



**Government of the District of Columbia
Department of Health
Health Regulation and Licensing Administration**



BOARD OF MEDICINE

NEW LICENSE APPLICATION FOR MEDICINE & OSTEOPATHY (MD/DO)

SECTION 4A. POST SECONDARY SCHOOLS ATTENDED

List post secondary schools attended, in reverse chronological order, beginning with the most recent at the top.

School Name, City, State, Country	Date of Graduation mm/yyyy	Degree/Certificate

SECTION 4B. MEDICAL TRAINING AND MEDICAL PRACTICE – POSTGRADUATE EXPERIENCE

List experience covering the five (5) year period prior to the submission of the application (**MONTH & YEAR**) and all training. Include letters from employing facilities, organizations, and training. **For "TRAINING AND PRACTICE DESCRIPTIONS", use the letter key code below.** List experience in reverse chronological order, beginning with the most recent. Please explain all gaps greater than 3 months.

Organization/Institution	Start Date mm/yyyy	End Date mm/yyyy	Type of Position (Use Key Code Below)

TRAINING AND PRACTICE DESCRIPTIONS/TYPE OF POSITION KEY CODE

- A. FELLOWSHIP B. INTERNSHIP C. RESIDENCY D. EMPLOYMENT E. PRIVATE PRACTICE
F. OTHER...(Attach a typed explanation on a separate sheet of paper to this form.)**

SECTION 4C. MEDICAL LICENSES IN OTHER STATES/JURISDICTIONS

List all states and jurisdictions in which you have ever held a license (excluding training licenses) and provide letters of verification. Use additional sheet if necessary.

Are you currently applying for licensure in any other jurisdiction? If yes please list: _____

Jurisdiction	Issue Date mm/yyyy	Expiration Date mm/yyyy	License Number



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SECTION 5A. PRACTICE TIME IN THE DISTRICT

Please provide practice information

(1.A) Do you plan to practice in the District of Columbia? Yes No

(1.B) What type of medical practice? Academic Administrative Clinical Research

(1.C.) How many hours will you practice in the District of Columbia?	<less than 20 hours/week	>more than 20 hours/week
• ACADEMIC MEDICINE		
• ADMINISTRATIVE MEDICINE		
• CLINICAL MEDICINE		
• RESEARCH MEDICINE		

(2) Please indicate if you do or will practice in: Maryland Virginia

SECTION 5B. SPECIALTIES

Please select the appropriate specialties.

If your practice is limited to a specialty, please indicate the code from the specialty code listed below. **Primary** _____
Secondary _____

SPECIALTY CODE

<p>AC Academic Medicine ADM Administrative Medicine AI Allergy & Immunology AN Anesthesiology DE Dermatology EM Emergency Medicine FM Family Medicine GE Geriatrics HOS Hospitalist IN Internal Medicine (General) IN Internal Medicine</p> <ul style="list-style-type: none"> • IN/CA Cardiology • IN/EN Endocrinology • IN/GI Gastroenterology • IN/HEM Hematology • IN/ID Infectious Disease • IN/NEP Nephrology • IN/NEU Neurology • IN/ONC Oncology • IN/PCC Pulmonary Critical Care • IN/PUD Pulmonary Disease • IN/RH Rheumatology <p>MG Medicine Genetics</p>	<p>NU Nuclear Medicine OB Obstetrics & Gynecology OC Occupational Health OP Ophthalmology OMT Osteopathic Manipulative Treatment ENT Otolaryngology PA Pathology PED Pediatrics (General) PED Pediatrics</p> <ul style="list-style-type: none"> • PED/AD Adolescent Medicine • PED/CA Cardiology • PED/EN Endocrinology • PED/GI Gastroenterology • PED/HEM Hematology • PED/NEO Neonatology • PED/NEP Nephrology • PED/NEU Neurology • PED/ONC Oncology • PED/PCC Pulmonary Critical Care • PED/PUD Pulmonary Disease • PED/RH Rheumatology 	<p>PMR Physical Medicine & Rehabilitation PR Preventive Medicine/Public Health PSY Psychiatry RA Radiology REM Research Medicine SU Surgery (General) SU Surgery</p> <ul style="list-style-type: none"> • SU/BT Burn/Trauma • SU/CS Cardiac Surgery • SU/CO Colon & Rectal Surgery • SU/GE General Surgery • SU/NE Neurological Surgery • SU/OR Orthopedic Surgery • SU/PL Plastic Surgery • SU/TH Thoracic Surgery • SU/TP Transplant • SU/UR Urology • SU/VA Vascular <p>Other: _____</p>
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BOARD CERTIFICATION(S)

Are you board certified in any specialty? Yes No (If yes please list in the provided space below)

Please list certifying organization(s)



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SECTION 5. REQUIRED SCREENING QUESTIONS

Please answer questions 1 through 15 by placing an X in the appropriate boxes. If you answer "YES" to any question, you must provide full information and complete details **on a separate sheet of paper attaching copies of all relevant documents such as final court orders or panel review decisions.**

