Medical Licensing Services

APPLICATION FOR LICENSURE

Last Name: _____First Name: _____Middle Name: _____

other names (if applicable) : _____

Home Address: _____City: _____ State____Zip: _____

Work Address: _____ City: _____State _____ Zip: _____

Home Phone # _____ Work Phone #_____Cell Phone #_____

Fax # _____ Pager #_____Which # preferred? _____

Email Address: (personal) _____ (business) _____

SS# _____ Birth date: _____ __

Physical Data
Drivers License # _____ State_____Date of Expiration _____

HT _____ WT _____ Eye Color _____ Hair Color _____

Male/Female: _____ Ethnicity: _____

Are you a US citizen? yes_____ no _____ Birth place: _____
city, state, country

Non-Citizens Only:

Alien Registration # _____ Visa Type _____ Exp Date _____

Naturalization Date (if applicable) _____ Birth place: _____

US Military

Branch of Service _____ Rank _____

Active Duty/Reserve/Discharged : _____ Date of Discharge: _____
(if applicable)

Document updated 05/2014 Phone: (904)240-4221 Fax: (904) 240-4211
info@medcred.net medcred2009@hotmail.com www.medcred.net
Google Phone: (765) MED CRED (765-633-2733)/mobile (904)334-8444

Have charges ever been brought against you by any branch of the US Military or Public Health Service? Y or N

If yes please explain

_____

_____

_____

Personal References: (must be from a colleague who has factual knowledge of your personal and professional qualifications)

Most states require three. Please fill in all three references, as I will need to contact them and have them filled out required documents on your behalf. Contacting these individuals ahead of time could speed up the process.

1) Name: _____ MD or DO _____
Address: _____
City: _____ State _____ Zip Code _____
Telephone: _____ email _____
How this person knows you professional?

_____

_____

_____

2) Name: _____ MD or DO _____
Address: _____
City: _____ State _____ Zip Code _____
Telephone: _____ email _____
How this person knows you professional?

_____

_____

_____

3) Name: _____ MD or DO _____
Address: _____
City: _____ State _____ Zip Code _____
Telephone: _____ email _____
How this person knows you professional?

_____

_____

_____

4) Name: _____ MD or DO _____
Address: _____
City: _____ State _____ Zip Code _____
Telephone: _____ email _____
How this person knows you professional?

_____
_____
_____

EDUCATION

HIGH SCHOOL

Name of High School: _____Dates of Attendance: _____TO_____

Address: _____ City: _____ State: _____ Zip: _____

UNDERGRADUATE / GRADUATE EDUCATION

1) Name of University: _____ Dates of Attendance: _____TO_____

Address: _____ City: _____ State: _____ Zip: _____

Degree Earned: _____ Date of Degree: _____ (mo/day/year)

Explanation of gaps in education:

_____
_____
_____
_____
_____

2) Name of University: _____ Dates of Attendance: _____TO_____

Address: _____ City: _____ State: _____ Zip: _____

Degree Earned: _____ Date of Degree: _____ (mo/day/year)

***utilize additional paper for additional undergraduate education**

Explanation of gaps in education:

_____
_____
_____
_____
_____

MEDICAL SCHOOL **(please provide copy of Med School Degree with English interpretation if in any other language)**

Name of University: _____ Dates of Attendance: _____TO_____

Address: _____ City: _____ State: _____ Zip: _____

Degree Earned: _____ Date of Degree: _____ (mo/day/year)

1) Have you ever been dropped, suspended, placed on probation, asked to resign or expelled from ANY school, college or university? YES OR NO

2) Did you attend medical school for a period other than the normal curriculum or were you required to repeat ANY of your medical education including classes, test/exams, lectures or any other part of the curriculum? YES OR NO

3) Did you take ANY type of break or leave of absence for any reason during medical school? (Including maternity/paternity, medical leave or any other type of break or leave) YES OR NO

4) Have you ever defaulted on any health education loan or scholarship obligation in the US? YES OR NO

5) If you are an international medical graduate, did you perform your core clerkships in the US? (If yes list on a separate sheet core clerkship, institution, address and date of each rotation) YES OR NO

Explanation of gaps in education: (please provide additional sheets of paper if needed)

_____
_____
_____
_____
_____

Post Graduate Training (Internship/Residency/Fellowship) (please provide a copy of internship/residency/fellowship certificate)

