

## **TABLE OF CONTENTS**

		<b><u>Page</u></b>
<b>SECTION I</b>	<b>Instructions and Important Information</b>	<b>1 – 6</b>
<b>SECTION II</b>	<b>Fee Information</b>	<b>7</b>
<b>SECTION III</b>	<b>Notices</b>	<b>8 – 9</b>
<b>SECTION IV</b>	<b>Application Form</b>	<b>1 – 11</b>
<b>SECTION V</b>	<b>Required Forms</b>	<b>IML 2, 3, 7</b>
<b>SECTION VI</b>	<b>Checklist</b>	<b>12</b>

# **SECTION I**

## **Instructions and Important Information**

MARYLAND BOARD OF PHYSICIANS  
P.O. Box 37217  
Baltimore, Maryland 21297  
Telephone: 410-764-4777 800-492-6836

Dear Applicant:

Thank you for considering Maryland as your place to practice medicine.

The following is your *Application for Initial Medical Licensure* and the supplemental verification forms you will need. **Before you submit your application, please make certain that your name appears exactly the same way on all documents submitted by yourself or others. If the name differs, please provide a complete explanation for any differences and an official document to support the changes.**

The following suggestions will help you expedite the processing of your application :

**Read all cover pages before you begin to fill out the application.**

**Read each item of the application thoroughly and respond completely.**

**Send the supplemental verification forms to the correct verifier and follow up with the verifier to be certain the forms have been completed and mailed to the Board.**

You will receive a postcard informing you that the Board has received your application. *Please do not call the Board to inquire about the status of your application unless it has been more than 60 days since you received the postcard and you have not heard from the Board.* If you have been licensed before that time, you will be able to find your name and license information on the Maryland site at [www.mbp.state.md.us](http://www.mbp.state.md.us).

We look forward to receiving your completed application, and we will process it as rapidly as possible.

The Licensure Team  
Board of Physicians

*If you have been licensed previously in Maryland, do not use this application. Please download the reinstatement application at [www.mbp.state.md.us](http://www.mbp.state.md.us).*

**MARYLAND BOARD OF PHYSICIANS**  
**P.O. Box 37217**  
**Baltimore, Maryland 21297**  
**Telephone: 410-764-4777 800-492-6836**

Authority: Maryland Annotated Code, Health Occupations Sections 14-307 and 14-308; Code of Maryland Regulations (COMAR) 10.32.01.01 through 10.32.01.04

***GENERAL INSTRUCTIONS***

The Maryland Board of Physicians (“Board”) will process your application as quickly as possible, but much of our ability to do this depends on you. From our years of experience, we can assure you that applicants who use the following approach have far fewer problems and are processed much more rapidly than those who do not:

1. **Obtain a 2” x 2” passport-quality photograph for your application.**
2. **Complete the application yourself. Do not delegate this important task to someone else.**
3. **Take your time and *read everything*. Do not rush through the application.**
4. **Print clearly or type your answers and all other information.**
5. **The enclosed application has been designed to give us the information we need in the order we need it. Even if a format looks familiar, carefully read the instructions for each item before you answer, and complete each item before moving to the next.**
6. **For your own records and for reference during the licensure process, keep a copy of your application and all forms that you send to a third party.**
7. **Make sure that all application materials are sent to the Board as timely as possible in accordance with the instructions in the application packet. The Board cannot waive information required by its laws and regulations.**
8. **Not all physicians who apply will receive a license. Making commitments on loans, dates to start your practice, purchases of homes, etc., before you are granted a license can set you or your colleagues up for disappointment or financial setbacks.**
9. **Please note that application and check made payable to the Maryland Board of Physicians must be mailed to the following address:**

**Maryland Board of Physicians  
P.O. Box 37217  
Baltimore, Maryland 21297**

**DO NOT mail or hand deliver your application to the Board office. Any application that is mailed or hand delivered to the Board office will be forwarded to the above address within 24—48 hours. This will delay the processing of your application.**

**Please note that all supporting documentation must be mailed to the following address:**

**Maryland Board of Physicians  
4201 Patterson Avenue  
Baltimore, Maryland 21215-0095**

Included with the application are forms that you must complete and send to third parties. These supplemental forms are in Section V of this application packet.

The documents *Grounds for Board Action in Maryland*: Maryland Annotated Code, Health Occupations § 14-404, and *Code of Maryland Regulations* (COMAR) 10.32.01.01 can be found at the Board's website [www.mbp.state.md.us](http://www.mbp.state.md.us). Please refer to them as needed as you complete the application.

## *PROCESSING AN APPLICATION*

*Please do not call your analyst to check on the status of your application. Your application will be processed as outlined below. If all of your materials have not been received within 60 days from the date the Board received your application, an analyst will send you a status letter. Be certain to provide a telephone number or numbers where you can be reached and immediately notify your analyst in writing of any address or telephone number change.*

Your application is one of approximately 2000 applications the Board will receive this year. When your application is received, it is date-stamped and assigned to an analyst. Using the control number assigned when your application and check was received by the Board, your analyst also checks to see if the Board has received any documents in support of your application. Any documents received are incorporated into your file before the file is sent to your analyst. You will receive a postcard confirming the Board's receipt of your application. **Please do not call to check on the status of your application unless it has been more than 60 days since you received your postcard from the Board and you have not heard from your analyst.**

The Board has designated a 4-month period for processing applications. After receiving your application file, the analyst first performs a quick review to determine the initial state of completeness. A final review of the application can be performed only after all required information and documentation has been received. Completed files are reviewed in the order they are received.

Within 60 days of receiving your application, your analyst will determine whether your application is complete. If your application is not complete within 60 days, your analyst will send you a status letter outlining the items needed to complete the application. You will then have a specified period of time to remedy any deficiencies. Generally, the Board will keep an application open for 120 days. If you fail to correct deficiencies within the required period, your application may be closed, and you may be required to submit a new application, pay the required fee, and meet all requirements for medical licensure in Maryland.

Your analyst's goal is to license you within ten days of receiving the last document or piece of information needed to complete your application. You can save weeks in the licensing process simply by being thorough and accurate in completing your application, by correctly completing the applicant section of forms that must be completed by third parties, and by arranging for third parties to return documents directly to the Board as quickly as possible. Please check with all third parties to see if a fee is required to verify the information you are requesting; all fees are the responsibility of the applicant.

