Regular Mailing Address
STATE BOARD OF MEDICINE
P.O. BOX 2649
HARRISBURG, PA 17105-2649
717-783-1400/717-787-2381
Email: st-medicine@pa.gov

Courier Delivery Address
STATE BOARD OF MEDICINE
2601 NORTH THIRD STREET
HARRISBURG, PA 17110

APPLICATION FOR INSTITUTIONAL LICENSE

PURPOSE: An Institutional License authorizes a qualified person to teach or practice medicine and surgery for a period of time specified by the Board, not exceeding 3 years, in one of the medical colleges, its affiliates, or hospitals within this Commonwealth. In order to qualify for an institutional license, an applicant shall satisfy one of the following:

- An applicant shall be a graduate of an unaccredited (International) medical college who has attained, through professional growth and teaching experience, the status of teacher in a particular area of medicine **or**
- Has achieved outstanding medical skills in a particular area of medicine and surgery and wishes to practice, demonstrate, or teach in that area, but not otherwise licensed to do so.

IMPORTANT – You will be required to provide the name of the sponsoring physician, the hospital/medical college name, and hospital/medical college mailing address. This will be the address associated with this application to which all correspondence will be mailed. The Board will be in direct correspondence with the sponsoring physician at the hospital/medical college. To determine the status of your application, you must contact the hospital/medical college.

APPLICANTS MUST COMPLETE THE FOLLOWING:

1.	Submit the $35.00 fee, check or money order, made payable to the "Commonwealth of Pennsylvania." **FEES ARE NOT REFUNDABLE.** Check or money order must be in US funds. **Note**: A processing fee of $20.00 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment. Your cancelled check is your receipt of payment.
2.	Complete pages 1 and 2 of the application.
3.	If documents will be submitted to the Board under a name different from your present name, submit a copy of the legal document evidencing the name change (i.e., marriage license, divorce decree, naturalization, etc.).
4.	The Bureau of Professional and Occupational Affairs (BPOA), in conjunction with the Department of Human Services (DHS), is providing notice to all health-related licensees and funeral directors that are considered "mandatory reporters" under section 6311 of the Child Protective Services Law (CPSL) (23 P.S. § 6311), as amended, that EFFECTIVE JANUARY 1, 2015, all persons applying for issuance of an initial license shall be required to complete 3 hours of DHS-approved training in child abuse recognition and reporting requirements as a condition of licensure. Please review the Board website for further information on approved CE providers. Once you have completed a course, the approved provider will electronically submit your name, date of attendance, etc., to the Board. Child Abuse Continuing Education Providers Information can be found here.

PLEASE NOTE: If a pending application is older than one year from the date submitted and the applicant wishes to continue the application process, the Board shall require the applicant to submit a new application including the required fee. In order to complete the application process, many of the supporting documents associated with the application cannot be more than six months from the date of issuance.

5.	**Verification of Medical Education** - Complete Section 1 of the Verification of Medical Education and forward to your medical school for completion of Section 2. • The school must return the completed verification **directly to the Board.** • Provide a transcript – If the official transcript does not provide detailed information regarding the courses attended from which the applicant's eligibility is determined, the Board retains the right to request a copy of the medical school curriculum. • If you attended more than one medical school, documents must be received directly from ALL schools. All documents must be in ENGLISH or an official translation must be submitted to the Board from an official translation agency or professor of the language. **PLEASE NOTE: If you have current ECFMG certification and ECFMG verified your medical education at the time you received certification (after July 1, 1986), you DO NOT need to provide the verification of medical education outlined above. The verification of your medical education through ECFMG will satisfy this requirement. Request verification of your ECFMG Certification directly from ECFMG. Your certification must be current and valid. The name of the State Medical Board that the Status Report should be sent to is Pennsylvania State Board of Medicine–State Code: 039. If ECFMG DID NOT verify your medical education at the time you received ECFMG certification, you MUST provide the Board with verification of your medical education as outlined and listed above.**

6.	**Curriculum Vitae** - Attach a current Curriculum Vitae listing **ALL** periods of employment or unemployment (i.e., child rearing, research, etc.) from graduation from medical school to present. The list must be in chronological order, include the month and year, and indicate the state/territory in which the employment occurred.
7.	**Position Verification** - Request a letter from the foreign hospital/facility indicating the faculty appointment title, specialty and dates of the teaching appointment and/or a statement that you have achieved outstanding medical skills in your specialty.
8.	**Employment Verification** - Request a letter from the Pennsylvania medical college or hospital indicating the position available to you (including the faculty appointment title), specified specialty and dates of appointment.
9.	**Verification of Licensure** - Contact the state board office(s) where you hold or have ever held a license, certificate, permit, registration or other authorization to practice a profession or occupation and request letters of good standing. The letter must include the following: license issue and expiration date, license status (current or expired) and disciplinary standing. The letter(s) of good standing must be sent directly to the Board.
10.	Provide an official notification of information (Self Query) from the National Practitioner Data Bank. Please refer to the NPDB website for additional information. When you receive the "Response to your Self Query," forward the entire report directly to the Board Office. You should make a copy for your records.

