



**Government of the District of Columbia
Department of Health**



**HEALTH REGULATION AND LICENSING ADMINISTRATION
BOARD OF MEDICINE**

MEDICAL TRAINING LICENSE (MTL) APPLICATION

All applicants must complete every section of this application and submit the original application and all required supporting documents. If more space is needed to fully answer questions, attach additional sheets with typed responses. False or misleading statements will be cause for disciplinary action and could be cause for criminal prosecution pursuant to DC Official Code 22-2405. If you have any questions, call HPLA Customer Service at 1-877-672-2174 Monday through Friday, 8:15AM to 4:40PM EST.

Please Note: Please refer to application instructions before completing this form.

SECTION 1A. LICENSURE TYPE & FEES	SECTION 1B. BASIS OF APPLICATION
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SELECT LICENSURE TYPE: Medical Training License(MTL)

- MTL I(A) – U.S. / Canadian Medical School Graduate
- MTL I(B) - Foreign Trained Medical School Graduate
- MTL II - Foreign Trained Physician entering a Fellowship
- Medical Training Registrant* Rotation 90 days or less (NO FEE)
DO NOT COMPLETE THIS FORM: Please go to www.doh.dc.gov/bomed and Complete the Medical Training Registrant Form

Select the basis by which you are applying:

MTL LICENSE FEE: **\$100.00**

CRIMINAL BACKGROUND CHECK: For payment and to schedule an appointment Call 1-877-783-4187 or www.L1enrollment.com
All applicants are required to undergo a Criminal Background Check.

SECTION 2A. APPLICANT INFORMATION

Note: LEGAL NAME: *(Do not use any initials unless they are a part of your name)*

_____ FIRST NAME MI LAST NAME (SUFFIX: Jr., Sr. etc.)

Name of Medical School Attended: _____ Country: _____ Graduation Date: _____

DEGREE(S): M.D., D.O., PH.D., MBBS OTHER DEGREE _____

Have you held, or do you currently hold, a license to practice medicine in your country? YES NO

_____ Date of Birth _____ Social Security Number * GENDER: MALE FEMALE

**All Applicants must provide a Social Security Number. If you are a foreign graduate and do not have a SSN or are waiting for one to be issued, you must complete the SSN affidavit form and submit it with your application. You must provide your SSN to the Board of Medicine within 15 days of being issued a SSN number. You can download the affidavit form by clicking [here](#).*

SECTION 2B. OTHER NAMES USED: (Please print clearly)
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If your name has changed at any point since you first registered with the American Medical Association, taken any exams or attended college or university, you must provide a copy of a legal name change documents for EACH time that it has changed. Acceptable documents for individuals are marriage certificates, divorce decrees, or court orders.

_____ FIRST NAME MI LAST NAME (SUFFIX: Jr., Sr. etc.)

_____ FIRST NAME MI LAST NAME (SUFFIX: Jr., Sr. etc.)

_____ Place of Birth : State/Providence/Territory _____ Country if not USA

SECTION 2C: RACE & ETHNICITY DESIGNATION:	LANGUAGE(S) SPOKEN:
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- American Indian/Alaskan Native Asian/South Asian Black or African American
- Caucasian/White Hispanic or Latino
- Other _____ Native Hawaiian or other Pacific Islander

Language(s) spoken other than English:

Spanish French

German Arabic

Other _____



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SECTION 4. TRAINING YEAR AND TRAINING INSTITUTION:

Select the Postgraduate Training year you are applying for?

PGY1 PGY2 PGY3 PGY4 PGY5 PGY6 PGY7 PGY8 Other: _____

Is your postgraduate training application for a fellowship? YES NO

Is your Fellowship ACGME or AOA Approved? YES NO

If no, please list accrediting body, if any: _____

Are you an Military/NIH resident or fellow? YES NO

Select the hospital that is the principal sponsor of your training program in the District:

- | | |
|---|---|
| <input type="checkbox"/> Children's National Medical Center | <input type="checkbox"/> MedStar National Rehabilitation Hospital |
| <input type="checkbox"/> George Washington University Hospital | <input type="checkbox"/> MedStar Washington Hospital Center |
| <input type="checkbox"/> Howard University Hospital | <input type="checkbox"/> Providence Hospital |
| <input type="checkbox"/> MedStar Georgetown University Hospital | <input type="checkbox"/> Saint Elizabeths Hospital |

