

Instructions for Application for Exceptions From Licensing

In addition to providing the Board with the completed Application for Exceptions From Licensing Form, the contact person at the sponsoring Maryland institution must provide the following information/documentation:

1. Verification that the “visiting” physician's license is currently in good standing in the state where the physician is currently practicing medicine.
2. A copy of the “visiting” physician's current curriculum vitae.
3. Verification from the institution requesting the Exception From Licensure that the credentials of the “visiting” physician have been reviewed and approved by the appropriate staff. The verification must include the name, title, address, and phone number of the person who is authorized to review and approve the credentials and clinical procedure performed by the “visiting” physician.
4. A copy of the liability insurance certificate documenting coverage of the “visiting” physician for the time period requested on the Exception From Licensing application.

****The completed Application For Exceptions From Licensing Form, along with the above listed items, must be received by the Board at least 30 days prior to the date of the scheduled procedure.***

Maryland Board of Physicians

P.O. Box 2571
Baltimore, Maryland 21215-0095
410-764-4777 or 1-800-492-6836

APPLICATION FOR EXCEPTIONS FROM LICENSING

Authority: Md. Code Ann., Occ., §14-302(2)

Instructions: Please complete the application as indicated below and return it to the above address.

PLEASE PRINT OR TYPE

Name of Maryland Physician: _____

License Number: _____ **Expiration Date:** ____/____/____

Name of Out-of-State Physician: _____

City: _____ **State:** _____ **Zip Code:** _____

Date of Birth: ____/____/____ **Social Security Number:** ____/____/____

Medical School Attended: _____

Date of Graduation: ____/____/____

Jurisdiction where licensed: _____

License Number: _____ **Expiration Date:** ____/____/____

Site of Consultation: _____

Address of Consultation: _____

City: _____ **State:** _____ **Zip Code:** _____

Sponsoring facility/organization: _____

Procedure(s) to be performed: _____

Date(s) of Consultation: ____/____/____

ATTESTATION

I affirm that the information I have given in this application is true and correct to the best of my knowledge and belief.

_____/_____/_____
Maryland Physician's Signature **Date** **Daytime phone number**