1) Name of program: _____ Appointment _____

Dates of Attendance: From: _____ TO _____
MO/DA/YEAR MO/DA/YEAR

Address: _____ City: _____ State: _____ Zip: _____

Program Director: _____Residency Coordinator: _____

PD Phone # _____ RC Phone # _____

PD Email: _____ RC Email: _____

2) Name of program: _____ Appointment _____

Dates of Attendance: From: _____ TO _____
MO/DA/YEAR MO/DA/YEAR

Address: _____ City: _____ State: _____ Zip: _____

Program Director: _____Residency Coordinator: _____

PD Phone # _____ RC Phone # _____

3) Name of program: _____ Appointment _____

Dates of Attendance: From: _____ TO _____
MO/DA/YEAR MO/DA/YEAR

Address: _____ City: _____ State: _____ Zip: _____

Program Director: _____Residency Coordinator: _____

PD Phone # _____ RC Phone # _____

PD Email: _____ RC Email: _____

1) Have you ever been dropped, suspended, placed on probation, asked to resign or expelled from ANY postgraduate training program? YES OR NO

2) Did you attend residency for a period other than the normal curriculum or were you required to repeat ANY of your post graduate training including classes, test/exams, lectures or any other part of the curriculum? YES OR NO

3) Did you take ANY type of break or leave of absence for any reason during your post graduate training program? (Including maternity/paternity, medical leave or any other type of break or leave) YES OR NO

Explanation of gaps in education: (please provide additional sheet of paper if necessary)

_____
_____
_____
_____

Licenses (please provide copies of all licensures and certifications)

Medicare/Medicaid

UPIN # _____ NPI # _____

National Board, FLEX, SPEX, USMLE or State Board (please provide copies of USMLE # or unofficial transcripts if available)

USMLE# _____ **NBME certification #** _____

NBME/USMLE (circle one) step 1: Date _____ State _____attempts____
NBME/USMLE (circle one) step 2: Date _____ State _____attempts____
NBME/USMLE (circle one) step 3: Date _____ State _____attempts____
Other Exams: _____(indicate exam SPEX, FLEX, etc)
Exam _____ Date Taken _____State_____ attempts_____
Exam _____ Date Taken _____State_____ attempts_____
Exam _____ Date Taken _____State_____ attempts_____

ECFMG Certificate **(please provide a copy of certificate, if applicable)**

ECFMG Certificate Number _____ Issue Date: _____

1) Have you ever failed to receive specialty board certification or re-certification for any reason? YES OR NO

Provide explanations for any yes responses: (please attach additional sheet of paper if needed)

_____
_____
_____
_____

Board of Medical Specialties **(Please provide a copy of board certificates)**

1) Are you certified by any specialty board recognized by the American Board of Medical Specialties? YES OR NO

if yes,

Board Name _____
Certification/Specialty/Sub-Specialty _____
Date of Certification _____

Board Name _____
Certification/Specialty/Sub-Specialty _____
Date of Certification _____

Board Name _____
Certification/Specialty/Sub-Specialty _____
Date of Certification _____

2) Have you ever failed to receive specialty board certification or re-certification for any reason? YES OR NO

Provide explanations for any yes responses: (please attach additional sheet of paper if needed)

_____
_____
_____
_____

DEA Number / STATE CSR **(for controlled substance prescription writing) (please provide copies of DEA licenses)**

DEA # _____ Start Date: _____Date of Exp _____State ____
DEA # _____ Start Date: _____Date of Exp _____State ____
DEA # _____ Start Date: _____Date of Exp _____State ____
DEA # _____ Start Date: _____Date of Exp _____State ____

CSR # _____ Start Date: _____Date of Exp _____State ____
CSR # _____ Start Date: _____Date of Exp _____State ____

1) Have you ever been warned or called before the US Drug Enforcement Administration (DEA) ? YES OR NO

2) Have you ever been made an offer to compromise or entered into any arrangement plea or agreement instead of a federal prosecution for a drug violation regulated by DEA? YES OR NO

3) Have you ever been denied or surrendered a DEA registration? YES OR NO

4) Have you ever been denied or been excluded from Medicare and/or state health care programs? YES OR NO

Provide explanations for any yes responses: (please attach additional sheet of paper if needed)

_____
_____
_____
_____

CURRENT LICENSES: **(please provide copies of licenses even if they are inactive they must be reported)**

License # _____ State _____
Issue Date _____Expiration Date _____
Active or Inactive (circle one) Training License: Y or N

License # _____ State _____
Issue Date _____Expiration Date _____

Active or Inactive (circle one) Training License: Y or N

License # _____ State _____
Issue Date _____Expiration Date _____
Active or Inactive (circle one) Training License: Y or N

