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 2571
Baltimore, MD 21215

NOTICE TO PHYSICIANS WHOSE LAST NAMES BEGIN WITH **A** THROUGH **L**

The Maryland Board of Physicians (the "Board") reinstates licenses year round. Licenses are reinstated with an expiration date that is determined by the last name of the applicant. If deemed eligible for reinstatement of medical licensure, when would you like to be reinstated?

Please read page 2 and choose when you would prefer to be reinstated. Complete the form and mail it to the Board with your completed reinstatement application.

Thank you for your cooperation.

IF YOUR LAST NAME DOES NOT BEGIN WITH THE LETTERS **A** THROUGH **L,**
PLEASE DISREGARD THIS FORM.

IF APPLICABLE, PLEASE COMPLETE PAGE 2.

MARYLAND BOARD OF PHYSICIANS
P.O. Box 2571
Baltimore, MD 21215

APPLICATION FOR REINSTATING PHYSICIANS

APPLICANT'S PREFERRED DATE OF REINSTATEMENT

The Maryland Board of Physician (the Board) reinstates eligible applicants year round. Licenses are issued with an expiration date that is determined by the last name of the applicant. Licenses of physicians whose last names begin with the letters **A through L** expire on **September 30th** of **even** years (example: 2018, 2020, etc.).

Instructions: If your last name begins with the letters **A- L,** please choose Option 1 or Option 2. Please print your name, sign and date the form and include it with your application for reinstatement.

Option 1

_____ If determined eligible for reinstatement of licensure, I wish to be reinstated **BEFORE September 30, 2018**. If reinstated, I understand that: (1) I will be required to renew the license and pay a renewal application fee before the license expires on **September 30, 2018**; and (2) the Board will issue the license only upon receipt of this signed and dated form.

Signature_____ Date_____

Name in Print_____

Option 2

_____ If determined eligible for reinstatement, I wish to be reinstated **AFTER September 30, 2018**. If reinstated, I understand that: (1) the license will be issued after **September 30, 2018**; (2) the license will expire on **September 30, 2020**; (3) **I MAY NOT** practice medicine in Maryland prior to receiving my license; and (4) the Board will only issue the license upon receipt of this signed and dated form.

Signature: _____ Date_____

Name in Print: _____

Updated 12/2017

MARYLAND BOARD OF PHYSICIANS

Baltimore, Maryland

www.mbp.state.md.us

APPLICATION FOR REINSTATEMENT OF MEDICAL LICENSE

Dear Applicant:

Attached is an application packet for reinstatement of your license to practice medicine in Maryland.

The fee to reinstate a medical license is **$600** or **$700**. Fees are based on when the license expired. If the licensee's last name begins with the letters **A-L**, the license expires on September 30th of even years. If the licensee's last name begins with the letters **M-Z**, the license expires on September 30th of odd years.

If your license expired within the last 24 months prior to submitting your application for reinstatement, the reinstatement fee is **$700**. If your license expired more than 24 months prior to submitting your application for reinstatement, the reinstatement fee is **$600.** If you are unsure of which fee to pay, please contact the Board at 410-764-4777 before submitting your application.

The application fee is **non-refundable.** 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

Applications and payments sent to any address other than the P.O. Box 37217 address will delay the processing of your application by at least one week. **Please note:** Federal Express (FedEx) or UPS do not deliver to post office boxes.

Applications are processed in the order they are received. **Please allow at least 4 to 6 weeks for the processing of your application**. Board staff will make every effort to process your application as quickly as possible. Incomplete applications and/or failure to submit the required information will delay the processing of your application.

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

Supporting documentation must come directly from the source. For example, verification of other state licenses must come directly from the state board.

The Board will keep your application open for 120 days from the original date of receipt. All requirements for reinstatement must be met within the 120-day period. If the requirements are not met, your application will be closed, and you will be required to submit a new application and full reinstatement fee.

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 REINSTATEMENT OF MEDICAL LICENSE

INSTRUCTIONS AND IMPORTANT INFORMATION

This application should only be completed by physicians who have an expired Maryland license to practice medicine and wish to reinstate it.

FEE: $600—*Pay this fee if your license expired more than 24 months ago.*
$700—*Pay this fee if your license expired less than 24 months ago.*

1. **Maryland License Number:** Enter your license number. If you do not remember your license number, you may find it on the Board's Website at *https://www.mbp.state.md.us/bpqapp/*. License numbers begin with a "D" or "H" prefix.

2. **Expiration Date:** Provide the date your license expired. If your last name begins with the letters **A-L**, your license expires on September 30th of even years. If your last name begins with the letters **M-Z**, your license expires on September 30th of odd years.