IMPORTANT INFORMATION

1.	**PLEASE FOLLOW ALL DIRECTIONS. ANY DISCREPANCIES WILL CAUSE A DELAY IN THE ISSUANCE OF A LICENSE.**
2.	**IF THE APPLICATION PROCESS IS NOT COMPLETED WITHIN ONE YEAR, APPLICANTS WILL BE REQUIRED TO SUBMIT AN UPDATED APPLICATION (ANOTHER APPLICATION PROCESSING FEE) ALONG WITH SUPPORTING DOCUMENTS, AS NECESSARY.**
3.	**IT IS YOUR RESPONSIBILITY TO MAINTAIN A COPY OF THIS APPLICATION AND ALL DOCUMENTS SUBMITTED TO THE BOARD OR RECEIVED FROM THE BOARD.**
4.	**YOU MAY NOT PRACTICE IN THE COMMONWEALTH OF PENNSYLVANIA UNTIL THE PENNSYLVANIA STATE BOARD OF MEDICINE HAS ISSUED A LICENSE.**
5.	**YOU MUST COMPLY WITH MALPRACTICE INSURANCE REQUIREMENTS.**
6.	**FEES INCURRED FOR THIS APPLICATION ARE NON-REFUNDABLE AND ARE CONSIDERED PROCESSING FEES.**
7.	**EFFECTIVE JAN. 1, 2017, ACT 191 OF 2014 REQUIRES ALL PRESCRIBERS AND DISPENSERS TO REGISTER FOR THE PENNSYLVANIA PRESCRIPTION DRUG MONITORING PROGRAM (PA PDMP). PRESCRIBERS ARE REQUIRED TO QUERY THE PA PDMP SYSTEM FOR EACH PATIENT THE FIRST TIME THE PATIENT IS PRESCRIBED A CONTROLLED SUBSTANCE BY THE PRESCRIBER, WHEN THERE IS CLINICAL CONCERN THAT THE PATIENT MAY BE ABUSING OR DIVERTING A CONTROLLED SUBSTANCE(S), AND/OR EACH TIME THE PATIENT IS PRESCRIBED AN OPIOID DRUG PRODUCT OR A BENZODIAZEPINE. TO LEARN MORE AND TO REGISTER, PLEASE VISIT WWW.DOH.PA.GOV/PDMP.**

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Submit a $35 fee, check or money order, made payable to the "Commonwealth of Pennsylvania." **FEES ARE NOT REFUNDABLE.** Note: A processing fee of $20 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment.

YOU MAY NOT PRACTICE MEDICINE IN THE COMMONWEALTH OF PENNSYLVANIA UNTIL THE PENNSYLVANIA STATE BOARD OF MEDICINE HAS ISSUED A LICENSE. YOU MUST COMPLY WITH MALPRACTICE INSURANCE REQUIREMENTS.

TO BE COMPLETED BY APPLICANT
(Please print or type)

NAME:	Last		First		Middle			
DATE OF BIRTH:	Month	Day	Year	**SOCIAL SECURITY NUMBER:**				
EMAIL ADDRESS:								
NAME OF SPONSORING PHYSICIAN:								
NAME OF HOSPITAL/MEDICAL COLLEGE:								
HOSPITAL/MEDICAL COLLEGE ADDRESS:	Street							
City	State		ZIP					

If documentation submitted in connection with this application will be received in a name other than the name under which you are applying, please list the name or names below:

_____

NAME & ADDRESS OF MEDICAL SCHOOLS ATTENDED

1. NAME OF MEDICAL SCHOOL:									
ADDRESS OF SCHOOL:									
DATES OF ATTENDANCE:	**From**	Month	Day	Year	**To**	Month	Day	Year	
DATE OF GRADUATION:	Month		Day	Year					
2. NAME OF MEDICAL SCHOOL:									
ADDRESS OF SCHOOL:									
DATES OF ATTENDANCE:	**From**	Month	Day	Year	**To**	Month	Day	Year	
DATE OF GRADUATION:	Month		Day	Year					

LEGAL QUESTIONS

You must answer the following questions. If you answer "YES" to #2 through #12, provide complete details on a separate sheet as well as copies of relevant documents.

