a Veteran, Service Member or Military Spouse

PLEASE REVIEW AND COMPLETE BEFORE PROCEEDING

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

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

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

"Military Spouse" includes a surviving spouse of:

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

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

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

Complete ONLY if You Meet the Following Criteria

Check the appropriate box.

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

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

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

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

_____ _____

Name of Applicant (PRINT) Military Branch

Initial Medical Licensure
By Reciprocity
PERSONAL INFORMATION
10/2017 IML-R

MARYLAND BOARD OF PHYSICIANS

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

APPLICATION FOR INITIAL MEDICAL LICENSURE BY RECIPROCITY

FOR BANK USE ONLY
Date _____
Check Number _____
Amount Paid _____
Name Code _____
App ID 3
Fees: AMG-$790.00 or FMG-$890.00

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 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:

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: _____	

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. POSTGRADUATE TRAINING

American Medical Graduates must have successfully completed at least one year (12 consecutive months) 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 (12 consecutive months for each year of training) of ACGME or AOA-accredited postgraduate training or equivalent training as determined by the Board.

Check Box A or B to confirm the postgraduate training you completed and initial the statement in Box A or B. Also initial C and D below.

☐ **A. American Medical Graduate**

_____ I confirm that I completed at least one year (12 consecutive months) of accredited postgraduate training and did not have a break in any program I started.

☐ **B. Foreign Medical Graduate (Schools that are not in the U.S., U.S. territories, Puerto Rico, or Canada)**

_____ I confirm that I completed at least two years (2 x 12 consecutive months) of accredited postgraduate training and did not have a break in any program I started.

C. _____ I confirm that I did not have any condition or impairment that affected my ability to practice medicine during my training.

D. _____ I confirm that, during my years of postgraduate training, there was no action taken against me 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.)

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."

12. 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.

Activities after completing medical school: Please type or print.

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

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

DO NOT ATTACH A RESUME OR CURRICULUM VITAE

13. Medical Licensing Examinations. Review items a through e in the box below and identify ALL medical licensing examinations that you have ever taken. If you have not taken any of the exams listed, complete the IML application. *https://www.mbp.state.md.us/forms/dr_initial.pdf*

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

An applicant who passed any of the required exams after having failed any part, step, level, or component three or more times is not eligible for licensure by reciprocity in Maryland and must complete an application for Initial Medical Licensure (IML).

Check all lines that apply:

a. _____ USMLE Steps 1, 2 and 3

b. _____ FLEX Components 1 and 2 (**Passing score is 75 on each component)**

c. _____ National Board of Medical Examiners (NBME)

d. _____ National Board of Osteopathic Medical Examiners Certifications **(Those issued before January 1, 1971 are not accepted for licensure in Maryland)**

e. _____ Medical Council of Canada (MCC)—Licentiate of the Medical Council of Canada

14. Medical Licensing History.
Please complete items A through D.

A. Please list in the chart below all licenses ever issued to you by a U.S. state/territory, Puerto Rico, or Canada.

B. Of the states listed below, which one is the reciprocal state? _____ Date of licensure in that state: _____

C. List all statute and regulations from the reciprocal state (effective on the date noted in B) that show you meet the current Maryland requirements for licensure by reciprocity. Be specific and include names of titles, title numbers, section numbers, etc.

_____

_____

_____

_____

D. Has any disciplinary action ever been taken against your license ? ☐ Yes ☐ No If "Yes," please enclose an explanation.

STATE (Or Puerto Rico or Canadian Province)	LICENSE NUMBER or Registration Number	CURRENT STATUS					
		Active	Inactive	Expired / Lapsed	Surrendered in good standing	Surrendered / Suspended	Revoked

(If more space is needed, please attach an additional signed and dated sheet.)

15. Character and Fitness Questions (Check either **YES** or **NO) Please answer questions "a" through "q."**

	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 (CDS) 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 CDS.
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?
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? 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

16. 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 _____

17. (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: _____

18. 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 _____

19. 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 through 15 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 of the Health Occupations Article) 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
(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 notorial 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