Maryland law requires that the Board of Physicians obtain the Social Security number of any person applying for a professional license or certificate. Disclosure of your Social Security number is mandatory. The Maryland Board of Physicians is permitted by State or Federal law, and regulation to use a Social Security number for the following purposes:

- A. Verification of identity with respect to actions related to your license (Code of Maryland Regulations 10.32.01.);
- B. Administration of the Child Support Enforcement Program (Family Law Article, §10-119.3);
- C. Identification by the Department of Assessments and Taxation of new businesses in Maryland (Health Occupations Article, §1-210);
- D. Verification by the Maryland Medicaid program of licensure and sanctions for providers participating in Medicaid (42 U.S.C. §1396(a) (49); 42 U.S.C. §1396r-2; 42 U.S.C. §1320 a-7).

You will receive your license in the mail, usually within a week to ten days after you are licensed. The day after you are licensed, you may find your name and license information at the Maryland Board of Physicians website [www.mbp.state.md.us](http://www.mbp.state.md.us).

An applicant may request to withdraw an application at any time during the processing period. However, an application may not be withdrawn if the applicant has been charged with an offense or is under investigation. Under COMAR 10.32.01.04H(5) the Board has the right to disapprove any request to withdraw an application. An applicant whose request for withdrawal is approved or who is found ineligible will receive a refund of \$480.00.

*PROCESSING AN APPLICATION CON'T*

The Board reserves the right to make all investigations it may deem necessary in processing your application for medical licensure, including, but not limited to, the following:

1. **National Practitioner Data Bank (NPDB):** Please be informed that the Board will request from the NPDB information that includes, but is not limited to:
  - (a) medical malpractice judgments against you;
  - (b) settlements that you have made in medical malpractice actions;
  - (c) actions taken against you or your privileges by state disciplinary or licensing authorities; and
  - (d) actions taken against you or your privileges by a hospital or hospital disciplinary authority which resulted in a loss, limitation, or suspension of privileges for a period greater than 30 days.
2. **Healthcare Integrity and Protection Data Bank (HIPDB):** The Board receives a report on each applicant from the HIPDB.
3. **Federation of State Medical Boards (FSMB):** The Board receives a report on each applicant from the FSMB.
4. **Further Investigations:** The Board may make further investigations as necessary to process an application.

**ENGLISH LANGUAGE COMPETENCY REQUIREMENTS  
FOR MEDICAL LICENSURE IN MARYLAND**

All applicants must document completion of both Requirement 1 **and** Requirement 2 below in order to satisfy the statutory and regulatory requirements for English language competency for medical licensure in Maryland:

Requirement 1: Demonstrate *written* competency in English by documenting one of the following:

1. After at least three years of attendance, graduate from a high school (including General Education Development ["GED"] programs), undergraduate college, or university where English was the **only** language of instruction throughout the applicant's inclusive dates of attendance; **or**
2. Graduation from medical school (**not** a Master's degree or Ph.D. degree program) where English was the **only** language of instruction throughout the applicant's inclusive dates of attendance; **or**
3. A passing score on the USMLE Step 2 Clinical Skills; **or**
4. (a) A score of at least 550 on the paper-and-pencil Test of English as a Foreign Language ("TOEFL") **or** a score of at least 213 on the computer-based TOEFL **or** a score of at least 79 on the Internet based TOEFL (iBT); **or**  
 (b) A passing score of the Education Commission for Foreign Medical Graduates ("ECFMG") English test taken beginning January 1974.

**AND**

Requirement 2: Demonstrate *spoken* competency in English by documenting the following:

1. Item 1, 2, or 3 above; **or**
2. Successful completion of one of the following examinations as indicated:
  - (a) *The Test of Spoken English ("TSE")*. Attain a score of at least 220 on TSE taken before July, 1995, or a score of at least 50 on the TSE taken beginning July, 1995, **or** a score of at least 26 on the Speaking section of the Internet based TOEFL (iBT); **or**
  - (b) *The Oral Proficiency Interview ("OPI")*. Attain a score of at least 2 or Advanced for examinations taken after October 1, 1994, as determined by the Board (NOTE: A prospective OPI applicant must have an application for initial medical licensure on file with the Board before OPI testing can be scheduled).

**Information about the OPI, TOEFL and TSE**

If you need to schedule a TOEFL examination, or to arrange for your scores to be sent to the Board, contact the Educational Testing Service by phone at 1-609-771-7100; by fax at 1-609-771-7500; by e-mail at [toefl@ets.org](mailto:toefl@ets.org); or by website at [www.toefl.org](http://www.toefl.org).

For information about the OPI, contact Language Testing International at 1-914-963-7110. LTI will explain to you how to make payment for testing. Within 24-72 hours of receiving your payment, LTI can schedule your interview. Before you schedule your interview, contact the Board at 410-764-4760 or 1-800-492-6836, extension 4760 and arrange a specific date, time, and location for your telephone interview. Remember, you must have an application on file with the Board before LTI will schedule your interview.

## **New Physician Orientation Education Program**

*Maryland Board of Physicians online New Physician Orientation Educational Program:* All newly licensed physicians are required to complete this program prior to the first renewal of the license. You may access this program at the Board's website [www.mbp.state.md.us](http://www.mbp.state.md.us). Click on New Physician Orientation.

## **Controlled Dangerous Substances Registration**

For information regarding Controlled Dangerous Substances Registration, you may contact the following agencies. You must obtain your Controlled Dangerous Substances Registration from the Department of Health and Mental Hygiene, Division of Drug Control prior to contacting the Drug Enforcement Administration.

### *Controlled Dangerous Substances Registration*

Division of Drug Control  
Department of Health and Mental Hygiene  
4201 Patterson Avenue, 1st Floor  
Baltimore, Maryland 21215  
410-764-2890  
[www.dhmh.state.md.us/drugcont](http://www.dhmh.state.md.us/drugcont)

### *Drug Enforcement Administration*

Drug Enforcement Administration  
U.S. Department of Justice  
200 St. Paul Street, Suite 2222  
Baltimore, Maryland 21202  
410-244-3591  
[www.usdoj.gov/dea](http://www.usdoj.gov/dea)

## **Federation Credentials Verification Service (FCVS)**

FCVS can assist applicants with the credentialing process. Maryland is one of many states that now accept credentials verified by FCVS. For further information, contact FCVS at 817-868-5000, 888-275-3287, or [www.fsmb.org](http://www.fsmb.org). Please be aware that **the FCVS profile does not include the Record of Scores from NBME** for those who may need it, and **does not include the verification of medical licenses in other states.. Applicants who use FCVS will need to arrange for these verifications to be sent to the Board.** If you plan to use FCVS services, please begin the process at least two months prior to submitting your application to the Board and send a note with your application stating that you are using the FCVS service.

