ATTENTION!

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

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

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

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

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

Notice: Criminal History Records Check Required

Dear Applicant for Initial License or Reinstatement of License:

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

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

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

Timing of CHRCs

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

Fingerprints

A. For Initial Applicants and Reinstatements

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

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

1. Within Maryland

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

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

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

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

Timing of CHRCs

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

Fees:

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

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

Questions?

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

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

MARYLAND BOARD OF PHYSICIANS

P.O. BOX 32712
BALTIMORE, MD 21297
410-764-4777; 1-800-492-6836

APPLICATION FOR LIMITED LICENSE FOR POSTGRADUATE TEACHING

Instructions and Important Information

Authority : Md Code Ann., Health Occ. §14-318
COMAR 10.32.01.06

1. **Accuracy in Completing the Required Forms:** Read carefully and thoroughly the instructions and requirements in the application packet before completing the application form and submitting an application. The application packet is made up of four pages of instructions and important information; 14 forms; including an 8-page application form; 2-page checklist; list of grounds for action under Md Code Ann., Health Occ. §14-404 and COMAR 10.32.01.06.

2. **Complete Application:** A complete application consists of the following:

   a. A fully completed application form, **MBP Form LLPT1 7/03.**

      Your careful attention to submission of a complete and legible application form will make it unnecessary for the Board of Physicians (the Board) to return your application form or write to you later for additional information. An incomplete application form will delay the processing of the application. *Send your application and fees to the following address:*

      The Limited License for Postgraduate Teaching Unit
      Board of Physicians
      P.O. Box 37217
      Baltimore, MD 21297

   b. Fully completed forms **MBP Form LLPT2 7/03 through MBP LLPT12 7/03.** Make as many copies of the forms as you need and send them to the appropriate individuals and agencies after you have completed part 1 of each form. See the checklist for more information. Sending self-stamped envelopes with the supplemental forms to the appropriate individuals and agencies may help facilitate their response to your request. The supplemental forms should be mailed to the address indicated on the top of the form.

      It is your responsibility to make sure that all the necessary documents, including those from the individuals and agencies you have sent appropriate forms to, are received by the Board on time. Applications are kept open for 120 days. Within 60 days of receipt of your application, the Board will send you a written status report on your application.

c. Check or money order made payable to the Board of Physicians in the amount of $300.00.

Only applications that have been submitted with the appropriate fees will be processed.

Payment of fee is a condition for licensure (COMAR 10.32.01.06(D)). Any applicant who attempts to fulfill this requirement by submitting a check with insufficient funds has not complied with COMAR 10.32.01.06 D. The Board will notify you upon receipt of a returned check. Failure to correct the deficiency may result in a mistakenly granted license being declared null and void by the Board.

Please use the attached checklist to review the completeness of your application.

3. **Name:** Enter your name on the appropriate line. If any of your credentials bears a name that does not completely match the name on your application, explain the name change and attach a copy of a legal document that supports/explains the change.

4. **Submission of Application:** Please submit your completed application form only if you have either met all the requirements or would complete all the requirements for limited license for postgraduate teaching within 30 days of submission.

5. **Information on Age, Social Security Number, Sex, and Race:** Age is a requirement for licensure because all successful applicants must be at least 18 years of age. (Md Health Occ. Code Ann § 14-307(c)). Maryland law requires the Board of Physicians to collect Social Security numbers from all persons applying for their professional licenses or certificates. Disclosure of your Social Security number is mandatory. The Maryland Board of Physicians is permitted by State or Federal law or regulation to use the Social Security number for the following purposes:
   A. Verification of identity with respect to actions related to your license (Code of Maryland Regulations 10.32.01.);
   B. Administration of the Child Support Enforcement Program (Family Law Article, §10-119.3);
   C. Identification by the Department of Assessments and Taxation of new businesses in Maryland (Health Occupations Article, §1-210);
   D. Verification by the Maryland Medicaid program of licensure and sanctions for providers participating in Medicaid (42 U.S.C. §1396(a)(49); 42 U.S.C. §1396r-2; 42 U.S.C. §1320 a-7).

   Age, social security number, sex, and race are necessary for identification purposes and criminal background checks, based upon the requirement for licensure that each applicant be of good moral character. Failure to provide the information may delay the processing of an application.

6. **Photograph:** Paste securely a 2"x 2" front view photograph of your head and shoulders on the last page of the application form. Your photograph must have been taken within 60 days of the application and of passport quality. Your legible signature must be across the bottom of the photograph.

7. **Notarization of Documents:** The notary public must certify each document with the statement "This is a true copy of the original, with nothing added or amended." If you live in a state where a notary public is prohibited from certifying documents, you must write the statement on each document, present the original and photocopy of each document to the notary public, sign the

statement in front the notary public who must also sign and date the document. In addition, the notary public must also write the date of expiration of his/her commission and affix his/her seal or stamp on the document. Copies of notary seal are not acceptable.

8. **Certified Translation:** Translations must be prepared by certified translator. Acceptable translators are: an employee of a professional translating company, a member of the American Translators Association or a Faculty Member of the modern languages or Linguistics Department of a United States college or university. Translations must be prepared on letterhead paper of the translating agency or letterhead paper of the modern languages or Linguistics Department of a United States college or university, or bear the translator's certification seal.