License # _____ State _____
Issue Date _____Expiration Date _____
Active or Inactive (circle one) Training License: Y or N

License # _____ State _____
Issue Date _____Expiration Date _____
Active or Inactive (circle one) Training License: Y or N

License # _____ State _____
Issue Date _____Expiration Date _____
Active or Inactive (circle one) Training License: Y or N

***please duplicate this page and add additional licenses on attached sheet of paper if necessary**
****omission of any licensing activities can hold your licensure application up tremendously. Please be diligent in this area.**

1) Have you had ANY application for a medical license or professional license denied by ANY state board or other governmental agency of ANY state, territory, or country? YES OR NO

2) Have you ever been allowed to withdraw an application for medical licensure for ANY reason or during a pending investigation in ANY jurisdiction in lieu of your license being denied? YES OR NO

3) Have you ever been notified, invited or required to appear before ANY licensing agency for a hearing on a complaint of ANY nature including, but not limited to, a charge or violation of the Medical Practice Act, involving unprofessional or unethical conduct? YES OR NO

4) Have you ever had any professional license or license to practice medicine revoked, suspended, placed on probation, received a citation, or other disciplinary action taken in ANY state, territory or country? YES OR NO

Provide explanations for any yes responses: (please attach additional sheet of paper if needed)

_____
_____
_____
_____

PROFESSIONAL ORGANIZATIONS

Membership _____ ID # _____ Exp _____

Membership _____ ID # _____ Exp _____

Membership _____ ID # _____ Exp _____

1) Have you ever failed to receive specialty board certification or re-certification for any reason? YES OR NO

2) Have you ever had any sanctions taken against you by a specialty board or other similar national organization? YES OR NO

3) Have you ever had an application for membership denied by a medical society or association or had a medical society or association membership suspended? YES OR NO

4) Have you ever been notified to appear before a medical society or association about charges or complaints filed against you? YES OR NO

Provide explanations for any yes responses: (please attach additional sheet of paper if needed)

_____
_____
_____
_____

WORK HISTORY

Practice/Employment:
ALL employment, non-employment, and/or ANY unaccounted period of time from date of you graduating medical school to present must be reported.

Place of Employment: _____
Address _____ City _____ State ___ Zip _____
From: _____ (mo/yr) TO _____ (mo/yr)Phone # _____
Contact person: _____

Place of Employment: _____
Address _____ City _____ State ___ Zip _____
From: _____ (mo/yr) TO _____ (mo/yr) Phone # _____
Contact person: _____

Place of Employment: _____
Address _____ City _____ State ___ Zip _____
From: _____ (mo/yr) TO _____ (mo/yr) Phone # _____
Contact person: _____

Place of Employment: _____
Address _____ City _____ State ___ Zip _____
From: _____ (mo/yr) TO _____ (mo/yr) Phone # _____
Contact person: _____
Place of Employment: _____
Address _____ City _____ State ___ Zip _____
From: _____ (mo/yr) TO _____ (mo/yr) Phone # _____
Contact person: _____

Place of Employment: _____
Address _____ City _____ State ___ Zip _____
From: _____ (mo/yr) TO _____ (mo/yr) Phone # _____
Contact person: _____

Place of Employment: _____
Address _____ City _____ State ___ Zip _____
From: _____ (mo/yr) TO _____ (mo/yr) Phone # _____
Contact person: _____

Place of Employment: _____
Address _____ City _____ State ___ Zip _____
From: _____ (mo/yr) TO _____ (mo/yr) Phone # _____
Contact person: _____

***if any additional activites please duplicate this page and add additionals to the attached sheet**
****omission of any activities can hold your licensure application up tremendously. Please be diligent in this area**

1) Have you ever had your employment terminated for cause? Yes OR No

2) Have you ever been asked to or allowed to resign from a facility instead of disciplinary action or during any pending investigations into your practice? Yes OR No

Provide explanations for any yes responses: (please attach additional sheet of paper if needed)

_____
_____
_____
_____

Staff privileges:
List all hospital(s), health institution(s), clinic (s), or medical facilities where you **currently** hold staff privileges. DO NOT list training privileges.