## **The Americans with Disabilities Act**

The Maryland Board of Physicians supports the Americans with Disabilities Act and will provide this material in an alternative format to facilitate effective communication with sensory impaired individuals (for example, braille, large print, audio tape). If you need such accommodation, please notify the Board ADA designee, Ellen Douglas Smith at 410-764-4777 or 1-800-492-6836. For the hearing impaired, please contact the Maryland Relay Services TTY/Voice number at 1-800-735-2258. If you have a complaint concerning the Board's compliance with the ADA, please contact Ms. Smith.

## **Statutes and Regulations**

The statutes (Health Occupations Article, Title 14, Sections 14-101 to 14-702) and the Code of Maryland Regulations (COMAR) may be accessed at the Board's website at [www.mbp.state.md.us](http://www.mbp.state.md.us).

## **SECTION II**

### **Fee Information**

MARYLAND BOARD OF PHYSICIANS  
P.O. Box 37217  
Baltimore, Maryland 21297  
Telephone: 410-764-4777 800-492-6836

***FEE INFORMATION ABOUT PHYSICIAN LICENSURE IN MARYLAND***

1. The fees for initial medical licensure in Maryland are as follows:

Graduates of medical schools in the U. S., its territories, Puerto Rico, and Canada: \$790.00  
Graduates of Foreign Medical Schools: \$890.00  
The fees include support for the Physician Rehabilitation Program and peer review services.  
All checks must be mailed to the above address. DO NOT mail or hand deliver your check to the Board office.

2. These fees break down in the following manner:

- a. Original physician or osteopath licensure application: 310.00 (non-refundable)
- b. Foreign credentials evaluation 100.00 (non-refundable)
- c. Physician license fee of \$20.00 per month until expiration of initial license: 480.00 (partially refundable: see below)

Maryland licensure operates on a 24-month cycle. A physician whose last name begins with the letters A-L must renew his/her license by September 30, in even-numbered years; a physician whose last name begins with M-Z must renew his/her license by September 30, in odd-numbered years. **This means that some physicians will have to renew and pay their renewal fee soon after paying their initial licensure fee. To offset this, newly licensed physicians receive a refund of \$20.00 for each month within the licensing cycle that they did not have a license.** For example,

Dr. A applied for a license in July 2006 and paid the \$790.00 fee.

Dr. A was licensed during the month of August 2006. He was required to submit a renewal application and renewal fee by September 30, 2006 (to be effective by October 1, 2006) and pay the \$512.00 renewal fee. (Physicians whose last names begin with A-L always renew in even-numbered years.)

However, because Dr. A had his license for only 2 months out of the 24 months of the licensing cycle before he was required to renew, Dr. A received a refund of \$440.00 (22 months without a license x \$20.00).

Refunds are issued by the State Comptroller's office and are usually mailed within eight to ten weeks of initial licensure. Please take note of these timeframes and plan accordingly.

Pursuant to the Code of Maryland Regulations (COMAR) 10.32.01.03(C) payment of fees is a condition for licensure. Any applicant who attempts to fulfill this requirement by submitting a check with insufficient funds will not be in compliance with COMAR 10.32.01.03(C). The Board will notify the applicant upon receipt of a returned check. Failure to correct the deficiency may result in a mistakenly granted license being declared null and void by the Board. Any physician who practices medicine in Maryland without a valid license may be subject to a fine of up to \$50,000. (Md. Code Ann., Health Occ. §§ 14-601, 14-607(4) ).

## **SECTION III**

### **Notices**

# **EXAMINATION TRANSCRIPTS FOR INITIAL MEDICAL LICENSURE IN MARYLAND**

If you took the FLEX-weighted average, FLEX Components 1 and 2, SPEX or USMLE Steps 1, 2 and 3 examination(s), ask the Federation of State Medical Boards (FSMB) to send your transcripts to the Maryland Board of Physicians. All requests must be made on an Examination and Board Action History Report (EBAHR) form obtained through the FSMB website at [www.fsmb.org](http://www.fsmb.org). Click on Examination Services and then click on Transcripts and follow the instructions for obtaining the EBHAR form and examination transcripts.

For questions concerning the EBAHR form, contact the FSMB Examination Department at 1-800-876-5396.

## **Notice to Applicants Who Are Graduates of Foreign Medical Schools**

Md Code Ann., Health Occ. §14-308 (b)(6)(i) changes the licensure requirements for graduates of foreign medical schools.

**Effective October 1, 2000**, all applicants for medical licensure who are graduates of foreign medical schools will be required to demonstrate successful completion of two (2) years of postgraduate training.

The full text of Md Code Ann., Health Occ. §14-308 (b)(6)(i) may be accessed at the Board's website at [www.mbp.state.md.us](http://www.mbp.state.md.us).

## **SECTION IV**

### **Application Form**

Initial Medical Licensure  
PERSONAL INFORMATION  
10/2009 INT

**STOP! Completed application and check must be mailed to:  
MARYLAND BOARD OF PHYSICIANS**

P.O. Box 37217 • Baltimore, MD 21297  
Telephone: 410-764-4777 Fax: 410-358-1298 Toll Free: 800-492-6836

**APPLICATION FOR INITIAL MEDICAL LICENSURE**

**FOR BANK USE ONLY**

Date \_\_\_\_\_  
Check Number \_\_\_\_\_  
Amt Paid \_\_\_\_\_  
Name Code \_\_\_\_\_  
AppID 17 \_\_\_\_\_

Please print legibly or type the required information. Do not leave any item unanswered. If an item does not apply to you, write "N/A" (Not Applicable) for that item. An incomplete application form will delay the processing of your application.

1. **Your Complete Current Legal Name:** As listed on your U.S. birth/marriage certificate, U.S. passport, or most recent document issued by the INS.

Last name and generational indicator (Jr., Sr., II, III, etc.):  
[Grid for last name and generational indicator]

First name and middle name:  
[Grid for first and middle name]

(If applicable, please check a box and complete below)  Complete Maiden Name OR  Complete Former Name  
[Grid for maiden/former name]

**Stop!** If any credential you submit bears a name other than your current legal name as listed above, or if you have been licensed in another state under any name other than your current legal name, sign and date an attachment which includes each different name, an explanation of why the name differs from your current legal name, and a copy of the legal document to support the name change.

2. **Public Address:** Your public address of record. This address, usually your office, is available to the public and will be posted on the internet.

Street Address: **If you change your address prior to being licensed, immediately notify the Board in writing.**  
[Grid for street address]

City State Zip Code  
[Grid for city, state, and zip code]

3. **Non-Public Address:** This address, usually your home, is for Board use only. However, if no public address is listed, this address will be made public.