   The translator must certify that the translation is true to the original document and that in the original document there were no erasures, additions, deleted words nor any peculiarities whatsoever. Translations must be accurate and literal. All information appearing on the document which is to be translated must also appear on the translation, including pre-printed information, such as the letterhead of a university, titles, etc.

   All stamps, seals and logos must be translated, if legible. If not legible, they must be indicated as illegible. All signatures must be indicated. All signatures must be indicated. All numbers must be translated unless they appear as follows -1 2 3 4 5 6 7 8 9 0. If they do not appear on the document to be translated as stated above. They must be accurately transcribed. Any other information on the document must be translated, unless they are "symbols," and if so, must be indicated as such.

   Note: Translations prepared in foreign countries often have certifications on the translations. If information appears in a foreign language on the translation, it must also be translated according to the previously stated guidelines.

9. **Further Investigation:** The Board reserves the right to make further investigation as it may deem necessary in processing your application for limited license for postgraduate teaching.

10. **Inquiry on Status of Application:** Because applications may contain confidential information, the Board will not respond to inquiries by third parties, unless the applicant specifies, in writing, that the Board may respond to a third party. Applicants will be notified in writing of the status of their applications.

11. **Withdrawal of Application:** An applicant may request the withdrawal of application within the 120-day processing period. There is no refund for withdrawal of an application.

12. **Closure of Application:** The Board will keep your application open for 120 days. Make sure that all the required information and documents are received by the Board within 120 days of submission of your application. In general, an application will be closed after 120 days. When an application is closed and if the physician wants to be licensed in Maryland, the physician is required to submit a new application, pay the fee and meet all the requirements for limited license for postgraduate teaching.

13. **Terms and Renewals of Postgraduate Teaching Licenses**: The Board shall issue a postgraduate teaching license to an eligible applicant with a term of 1 year. The Board may renew a postgraduate teaching license only once for an extension of 1 year.

14. **Controlled Substance Registration**: Licensed physicians who want to apply for controlled Substance Registration may call the Office of Drug Control at 410-764-2890.

15. **Change of Name/Address:** Each licensee must notify the Board in writing of any change in name or address within 60 days of the change. Failure to do so may subject you to an administrative penalty of $100.00. (MD Health Occ. Code Ann. §14-316 (f)).

16. **Practicing Medicine Without a License:** A physician who does not have an active license is not authorized to practice medicine in Maryland. Any person who practices medicine in Maryland without a license is subject to a civil fine of not more than $50,000.00 to be levied by the Board. (Md Health Occ. Code Ann. §§14-601, 607)

17. **Contact Agencies:**

    a. **For FLEX, SPEX, and USMLE Step 3 results**
    Federation of State Medical Boards (FSMB)
    Federation Place, P.O. Box 619850, Dallas, TX 75261-985000
    www.fsmb.org

    b. **For NBME results**
    National Board of Medical Examiners
    3750 Market Street, Philadelphia, PA 19104-3190; 215-590-9500
    www.nbme.org

    c. **For NBOME results**
    National Board of Osteopathic Medical Examiners
    2700 River Road, Suite 407, Des Plaines, IL 60018; 708-635-9955
    www.nbome.org

    d. **For USMLE Steps 1 and 2 results** (Contact either NBME or FSMB or ECFMG.)
    Educational Commission for Foreign Medical Graduates (ECFMG.)
    3624 Market Street, Fourth Floor
    Philadelphia, PA 19104-2685; 215-386-5900
    www.ecfmg.org

    e. **For LMCC test results**
    Medical Council of Canada
    PO Box CP 8234, Station "T", Ottawa, Ontario, Canada, K1G 3H7, 613-521-6012
    www.mcc.ca

    f. **For Test of English as a Foreign Language (TOEFL) and Test of Spoken English (TSE) scores**
    TOEFL/TSE
    P.O. Box 6157, Princeton, New Jersey 08541-6157; 609-771-7100
    www.toefl.org

    g. **For Oral Proficiency Interview (OPI) results**
    Language Testing International (LTI)
    235 Mamaroneck Avenue, Suite 103, White Plains, NY 10605, 914-948-5100

h. **For special accommodations at the Board of Physicians, based on Americans with Disabilities Act (ADA)**

The Board of Physicians (the Board) supports the Americans with Disabilities Act and will provide this material in an alternative format to facilitate effective communication with sensory impaired individuals. (For example, braille, large print, audio tape)

If you need such accommodations, please notify the ADA designee at the Board, Ellen Douglas Smith, at 410-764-2477 or Toll Free 1-800-492-6836 (TTD for disabled: 800-735-2258).

