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 Code 22-2405***. If you have any questions, call HRLA Customer Service at **(877) 672-2174 Monday through Friday, 8:30AM to 4:00PM EST.**

- **STOP: BEFORE COMPLETING THIS FORM, PLEASE REFER TO APPLICATION INSTRUCTIONS.**
- **ALL APPLICANTS ARE REQUIRED TO UNDERGO A CRIMINAL BACKGROUND CHECK PER DC OFFICIAL CODE SECTION 3-1205.22.** For payment and to schedule an appointment Call **1-877-783-4187** or www.L1enrollment.com
- 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.

SECTION 1. MEDICAL TRAINING LICENSURE TYPE & FEE

MTL LICENSE FEE: $100.00

☐ **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**

Have you held, or do you currently hold, a full unrestricted license to practice medicine in the US or another country? ☐ **YES** ☐ **NO**

Are you a Military/NIH resident or fellow? ☐ **YES** ☐ **NO**

SECTION 2. APPLICANT INFORMATION

LEGAL NAME: ***(Do not use any initials unless they are a part of your name)*** **GENDER:** ☐ **MALE** ☐ **FEMALE**

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

DEGREE(S): ☐ **MD,** ☐ **DO,** ☐ **MBBS,** ☐ **MBA,** ☐ **MPH,** ☐ **PHD.,** ☐ **OTHER DEGREE** _____

____/____/____ _____ _____ _____ - _____ - _____
Date of Birth **Place of Birth: State/Providence/Territory** **Country if not USA** **Social Security Number** *

***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 may download the affidavit form at** http://doh.dc.gov/node/290382

SECTION 3. OTHER NAMES USED: (Please print clearly)

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.)**

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SECTION 4A: RACE & ETHNICITY DESIGNATION (Optional)

- ☐ American Indian/Alaskan Native
- ☐ Asian/South Asian
- ☐ Black or African American
- ☐ Caucasian/White
- ☐ Hispanic or Latino
- ☐ Other _____
- ☐ Native Hawaiian or other Pacific Islander
- ☐ Choose Not to Disclose

SECTION 4B: LANGUAGE(S) SPOKEN

Language(s) spoken other than English:

- ☐ Spanish
- ☐ French
- ☐ Amharic
- ☐ Cantonese
- ☐ German
- ☐ Vietnamese
- ☐ Tagalog
- ☐ Mandarin
- ☐ Russian
- ☐ Other _____

SECTION 5. PREFERRED MAILING ADDRESS

NOTE: A P.O. BOX MAY NOT BE USED FOR AN ADDRESS. Please provide a street address. If the address provided is not a DC/Local address you must provide the Board with your local address within 30 days of obtaining license approval.

All Medical Training Licensees are required to update name changes or address changes within 30 days of the change. Submit update requests to the DC Board of Medicine - MTL. Include your name, phone number and any other pertinent information that will assist us in ensuring that the information is updated to the appropriate record/file.

HOME ADDRESS:_____
(Street Number and Street Name) (City) (State/Province/Territory) (Zip Code)

APARTMENT #: _____ **PHONE NUMBER: (**_____**)** _____ **-** _____ **FAX: (**_____**)** _____ **-** _____

EMAIL ADDRESS: _____ **(REQUIRED)**

IMPORTANT MESSAGE

Physicians are required to update changes to their name, home address or business address within thirty (30) days of the change. Failure to do so may result in disciplinary action. It is imperative that you update your information in writing, by email or fax to the District of Columbia Health Regulation Licensing Administration Processing Department. Submit your request to the Attention of the "Processing Center". Include your name, phone number and any other pertinent information that will assist us in ensuring that the information is updated to the appropriate record/file.

899 N. Capitol St. NE, 2nd Floor
Washington, DC 20002
E: dcbomed@dc.gov
F: (202) 442-8117

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

SECTION 6. GRADUATE AND MEDICAL SCHOOLS ATTENDED

List post medical school and medical schools attended and provide copies of medical school transcripts

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

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SECTION 7. OTHER TRAINING AND PRACTICE

List other training and experience covering the five (5) year period prior to the submission of the application and all training. For "Type of Position", use the letter key code below. List experience in reverse chronological order, beginning with the most recent. Please explain all gaps greater than three (3) months. Use additional sheets if necessary.

