Government of the District of Columbia
Department of Health

HEALTH REGULATION AND LICENSING ADMINISTRATION
BOARD OF MEDICINE

APPLICATION INSTRUCTIONS FOR A MEDICAL TRAINING LICENSE IN THE DISTRICT OF COLUMBIA

We welcome your interest in becoming a licensed Postgraduate Physician Medical Trainee in the District of Columbia and look forward to providing expedient and professional service. However, the quality of our service is dependent on the completeness of your application. Please read these instructions carefully. Any application not completed in accordance with these instructions will be returned without action. All fees are earned when paid and cannot be transferred or refunded.

All individuals who wish to practice as a Medical Trainee in the District of Columbia have to meet the general requirements of these instructions.

WHERE TO FILE

All new license applications and documents should be sent to the following address:

Department of Health
Health Professional Licensing Administration
899 North Capitol Street, NE
First Floor
Washington, DC 20002

Checks or money orders for application and license fees should be made payable to **DC Treasurer** and submitted along with your application.

If you have any questions, call DOH/HPLA's Customer Service line at 1-877-672-2174 between 8:15 a.m. and 4:40 p.m. EST Monday through Friday. Please read these instructions carefully to facilitate prompt processing of your application. Illegible applications, and applications submitted without required signatures, or with incorrect fees, will be returned in their entirety, including fees. Please print or type all information except signatures.

GENERAL REQUIREMENTS FOR ALL APPLICANTS

A. Applicant must not have been convicted of an offense, which bears directly on the applicant's fitness to be licensed.

B. Applicant must be at least 18 years of age.

C. Applicant shall submit the following:

1. A complete and signed application form;
2. Please submit two (2) identical, recent passport-size photographs (2x2 inches in size) on a plain background, which are front-view and fade-proof. The photos must be original photos and cannot be computer-generated copies or paper copies. In addition, we will not accept 3x3 or larger Polaroid - type photos. Please be sure to mail in your two photos and write on the back of the photos your full name and either your license number or Social Security Number. Photos will be placed on the pocket license.
3. You will also need to submit one (1) clear photocopy of a government issued photo ID, such as your valid driver's license, as proof of identity.
4. Hospital GME Attestation – (Must be submitted by GME Director)
5. Hospital Acceptance Letter/Confirmation

D. Comply with all other applicable requirements set forth in these instructions.

Application Fees

All fees are earned when paid and cannot be transferred or refunded. Please make check or money order payable to DC Treasurer.

Application fee for license..... $100.00

Renewal fee……. $50.00

For information concerning the application process call (877)-672-2174

EDUCATIONAL REQUIREMENTS

Medical School Graduate

COMPLETING THE LICENSE APPLICATION

Section 1A. LICENSURE TYPE & FEES

Check the box next to the license description for which you are applying. Also check the corresponding box in the FEES section. Please pay close attention to the selections in that there are several combinations depending on whether you are a:

- MTL I(A) - US or Canadian Trained Medical School Graduate
- MTL I(B) – Foreign Trained Medical School Graduate
- MTL II – Foreign Physician entering a Fellowship - ***Please Note: Eligibility for full licensure in the District of Columbia is at the discretion of the Board**

Section 1B. BASIS OF APPLICATION

a. Check the box next to the basis by which you are applying. It is recommended that you pay by check, so that you have ready proof of payment. Checks or money orders should be made payable to **DC Treasurer** and submitted with your application packet. **A Criminal Background Check (CBC)** is required for licensure approval. To schedule a CBC appointment, call 1-877-783-4187 or go to www.l1enrollment.com. For CBC questions, contact 202-442-9004 or go to www.doh.dc.gov/cbc. The application fee is non-refundable.

b. *The Total Due amount is the fee that must be paid for your DC license to be processed. A charge of $65.00 will be imposed for dishonored checks (Public Law 89-208).

Section 2A. APPLICANT INFORMATION

Enter your legal name exactly as it should appear on the license. The Child Support and Welfare Reform Compliance Act of 2000, Act 13-559, requires that the Department of Health now collect and maintain social security numbers for all licensees. If a foreign applicant and you do not yet have a social security number, you must complete the Social Security Affidavit Form. Your social security number will not be made available to the public. All applicants must be at least 18 years of age. If your name has changed at any point since you first attended college or university, you must provide a copy of a legal name change document for EACH time that it has changed. Acceptable documents are marriage certificates, divorce decrees or court orders.