MARYLAND BOARD OF PHYSICIANS
P.O. Box 37217
Baltimore, Maryland 21297
410-764-4777; 1-800-492-6836

APPLICATION FORM FOR LIMITED LICENSE FOR POSTGRADUATE TEACHING

FOR BANK USE ONLY

DATE:_____/_____/ 200___

CHECK NUMBER:_____

AMT PAID: $ _____

NAME CODE:_____

APPID: 18

For Board Use Only
License #: _____
Effective Dates: _____
Lic. Requested By: _____

1. **Name**:_____
(Print: Last name and generational indicator, if applicable First Name Middle Name

2. **Address**:_____
Street Address, Including Suite/Apartment Number

_____
Town/City State/Country Zip Code

3. **Name Change:** If your credentials and application form bear different names, write below the said names and your explanation for the discrepancy/discrepancies and attach a notarized copy of the legal document supporting the name change. If the legal document is in a language other than English, attach a notarized copy of the cer tified translation as well.

_____

_____

4. **Telephone Number** (including area code):_____

5. **Information for Identification**:

a. Date of Birth: _____ b. Sex: _____ _____
MM/DD/YYYY Female Male

c. Country of Birth: _____ d. SSN: _____

e. Race/Ethnicity:
____ Alaskan Native
____ Asian
____ Black or African American
____ Caucasian
____ Hispanic or Latin
____ Native American
____ Other (Specify) _____

6. **Medical School Diploma:** Attached is a notarized copy of your medical school diploma to this application. If your medical school diploma is in a language other than English, attached a notarized copy of the certified translation.

7. **Documentation of Postgraduate Training, MBP Form LLPT2 07/2003:** The postgraduate training program you have successfully completed shall have been in the specialty identified by the American Board of Medical Specialties (ABMS) in which you will function as a postgraduate teacher and shall have included at least the same number of years of specialty postgraduate training as would be required for certification by that specialty's board in the United States. Complete the list below.

Training Programs Completed (Specify specialty)	**Inclusive Dates of Attendance**	**Locations (Specify name of hospital/institution and complete Address)**

Total of Years = _____

Complete Part 1 of the **MBP Form LLPT2 07/2003** and send it to each of the program directors of the postgraduate training you have attended in the United States and/or other countries for completion of Part 2 and mailing directly to the Board.

8. **Documentation From U.S. and/or Foreign Specialty Boards, MBP Form LLPT3 07/2003:** Complete Part 1 of the appropriate form and send it to each of the specialty boards that has ever certified you for completion of Part 2 and mailing directly to the Board.

Check off the item that applies to you.

_____ I am ABMS certified.

_____ I am not ABMS certified.

9. For each question, check the appropriate box that reflects your response

YES NO

_____ a. Has any state licensing or disciplinary or a comparable body in the armed services denied your application for medical licensure, reinstatement, or renewal?

_____ b. Has state licensing or disciplinary board, or any comparable body in the armed services taken action against your license, including but not limited to limitations of practice, required education, admonishment, reprimand, suspension or revocation for an act that would be grounds for disciplinary action under Md. Code Ann., Health Occ. §14-404?

_____ c. Have any investigation or charge been brought against you by any licensing or disciplinary body or comparable body in the armed services?

_____ d. Has your application for medical or health professional license been withdrawn for reasons that would be grounds for disciplinary action under Md. Code Ann., Health Occ. §14-404?

_____ e. Has any investigation or charges been brought against you by any hospital, related institution, or alternative health care system that might be grounds for action under Md. Code Ann., Health Occ. §14-404?

_____ f. Have you ever had any limitations or loss of privileges by any hospital, related health care facility or alternative health care system that might be grounds for action under Md. Code Ann., Health Occ. §14-404?

_____ g. Have you ever had a plea of guilty, nolo contendere, conviction, or receipt of probation before judgement for any criminal act?

_____ h. Have you ever had a plea of guilty, nolo contendere, conviction, or receipt of probation before judgment for any alcohol or controlled dangerous substance offense, including but not limited to, driving while under the influence of alcohol or controlled dangerous substance?

_____ I. Are there any pending criminal charges against you in any court of law, excluding minor traffic violations?

_____ j. Do you have a physicial or mental condition that currently impairs your ability to practice medicine?

_____ k. Are you currently illegally using drugs?

_____ l. Have you ever been named as defendant in the filing or settlement of a medical malpractice action within the past 5 years?

If you answered **YES** to any of the questions (a) through (l), attach a separate page with a complete explanation of each occasion. Each statement must have your name inprint, signature and a date.

10. **Experience as an Academician, MBP Form LLPT4 07/2003**: List below your academic experiences; if you use attachments, each page must have your name in print, signature, and date. You are required to have functioned independently as an academician for at least 3 years after the completion of postgraduate specialty training.

Academic Appointments (Specify titles)	**Locations (Give full names and addresses institutions and departments)**	**Inclusive Dates of appointments**	**Specific Dates**

Complete Part 1 of the **MBP Form LLPT4 07/2003** and send it to every educational institution that ever accorded you an academic appointment for completion of Part 2 and mailing directly to the Board.

11. **Experience as a Clinician, MBP Form LLPT5 07/2003**: List below all the facilities or sites where you ever practiced as a clinician. You are required to have functioned independently as a clinician for at least 3 years after completion of postgraduate specialty training.

Titles	**Names of Facilities/Sites Including Country**	**Complete Address,**	**Inclusive Dates of Practice**	**Specific Duties**

Complete Part 1 of the **MBP Form LLPT5 07/2003** and send it to every one of your facility/site administrators for completion of Part 2 and mailing directly to the Board.