Street Address: **(Do NOT use a P. O. Box) If you change your address prior to being licensed, immediately notify the Board in writing.**  
[Grid for street address]

City State Zip Code  
[Grid for city, state, and zip code]

4. **Telephone (s):** Home Office:  
[Grid for home and office phone numbers]

Cell/Pager: E-mail address:  
[Grid for cell/pager and email address]

5. **Date of Birth:** Month Day Year  
[Grid for date of birth]

6. **Gender:**  Male  Female

7. **Race:** Multiracial applicants may select all applicable categories  American Indian or Alaska Native  Asian  Black or African American  Native Hawaiian or other Pacific Islander  White

**Ethnicity:**  Hispanic or Latino  Not Hispanic or Latino

8. **Social Security Number:**  
[Grid for social security number]

<b>For Board Use Only</b>	License Number: [Grid]	BPQA School Code: [Grid]
	Date Issued: [Grid]	Federation School Code: [Grid]
	Licensed By: _____ Licensing Exam: _____	

**9. Chronology of Activities: DO NOT ATTACH RESUME OR CURRICULUM VITAE**

Beginning with the date you completed medical school and continuing through the present, list chronologically all of your activities. Account for all periods of time including each post-graduate training program you attended, regardless of whether or not you completed the program; each job you held, regardless of whether or not it was medically related or you were compensated; and any period of unemployment.

Date Medical School was Completed:	month	year

**Activities after completing medical school:** Please type or print .

month	year	TO	month	year	Activity:
					Address:
month	year	TO	month	year	Activity:
					Address:
month	year	TO	month	year	Activity:
					Address:
month	year	TO	month	year	Activity:
					Address:
month	year	TO	month	year	Activity:
					Address:
month	year	TO	month	year	Activity:
					Address:
month	year	TO	month	year	Activity:
					Address:
month	year	TO	month	year	Activity:
					Address:

**CONTINUED ON PAGE 3:** If you will need more space than page 3 allows, please photocopy page 3 for your use or attach a separate sheet. Please sign and date each sheet you attach.

**Chronology** (Cont'd) Please photocopy this page if more space is needed. Sign and date all additional pages.

month	year	TO	month	year	<b>Activity:</b>
					<b>Address:</b>
month	year	TO	month	year	<b>Activity:</b>
					<b>Address:</b>
month	year	TO	month	year	<b>Activity:</b>
					<b>Address:</b>
month	year	TO	month	year	<b>Activity:</b>
					<b>Address:</b>
month	year	TO	month	year	<b>Activity:</b>
					<b>Address:</b>
month	year	TO	month	year	<b>Activity:</b>
					<b>Address:</b>
month	year	TO	month	year	<b>Activity:</b>
					<b>Address:</b>
month	year	TO	month	year	<b>Activity:</b>
					<b>Address:</b>

10. MEDICAL EDUCATION: List all medical schools you have attended

From: MM/YY To MM/YY

\_\_\_\_\_  
\_\_\_\_\_

Medical School From Which You Received Your Medical Degree: \_\_\_\_\_

Name of University Affiliation (if applicable): \* \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State/Province: \_\_\_\_\_ Country of citizenship during medical education: \_\_\_\_\_

Language(s) of Instruction: \_\_\_\_\_

Type of Degree:  M.D.  D.O.  M.D./Ph.D.  M.B.B.S.  M.B.B.Ch.  Other: \_\_\_\_\_ (specify)

Date Degree The date you officially received your degree after all prerequisite obligations, required training, government service, etc.

Was Conferred: was satisfied. Month  Day  Year

**GRADUATES OF FOREIGN MEDICAL SCHOOLS (Schools not in the U.S. or its territories, Puerto Rico, or Canada)**  
Attach the following documents to this application:

- 1) A copy of your valid ECFMG certificate or Fifth Pathway Certificate;
- 2) A copy of your medical school diploma and a certified translation;
- 3) If you listed an affiliation above (see \* in 10 above), attach a copy of the Certificate of Medical Education and Examinations Taken, Good Conduct Certificate or Intern Certificate. The certificate must include your name, name of the medical school, name of the university, and a certified translation .

If your name is not written the same way on all documents, you must submit documentation to explain how and why your name differs and submit one of the following documents to support the name change; Passport, INS card, birth certificate, court document, marriage license, court decree.

11. How have you satisfied Maryland's *written and oral* English language competency requirements?

(See *English Language Competency Requirements for Medical Licensure in Maryland* in the introductory material included with your application.)

- a.  I graduated from a medical school or, after at least three years of attendance, a high school (includes GED), undergraduate college, or university **where English was the *only* language of instruction throughout** (you must provide documentation); **or**
- b.  I passed either  the TOEFL or  the ECFMG English test after December 31, 1973 **AND** I passed the  TSE or  OPI. If you have taken the Test of English as a Foreign Language (TOEFL) and either the Test of Spoken English (TSE) or the Oral Proficiency Interview (OPI), please request that Education Testing Service and/or Language Testing International send verification of your scores directly to the Board;
- c.  I passed the USMLE Step 2 Clinical Skills Exam.

Are you claiming speech impairment?  NO  YES If "YES," please write or call the Board for additional information.

12. **POSTGRADUATE TRAINING** (DO NOT ATTACH RESUME OR CURRICULUM VITAE. ) List in chronological order **ALL** postgraduate training undertaken in the United States, its territories or possessions, Puerto Rico, or Canada regardless of whether you did or did not complete the program, and regardless of whether you were or were not compensated. (Copies of training certificates are helpful, but not required.)

**NOTE:** On a case by case basis, the Board may consider **full time teaching in an LCME accredited medical school in the United States** as an alternative to the accredited postgraduate clinical medical education required in the Code of Maryland Regulations 10.32.01.03D. Applicants who intend to request consideration of teaching experience as an alternative to accredited postgraduate clinical medical education should contact the Board's licensure division for further information.

**Effective October 1, 2000, graduates of all medical schools NOT in the U.S., its territories or possessions, Puerto Rico, or Canada are required to submit evidence acceptable to the Board of successful completion of 2 years of training in a postgraduate clinical medical education program accredited by an accrediting organization recognized by the Board (ACGME, AOA, or equivalent). If you have not met this requirement, DO NOT submit this application.**

A Fifth Pathway Program graduate must have been a U.S. citizen during the time of medical education and must have successfully completed two years of ACGME accredited postgraduate clinical medical education *after* successfully completing a Board approved Fifth Pathway program. If you have not met these two criteria, DO NOT SUBMIT THIS APPLICATION.