1.	Have you ever been arrested, charged, convicted, pled guilty to, 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"/>
2.	Have you ever been licensed in any healthcare field in any state or jurisdiction? If yes, please list profession(s) & jurisdiction(s). HEALTH PROFESSION(S) _____ JURISDICTION(S) _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3.	Have you been a defendant or respondent to a claim for damages or a malpractice action?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
4.	Have you ever voluntarily surrendered a license or registration certificate (or allowed it to lapse) after formal charges had been brought against you or while you were under investigation?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
5.	Have you ever surrendered your clinical privileges (voluntary or involuntary) or had your clinical privileges denied, revoked, or suspended at any hospital or health care facility?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
6.	Have you ever been terminated or resigned (voluntary or involuntary) from a clinical or professional training program for any reason?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
7.	Has any licensing authority taken adverse action against your license or privileges or informed you of any pending charges?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
8.	Has any licensing authority, health facility, or peer review board informed you of any pending charge(s) or investigation(s) against you?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
9.	Are you presently or have you ever been under a corrective action plan imposed by an employer, medical facility or educational program?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
10.	Do you have a medical condition or have you become aware of any medical condition that currently impairs or limits your ability to practice medicine safely or that could affect your performance or impact your ability to practice your profession?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
11.	Are you currently being treated, or within the past five (5) years have you been treated, for a physical or mental condition that, but for the treatment, could impair your ability to practice your profession?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
12.	Have you ever engaged in the excessive use of alcohol, controlled substances or prescription drugs or have you received treatment or therapy for abuse of alcohol or drugs?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
13.	Within the last ten (10) years, have you voluntarily resigned, been asked to resign, terminated, or disciplined by any employer due to practice or moral turpitude issues?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
14.	Have you ever withdrawn a license application or have you been denied a license or denied the privilege of taking a license examination by any professional licensing board or agency?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
15.	Have you ever had a professional liability policy cancelled or not renewed?	Yes <input type="checkbox"/>	No <input type="checkbox"/>



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SECTION 6A. SUPPORTING DOCUMENTS

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

- Two recent and identical passport-type photos of the applicant’s face (approx. 2”X2”) with applicants name printed on the back.**
The photos must be original photos and cannot be computer-generated copies or paper copies.
- One photocopy of a government issued photo ID**
- Criminal Background Check (CBC) -To access form and instructions go to www.doh.dc.gov/service/criminal-background-check or contact the CBC unit at 1-877-783-4187.**
- One (1) character reference form**
Must be completed by an MD or DO in a supervising role.
- AMA/AOA Profile** *The profile should be submitted from the issuing institution.*
- FCVS** *If applicable.*
- Verification(s) of licensure** *These should be provided in a sealed envelope from the issuing jurisdiction(s) for each license identified in Section 4C.*
- All undergraduate, graduate, and professional school transcripts.**
Transcripts should be provided in a sealed envelope from the issuing institution for each school that you attended and listed in Section 4A.
- Documentation of all experience covering the five (5) year period prior to the submission of the application and all training** *Proof of experience should be submitted as a letter on official letterhead from the overseeing institution/organization.*
- Examination Scores** *In a sealed envelope from the examination contractor or administrator.*
- ECFMG Certificate** *(for foreign applicant)*
- Eminence application package** *(if Eminence 1 or Eminence 2 applicant)*

SECTION 6B. Controlled Dangerous Substance Registration

Will you be applying for a controlled substance registration?

YES (If yes, please visit the Pharmaceutical Control Division @ www.doh.dc.gov/pcd or contact 202-478-9310 or 202-442-5877

NO

SECTION 6C. Payment/Mailing Information

Make check or Money order payable to “DC TREASURER”
A charge of \$65.00 will be imposed for dishonored checks
(Public Law 89-208)

Mail your application package and check to:
Board of Medicine- MD/DO New Application
HRLA 1
PO Box 37801
Washington, DC 20013



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SECTION 7A.

Clean Hands Before Receiving a License or Permit Act of 1996 Certification Form Requirement

Please read the information below carefully 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 Permit** for which you are now applying, and fine you one thousand dollars (\$1,000.00), pursuant to D.C. Official Code § 47-2864 (2001).

IF YOU ANSWER “YES” TO THIS QUESTION, PLEASE SUBMIT PROOF OF THE ARRANGEMENTS YOU HAVE MADE TO PAY THE OUTSTANDING DEBT. IF YOU DO NOT HAVE AN APPROVED PAYMENT SCHEDULE TO PAY THE AMOUNT YOU OWE OR IF NO APPEAL IS PENDING, THE LAW REQUIRES THAT YOUR NEW LICENSE APPLICATION BE DENIED.

As of this date, do you owe more than one hundred dollars (\$100.00) to the District of Columbia Government as a result of any of the following:

- Fines, penalties, or interest assessed pursuant to *D.C. Official Code Title 8, Chapter 8* (Litter Control Administrative Act of 1985);
- Fines or interest assessed pursuant to *D.C. Official Code Title 8, Chapter 9* (Illegal Dumping Enforcement Act of 1994);
- Fines, penalties, or interest assessed pursuant to *D.C. Official Code Title 2, Chapter 18* (Civil Infractions Act of 1985);
- Past due taxes;
- Past due District of Columbia Water and Sewer Authority service fees; or
- Fines or penalties assessed pursuant to *D.C. Official Code Title 50, Chapter 23* (Traffic Adjudication)?

Yes No

The information presented above is in compliance with the requirement to submit with your application for licensure or permit under the *Clean Hands Before Receiving a License or Permit Act of 1996*, effective May 11, 1996 (*D.C. Law 11-118, D.C. Code §47-2861 et seq.*).

SECTION 7B. LICENSEE AFFIDAVIT

I hereby attest that the information given in this application, including all writings and exhibits attached hereto, is true and complete to the best of my knowledge. I understand that the making of a false statement on this application, including all writings and exhibits attached hereto, is punishable by criminal penalties.

LICENSEE SIGNATURE

PRINT NAME

DATE

Update by: MR 2/23/15