12. **Statement From A Hospital Chief of Staff on the Applicant's Ability to Practice Medicine or Professional Competency, MBP Form LLPT6 07/2003:** Complete Part 1 of the form and send it to the chief of staff of any hospital where you practiced within the 5 years preceding the application for a postgraduate teaching license for completion and mailing directly to the Board.

13. **Medical Licensing Examination Results:** Use **MBP Form LLPT7 07/2003** for national medical licensing exami nations and **MBP Form LLPT8 07/2003** for state board examinations that you have taken. Complete Part 1 of the appropriate form and send it to each of the medical licensing authorities that administered a medical licensing examination to you. Request that your examination results and dates of administration be sent directly to the Board.

You must identify all the medical licensing examinations that administered the examinations to you by checking off all the items below that apply to you.

_____ ECFMG

_____ FLEX

_____ FLEX-weighted average

_____ National Boards of Medical Examiners

_____ National Board of Osteopathid Medical Examiners

_____ SPEX

_____ State Written Exam (USA - prior to 1985)

_____ USMLE

_____ LMCC

_____ O-Other (Specify):

If the document is not in the English Language, attach a notarized copy of the certified translation of the document as well.

14. **Information From the Teaching Institution Supporting the Application, MBP Form LLPT9 07/2003:** Complete Part 1 of the form and send it to the teaching institution that is seeking a limited license for postgraduate teaching on your behalf for completion of Part 2 and mailing directly to the Board.

15. **English Language Competency, MBP Form LLPT14 07/2003:** You are required to demonstrate oral and written English language competency. If you graduated from either: (a) a high school, including GED, or under graduate college or university, where English was the language of instruction throughout your attendance, after at least three years of enrollment: or (b) a professional school, where English was the language of instruction throughout your inclusive dates of attendance, complete Part 1 of the appropriate form and send it to your school for completion of Part 2 and subsequent mailing directly to the Board. In addition, complete the section below.

Name and Mailing Address of School: _____

_____

_____

_____

Degree Received: _____**Date of Graduation**: _____

Inclusive dates of atendance: From (mo/yr):_____ to (mo/yr): _____

Language (s) of Instruction: _____

If neither (a) nor (b) above applies to you, you must submit a score of at least 220 on the Test of Spoken English (TSE) on tests taken before July 1995 or a score of at least 50 on tests taken beginning July 1995 and a score of at least 550 on the Test of English as a Foreign Language (TOEFL) on the paper and pencil test or a score of at least 213 on the computer based TOEFL.

Check off the item below that applies to you.

_____ a. I have met the requirements on English language competency as listed above and understand that the Board will conduct direct source verification of my English language competency.

_____ b. I have attached evidence of my GED to this application. (This applies only to applicants who have GED.)

_____ c. I have achieved the required scores on TOEFL and TSE and have requested that my scores be sent to the Board to the Board directly by TOEFL/TSE.

REMINDER TO THOSE WHO DO NOT MEET THE REQUIREMENTS: Apply for medical licensure only after achieving scores of 220 or better and 550 or better on the TSE and TOEFL, respectively.

16. **Claims of Speech Impairment, MBP Form LLPT12 07/2003, if Applicable:** If you will claim speech impairment, complete Part 1 of the form and send them to the appropriate individuals for completion of Part 2 and mailing directly to the Board.

If you failed the TSE once, you must submit, with your application form and before your second attempt at pass ing the TSE, the documentation of your ability to communicate with patients and health care providers.

After the second examination, documentation of an impairment may not be submitted or accepted unless there has been an intervening medical/surgical event which has created the impairment.

You will be allowed to claim the impairment only if you reported to the Board before the third examination the intervening medical/surgical event which has created the impairment and the Board determines that the med ical/surgical event did indeed create the impairment.

If you have properly claimed and documented a speech impairment, the Board shall accept the documentation if you are able to prove the ability to communicate with allied health personnel and patients. Proof shall include documentation from 3 licensed physicians that you can communicate in a professionally competent manner with patients and health care providers or a hearing before the Board where you will be asked to describe the man ner in which you would obtain a history and physical examination from a typical patient.

Check off the item below that applies to you.

_____ I am claiming speech impairment.

_____ I am not claiming speech impairment.

17. **Additional Information:** Check off the items below that apply to you and make sure that you have attached the required information to this application. Each attachment must bear your name in print, signature, and date.

_____ I have attached to this application my malpractice history.

_____ I have attached to this application my driving record including, but not limited to, convictions for driving while intoxicated or while under the influence of a chemical substance or medication.

The Board may require you to submit to physical or mental examination, or both, by a physician or evaluation program for treatment of impaired physicians, or both, chosen by the Board. You will bear the expense for these examinations.

18. **Attachments to This Application:**

_____ I have attached to this application a total of _____ pages. Each page has my name in print, signature, and date.

_____ have not attached anything to this application.

Name in Print: _____

19. **Certification:** Please read this section carefully before signing your name

I agree that I will cooperate fully with any request for information, inspection of my medical practice or investigation, including the subpoena of documents or records, incident to my medical practice while licensed in the State of Maryland.