1) Name of institution : _____ Dates of Service: _____

Address: _____ City _____ State _____ Zip _____

Direct Supervisor/Chief of Staff: _____

Contact # _____ Type of Service _____

2) Name of institution : _____ Dates of Service: _____

Address: _____ City _____ State _____ Zip _____

Direct Supervisor/Chief of Staff: _____

Contact # _____ Type of Service _____

3) Name of institution : _____ Dates of Service: _____

Address: _____ City _____ State _____ Zip _____

Direct Supervisor/Chief of Staff: _____

Contact # _____ Type of Service _____
*** additional staff privileges please list on separate sheet of paper**

Faculty appointments (please provide documentation)

Name of Institution _____ Title of appointment_____

Address: _____ City _____ State _____ Zip _____

Contact Person: _____Phone #_____

Name of Institution _____ Title of appointment_____

Address: _____ City _____ State _____ Zip _____

Contact Person: _____Phone #_____

Name of Institution _____ Title of appointment_____

Address: _____ City _____ State _____ Zip _____

Contact Person: _____Phone #_____
*** additional faculty appointments please list on separate sheet of paper**

1) Have you ever had any staff privileges denied, suspended, revoked, modified, restricted or placed on probation or have you been asked to resign or take a temporary leave of absence or otherwise acted against by any facility? YES OR NO

2) Have you ever had any staff privileges restricted or not renewed by any facility instead of disciplinary action? YES OR NO

3) Have you had responsibility for graduate medical education within the last 10 years? YES OR NO

4) Do you currently hold a faculty appointment at a medical or health-related institution of higher learning? YES OR NO

Provide explanations for any yes responses: (please attach additional sheet of paper if needed)

_____

_____

_____

_____

Malpractice Insurance**(please provide copy of liability certificate)**

Carrier: _____Contact Number_____
Point of Contact: _____Dates of Coverage: _____ to _____

Carrier: _____Contact Number_____
Point of Contact: _____Dates of Coverage: _____ to _____

Carrier: _____Contact Number_____
Point of Contact: _____Dates of Coverage: _____ to _____

1) Have you ever had a malpractice/liability case whereby you were involved ?
YES OR NO

a) Name of Patient: _____
Last Name First Name Middle Name

Age of Patient: _____ DOB: _____Date of Occurrence :_____

Location of incident:

Site: _____Address: _____

City: _____ State _____ FL ____ Zip: _____

Position in case: _____ Filed Against _____

Other Physicians: _____

Disposition _____ Amount of Settlement _____

b) Name of Patient: _____
Last Name First Name Middle Name

Age of Patient: _____ DOB: _____Date of Occurrence :_____

Location of incident:

Site: _____Address: _____

City: _____ State _____ FL ____ Zip: _____

Position in case: _____ Filed Against _____

Other Physicians: _____

Disposition _____ Amount of Settlement _____

c) Name of Patient: _____
Last Name First Name Middle Name

Age of Patient: _____ DOB: _____Date of Occurrence :_____

Location of incident:

Site: _____Address: _____

City: _____ State _____ FL ____ Zip: _____

Position in case: _____ Filed Against _____

Other Physicians: _____

Disposition _____ Amount of Settlement _____

***any additional malpractice claims please answer all above questions on an attached sheet of paper.**
****please provide all court documentation**

Additional Questions

1.) Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to any crime in any jurisdiction other that a minor traffic offense?
YES OR NO

2) Have you ever been arrested or criminally or civilly charged with any intentional or negligent action related to the use or misuse of drugs, alcohol, or illegal chemical substances? YES OR NO

3) Have you lost your civil rights? YES OR NO

4) If yes, were they restored? YES OR NO

5) Have you been enrolled in, required to enter into, or participated in any drug and/or alcohol recovery program or impaired practitioner program?
YES OR NO

6) Have you been treated for or had a recurrence of a diagnosed mental disorder or impairment? YES OR NO

7) Have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice medicine? YES OR NO

8) Have you been treated for or had a recurrence of a diagnosed substance-related (alcohol and/or drug) disorder? YES OR NO

Provide explanations for any yes responses: (please attach additional sheet of paper if needed)

_____
_____
_____
_____

Continuing Medical Education (CME)

Some states require different courses and/or jurisprudence examinations. As we process your licensure packet, MedCred will cover any additional requirements you may encounter in the licensure process OR you are welcome to research the medical board for yourself. Typically the board will not ask for a copy of these requirements on an initial licensure application but you are subject to be able to produce the certificate of successful completion. Please see a standard representation of a board's requirements listed below:

FLORIDA MEDICAL BOARD (EXAMPLE)

Prevention of Medical Errors: Check the box to certify that you have completed a minimum of two (2) hours of Prevention of Medical Errors continuing medical education since June 1, 2002. The education must meet requirements defined in § 456.013(7), Florida Statutes, and be completed prior to the issuance of your license number. Please contact the Florida Medical Association (FMA) at (850) 224-6496 or www.fmaonline.org for a list of providers of CME. Other resources for CME are the American Medical Association (AMA) at (312) 464-4952, or Medical Education Group Learning Systems (MEGLAS) at 800-547-0308 or www.informed.cme.edu.
Please note: You will be required by Chapter 456, F.S., to take an HIV/AIDS course approved by the board for your first renewal and a two (2) hour Domestic Violence Course approved by the board prior to your third renewal.