If after 10/1/92 you passed any medical licensing exam (or part, step, or component thereof) that you failed three times, either before or after 10/1/92, then you must successfully complete another year of ACGME/AOA accredited clinical postgraduate training in addition to the year(s) usually required by Maryland. **All** of the additional year must have begun after the date of the last fail. Teaching will not be accepted as an alternative to a year required following three or more fails. If you have not met this requirement, DO NOT submit this application. If you failed any part, step, or component of a medical exam four times, DO NOT SUBMIT THIS APPLICATION; you are not eligible for medical licensure in Maryland.

**NOTE: Postgraduate training program cycles usually run from July 1 to June 30. If the dates of your postgraduate training are not within the usual cycle, fall short of the complete cycle, or extend beyond the usual cycle, please attach a complete explanation of why your training was "off-cycle."**

PG Year #s	Place of Training:	month	year	TO	month	year
	Address:	Specialty:	Accredited by: ACGME <input type="checkbox"/> AOA <input type="checkbox"/> RCPSC <input type="checkbox"/>			
PG Year #s	Place of Training:	month	year	TO	month	year
	Address:	Specialty:	Accredited by: ACGME <input type="checkbox"/> AOA <input type="checkbox"/> RCPSC <input type="checkbox"/>			
PG Year #s	Place of Training:	month	year	TO	month	year
	Address:	Specialty:	Accredited by: ACGME <input type="checkbox"/> AOA <input type="checkbox"/> RCPSC <input type="checkbox"/>			
PG Year #s	Place of Training:	month	year	TO	month	year
	Address:	Specialty:	Accredited by: ACGME <input type="checkbox"/> AOA <input type="checkbox"/> RCPSC <input type="checkbox"/>			
PG Year #s	Place of Training:	month	year	TO	month	year
	Address:	Specialty:	Accredited by: ACGME <input type="checkbox"/> AOA <input type="checkbox"/> RCPSC <input type="checkbox"/>			

(ATTACH A SEPARATE SIGNED AND DATED PAGE IF ADDITIONAL SPACE IS NEEDED)



14. **Medical Licensing Examinations** (USMLE, NBME, NBOME, FLEX, FLEX-Weighted Average, Medical Council of Canada, and licensing exams given by individual states prior to January 1, 1985) **DO NOT SUBMIT THIS APPLICATION until you have received written verification of having passed all parts, steps, or components of your medical licensing examinations.**

Identify below ALL the medical licensing examinations that you have ever taken. Ask the administering authority of each exam to send the complete medical licensing examination history and scores directly to this Board. In each examination category below, you will find information to help you contact the administering authority.

a. Have you ever failed any medical licensing examination (or part, step, or component thereof)? NO  YES

b. Have you failed any medical licensing examination (or part, step, or component thereof) three or more times? NO  YES

If you answered "Yes" to a. and b., you must have successfully completed another year of ACGME-accredited clinical postgraduate training, in addition to the year(s) of training usually required for licensure in Maryland. No part of the additional year may have been taken before the date of the last fail. If you have not met this requirement, you are not eligible for licensure in Maryland at this time. DO NOT submit this application until you have fulfilled this requirement.

**IF YOU HAVE FAILED ANY PART, STEP, COMPONENT OR APPROVED EXAMINATION COMBINATION MORE THAN 3 TIMES, You may not be eligible for medical licensure in Maryland. For a complete explanation see COMAR 10.32.01.03 Licensure—Qualifications for Initial Licensure**

a. **State Board Examination List state(s):** \_\_\_\_\_  
**STATE BOARD DOES NOT INCLUDE STEP 3 OF USMLE, ORAL EXAMS, OR INTERVIEWS. State Board Examinations were licensing exams given by individual states. State Board Examinations taken after December 31, 1984 are not accepted for licensure in Maryland.**  
Send a copy of MBP IML7, *State Board Licensure and Examination Certification*, form to the state(s) which administered your licensing exam and ask the state(s) to send your exam results directly to the Maryland Board of Physicians. Also send a copy to each state that has ever issued you a license.  
**NOTE: Many states charge a fee for exam transcripts. Contact each state board prior to sending form IML7, as all fees are the responsibility of the applicant.**

**Federation of State Medical Boards** (See Page 8 if you took a combination of these exams or combined either with the NBME exams)

b.  **FLEX-Weighted Average: All FLEX-Weighted exams prior to 1985 must have been taken in one sitting (3 consecutive days). Flex weighted average exams taken in more than one sitting must have current ABMS or AOA Board Certification unless you are currently certified by a member board of the American Board of Medical Specialties.**

c.  **FLEX Components 1 and 2: Examinations must be passed within 5 years of each other.**

d.  **USMLE Steps 1, 2, and 3: Passing scores on all parts must have been completed within a 10-year period beginning with the month and year when the applicant first passed either step 1 or step 2.**  
If you took any of the above examinations you must ask the Federation of State Medical Boards (FSMB) to send your transcripts to the Board by accessing their website at [www.fsmb.org](http://www.fsmb.org). Click transcript requests.

e.  **National Board of Medical Examiners** (See Page 8 if you combined this examination with FLEX or USMLE exams)  
If you have received NBME certification, ask NBME to send to the Board both the Endorsement of Certification *and* the Record of Scores. All requests must be made through the NBME website at <http://www.nbme.org> or call 215-590-9592. If you took NBME exams but were not certified, or you took NBME as part of hybrid exams, ask NBME to send only your Record of Scores.

f.  **National Board of Osteopathic Medical Examiners** Certifications issued before January 1, 1971 are not accepted for licensure in Maryland. If you have received NBOME certification, ask NBOME to send to this Board the verification of certification and the complete history of your medical examinations. Contact NBOME at 773-714-0622 for instructions and fee information.

g.  **Medical Council of Canada**  
Licentiate of the Medical Council of Canada  
Please request that verification of your Licentiate Certification and a complete LMCC examination history be sent directly to this Board. Call MCC at 613-521-6012 for instructions and fee information.

### HYBRID EXAMINATIONS

The following combinations are the only hybrid examinations accepted by the Maryland Board.