Further, I agree that if I become licensed I can only practice within the teaching institutions and programs specified within the application, and practice medicine only in conjunction with my assigned teaching responsibilities. I am not authorized to practice medicine outside my teaching responsibilities.

I agree that anybody, including but not limited to government agencies, the National Practitioner Data Bank, hospitals, and other licensing bodies, can release to you any information necessary for the processing of my application for medical licensure in Maryland.

I shall inform the Board within 30 days of any action that would be grounds for disciplinary action under Health Occupations Article, §14-404, Annotated Code of Maryland, that occurred at any time during the application period. I shall also inform the Board within 30 days of any arrest or conviction that occurred at any time during the application period.

I certify that the information supplied in this application is true and accurate to the best of my knowledge.

Signature of Applicant_____Date_____

20. **Affidavit of Applicant** (This must be completed in front of a notary public.)

_____, M.D., of _____
(name) (County, city, state, country)

_____ Hereby affirms that he/she is the person referred to in the above application for limited license for postgraduate teaching in the State of Maryland; and that all statements made in this application are true. **The physician's signature bearing my notarial seal or stamp is that of the person, here present, making this application.**

_____
Signature of Applicant **Date**

Notary public's signature: _____

Date of notarization: _____

Notary public's name in print: _____

Notary public's commission expires on _____

PASTE SECURELY APPLICANT'S PHOTOGRAPH HERE (Applicant, your legible signature must be across the bottom of the photograph.)

MARYLAND BOARD OF PHYSICIANS

P.O. Box 2571
Baltimore, Maryland 21215-0095

APPLICATION FOR LIMITED LICENSURE FOR POSTGRADUATE TEACHING

Documentation of Postgraduate Training

Part 1- Applicant, please complete this part of the form and send it to each of the program directors of the accredited training programs that you participated in.

Name: _____
Last name and generational indicator, if applicable First name Middle name

Address:_____

Birthdate: _____Social Security Number: _____

Completed Postgraduate Training at:_____
Name of hospital/ Institution

Area of Training: _____ Inclusive Dates of Attendance _____

Part 2- Program Director, please complete this part of the form and send it directly to the Maryland Board of Physicans at the above address. If using attachments, please sign, date, and print your name and the name of the applicant on each page.

This is to verify that the applicant attended the postgraduate training program that is accredited by the at the institution during the inclusive dates cited above. Below please find a summary of the:

1. Applicant's experience and performance during training:

2. Outcome of the applicant's training (Did the applicant successfully complete the year(s) of training?):

PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM.

3. Applicant's limitations of privileges during the postgraduate training year(s):

4. Applicant's physical and/or mental health problems, if any, that affected the applicant's ability to practice medicine during the year(s) of postgraduate training:

5. All actions against the applicant by any training program, hospital, medical board, licensing authority, or court for an act that would be grounds for disciplinary action under Health Occupations Article, §14-404, Annotated Code of Maryland, if applicable (See attached.):

Attestation:

I attest that the above information on the applicant is true, accurate, and complete.

_____

Signature of Program Director Date

_____

Name in print Title

_____

Address

MARYLAND BOARD OF PHYSICIANS
P.O. Box 2571
Baltimore, Maryland 21215-0095

APPLICATION FOR LIMITED LICENSE FOR POSTGRADUATE TEACHING

Documentation From U.S. and/or Foreign Specialty Boards

Part 1: Applicant, complete this part and send it to each of the specialty boards identified by the American Board of Medical Specialties (ABMS) in the U.S. or their counterpart specialty boards in the other countries.

Name: _____
(Print) Last name and generational indicator (e. g., Jr., Sr., II, III) First name Middle name

Address: _____

Birthdate (mo/day/yr): _____ Social Security Number: _____

Name and Address of Medical School of Graduation: _____

Specialties:_____

Certified By: _____
Names of Specialty Boards

Applicant, please submit copies of the requirements for certification of the specialty boards in the United States and in the country where said certification has been obtained.

Part 2: Authorized official, please complete this part of the form that applies to the applicant and your board. Send the completed form directly to the Maryland Board of Physicans at the above address.

Information from American Board of Medical Specialties

I certify that the applicant has been identified by _____

an ABMS board, as a specialist in _____ Effective _____

The current status of the specialty certification is: _____

Additional Information:_____

PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM

_____

Signature of Authorized Official at The Specialty Board Date

_____

Name and Title of Authorized Official in Print

_____

Full Name and Address of the Specialty Board

SEAL OF THE SPECIALTY BOARD (MEMBER BOARD OF ABMS)

Information from Specialty Boards in Other Countries Whose Standards Are Equivalent to Those of ABMS

I certify that the applicant has been identified by _____.

That has standards equivalent to those of the ABMS in the U.S., as a specialist in _____

_____ effective_____. The current status of the specialty

certification is: _____.