9) Have you successfully completed a course in prevention of medical errors?
YES OR NO
A course must be successfully completed a minimum of two (2) hours in medical errors. If you are recently out of residency this course could be and is most often embedded in your conferences.

Dispensing Practioner

10) Dispensing Practitioner Registration in some states allow you for a fee to have a mini-pharmacy in a private office for profit. Are you interested in dispensing out of your private practice? YES OR NO
If yes, a fee in some states are applied.

General Licensure Information (check all that may apply)

Which state(s) are you interested in pursuing licensure with?

1) _____
2) _____
3) _____

____ Initial physician licensure application
____ Temporary Licensure
____ Renewal License
____ DEA license

Payment Options:

1) Checks / Money Orders / Cashier Checks
   - Board Applications typically require payment via check.
   - MedCred will supply you with an invoice that itemizes the costs. We will write checks out on your behalf. You can pay us in one lump sum.

2) Credit Card (quickest way for expediting most services) (some requirements mandate credit card usage)
   - Transcripts and some credentialing services (ie USMLE, DEA) can be expedited via a credit card payment. If you are requiring licensure to be expedited it is highly recommended to afford **Med Cred** either your credit card information or payments received into the Pay Pal account.

   Credit Card # _____ Exp date _____
   Credit Card Type_____Credit Card 3 digit code ____Billing zip:_____
   Name as it appears on card _____

*** Med Cred wants to ensure you that the utmost safety is utilized when credit card information is made available. Med Cred stores all of their documents under lock and key. (Not Electronical)**

Acquisition Agreement

I , _____, hereby acknowledge that I have attained the services of **Med Cred** – Medical Credentialing Services for assistance with licensure in the state(s) of: (please list all states)

_____

I understand that the fee for this service is $450 per state ($400 for Resident Physicians). The DEA license will be obtained after the license has been received and there is a separate charge for that service of $50 per state. This includes the administrative processing charges associated with a licensure packet. This fee does not include any expedited delivery fees (normal postage and delivery fees will not be charged), fees for using pay pal, the state's fee for licensure or the other fees associated with the supporting documentation that must be obtained for the licensure process. (ie transcripts, verifications, fingerprints) An initial invoice will be sent for the service being provided, prior to starting the licensure packet. Once payment has been received, **Med Cred** will start work on your packet and upon completion of your licensure packet a final invoice will be sent out for miscellaneous charges associated with any rush deliveries or services you may require Med Cred to do for you. Please note that rush services does not guarantee licensure by a specific date. An additional invoice will be sent for supporting documents if the credit card is not supplied and Pay Pal services is preferred. Please note that there is a 3.5% convenience fee for the utilization of this secured service.

Signature: _____

Printed Name: _____

Date signed: _____

Disclaimer

I certify that all the information contained in the application is true and complete to the best of my knowledge and belief. I understand that any misrepresentations or falsifications may result in not being able to obtain a license and any and all other penalties resulting from the misrepresentation. I understand that **Med Cred** is not guaranteeing licensure by any state as it is directly and solely up to the credentialing specifics governed by each state's medical board.

Signature: _____

Printed Name: _____

Date signed: _____

While MedCred is processing your application and putting together a signature packet, what documents could you be gathering to have ready to return with the signature packet? Please send copies as these will not be returned to you.

___ Driver's License (legible copy; picture must be visible)
___ Social Security card
___ Birth Certificate
___ Passport (legible copy; picture must be visible)
___ Undergraduate degree
___ Medical School Degree
___ Graduate School Degree
___ Residency Certificate
___ Fellowship Certificate
___ Board Certificate
___ CV
___ All previous license; even if expired
___ All previous DEA licenses or controlled substance certificates; even if expired
___ Malpractice Certificate
___ Recent Medication Errors certificate; within the last year
Must be Florida Medical Association Approved
___ Court documents/legal documents on any malpractice cases
___ Two 2 X 2 Passport photos