**Passing scores on all parts of hybrid examinations must have been completed within a 10-year period, beginning with the month and year the examinee first passes a part or component or step of the combined examination. ALL HYBRID EXAMINATIONS MUST HAVE BEEN COMPLETED BEFORE JANUARY 1, 2000.**

h. <input type="checkbox"/> USMLE 1 + NBME II + NBME III i. <input type="checkbox"/> USMLE 1 + USMLE 2 + NBME III j. <input type="checkbox"/> USMLE 1 + NBME II + USMLE 3 k. <input type="checkbox"/> NBME I + USMLE 2 + USMLE 3 l. <input type="checkbox"/> NBME I + USMLE 2 + NBME III m. <input type="checkbox"/> NBME I + NBME II + USMLE 3	n. <input type="checkbox"/> FLEX 1 + USMLE 3 o. <input type="checkbox"/> FLEX 2 + USMLE 1 + NBME II p. <input type="checkbox"/> FLEX 2 + USMLE 1 + USMLE 2 q. <input type="checkbox"/> FLEX 2 + NBME I + USMLE 2 r. <input type="checkbox"/> FLEX 2 + NBME I + NBME II
--	--

- If your hybrid exams included any part of the NBME examination, contact NBME at <http://www.nbme.org> or call 215-590-9592 for instructions and request that your Endorsement of Certification *and* your Record of Scores be sent directly to the Maryland Board of Physicians.
- If your hybrid exams included only FLEX and USMLE examinations, request your transcript from the Federation of State Medical Boards at [www.fsmb.org](http://www.fsmb.org).

#### 15. Licensing History:

- a.  I have never been licensed in the U.S., its territories, or Puerto Rico and have never been licensed or registered in Canada.
- b.  I have an application for license pending in the following states: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_
- c. Please list below all licenses ever issued to you by a U. S. state/territory or Puerto Rico. Also list all Canadian licenses and registrations.
- d. Has any disciplinary action ever been taken against your license?  No  Yes If yes, please enclose an explanation.

STATE (Or Puerto Rico or Canadian Province)	LICENSE NUMBER or Registration Number	CURRENT STATUS					
		Active	Inactive	Expired/Lapsed	Surrendered in good standing	Surrendered / Suspended	Revoked

(If more space is needed, please attach an additional signed and dated sheet.)

16. Check YES or NO.

- Did you successfully complete a medical licensing exam (USMLE, NBME, etc.) within the 15-year period prior to filing this application?
- During the past 10 years, have you maintained uninterrupted licensure since you were first issued a license in the United States, its territories, Puerto Rico, or Canada ?
- Do you have lifetime certification from, or within the past 10 years have you been certified or recertified by, a specialty board recognized by the American Board of Medical Specialties, the American Osteopathic Association, or the Royal College of Physicians and Surgeons of Canada?
- If "YES," in which specialty were you certified? \_\_\_\_\_ Date certified \_\_\_\_\_

⇒ If you have answered "NO" to **all three** of the above questions, you **MUST** take the Special Purpose Examination. After you submit this application, contact the Federation of State Medical Boards at 817-571-2949 and arrange to take the SPEX in Maryland, and have scores sent to the Maryland Board directly.

17. Character and Fitness Questions (Check either YES or NO)

- |    | YES                      | NO                       |  |
|----|--------------------------|--------------------------|--|
| a. | <input type="checkbox"/> | <input type="checkbox"/> | Has a state licensing or disciplinary board (including Maryland), or a comparable body in the armed services, denied your application for licensure, reinstatement, or renewal?  |
| b. | <input type="checkbox"/> | <input type="checkbox"/> | Has a state licensing or disciplinary board (including Maryland), or a comparable body in the armed services, taken action against your license? Such actions include, but are not limited to, limitations of practice, required education admonishment, reprimand, suspension, or revocation. Refer to the document <i>Grounds for Board Action in Maryland</i> at the Board's website <a href="http://www.mbp.state.md.us">www.mbp.state.md.us</a> . |
| c. | <input type="checkbox"/> | <input type="checkbox"/> | Has any licensing or disciplinary board in any jurisdiction (including Maryland), or a comparable body in the armed services, filed any complaints or charges against you or investigated you for any reason?  |
| d. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever withdrawn your application for a medical license or other health professional license?   |
| e. | <input type="checkbox"/> | <input type="checkbox"/> | Has a hospital, related health care institution, HMO, or alternative health care system investigated you or brought charges against you?   |
| f. | <input type="checkbox"/> | <input type="checkbox"/> | Has a hospital, related health care facility, HMO, or alternative health care system denied your application for, or failed to renew your privileges; or limited, restricted, suspended, or revoked your privileges in any way?  |
| g. | <input type="checkbox"/> | <input type="checkbox"/> | Have you committed a criminal act to which you pled guilty or nolo contendere, or for which you were convicted or received probation before judgement?   |
| h. | <input type="checkbox"/> | <input type="checkbox"/> | Have you committed an offense involving alcohol or controlled dangerous substances to which you pled guilty or nolo contendere, or for which you were convicted or received probation before judgement? Such offenses include, but are not limited to, driving while under the influence of alcohol and/or controlled dangerous substances.  |
| i. | <input type="checkbox"/> | <input type="checkbox"/> | Excluding minor traffic violations, are you currently under arrest or released on bond, or are there any current or pending charges against you in any court of law?   |
| j. | <input type="checkbox"/> | <input type="checkbox"/> | Do you illegally use drugs?  |
| k. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any physical or mental condition that currently impairs your ability to practice medicine or that would cause reasonable questions to be raised about your physical, mental, or professional competency?   |
| l. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been named as a defendant in a medical malpractice action?   |
| m. | <input type="checkbox"/> | <input type="checkbox"/> | Are you in default of a service obligation that you incurred by receiving State or federal funds for your medical education?   |
| n. | <input type="checkbox"/> | <input type="checkbox"/> | Have you failed to make arrangements to satisfy State or Federal loans that financed your medical education?   |
| o. | <input type="checkbox"/> | <input type="checkbox"/> | Has your employment by any hospital, HMO, other health care facility or institution, or military entity been terminated for disciplinary reasons?  |
| p. | <input type="checkbox"/> | <input type="checkbox"/> | Have you voluntarily resigned from any hospital, HMO, other health care facility or institution, or military entity while under investigation by that institution for disciplinary reasons?  |
| q. | <input type="checkbox"/> | <input type="checkbox"/> | Has the use of drugs and/or alcohol ever resulted in an impairment of your ability to practice your profession?  |
| r. | <input type="checkbox"/> | <input type="checkbox"/> | Have you surrendered your license or allowed it to lapse while you were under investigation by any licensing or disciplinary board of any jurisdiction or any entity of the armed services?  |

»»» If you answered "YES" to any of the questions in item 17, on the following page please list all adverse actions taken against you and provide a complete explanation. Attach any supporting documentation that applies (copies of all complaints, malpractice claims, adverse or disciplinary actions, arrests, pleadings, judgements, or final orders). Sign and date all pages submitted.



**19. Release:**

I agree that the Maryland Board of Physicians (the Board) may request any information necessary to process my application for medical licensure in Maryland from any person or agency, including but not limited to postgraduate program directors, individual physicians, government agencies, the National Practitioner Data Bank, the Healthcare Integrity and Protection Data Bank, the Federation of State Medical Boards, hospitals and other licensing bodies, and I agree that any person or agency may release to the Board the information requested. I also agree to sign any subsequent release for information that may be requested by the Board.