Additional Information:

_____

Signature of Authorized Official at the Specialty Board Date

_____

Name and Title of Authorized Official in Print

_____

Full Name and Address of the Specialty Board

SEAL OF THE FOREIGN SPECIALTY BOARD

MARYLAND BOARD OF PHYSICIANS

P.O. Box 2571
Baltimore, Maryland 21215-0095

APPLICATION FOR LIMITED LICENSE FOR POSTGRADUATE TEACHING

Experience As An Academician

Part 1 - Applicant, please complete this part of the form and send it to each of the medical schools where you taught after completion of your postgraduate specialty training.

Name: _____
(Print) Last name and generational indicator, if applicable First name Middle name

Birthdate: _____ Social Security Number: _____
Month/ day /year

Names of the medical schools where you taught and the inclusive dates of your teaching:

Medical Schools and Mailing Addresses, Including Departments Inclusive Dates

_____

_____

_____

_____

_____

Part 2 - Authorized medical school official, please complete this part of the form and send it directly to the Maryland Board of Physicans at the above address.

I hereby certify that the above information provided by the applicant are correct and in accord with our medical school records. The applicant's faculty appointment as _____(e.g., Associate Professor) is/was from_____to_____. His/her specific duties were/are:

_____

_____

_____

_____

_____

PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM.

Reason for termination of faculty appointment: _____

_____

_____

Overall job performance: _____

_____

_____

_____

_____

_____ _____

Name of the Dean of the Medical School in Print Date

_____

Signature of the Dean of the Medical School

SEAL OF THE MEDICAL SCHOOL

MARYLAND BOARD OF PHYSICIANS

P.O. Box 2571
Baltimore, Maryland 21215-0095

APPLICATION FOR LIMITED LICENSE FOR POSTGRADUATE TEACHING

Experience As A Clinician

Part 1 - Applicant, please complete this part of the form and send it to each of the medical directors of the facilities where you have practiced medicine after completion of your postgraduate specialty training.

Name: _____
(Print) Last name and generational indicator, if applicable First name Middle name

Birthdate: _____Social Security Number: _____License Number: _____

Name of Hospital, Chairman, and Department Where You Practiced: _____

Inclusive Dates of Practice: _____

Part 2 - Medical director, please complete this part of the form and send it directly to the Maryland Board of Physicans at the above address. If attachments will be used, please sign, date, and print your name as well as the name of the applicant on each page.

A. In what capacity did you work with the applicant? _____

B. I verify that the information provided by the applicant about his/her practice at the _____

_____ at the _____
Name of Department and Facility Address

_____ is true and accurate to the best of my knowledge.

Description of the experience received by the applicant, his/her performance, and, if applicable, explanations on the circumstances under which the facility/hospital privileges were limited, revoked, or allowed to lapse.

_____
Signature of Medical Director Date

_____
Name and Address of Medical Directors in Print

_____

SEAL OF THE FACILITY

MARYLAND BOARD OF PHYSICIANS

P.O. Box 2571
Baltimore, Maryland 21215-0095

APPLICATION FOR LIMITED LICENSE FOR POSTGRADUATE TEACHING

Statement From A Hospital Chief of Staff on the Applicant's
Ability to Practice Medicine or Professional Competency

Part 1 - Applicant, please complete this part of the form and send it to the chief of staff of one of the hospitals where you have practiced within the last five years.

Name:_____
(Print) Last name and generational indicator, if applicable First name Middle name

Address:_____

Birthdate: _____Social Security Number: _____ License Number:_____
mo./day/year

Names of Hospital, Chairman and Department Where You Practiced: _____

_____

Inclusive Dates of Practice: _____

Part 2 - Hospital Chief of Staff, please complete this part of the form and send it directly to the Maryland Board of Physicans at the above address. If you will use attachments, please sign, date, and print your name as well as the name of the applicant on each page.

This is to verify that Dr. _____ has practiced at the
Name of Applicant

_____
Name of Hospital

from_____to _____. Below is my or my predecessor's assess ment of his ability to practice medicine, or professional competency during the identified period. My predecessor, if applicable, is Dr. _____.

Assessment of the Applicant's Ability to Practice Medicine or Professional Competency:

_____
Signature of Chief of Staff Date

_____
Name and Address of Chief of Staff in Print

MARYLAND BOARD OF PHYSICIANS

P.O. Box 2571
Baltimore, Maryland 21215-0095

APPLICATION FOR LIMITED LICENSE FOR POSTGRADUATE TEACHING

Medical Licensing Examination Results

Part 1 - Applicant, please complete this part of the form and send it to every medical licensing examination authority that administered each of the examinations that you have taken prior to this application.

Name: _____
(Print) Last name and generational indicator, if applicable First name Middle name

Birthdate: _____ Social Security Number: _____

Institution That Conferred M.D/D.O. on You: _____

Date of Graduation: _____ Degree Received:_____

Part 2 - Medical licensing authority, please send directly to the Maryland Board of Physicans at the above address an original and official report on the applicant's complete medical licensing examination results and dates of test administration.

MARYLAND BOARD OF PHYSICIANS
P.O. Box 2571
Baltimore, Maryland 21215-0095

APPLICATION FOR LIMITED LICENSE FOR POSTGRADUATE TEACHING

Medical Licensing Examination Results: State Board Examination Certification

Part 1 - Applicant, please complete this part of the form and send it to each of the state medical boards that administered state written examinations to you.

