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

www.mbp.state.md.us

RADIATION THERAPIST APPLICATION FOR REINSTATEMENT

Dear Applicant:

Attached is an application packet for reinstatement of your license as a Radiation Therapist in Maryland. Requirements for reinstatement are as follows:

- ◊ Submission of the completed application;
- ◊ Payment of the **$150.00 non-refundable** application fee. *Checks or money orders should be made payable to the **Maryland Board of Physicians**;*
- ◊ Documentation of 24 hours of approved continuing education credits earned during the 2-year period immediately preceding the application for reinstatement or current registration by the ARRT; and
- ◊ Payment or agreement with Office of the Comptroller to pay unpaid unemployment insurance or taxes;

Mail your application and check to:

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

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

Applications are processed in order of receipt. **Please allow at least 3 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.

Board staff will contact you if additional documentation is required. Please make sure your contact information is current. Please do not call the Board to check on the status of your application, as constant interruptions slow down the process.

Documents submitted to support your application must come directly from the source. For example, verification of other state licenses must come directly from the state board.

Board staff will not disclose the status of your application to another party unless you have completed the Third Party Option on page 6 of the application or provided documentation allowing staff to disclose the status to another party. Other parties include family members, friends and future employers, etc.

The Board will keep your application open for 120 days from the original date of receipt. All requirements for licensure must be met within the 120 day period. The Board does not grant exemptions from these requirements. If the requirements are not met, your application will be closed and a new application and full application 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 find out if a license was issued to you. When you get to 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 Allied Health Division
Board of Physicians

MARYLAND BOARD OF PHYSICIANS

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

APPLICATION FOR REINSTATEMENT OF RADIATION THERAPIST

INSTRUCTIONS AND IMPORTANT INFORMATION

The application should only be completed by individuals who have an expired Maryland Radiation Therapist license and wish to reinstate it.

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/.* Numbers begin with an "O" prefix.

2. **Expiration Date:** Provide the date your license expired. Licenses expire on April 30 of odd years.

3. **Identifying Information**:
   - **Enter 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 explaining 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 of Physicians to collect Social Security numbers from all persons applying for 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).

   - **Date of Birth**: Health Occupations Article §14-5D-08(b)(2), Annotated Code of Maryland requires applicants to be at least 18 years old. Date of birth will also be used for identification and criminal background checks.

   - **Gender:** 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.

INSTRUCTIONS AND IMPORTANT INFORMATION CONTINUED

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.

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

6. School Information: Please provide the name and location of the 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. Continuing Education: Documentation of 24 hours of approved continuing education credits earned during the 2-year period immediately preceding the application for reinstatement or current ARRT registration.

9. List reasons for allowing license to lapse.

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

11. Licensure in Other States: Please complete the **Verification of Other State Licenses form (RRT 1)** if you have ever held a license, certification or registration to practice:

a. As a Radiation Therapist in any state or jurisdiction; or
b. Any other health care profession in any other state(s) or jurisdiction, including Maryland.

12. 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 any supporting documents. If you were 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. DD14. Failure to provide a detailed explanation and the required supporting documentation will delay the review process.

13. Release: Sign and date the release. You are giving the Board and Radiation Therapy, Radiography, Nuclear Medicine Technology, and Radiology Assistance Advisory Committee permission to request additional information to support your application for licensure.

14. Optional Third Party Release: If you wish the Board to release your information to a third party, complete the third party release statement.

15. Cooperation in an Investigation: You may be asked to cooperate fully with any request for information related to your practice as a radiation therapist.

16. Certification: Please sign and date the certification.

INSTRUCTIONS AND IMPORTANT INFORMATION CONTINUED

Expiration and Renewal: Regardless of the date your license is reinstated, it will expire April 30 of the first odd year following reinstatement. Approximately 30 - 60 days prior to expiration, you should receive a notice to renew your license. The renewal notice will be mailed to the current address on file with the Board. You will be required to renew by April 30 of the odd year whether or not you receive the renewal notice.

PRACTICING AS A RADIATION THERAPIST: A person may not practice, attempt to practice, or offer to practice as a Radiation Therapist in Maryland unless licensed to practice by the Board. A person may not provide, attempt to provide, offer to provide, or represent that the person provides radiation therapy unless the person is licensed to practice by the Board. Individuals practicing without a license may be fined up to $5,000.

The Maryland Board of Physicians 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 accommodation, please notify the Board 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.

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

RADIATION THERAPIST
REINSTATEMENT
APPLICATION
6/2017

MARYLAND BOARD OF PHYSICIANS
P.O. Box 37217 • Baltimore, MD 21297
Telephone: 410-764-4777 Fax: 410-358-0404 Toll Free: 800-492-6836

FOR BANK USE ONLY
Date _____
Check Number _____
Amt Paid _____
Name Code _____
App ID:12
Fee: $150

APPLICATION FOR REINSTATEMENT OF RADIATION THERAPIST

1. Maryland License No.: 2.	O	0	0	0					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 #:	Work #:
Pager #:	Cell #:
Fax #:	Email address:

6. SCHOOL INFORMATION:

Professional School of Graduation: _____

Location (City/State) of Professional School: _____

Graduation Date: _____

For Board Use Only	Date Reinstated:							Expiration date:							

7 . Chronology of Employment Activities: Beginning with your most recent, describe your employment history since your license expired. Explain any lapse in time over one year in which you were not employed. Include non-health related employment history.