		Yes	No
1	Do you hold or have you ever held a license, certificate, permit, registration or other authorization to practice any health-related profession or occupation in any state or jurisdiction? **If you answered yes, provide the profession and state or jurisdiction.** **LIST**: _____		
2	Have you withdrawn an application for a professional or occupational license, certificate, permit or registration, had an application denied or refused, or for disciplinary reasons agreed not to apply or reapply for a professional or occupational license, certificate, permit or registration in any state or jurisdiction?		
3	Have you had disciplinary action taken against a professional or occupational license, certificate, permit, registration or other authorization to practice a profession or occupation issued to you in any state or jurisdiction or have you agreed to voluntary surrender in lieu of discipline?		
4	Do you currently have any disciplinary charges pending against your professional or occupational license, certificate, permit or registration in any state or jurisdiction?		
5	Have you been convicted (found guilty, pled guilty or pled nolo contendere), received probation without verdict or accelerated rehabilitative disposition (ARD), as to any criminal charges, felony or misdemeanor, including any drug law violations? Note: You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.		
6	Do you currently have any criminal charges pending and unresolved in any state or jurisdiction?		
7	Have you ever had practice privileges denied, revoked, suspended, or restricted by a hospital or any health care facility?		
8	Have you had your DEA registration denied, revoked or restricted?		
9	Have you had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority?		
10	Have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?		
11	Have you engaged in, the intemperate or habitual use or abuse of alcohol or narcotics, hallucinogenics or other drugs or substances that may impair judgment or coordination?		
12	Since May 19, 2002, have you been the subject of a civil malpractice lawsuit? **If yes, please submit a copy of the entire Civil Complaint, which must include the <u>filing date</u> and <u>the date you were served</u>. Submit a statement which includes complete details of the complaints that have been filed against you.** ****If you previously reported the complaint to the Board provide the docket number _____**		

SIGNED STATEMENT

NOTICE: Disclosing your Social Security Number on this application is mandatory in order for the State Boards to comply with the requirements of the Federal Social Security Act pertaining to Child Support Enforcement, as implemented in the Commonwealth of Pennsylvania at 23 Pa. C.S. § 4304.1(a). At the request of the Department of Human Services, the licensing boards must provide to the Department of Human Services information prescribed by the Department of Human Services about the licensee, including the social security number. In addition, Social Security Numbers are required in order for the Board to comply with the reporting requirements of the U.S. Department of Health and Human Services, National Practitioner Data Bank.

I verify that this application is in the original format as supplied by the Department of State and has not been altered or otherwise modified in any way. I am aware of the criminal penalties for tampering with public records or information under 18 Pa. C.S. § 4911. I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa. C.S. § 4904 (relating to unsworn falsification to authorities) and may result in the suspension, revocation or denial of my license, certificate, permit or registration.

_____ _____

Signature of Applicant Date

_____

Printed Name of Applicant

PENNSYLVANIA STATE BOARD OF MEDICINE

VERIFICATION OF MEDICAL EDUCATION

SECTION 1 – TO BE COMPLETED BY APPLICANT

NAME:	Last	First	Middle
NAME OF MEDICAL SCHOOL:			
LOCATION:			

Submit the verification of medical education form to your medical school and request the school return the completed form and an official transcript directly to the board in an official school envelope.

SECTION 2 – TO BE COMPLETED BY DEAN OR REGISTRAR OF MEDICAL SCHOOL

NAME OF MEDICAL SCHOOL:				
NAME OF MEDICAL STUDENT:	Last	First	Middle	
DATE STUDENT BEGAN TO ATTEND THIS MEDICAL SCHOOL:		Month	Day	Year
DATE OF GRADUATION:		Month	Day	Year

I CERTIFY THAT ALL OF THE INFORMATION LISTED ABOVE IS CORRECT

NAME OF DEAN/REGISTRAR:				
SIGNATURE OF DEAN/REGISTRAR:				
DATE:	Month	Day	Year	

(Seal of School)

Upon completion, school must return this completed form and a certified copy of an official transcript directly to the Pennsylvania State Board of Medicine in an official school envelope.

DO NOT RETURN THIS FORM TO THE APPLICANT

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