Name: _____
(Print) Last name and generational indicator, if applicable First name Middle name

Social Security Number:_____ Date of Birth: _____

Part 2 - Authorized official of the State Medical Board, please complete this part of the form and send it directly to the Maryland Board of Physicians at the above address.

This is to certify that the _____ issued medical
Name of State Medical Board

registration/certificate license number_____to _____, M.D./D.O.
Name of applicant

on the _____ day of _____ , _____ based on _____
Year **Examination of credentials**

and prior graduation from _____on _____
Name of medical school **Date**

I further certify that the applicant passed the regular written examination given by this Board on the _____

day of_____,_____ , and obtained a general average of _____ percent in the
Year
following subjects:

Subjects	Percent	Subjects	Percent
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

_____ _____
Signature Of Authorized Official Date

_____
Title of Authorized Official **SEAL OF STATE MEDICAL BOARD**

MBP Form LLPT8 07/2003

MARYLAND BOARD OF PHYSICIANS

P.O. Box 2571
Baltimore, Maryland 21215-0095

APPLICATION FOR LIMITED LICENSE FOR POSTGRADUATE TEACHING

Information From the Teaching Institution Supporting The Application

Part 1: Applicant, complete this part and send it to the teaching institution that is supporting your application for completion of part 2 and mailing directly to the Maryland Board of Physicans at the above address.

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

Address, Including Country: _____

Birthdate: _____ Social Security Number: _____

Name and Address of Institution That Conferred the Medical Degree/Doctor of Osteopathy on You:

_____

_____

Part 2: Authorized official in the teaching institution that is supporting this application, please complete this part and send directly to the Maryland Board of Physicans at the above address the completed application.

I attest that the following is true and correct to the best of my knowledge.

1. Detailed evidence of the applicant's qualifications and competence:

2. Nature of the applicant's proposed responsibilities:

PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM.

3. Reasons for any limitations of practice responsibilities:

4. Degree of supervision under which the applicant will function:

5. Attachments; Attached securely to this form are_____ pages of the following attachments.

_____ copy of the relevant § of the hospital bylaws which detail the requirements for , and mechanism of, supervising of physicians.

_____ copy of the relevant § of the hospital bylaws which detail the requirements for, and mechanism of, supervision of postgraduate physician teachers.

_____

Signature of Authorized Official Date

_____

Name and Title of the Authorized Official in Print

_____

Name of the Teaching Institution, Including Department and Complete Mailing Address

_____

Telephone number, including area code

SEAL OF THE TEACHING INSTITUTION

MARYLAND BOARD OF PHYSICIANS
PO Box 2571
Baltimore, MD 21215-0095

APPLICATION FOR LIMITED LICENSE FOR POSTGRADUATE TEACHING

Verification of Education and Language of Instruction

Part 1 - Applicant, please complete this part of the form and send it to the institution that conferred the MD/DO on you.

Name: _____
Last name and generational indicator, if applicable First name Middle name

Birth date: _____ Social Security Number: _____
Month/date/year

Name of Institution that conferred the Medical Degree/Doctor of Osteopathy*_____
_____

Degree received: _____ Date of Graduation:_____
Month/day/year

Inclusive date of attendance: From _____ to _____
Month/year Month/year

_____ _____
Signature of Applicant Date

*If this institution is different from the medical school(s) where you obtained your medical education, write the name of your medical schools and the inclusive dated of your attendance

_____

Part 2 - Authorized official in the educational institution that conferred the medical degree or doctor or osteopathy on the applicant, please complete this part of the form and send it directly to the Maryland Board of Physicians at the above address.

I hereby certify that:

_____ A. The applicant graduated with a degree of _____ on _____.

_____ B. The language of instruction in this institution during the applicant's inclusive dates of attendance was _____.

_____
Name of School Official in Print

_____
Signature of School Official

_____
Title

SEAL OF INSTITUTION

MARYLAND BOARD OF PHYSICIANS

P.O. Box 2571
Baltimore, Maryland 21215-0095

APPLICATION FOR LIMITED LICENSE FOR POSTGRADUATE TEACHING

Claims of Speech Impairment

Part 1 - Applicant, please complete this part of the form and send a copy each to your physician and speech-language pathologist.

Name:_____
(Print) Last name and generational indicator, if applicable First name Middle name

Birthdate: _____ Social Security Number:_____

Nature and onset of speech impairment: _____

_____

_____

_____

Part 2 - Actively licensed, treating physician and a currently licensed speech-language pathologist, please complete this part of the form and send it directly to the Maryland Board of Physicians at the above address. If you will use attachments, please sign, date, and print your name as well as the name of the name of the applicant on each page.

I verify that the applicant has been under my care from _____ to _____

I original made the diagnosis of _____ on _____

based on the results of these tests: _____

The past and current treatment regimen are as follows:

_____ _____ _____
Signature of Physician/Speech Language Pathologist License Number, Name of State Date

_____
Name of Physician Speech-Language Pathologist and Address in Print

MARYLAND BOARD OF PHYSICIANS

P.O. Box 2571
Baltimore, Maryland 21215-0095

APPLICATION FOR LIMITED LICENSE FOR POSTGRADUATE TEACHING

Speech Impairment: Documentation of Ability to Communicate

Part 1 - Please complete this part of the form and send a copy to each of the three actively licensed physicians, who will vouch for your ability to communicate, for completion and mailing directly to the Board. Alternatively, the Board may require a hearing where you will be asked to describe the manner in which you would obtain a history and physical examination from a typical patient.