\_\_\_\_\_  
Applicant's Name (Printed)

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

**20. (OPTIONAL) Third Party Release:** Although the Board encourages you to complete all aspects of your application on your own, if you plan to use an intermediary to receive information about the status of your application, please complete this release.

I agree that the Maryland Board of Physicians may release any information pertaining to the status of my application to the following person:

**Name:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

**21.** I agree that I will cooperate fully with any request for information or with any investigation related to my medical practice as a licensed physician in the State of Maryland, including the subpoena of documents or records or the inspection of my medical practice.

During the period in which my application is being processed, I shall inform the Board within 30 days of any change to any answer I originally gave in this application, any arrest or conviction, any change of address or any action that occurs based on accusations that would be grounds for disciplinary action under Md. Code Ann., Health Occ. § 14-404.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

**22. Affidavit:** To be completed by the applicant in the presence of a notary public after the applicant's picture has been attached below.

I certify that I have personally reviewed all the responses to items 1-22 of this application and that the information I have given is true and accurate to the best of my knowledge. I understand and agree that I may not practice, attempt to practice, or offer to practice medicine in Maryland unless licensed by the Board.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

STATE OF \_\_\_\_\_

CITY/COUNTY OF \_\_\_\_\_

I HEREBY CERTIFY that on this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, before me, a Notary Public of the State and

City/County aforesaid, personally appeared the Applicant, \_\_\_\_\_, whose likeness is identifiable as that of  
(print applicant's name)

the person in the photograph attached to this application and who has made oath in due form of law to be the person referred to in the above application for license to practice Medicine and Surgery in the State of Maryland, and to have stated the truth in all statements made in this application.

AS WITNESS my hand and notarial seal. \_\_\_\_\_  
Notary Public

My Commission expires: \_\_\_\_\_

**SEAL**

**APPLICANT:**

PASTE YOUR PASSPORT-  
QUALITY PHOTO HERE  
BEFORE NOTARIZING

Sign your name legibly across the  
top or bottom of the photograph

## **SECTION V**

### **Required Forms**

VERIFICATION OF EDUCATION AND ENGLISH LANGUAGE INSTRUCTION

Part 1

APPLICANT: Complete Part 1 and send to the institution which issued your medical degree. If you satisfied Maryland's English language competency requirements somewhere other than your medical school, also send a copy of this form to that institution and ask them to return the completed form directly to the Board.

Name: \_\_\_\_\_  
Print last name and generational indicator (Jr., Sr., II, III, etc.) First name Middle name

Date of Birth: 

Month	Day	Year
<input type="text"/>	<input type="text"/>	<input type="text"/>

 Social Security Number: 

<input type="text"/>	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------	---	----------------------	----------------------	---	----------------------	----------------------	----------------------	----------------------

School Attended \_\_\_\_\_  
Only medical school, undergraduate school, or high school

Affiliated with (if applicable): \_\_\_\_\_  
Name of institution that conferred your degree, if different from medical college attended

Attended from: \_\_\_\_\_ to \_\_\_\_\_ Date of Graduation: \_\_\_\_\_

Part 2

REGISTRAR, DEAN, PRINCIPAL or OTHER AUTHORIZED OFFICIAL: Please complete this form and mail it to the above address.

I hereby certify that the above-named individual attended this institution during the inclusive dates from

Month	Day	Year
<input type="text"/>	<input type="text"/>	<input type="text"/>

 to 

Month	Day	Year
<input type="text"/>	<input type="text"/>	<input type="text"/>

; that all academic studies were taught in the language(s) of \_\_\_\_\_ ; that all clinical clerkships were taught in the language(s) of \_\_\_\_\_ ; and that he/she was conferred the degree of

M.D.  D.O.  M.D./Ph.D.  M.B.B.S.  M.B.B.Ch  Other: \_\_\_\_\_  
(specify)

on 

Month	Day	Year
<input type="text"/>	<input type="text"/>	<input type="text"/>

 after he/she had satisfied all prerequisite obligations.

Printed Name of Authorized Official \_\_\_\_\_ Name of Institution \_\_\_\_\_

Title of Authorized Official \_\_\_\_\_ Telephone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

Signature of Authorized Official \_\_\_\_\_ Date \_\_\_\_\_

SEAL  
OF THE  
INSTITUTION

VERIFICATION OF POSTGRADUATE MEDICAL EDUCATION

**Part 1**

**APPLICANT:** Complete Part 1 and sign where indicated in the Part 2 instructions. Print your name on top of the reverse page, and send a form to the director of each postgraduate training program you attended. Be sure to copy both sides.

a. Applicant's Name: \_\_\_\_\_  
Last Name and Generational Indicator (Jr., Sr., II, III, etc.)      First Name      Middle Name

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Date of Birth:      Month      Day      Year      Social Security Number:      \_\_\_\_\_

b. Name of Institution: \_\_\_\_\_

Department and Area of Training: \_\_\_\_\_

Complete Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

FROM:      Month      Year      TO      Month      Year

**Part 2**

**POSTGRADUATE TRAINING PROGRAM DIRECTOR:** Please complete Part 2 according to the records available and send directly to the Maryland Board of Physicians at the above address. Please do not send original or copies to me.

Applicant's Signature: \_\_\_\_\_

1. Did the applicant participate in postgraduate training in your department during the period listed above?\*

YES     NO    If "No," please enter exact dates: \_\_\_\_\_ to \_\_\_\_\_

Program Specialty: \_\_\_\_\_

\*If training was part-time, please explain the training schedule after item 8 of this form.

2. During the time of the applicant's participation, was the postgraduate training program accredited?     YES     NO

Accredited by:     ACGME: Program # \_\_\_\_\_     AOA: ID #: \_\_\_\_\_     RCPSC

3. Did the applicant participate in all of the components of the training as required by the accrediting body?

YES     NO    Comments (attach signed and dated additions as needed): \_\_\_\_\_

4. Did the applicant successfully complete all requirements of each year of training?

YES     NO    Comments (attach signed and dated additions as needed): \_\_\_\_\_

5. During the applicant's year(s) of training, did the applicant have any break in training?

NO     YES    Comments (attach signed and dated additions as needed): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(Continued on next page)

Applicant's Name (print): \_\_\_\_\_

6. Did the applicant have any physical or mental problem that affected the applicant's ability to practice medicine during the period of training?  
 NO  YES If "Yes," please give a detailed explanation\* \_\_\_\_\_
7. Was any action taken against the applicant by any training program, hospital, medical board, licensing authority, or court? Such actions include, but are not limited to investigations, limitations of privileges or special conditions, requirements imposed for academic incompetence, disciplinary actions, probationary actions, etc.  
 NO  YES If "Yes," please give a detailed explanation\* \_\_\_\_\_
8. In each year of training, did the applicant demonstrate sufficient academic and clinical ability to qualify for advancement without conditional or probationary status to the next year and next progressive level of responsibility in a designated specialty program?  
 YES  NO Comments:\*

\* If space is not sufficient, please attach a signed and dated detailed explanation.