Employment activities: Since your last renewal:

Please type or print.

month	year	TO	month	year	Activity/Position:
Name and telephone of Supervisor:					Name and Address of Employer:
month	year	TO	month	year	Activity/Position:
Name and telephone of Supervisor:					Name and Address of Employer:
month	year	TO	month	year	Activity/Position:
Name and telephone of Supervisor:					Name and Address of Employer:
month	year	TO	month	year	Activity/Position:
Name and telephone of Supervisor:					Name and Address of Employer:
month	year	TO	month	year	Activity/Position:
Name and telephone of Supervisor:					Name and Address of Employer:
month	year	TO	month	year	Activity/Position:
Name and telephone of Supervisor:					Name and Address of Employer:
month	year	TO	month	year	Activity/Position:
Name and telephone of Supervisor:					Name and Address of Employer:
month	year	TO	month	year	Activity/Position:
Name and telephone of Supervisor:					Name and Address of Employer:

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

Print Your Name: _____ Date:_____

8. Continuing Education: Radiation Therapists must provide documentation of having earned 24 hours of approved continuing education credits during the 2-year period immediately preceding the application for reinstatement or current ARRT registration.

The Board recognizes programs relevant to the practice of a radiation therapist approved by one of the following organizations: (1) In-service programs at a hospital or related institution; (2) American College of Radiology; (3) Maryland Society of Radiologic Technologists; (4) American Medical Association; (5) MedChi, the Maryland Medical Society; or (6) American Society of Radiologic Technologists

Please attach your continuing education documentation.

9. List reasons for allowing the Maryland Radiation Therapist license to expire:

_____

_____

_____

10. List reasons for seeking reinstatement of the Maryland Radiation Therapist license:

_____

_____

_____

11a. Licensure as an radiation therapist. List all states or other jurisdictions in which you have ever held a license to practice as an radiation therapist. Please complete and mail the attached **Verification of Other State License(s) (RTT 1)** form to the appropriate state board(s). If you have never been licensed as a radiation therapist, write N/A here _____.

State	License #	Category (RT(T))	Year Issued	Expiration Date

11b. Licensure as another health care practitioner. List all states or other jurisdictions in which you ever held a license to practice in ANY other health occupation. Please complete and mail the attached **Verification of Other State License(s) (RTT 1)** form to the appropriate state board(s). If you have never been licensed as ANY other health care provider, write N/A here _____.

State	License #	Category (CNMT, RT(R))	Year Issued	Expiration Date

12. Character and Fitness Questions (Check either **YES** or **NO) Please answer questions "a" through "q" on pages 4 and 5.**

	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 appropriate supporting documents. Failure to provide documentation and a signed and dated explanation will delay the processing of your application.

Continue to Page 5 for questions "k through "q"

12a. 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 appropriate supporting documents. Failure to provide documentation and a signed and dated explanation will delay the processing of your application.**

RELEASE AND CERTIFICATION

13. Release: I agree that the Maryland Board of Physicians (the Board) and Radiation Therapy, Radiography, Nuclear Medicine Technology and Radiologist Assistance Advisory Committee may request any information necessary to process my reinstatement application as a Radiation Therapist in Maryland 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, and I agree that any person or agency may release to the Board the information requested. I also agree to sign any subsequent releases for information that may be requested by the Board.

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

14. (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

15. Cooperation in an Investigation: I agree that I will cooperate fully with any request for information or with any investigation related to my practice as a licensed Radiation Therapist in Maryland, including the subpoena of documents 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. § 14-5B-14.

_____ _____
Applicant's Signature Date

16. Certification:

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. 14-5B-01 et seq.) and Code of Maryland Regulations (COMAR) 10.32.10 which govern the practice of Radiation Therapists in Maryland.

_____ _____
Applicant's Signature Date

STOP! Completed application and check for $150 must be mailed to Maryland Board of Physicians, P.O. Box 37217, Baltimore, Maryland 21297

RT(T)— Reinstatement
Verification of Licensure
in Other States
Form RTT 1

MARYLAND BOARD OF PHYSICIANS
4201 Patterson Avenue ■ P.O.Box 2571
Baltimore, Maryland 21215-0095
Telephone: 410-764-4777 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 to practice as a Radiation Therapist. Also use this form to send to each state board, including Maryland, that ever issued you a certification, license or registration to practice as ANY other health care practitioner. Please copy this form if you need to send it to more than one state board.

License Type: _____

State of Licensure: _____ License Number: _____

Date: _____ Expiration Date: _____

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

Social Security No. : _____ 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