DISTRICT OF COLUMBIA -- DEPARTMENT OF HEALTH
HEALTH OCCUPATION LICENSE RENEWAL FORM

GENERAL INSTRUCTIONS: The information printed Section 1 of this form shows the current information on record for your license. Complete all sections of this form, where applicable, including the fee calculation. If more space is needed to fully answer questions, attach additional sheets. False or misleading statements will be cause for disciplinary action and could be cause for criminal prosecution. Mail the form, the required fee, and all supporting documents to: **Department of Health, Health Professional License Administration, Board of Medicine, 717 14th Street NW, 6th Floor, Washington, D.C. 20005. This form is due back to HPLA by December 31, 2010. Forms postmarked after the 31st of December must contain an additional late fee of $85.00. If you have any questions, call HPLA Customer Service at 1-877-672-2174.**

1. DEMOGRAPHIC INFORMATION

Please make name and address changes on the reverse side of this form.

Preferred mailing address:	**License Number:**
PHONE: FAX: EMAIL:	**Birth Date:** **Other Address:**

*Pursuant to D.C. Official Code Section 3-1205.5 (b) (2001) (Health Occupations Revisions Act), **applicants are required to provide a Social Security Number (SSN)** on applications for a professional license. Please provide your Social Security Number in Section 5 of this form. If a Social Security Number is not available, a sworn affidavit stating that you do not have a Social Security Number must be submitted on a separate notarized letter.

2. SPECIAL INSTRUCTIONS

- Your license expires December 31, 2010.
- Renewal applications submitted after December 31, 2010 will be required to pay a $85.00 late fee.
- If you are unable to renew your license by December 31, 2010 or within the 60-day late renewal period, you will then be required to apply for reinstatement of your license.
- In addition, you must submit your pictures no later than the 60-day late renewal period. Failure to do so will result in your license lapsing and you will have to apply for reinstatement of your license. **You may not practice your profession in the District of Columbia until you reinstate your license.**
- You may reinstate your license in the District within 5 years of the expiration date of your license. Once the 5-year reinstatement period has ended, you must apply as a new applicant. You will receive a new license number upon approval.

IMPORTANT NOTICE: In compliance with 17 DCMR 4001.1(c), 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. Please send the photos along with your Renewal Application form. Photos will be placed on the pocket license. 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. **Your application is not complete and your license will not be renewed until your photos are received.**

INTERNET INSTRUCTIONS: This is a reminder that if you decide to register online, you must register at: http://www.hpla.doh.dc.gov.

If you renew online, you are still required to mail in two (2) 2x2 photographs as stated above. **Your license will not be renewed until your photos are received.**

Be sure to keep a copy of this renewal form and your payment for your records. Remember that you are required by law to notify your professional board of any address change within 30 days of the change. You may send address changes to the address in the GENERAL INSTRUCTIONS above. This will help ensure that you receive your next renewal notice in a timely manner.

3. LICENSE RENEWAL AND FEES – Select the type of action you wish to take for your license.

Please check the appropriate boxes to indicate other requests you would like to be processed with your license renewal and then total the fee column. This form will be returned unprocessed if the fee is not included or if the fee is less than required. Make your check or money order payable to "DC Treasurer**" CASH PAYMENTS ARE NOT ACCEPTED.**

A. ☐ Renewal **OR** ☐ Paid Inactive Status Request

B. Renewal License Fees:

- Medical Doctors or Doctors of Osteopathy = $500.00
- Chiropractors = $300.00
- Chiropractors – Ancillary Procedures = $153.00
- Physician Assistants = $145.00
- Acupuncturists = $290.00
- Surgical Assistants = $145.00
- Anesthesiology Assistants = $145.00
- Naturopathic Physicians = $145.00

Renewal Fee (Select from the list on "B")

C. ☐ Cancel License (No Fee**) (SEE #3)** $0.00 = $_____

D. ☐ Late Fee (if postmarked after December 31, 2008) **(SEE #4)** $85.00 = $_____

E. ☐ Name and/or Address Changed (see reverse side)

F. ☐ Duplicate License Request QTY: _____ x $34.00 = $_____

TOTAL FEE DUE = $_____

Make check or money order payable to DC TREASURER.
Mail to:
Department of Health
Health Professional Licensing Administration
Board of Medicine – Renewals
717 14th Street NW, 6th Floor
Washington, D.C. 20005

A Charge of $65.00 will be imposed for dishonored checks (Public Law 89-208)

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4. QUESTION ABOUT YOUR PRACTICE

If you have an "**MD**" or "**DO**" license prefix, please complete A-D. If you are a chiropractor ("CH" license prefix), complete A, B and E. Otherwise, complete A and B only.

A. Are you in active practice now? **(SEE #5 – MDs/DOs Section)**	Yes ☐ No ☐
B. If so, do you practice in the District of Columbia at all? ❖ If YES, what % of time? _____**%**	Yes ☐ No ☐
C. MD's and DO's Only – If your practice is limited to a specialty, please indicate the code from the specialty list at the right.	☐☐ Specialty Code
D. MD's and DO's Only – If you are certified by the American Board of any specialty, please indicate the code from the specialty list at the right.	☐☐ Specialty Code
E. Chiropractors Only – Are you authorized to perform non-invasive ancillary procedures?	Yes ☐ No ☐

SPECIALTIES CODES

- ACM 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
  - 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/RHU Rheumatology
- MG Medicine Genetics
- NU Nuclear Medicine
- OB Obstetrics & Gynecology
- OC Occupational Health
- OP Ophthalmology
- OMT/OMM Osteopathic Manipulative Treatment
- ENT Otolaryngology
- PA Pathology
- PED Pediatrics (General)
- PED Pediatrics
  - 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/RHU Rheumatology
- PMR Physical Medicine & Rehabilitation
- PR Preventive Medicine/Public Health
- PSY Psychiatry
- RA Radiology
- REM Research Medicine
- SU Surgery (General)
- SU Surgery
  - 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

5. CONTINUING EDCUATION

Check the box below if you have completed the required credit hours to renew your license. These courses must have been completed between 1/1/09 and 12/31/10.