3. **Identifying Information:**
   - **Full Legal Name:** If the name on the application differs from the name on your supporting documentation, please submit a copy of a marriage license, divorce decree, or court order authorizing the name change. The Board must be notified of any change in your name on a timely basis.

   - **Social Security Number:** Maryland law requires the Board to collect Social Security numbers from all persons applying for professional licenses or certificates. Disclosure of your Social Security number is mandatory. The Board 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. §1396a(a)(49); 42 U.S.C. §1396r-2; 42 U.S.C. §1320a-7).

   - **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.

   - **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.

4a. Non-Public Address: The non-public (home) address will be the location to which the Board directs all correspondence. If your address changes during the application process, please notify the Board in writing.

4b. 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 upon request.

APPLICATION FOR REINSTATEMENT OF MEDICAL LICENSE

INSTRUCTIONS AND IMPORTANT INFORMATION CONTINUED

5. Contact Information: The Board will contact you using the information provided.

6. School Information: Please provide the name and location of the medical school from which you graduated. Also include the date you graduated.

7. Employment Activities: Please complete and include all employment history beginning with the date your license expired.

8. Special Purpose Exam (SPEX) or Comprehensive Osteopathic Medical Variable-Purpose Exam (COMVEX): A physician applying for reinstatement may be required to pass the SPEX or COMVEX-USA exam if the physician:

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

Contact Information for the SPEX and COMVEX

SPEX: Contact the Federation of State Medical Boards at *http://www.fsmb.org/licensure/spex_plas/*

COMVEX: Contact the National Board of Osteopathic Medical Examiners - Client Services Department at clientservices@nbome.org or (866) 479-6828. The Website address is *http://www.nbome.org/comvex.asp.*

9. List the reasons for allowing your Maryland medical license to expire.

10. List the reasons for seeking reinstatement of your Maryland medical license.

11. Licensure in Other States: The Board requires primary source verification of medical licensure from other state boards/jurisdictions. 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 satisfactorily verify your license, you will be required to request a verification of licensure from the state board using the Verification of Other State Licenses form (**REIN 1**).

12. Continuing Medical Education (CME): A physician applying for reinstatement is required to earn at least 50 credit hours of Category 1 CMEs during the two-year period immediately proceeding *submission of the reinstatement application.

**The date this application is signed will be used for the date of submission.*

APPLICATION FOR REINSTATEMENT OF MEDICAL LICENSE

INSTRUCTIONS AND IMPORTANT INFORMATION CONTINUED

13. **Character and Fitness Questions:** Answer the Character and Fitness questions "YES" or "NO." If you answer "YES" to any item, please provide a detailed explanation, on a separate sheet of paper, and attach any supporting documents. If you were dishonorably discharged from the military, please provide documentation that includes, but is not limited to, the type of service, date and type of discharge, e.g. DD 214. *Failure to provide a detailed explanation and the required supporting documentation will delay the application process.*

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

15. **Optional Third Party Release:** Board staff will not disclose the status of your application to another party unless you have completed the optional Third Party Release on Page 7 of the application. Please complete the third party release if you want the status of your application disclosed to family members, friends, and future employers, etc.

16. **Cooperation in an Investigation:** You are expected to cooperate fully with any request for information related to your application for reinstatement of your medical license.

17. **Certification:** Sign and date the certification.

Expiration and Renewal: If your last name begins with the letters **A-L**, regardless of the date your license is reinstated, your license will expire on September 30 of the first <u>even</u> year following reinstatement.

If your last name begins with the letters **M-Z**, regardless of the date your license is reinstated, your license will expire on September 30 of the first <u>odd</u> year following reinstatement.

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 will be required to renew by September 30th of your renewal cycle year whether or not you receive the renewal notice.

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.

The Maryland Board of Physicians supports the Americans with Disabilities Act (ADA) and will provide this material in an alternative format to facilitate effective communication with sensory impaired individuals (for example, Braille, large print, audio tape). If you need such accommodation, please notify the Board's ADA designee, Yemisi Koya, at 410-764-4777 or 1-800-492-6836. For the hearing impaired, please contact the Maryland Relay Services TTY/Voice number at 1-800-735-2258. If you have a complaint concerning the Board's compliance with the ADA, please contact Ms. Koya.

Please keep a copy of your application.

MEDICAL LICENSE REINSTATEMENT APPLICATION 1/18/18

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

FOR BANK USE ONLY
Date: _____
Check Number: _____
Amt Paid: _____
Name Code: _____
App ID: 19

Fee: *$600*— Pay this fee if your license expired more than 24 months ago.
$700— Pay this fee if your license expired less than 24 months ago.

APPLICATION FOR REINSTATEMENT OF MEDICAL LICENSE

Please print legibly or type the required information. Do not leave any item unanswered.