**Attestation:** I attest that the information I have provided regarding the applicant is true, accurate, and complete according to all available records.

\_\_\_\_\_  
Printed Name of Program Director

\_\_\_\_\_  
Title

\_\_\_\_\_  
Hospital

\_\_\_\_\_  
Address

\_\_\_\_\_  
Department

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

STATE BOARD LICENSURE AND EXAMINATION CERTIFICATION

**Part 1** APPLICANT: Complete Part 1 and send a copy of this form to each medical board in the U.S., its possessions or territories, Puerto Rico, and Canada that ever issued you a license or administered to you a state/provincial licensing examination.

1. State of Licensure \_\_\_\_\_ 2. License Number \_\_\_\_\_ 3. Date of Birth \_\_\_\_\_

4. Last Name Under Which You Were Licensed \_\_\_\_\_ First Name \_\_\_\_\_ Middle Name \_\_\_\_\_

5. Current Name if Different from Above \_\_\_\_\_ First Name \_\_\_\_\_ Middle Name \_\_\_\_\_

6. Current Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

7. Social Security Number: \_\_\_\_\_ 8. Telephone Number: \_\_\_\_\_

9. Signature \_\_\_\_\_ Date: \_\_\_\_\_

**Part 2** AUTHORIZED OFFICIAL OF STATE MEDICAL BOARD: Please certify the following information regarding the above-listed individual and send this form directly to the Maryland Board of Physicians at the above address.

1. License Number \_\_\_\_\_ 2. Date of Original Licensure \_\_\_\_\_ 3. Date License Expires/Expired \_\_\_\_\_

4. Is the license in good standing or, if expired, was the license in good standing at the time of expiration  Yes  No

5. Is there, or has there ever been, derogatory information, pending charges, or disciplinary action taken against this license?  Yes  No

If "Yes":  Pending charges  reprimanded  suspended  revoked  surrendered  terms/condition/probation

==> On the back of this form, or as an attachment, please explain any derogatory information and include all available documentation.

6. Was the license administratively revoked, suspended, or surrendered because the licensee did not renew?  Yes  No

7. Was the applicant licensed in your state based on an examination administered by your state rather than an examination administered by the Federation of State Medical Boards, the National Board of Medical Examiners, or the National Board of Osteopathic Medical Examiners?  Yes  No

If the answer to question 7 was "Yes", please attach an official copy of the exam results.

Printed Name of Authorized Official \_\_\_\_\_

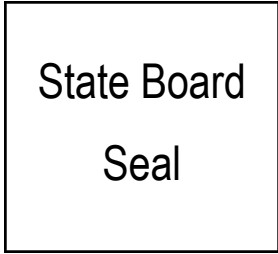
Title of Authorized Official \_\_\_\_\_

Signature of Authorized Official \_\_\_\_\_

Direct Telephone Number \_\_\_\_\_

Printed Name of State \_\_\_\_\_

Date \_\_\_\_\_



## **SECTION VI**

### **Checklist**

## CHECKLIST

Please review the checklist before signing page 11. A few minutes spent in review now may save days or weeks of delay in the processing your application.

- I have provided all the personal information requested on this application (page 1)
- My chronology of activities after graduating medical school is legible and there are no gaps in time. (pages 2 and 3)
- (If applicable) I have enclosed additional sheets for my chronology.
- I have provided all the information about my medical education. (item 10, page 4 )
- I have indicated how I have met Maryland's requirement for English proficiency.(Item 11, page 4)

### Graduates of Foreign Medical School

- My English proficiency requirements were satisfied somewhere other than medical school, so I have requested that documentation of both written and oral proficiency be sent to the Board. (See item 11 on page 4)

I have also enclosed the following documents:

- A copy of my valid ECFMG certificate (You must take the TOEFL if ECFMG English exam was before January 1, 1974)
- A copy of my medical school diploma and a certified translation.
- If applicable a copy of the Certificate of Medical Education and Examinations Taken or Good Conduct or Intern Certificate showing my name, the name of the medical school, and the name of the affiliated university; and a certified translation. (See page 4)

- I have completed Part 1 of form IML2 (follows Section V of the application) and sent a copy to the institution from which I received my medical degree and, if different, to the institution at which I received English instruction that meets the Maryland requirements.
- I have listed all postgraduate training I have undertaken in the U.S., Canada, or Puerto Rico (page 5); completed Part 1 of form IML3; signed Part 2; printed my name on side B; and sent a form IML3 to the director of each program in which I participated.
- I have listed all hospitals at which I have had privileges or provided services since the completion of postgraduate training and during the five year period prior to filing my application (page 6).
- I have listed all medical licensing examinations I have ever taken (page 7) and sent a copy of the request for transcripts and any fee that may be required to the appropriate administering authority of each exam (see instructions after exam listed on pages 7 and 8).
- I have listed every license/registration I have ever been issued in the U.S., its territories, Puerto Rico, or Canada.(page 8) and have sent a copy of IML7 to each medical board / issuing authority.
- I do not have to take the Special Purpose Exam (page 9)     I must take the SPEX and have made arrangements to do so.
- I have answered all character and fitness questions (page 9), explained all "yes" answers and, if applicable, enclosed all supporting documents (copies of all complaints, malpractice claims, adverse or disciplinary actions, arrests, pleadings, judgments, final orders, etc.)
- I have attached a 2"x 2" passport quality photograph to the last page (page 11) of this application.
- I have read the statements on page 11 of this application; signed and dated items 19, 20 (if applicable), 21 and 22; and arranged to have the application notarized.
- I have enclosed my check made out to "Maryland Board of Physicians" (or "MBP") in the amount of either \$790.00 (Graduates of LCME-accredited American and Canadian medical schools) or \$890.00 (Graduates of International Medical Schools).
- I have attached the following number of pages of documentation to support this application: \_\_\_\_\_
- I have signed the application in the presence of a notary and had the application notarized.

**STOP! Completed application and check must be mailed to the Maryland Board of Physicians,  
P.O. Box 37217, Baltimore, Maryland 21297.**