Physician Assistants ONLY	**Chiropractors ONLY**
☐ I have completed the 40 hours of Category I and 60 hours of Category II continuing education required to renew my license. **SEE # 5 FOR REQUIREMENT DETAILS**	☐ I have completed the 24 hours of continuing education required to renew my license. **SEE # 5 FOR REQUIREMENT DETAILS**

MD and DO ONLY

1. I have completed 50 hours of AMA or AOA- approved CME since January 1, 2009.	Yes ☐ No ☐
2. I am exempt from the CME requirement because I am deployed in the armed forces or serving in the US Congress.	Yes ☐ No ☐
3. I am exempt because I elected inactive status and understand that I can not practice in the District of Columbia.	Yes ☐ No ☐
4. I am exempt because this is my first renewal of a license obtained by examination.	Yes ☐ No ☐
5. I am exempt because I was enrolled in a ACGME or AOA – approved postgraduate training program during the past two years.	Yes ☐ No ☐
6. The Board exempted me due to disability (copy of exemption letter attached).	Yes ☐ No ☐
7. I have not completed the required 50 hours of CME since January 1, 2009.	Yes ☐ No ☐

SECTION 6. NAME CHANGE

If you are changing your name, you must provide legal documentation of the name change. Acceptable documentation for individuals includes a copy of marriage certificate, divorce decree, or court order.

Changed to current name by: ☐ Marriage ☐ Divorce ☐ Court Order

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

M M — D D — Y Y Y Y
DATE OF BIRTH CORRECTION

SSN/FEIN CORRECTION * (Required)

DISTRICT OF COLUMBIA -- DEPARTMENT OF HEALTH

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SECTION 7A. HOME ADDRESS CHANGE

☐ APARTMENT ☐ SUITE ☐ FLOOR ☐ PO BOX NUMBER

HOME STREET ADDRESS 1 (If applicable, use this line for additional building information. Otherwise, use this line to indicate STREET NUMBER & STREET NAME)

HOME STREET ADDRESS 2 (If additional space is needed, use this line to indicate STREET NUMBER & STREET NAME)

CITY E-MAIL (OPTIONAL)

STATE ZIP CODE + 4 HOME PHONE NUMBER HOME FAX NUMBER

SECTION 7B. BUSINESS ADDRESS CHANGE

Please note: This information will be made available to the public.

COMPANY NAME

☐ APARTMENT ☐ SUITE ☐ FLOOR ☐ PO BOX NUMBER

BUSINESS STREET ADDRESS 1 (If applicable, use this line for additional building information. Otherwise use this line to indicate STREET NUMBER & STREET NAME)

BUSINESS STREET ADDRESS 2 (If additional space is needed, use this line to indicate STREET NUMBER and STREET NAME)

CITY E-MAIL (OPTIONAL)

STATE ZIP CODE + 4 BUS PHONE NUMBER BUS FAX NUMBER

Indicate your preferred mailing address by placing "X" in the appropriate box. This will be the address to which all future licensing documents will be mailed.

☐ HOME ☐ BUSINESS

SECTION 8. QUESTIONS – Applicants MUST answer all of the following questions.

Please answer questions A through I by placing an "X" in the appropriate boxes. If you answer "Yes" to questions A through G below, 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.**

A. **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 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: Yes ☐ No ☐

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

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.).

B. Since your last application, have you been arrested, convicted, pled guilty to, or pled nolo contendere 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 ☐

C. Since your last application: Yes No

(1) Have you withdrawn an application for licensure or certification to practice your profession in any jurisdiction? ☐ ☐

(2) Has any licensing authority taken adverse action against your medical/osteopathy license or privileges or informed you of any pending charge(s)? ☐ ☐

(3) Has any licensing authority, health facility, or peer review board informed you of any pending charge(s) or investigation(s) against you? ☐ ☐

(4) Have you voluntarily surrendered a license or registration certificate (or allowed it to lapse) after formal charges have been brought against you or while you were under investigation? ☐ ☐

(5) Have you surrendered your clinical privileges (voluntary or involuntary) or had your clinical privileges denied, revoked, or suspended at any hospital or health care facility? ☐ ☐

D. Since your last application: Yes No

(1) Have you been diagnosed with a physical or mental condition that currently impairs your ability to practice your profession or that could affect your performance or impact your ability to perform your professional duties? ☐ ☐

(2) Are you currently being treated or have you been treated for a physical or mental condition that, but for the treatment, could impair your ability to practice your profession? ☐ ☐

E. Since your last application, have you been treated for abuse of alcohol, controlled substances, prescribed medications or illegal drugs? Yes ☐ No ☐

F. Since your last application, have you been a defendant or respondent to a claim for damages or a malpractice action? Yes ☐ No ☐

G. Since your last application: Yes No

(1) Have you been terminated or resigned from a clinical or professional training program for any reason? ☐ ☐

(2) Have you been terminated, asked to resign, disciplined or voluntarily resigned by any employer due to practice issues or moral turpitude issues? ☐ ☐

H. Do you currently practice your profession in the District of Columbia? Yes ☐ No ☐

I. I have completed the continuing education that is required for renewal or indicated why I am exempt on Section 5. Yes ☐ No ☐

SECTION 9. 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	LICENSEE NAME (Please print)	DATE