Name: _____
(Print) Last name and generational indicator, if applicable First name Middle name

Birthdate: _____ Social Security Number:_____

Nature and Duration of Speech Impairment:_____

_____

Part 2 - Licensed physician who will vouch for the applicant's ability to communicate orally with allied health personnel and patients, please complete this part of the form and send it directly to the Maryland Board of Physicans at the above address. If you will use attachments, please sign, date, and print your name as well as the name of the applicant on each page.

I attest to the applicant's ability to communicate orally in a professionally competent manner with allied health personnel and patients. I have observed the applicant in the following situations (Please be specific.):

_____

_____

_____

_____

_____ _____ _____
Signature of Actively Licensed Physician License Number, Name of State Date

_____
Name and Address of Actively Licensed Physician in Print

_____

MARYLAND BOARD OF PHYSICIANS

P.O. Box 2571
Baltimore, Maryland 21215-0095

APPLICATION FOR LIMITED LICENSE FOR POSTGRADUATE TEACHING

Attestation to Applicant's Good Moral Character

Part 1- Applicant, please complete this part of the form and send it to each of your two character references.

Name: _____
(Print) Last name and generational indicator, if applicable First name Middle name

Address: _____
(Print)

Part 2 - Individual providing character reference, please complete this part of the form and send it directly to the Maryland Board of Physicians at the above address. If you will use attachments, please sign, date, and print your name as well as the name of the applicant on each page.

Name:_____
(Print) Last name and generational indicator, if applicable First name Middle name

Profession:_____

have known the applicant for _____ number of years in the following capacity:

_____

_____

_____

_____

Attestation:

I attest that I am not related to the applicant and that I have known him/her for at least 5 years before the submission of his/her application for a limited license for postgraduate teaching in Maryland.

Further, I attest that by completing the following §, I have provided the Maryland Board of Physicians with my complete knowledge regarding the applicant's arrests, convictions, and loss or limitation of privileges to practice medicine in any setting.

Applicant's Arrests:_____

_____

PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM.

Applicant's Convictions: _____

Applicant's Loss of Privileges to Practice Medicine: _____

Lastly, I attest that the information above is true, accurate, and complete.

_____
Signature Date

_____
Name in Print

_____
Title

_____
Full Mailing Address

MARYLAND BOARD OF PHYSICIANS

P.O. Box 2571
Baltimore, Maryland 21215-0095

APPLICATION FOR LIMITED LICENSE FOR POSTGRADUATE TEACHING

Checklist

HAVE YOU:

1. Read and followed the instructions?
2. Completed the 8-page application form, MBP Form LLPT1 07/2003?
   a. Answered each item on the form?
   b. Attached to your application form copies of the following, if applicable?
      Notarized copy of the legal document explaining the name change
      Notarized copy of the certified translation of the legal document, as listed above
      Medical school diploma
      Notarized copy of the certified translation of the medical school diploma
      Explanations to YES answers to the questions under number 9
      Malpractice history
      Driving record including, but not limited to, convictions for driving while intoxicated or while under the influence of a chemical substance or medication
   c. Signed and dated the form?
   d. Signed legibly across the bottom of your recent photograph of passport quality?
   e. Pasted securely on the appropriate space your signed photograph?
   f. And your notary public completed the Affidavit section of the form?

3. Made as many copies of the forms listed in number four below as you need?

4. Completed part 1 in each of the following forms and sent them to appropriate individuals and agencies for completion of part 2 and mailing directly to the Board?
   a. Documentation of postgraduate training, MBP Form LLPT 07/2003

   b. Documentation from U.S. and/or Foreign Specialty Boards, MBP LLPT3 07/2003

   c. Experience as an academician, MBP LLPT4 07/2003

   d. Experience as a clinician, MBP LLPT5 07/2003

   e. Statement from a hospital chief of staff on the applicant's ability to practice medicine or professional competency, MBP Form LLPT6 07/2003

   f. Medical licensing examination results, MBP Form LLPT7 07/2003

   g. Medical licensing examination results: State Board examination certification, MBP Form LLPT8 07/2003

   h. Information from the teaching institution supporting the application, MBP Form LLPT9 07/2003

   i. English Language Competency, MBP Form LLPT10 07/2003

      If the form does not apply to you, please write "NOT APPLICABLE" underneath the title of the form. Sign, date, and print your name on the form, and attach it to your application form.

   j. Claims of speech impairment, MBP Form LLPT11 07/2003

   k. Speech impairment: documentation of ability to communicate, MBP Form LLPT12 07/2003

   m. You may wish to consider sending self-stamped envelopes to the appropriate individuals and agencies to help facilitate their response.

5. Enclosed a check for $300.00 payable to the Maryland Board of Physicans?