1. Maryland License No.:	0	0						**2. Expiration Date:**			-			-		

3. IDENTIFYING INFORMATION:

Last Name (Suffix, Jr., III):	**First Name:**
Middle Name/Initial:	**Maiden Name:**

Social Security Number:	**Date of Birth:**	**Gender:** Male ☐ Female ☐

4a. 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. If you change your address prior to being licensed, immediately notify the Board in writing.

Street Address 1:		
Street Address 2:		
City:	**State:**	**Zip Code:**

4b. PUBLIC ADDRESS: Your public address of record. This address, usually your office, is available to the public and may be posted on the internet. If you change your address prior to being licensed, immediately notify the Board in writing.

Facility Name:		
Street Address:		
City:	**State:**	**Zip Code:**

5. CONTACT INFORMATION:

Home or Cell Phone #:	**Work #:**
Personal E-mail Address:	**Official E-mail Address for Board Correspondence:**

6. SCHOOL INFORMATION:

Professional School of Graduation: _____

Location (City/State) of Professional School: _____

Graduation Date: _____

For Board Use Only	Date Reinstated:							Expiration Date:						

Print
Your
Name: ____ Date: ______________

7. Chronology of Employment Activities: Beginning with the most recent, describe your employment history since your license expired. Explain any lapse in time over one year in which you were not employed. ***Please do not attach a C.V. or resume.***

Employment activities since your license expired:
Please type or print.

month	year		month	year	
		TO			**Activity/Position:**
Name :			**Address:**		
month	year		month	year	
		TO			**Activity/Position:**
Name:			**Address:**		
month	year		month	year	
		TO			**Activity/Position:**
Name:			**Address:**		
month	year		month	year	
		TO			**Activity/Position:**
Name:			**Address:**		
month	year		month	year	
		TO			**Activity/Position:**
Name:			**Address:**		
month	year		month	year	
		TO			**Activity/Position:**
Name:			**Address:**		
month	year		month	year	
		TO			**Activity/Position:**
Name:			**Address:**		
month	year		month	year	
		TO			**Activity/Position:**

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

8. SPEX/COMVEX Examinations: Please check all that apply.

☐ a. The last time I passed a medical licensing exam was more than 15 years before *submitting this application for reinstatement.

☐ b. I have never had a specialty board certification.

☐ c. During the ten years preceding the *submission of this application for reinstatement, I did not pass a specialty board certification or recertification examination given by the American Board of Medical Specialties or the American Osteopathic Association Bureau of Osteopathic Specialists.

☐ d. I have not had a full, unrestricted medical license in at least one state of the U.S. or Canada within the ten-year period before *submitting this application for reinstatement.

☐ e. I have not actively practiced clinical medicine in the U.S. or Canada for at least seven of the ten years before *submitting this application for reinstatement.

**The date this application is signed will be used for the date of submission.*

If you checked any of the statements listed above, the Board may require you to pass the Special Purpose Examination (SPEX) or the Comprehensive Osteopathic Medical Variable-Purpose Examination (COMVEX). The SPEX is administered by the Federation of State Medical Boards, and the COMVEX is administered by the National Board of Osteopathic Medical Examiners. If you are required to take either the SPEX or COMVEX, the Board will notify you.

9. Please explain the reasons for allowing your Maryland medical license to expire:

_____

_____

_____

_____

10. Please explain the reasons for seeking reinstatement of your Maryland medical license:

_____

_____

_____

_____

_____

11. Licensure as a Physician: The Board requires primary source verification of medical licensure from other state boards/jurisdictions. The Board will make every effort to verify your license from each state board that you have held a license to practice medicine. If the Board cannot satisfactorily verify your license, you will be required to request a verification of licensure from the state board using the Verification of Other State Licenses form (**REIN 1**). If you have never been licensed as a physician in another state, please write N/A here _____.

State	License Number	Year Issued	Expiration Date

12. Continuing Medical Education (CME):

A physician applying for reinstatement is required to earn at least 50 credit hours of Category 1 CME during the two-year period preceding the submission* of the reinstatement application.

Please attach documentation of your 50 Category I CME to this application.