SECTION 5: RESIDENCY TRAINING PROGRAM SPECIALTY

Select your Program Specialty

- | | | |
|--|---|--|
| <input type="checkbox"/> Administrative Medicine | <input type="checkbox"/> Internal Medicine | <input type="checkbox"/> Plastic Surgery |
| <input type="checkbox"/> Adolescent Medicine | <input type="checkbox"/> Internal Medicine/Pediatrics | <input type="checkbox"/> Preventive Medicine/Public Health |
| <input type="checkbox"/> Allergy & Immunology | <input type="checkbox"/> Medicine Genetics | <input type="checkbox"/> Psychiatry & Neurology |
| <input type="checkbox"/> Anesthesiology | <input type="checkbox"/> Nephrology | <input type="checkbox"/> Radiation Oncology |
| <input type="checkbox"/> Cardiology | <input type="checkbox"/> Neurological Surgery | <input type="checkbox"/> Radiology |
| <input type="checkbox"/> Colon & Rectal Surgery | <input type="checkbox"/> Nuclear Medicine | <input type="checkbox"/> Thoracic Surgery |
| <input type="checkbox"/> Dermatology | <input type="checkbox"/> Obstetrics & Gynecology | <input type="checkbox"/> Urology |
| <input type="checkbox"/> Emergency Medicine | <input type="checkbox"/> Ophthalmology | <input type="checkbox"/> Vascular Surgery - Integrated |
| <input type="checkbox"/> Endocrinology | <input type="checkbox"/> Orthopedic Surgery | <input type="checkbox"/> Research: _____ |
| <input type="checkbox"/> Family Medicine | <input type="checkbox"/> Otolaryngology | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Gastroenterology | <input type="checkbox"/> Pathology | |
| <input type="checkbox"/> General Surgery | <input type="checkbox"/> Pediatrics | |
| <input type="checkbox"/> Hematology/Oncology | <input type="checkbox"/> Physical Medicine & Rehabilitation | |
| <input type="checkbox"/> Infectious Disease | | |



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SECTION 6: REQUIRED SCREENING QUESTIONS

Please answer questions 1 through 13 by placing X in the appropriate boxes. If you answer "YES" to any of the screening questions below, you must provide complete information and details on a separate sheet of paper, including copies of all relevant court or supporting documents and attach it to this form.

1.	Have you ever been arrested, convicted, pled guilty to, (including probation before judgment or other diversionary disposition), or pled no contest to the violation of any federal, state or other statute or ordinance constituting a felony or misdemeanor (including driving under the influence or while impaired, but excluding minor traffic violations)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
2.	Have you ever had a license, including training and temporary licenses, in any other jurisdiction in the US? If yes, list License type and State/Jurisdiction: License Type: _____ State/Jurisdiction: _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
3.	Has any entity, including any licensing or disciplinary body of any jurisdiction, hospital, or any branch of the Armed Services: a) Denied our application for licensure, registration, certification, privileges, or limited licensure, reinstatement or renewal? b) Taken any action against your license, registration, certification, limited licensure or privileges, including but not limited to reprimand, suspension, revocation a fine, or non-judicial sanction? c) Filed a complaint or initiated an investigation against you for conduct related to your license, registration, certification, limited licensure or privileges?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
4.	Have you ever surrendered or allowed your license or registration, certification, or limited licensure to lapse while under investigation by any licensing or disciplinary board of any jurisdiction or an entity of the Armed Services?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
5.	Has a complaint, investigation, or charge ever been brought against you, or are any currently pending, in any jurisdiction by any licensing or disciplinary board, or an entity of the Armed Services?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
6.	Has any medical school, postgraduate residency or fellowship training program ever denied you application, or terminated any contract or appointment for <u>any disciplinary matter</u> or while you were under investigation for any reason?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
7.	Have you voluntarily terminated any postgraduate residency training program or fellowship contract or appointment while under investigation by that program or related institution for any disciplinary reason?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
8.	Have you been suspended, placed on probation, formally reprimanded or asked to resign while in medical school or any postgraduate residency training program or fellowship?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
9.	Has your employment by any hospital, HMO, or other healthcare institution, or military entity been terminated for any disciplinary reasons?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
10.	Have you ever voluntarily resigned from any hospital, HMO, or healthcare institution, or military entity while under investigation for any disciplinary reasons?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
11.	Has a malpractice claim or legal action for damages been settled or awarded against you in any jurisdiction?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
12.	Have you had, or are you currently suffering from, or receiving treatment for, any physical disease, mental disorder or condition, including drug or alcohol abuse, that could impair the proper performance of your duties and responsibilities? If yes, please provide a letter from the treating professional to include diagnosis, treatment prognosis and fitness to practice medicine.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
13.	Have you ever been denied a credential, or the privilege of taking an examination, by any state, territory, or county licensing board/agency?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>

SECTION 7A. SUPPORTING DOCUMENTS

899 North Capitol Street, NE, 1stth Floor Washington, DC 20002 – Main Number: 1-877-672-2174 Fax Number: (202) 724-5145
Board of Medicine – www.doh.dc.gov/bomed