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

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 8. USMLE/COMLEX RESULTS

Note: Please provide copies of your results with your application.

a. **I have successfully passed USMLE Step 1 / COMLEX Level 1** ☐ YES ☐ NO

b. **I have successfully passed USMLE Step 2 / COMLEX Level 2** ☐ YES ☐ NO

c. **I have successfully passed USMLE Step 3 / COMLEX Level 3** ☐ YES ☐ NO
(Required for MTL II applicants)

SECTION 9. TRAINING

Select the Postgraduate Training year you are applying for:

☐ PGY1 ☐ PGY2 ☐ PGY3 ☐ PGY4 ☐ PGY5 ☐ PGY6 ☐ PGY7 ☐ PGY8 ☐ Other: _____

Is your training program ACGME or AOA Approved? ☐ YES ☐ NO ☐ DON'T KNOW

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

SECTION 9B: TRAINING INSTITUTION

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

☐ Children's National Medical Center
☐ George Washington University Hospital
☐ Howard University Hospital
☐ MedStar National Rehabilitation Hospital
☐ MedStar Washington Hospital Center
☐ MedStar Georgetown University Hospital
☐ Providence Hospital
☐ Saint Elizabeth's Hospital
☐ Unity Health Care

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SECTION 9C: FELLOWSHIP PROGRAM (MTL II APPLICANTS ONLY)

Name the Fellowship Specialty program you are entering: _____

Is the Fellowship program ACGME or AOA Approved? ☐ YES ☐ NO ☐ DON'T KNOW

SECTION 10: PROGRAM SPECIALTY

Select your Program Specialty

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

SECTION 11: 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 ☐ No ☐ N/A ☐
2.	Have you ever had a license, including training and temporary licenses, in any other jurisdiction in the US or foreign country? If yes, list License type and State/Jurisdiction: License Type: _____ State/Jurisdiction:_____	Yes ☐ No ☐ N/A ☐
3.	Has any entity, including any licensing: or disciplinary body of any jurisdiction, hospital, or any branch of the Armed Services: a) Denied your 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?	a) Yes ☐ No ☐ N/A ☐ b) Yes ☐ No ☐ N/A ☐ c) Yes ☐ No ☐ N/A ☐

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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 ☐ No ☐ N/A ☐
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 ☐ No ☐ N/A ☐
6.	Has any medical school, postgraduate residency or fellowship training program ever denied your application, or terminated any contract or appointment for any disciplinary matter or while you were under investigation for any reason?	Yes ☐ No ☐ N/A ☐
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 ☐ No ☐ N/A ☐
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 ☐ No ☐ N/A ☐
9.	Has your employment by any hospital, HMO, or other healthcare institution, or military entity been terminated for any disciplinary reasons?	Yes ☐ No ☐ N/A ☐
10.	Have you ever voluntarily resigned from any hospital, HMO, or healthcare institution, or military entity while under investigation for any disciplinary reasons?	Yes ☐ No ☐ N/A ☐
11.	Has a malpractice claim or legal action for damages been settled or awarded against you in any jurisdiction?	Yes ☐ No ☐ N/A ☐
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 ☐ No ☐ N/A ☐
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 ☐ No ☐ N/A ☐

SECTION 12. CLEAN HANDS

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 13. DOCUMENTS CHECKLIST

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 FOR YOUR RECORDS.

☐ CRIMINAL BACKGROUND CHECK: FOR PAYMENT AND TO SCHEDULE AN APPOINTMENT CALL 1-877-783-4187 OR WWW.L1ENROLLMENT.COM . APPLICANTS MAY ALSO WALK-IN TO THE D.C. DEPARTMENT OF HEALTH TO COMPLETE THE CBC REQUIREMENT.

☐ ONE (1) CLEAR PHOTOCOPY OF A GOVERNMENT ISSUED PHOTO ID

☐ CHARACTER REFERENCE FORM - HTTP://DOH.DC.GOV/NODE/290412

☐ SSN AFFIDAVIT FORM (IF NO SSN ISSUED) – WWW.DOH.DC.GOV/BOMED (IF FOREIGN TRAINED)

☐ MEDICAL SCHOOL TRANSCRIPTS (COPIES ACCEPTED)

☐ ECFMG CERTIFICATE (MTL 1B AND MTL II APPLICANTS – COPIES ACCEPTED)

☐ EXAMINATION SCORES: USMLE / COMLEX PARTS 1 & 2 (COPIES ACCEPTED)

☐ EXAMINATION SCORES: USMLE / COMLEX PART 3 (REQUIRED FOR MTL II APPLICANTS ONLY -COPIES ACCEPTED)

☐ PRINT AND MAIL ORIGINAL APPLICATION TO THE DC BOARD OF MEDICINE. SEND A COPY TO YOUR PROGRAM GME OFFICE AND RETAIN A COPY FOR YOUR FILES.

SECTION 14. 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 making a false statement on this application, including all writings and exhibits attached hereto, is punishable by criminal penalties.

_____ _____ _____

LICENSEE SIGNATURE | PRINT NAME | DATE

REPORT FRAUD, WASTE, AND ABUSE: To report fraud, waste, or abuse within the District government, contact the DC Office of the Inspector General's hotline by phone at 1-800-521-1639 (toll free) or 202-724-TIPS (8477), by email at hotline.oig@dc.gov, or by TTY at 711. For additional information, visit the Office of the Inspector General's website at oig.dc.gov.