For information about the type of continuing education the Board recognizes and the required documentation, please go to this web page:

http://www.dsd.state.md.us/comar/comarhtml/10/10.32.01.10.htm

**The date this application is signed will be used for the date of submission.*

13. Character and Fitness Questions (Check either **YES** or **NO) Please answer questions "a" through "q" on pages 5 and 6.**

	YES	NO	**Since your last renewal:**
a.	☐	☐	Has a state licensing or disciplinary board (including Maryland), a comparable body in the armed services or the Veterans Administration, 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, 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, filed any complaints or charges against you or investigated you for any reason?
d.	☐	☐	Have you 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 investigated you or brought charges against you?
f.	☐	☐	Has a hospital, related health care institution, HMO, or alternative health care system 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 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 committed an offense involving alcohol or controlled dangerous substances to which you pled guilty or *nolo contendere*, or for which you were convicted or received probation before judgment? Such offenses include, but are not limited to, driving while under the influence of alcohol or controlled dangerous substances.
i.	☐	☐	Are there any charges pending against you in any court of law, are you currently under arrest, released pending trial with or without bond, or is there an outstanding warrant for your arrest?
j.	☐	☐	Do you currently have any condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or a physical, mental, emotional, or nervous disorder or condition) that in any way affects your ability to practice your profession in a safe, competent, ethical, and professional manner?

»»» **If you answered "YES" to any question, on a separate sheet of paper, please provide a signed and dated detailed explanation and attach any supporting documents. Failure to provide documentation and a signed and dated explanation will delay the processing of your application.**

13. Character and Fitness Questions Continued (Check either **YES** or **NO)**
Since your last renewal:

	YES	NO	
k.	☐	☐	Have any malpractice claims or other claims for money damages 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 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 been terminated for disciplinary reasons?
o.	☐	☐	Have you 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 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 been dishonorably discharged from any military service of the U.S. Government? If so, attach a copy of your military discharge documentation that includes type of service, date of discharge, and type of discharge.

»»» **If you answered "YES" to any question, on a separate sheet of paper, please provide a signed and dated detailed explanation and attach any supporting documents.**
Failure to provide documentation and a signed and dated explanation will delay the processing of your application.

RELEASE AND CERTIFICATION

14. Release: I agree that the Maryland Board of Physicians (the Board) may request any information necessary to process my reinstatement application from any person or agency, including but not limited to former and current employers, government agencies, the National Practitioners Data Bank, the Federation of State Medical Boards, hospitals and other licensing bodies. I agree that any person or agency may release the information requested to the Board. I also agree to sign any subsequent releases for information the Board may request.

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

15. (OPTIONAL) Third Party Release: Although 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: _____

Phone: _____

Applicant's Signature _____ Date _____

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

During the period in which my application is being processed, I shall inform the Board within 30 days of any change to any answer I originally gave in this application, any arrest or conviction, any change of address, or any action that occurs based on accusations that would be grounds for disciplinary action under Md. Code Ann., Health Occ. §14-404.

Applicant's Signature _____ Date _____

17. Certification: **I certify that I have completed and attached at least 50 credit hours of Category 1 continuing medical education credits during the two years immediately preceding the *submission of this reinstatement application**.

I certify that I have personally reviewed all responses to the items in this application and that the information I have given is true and correct to the best of my knowledge and that any false information provided as part of my application may be cause for the denial of my application. I also certify that I am thoroughly familiar with the Statute (MD. Code Ann., Health Occ. §14-317) and Code of Maryland Regulations (COMAR) 10.32.01.11 which govern the reinstatement of physicians in Maryland.

**The date this application is signed will be used for the date of submission.*

Applicant's Signature _____ Date _____

STOP! Mail completed application and fee to Maryland Board of Physicians; P.O. Box 37217; Baltimore, Maryland 21297. Mailing them to any other address will delay the process.

REINSTATEMENT
VERIFICATION OF
OTHER STATE LICENSES
REIN 1 1/18/18

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

VERIFICATION OF OTHER STATE LICENSES

Part 1 **APPLICANT: Complete and sign Part 1 and send a copy of this form to each state board that ever issued you a license, certificate, or registration to practice as a Physician. Please copy this form if you need to send it to more than one state board.**

State of Licensure: _____ License Number: _____

Date: _____ Expiration Date: _____

Name: _____
(Print) Last (Generational Indicator, Jr., III) First Middle Maiden

Social Security Number: _____ - _____ - _____ Date of Birth: _____/_____/_____

Professional School of Graduation: _____ Year: _____

Signature: _____ Date: _____

Part 2 **AUTHORIZED OFFICIAL OF STATE MEDICAL BOARD: Please certify the following information regarding the above-listed individual and send this form directly to the Maryland Board of Physicians at the above address.**

_____ _____ _____
License Number Date Issued Expiration Date

Is/was the license in good standing? ☐ **Yes** ☐ **No**

If not in good standing is/was it: ☐ **Reprimanded** ☐ **Suspended** ☐ **Revoked** ☐ **Surrendered**

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

If yes, please explain: _____

_____

Other Derogatory Information or Pending Charges: _____

_____

_____ _____
Printed Name of Authorized Official Direct Telephone Number

_____ _____
Title of Authorized Official Printed Name of State

_____ _____
Signature of Authorized Official Date

State Board Seal