Section 2B. OTHER NAMES USED

If your name has changed at any point since you first attended college or university, you must provide a copy of a legal name change document for EACH time that it has changed. Acceptable documents for individuals are marriage certificates, divorce decrees, or court orders.

Section 2C. RACE &ETHNICITY DESIGNATION& LANGUAGE(S) SPOKEN

Please indicate your race and list any languages spoken other than English.

Section 3A. PREFERRED MAILING ADDRESS

Place an “X” in the appropriate box to indicate your preferred mailing address. This will be the address to which all future licensing documents will be mailed. Any change to your preferred mailing address must be submitted to the Board within 30 days of the change.

Section 3B. HOME / DC LOCAL ADDRESS

Include your home address in the sections provided. Please note that a Post Office (P.O.) Box address may not be used. If you do not currently have a DC/Local Address you must provide the Board with the address change information within 30 days.

Section 3C. UNDERGRADUATE AND MEDICAL SCHOOLS ATTENDED

List undergraduate and medical schools attended and provide certified copies of Medical School Transcripts.

Section 3D. PROFESSIONAL PRACTICE

Include all professional practices since graduation from medical school, including internship, residencies, and hospital affiliations.

a. Please indicate if you have taken and successfully passed USMLE Step 1 / COMLEX Level 1.
b. Please indicate if you have taken and successfully passed USMLE Step 2 / COMLEX Level 2. (You will be required to provide supporting documentation)
c. Please indicate if you have taken and successfully passed USMLE Step 3 / COMLEX Level 3. (Required if entering Fellowship)

Section 4. TRAINING YEAR AND TRAINING INSTITUTION

Please select postgraduate training year that you are applying for and indicate if your postgraduate training is for a fellowship. Select the principal sponsoring institution of your training program.

Section 5. TRAINING PROGRAM SPECIALTY

Place an X by your Training Program Specialty.

SPECIALTY CODE

Select your Program Specialty

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

Section 6. REQUIRED SCREENING QUESTIONS

If you answer "yes" to any of the screening questions then you must provide a complete explanation on a separate sheet of paper. If more space is required 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.

Section 7A. SUPPORTING DOCUMENTS

Please indicate the supporting documents you have included with this package or requested to be sent to the Board of Medicine. Keep a photocopy of all supporting documents for your records.

Section 7B. PAYMENT / MAILING INFORMATION

Checks or money orders for medical training license fee should be made payable to D C Treasurer and submitted along with your application.

All new license applications and documents should be sent to the following address:

District of Columbia Health Professional Licensing Administration
Attention: Processing Department - Board of Medicine
899 North Capitol St. NE, 1st Floor
Washington, DC 20002

Section 8A. CLEAN HANDS

Please read the information under this section before responding to this Yes or No question, as any false information provided requires that the Department of Health proceed immediately to revoke your license or registration.

Section 8B. APPLICANT AFFIDAVIT

By signing the application you are attesting under penalty of perjury that all information and attached documents are true to the best of your knowledge. Note: Please print application and mail the original to the Board of Medicine, mail a copy to your GME Director and retain a copy for your files.

ADDITIONAL APPLICATION FORMS

If you need additional copies of this application package you may visit the Board of Medicine website at www.doh.dc.gov/bomed or call HPLA's Customer Service number at (877)-672-2174. The forms that make up this package are:

Medical Training License, New License Instructions
Medical Training License, New License Application
Character Reference Form
Social Security Affidavit Form (completed only if no SS#)
Criminal Background Check

SUMMARY OF LICENSURE REQUIREMENTS

The following chart shows the licensure submission requirements for all application methods. The law governing physician assistant licensure in the District of Columbia is D. C. Law 6-99, the Health Occupations Revision Act of 1985. The regulations governing physician assistant are included in DC Municipal Regulations Title 17, Chapters 49. Any conflict between these instructions and the law and regulations is inadvertent. The law and the regulations take precedence in the event of any inadvertent conflict. Please contact the DC Medical Programs Branch/Allied Health if you have any questions regarding the interpretation of these laws as they pertain to your particular situation.

License Type	Licensing Description	Signed Application for License	Two 2" x 2" Photos	One (1) clear photocopy of a government issued photo ID	Hospital GME Director Attestation	Hospital Acceptance Letter/Confirmation	Criminal Background Check (CBC)	Check or Money Order
MTL	Medical Training Licenses	X	X	X	X	X	X	$100

X = Required
O = Not required

Check or money order MUST be made payable to **DC Treasurer**.