

**REQUIREMENTS AND INSTRUCTIONS FOR FILING - Limited and Temporary License  
PHYSICIANS (Educational/Teaching)**

Access this form via website at: [cca.hawaii.gov/pvl](http://cca.hawaii.gov/pvl)

This application is to be used when applying for an educational/teaching limited and temporary license issued by the Hawaii Medical Board ("HMB"). Applicants applying for government employed license must apply using the "Physician employed by Hawaii State Government or County" form. Applicants for a resident license must apply using the "Resident" application form.

**EDUCATIONAL/  
TEACHING  
LICENSE**

This license may be issued to a physician who is invited by the chief of service of a clinical hospital to provide professional education for students, interns, residents, fellows, and doctors of medicine in this State. The physician must provide proof that he/she is licensed as a physician in another state or country and the license is current and in good standing. In no case shall this license be valid for more than a period of twelve months from the date of issuance and is NOT renewable. However, a new license may be issued for another twelve-month period provided a new application with all supporting documents and fees are submitted. The holder of this license shall not open or appoint a place to meet patients, or receive calls from patients relating to the practice of medicine, beyond the parameters of the hospital that is sponsoring and monitoring the licensee.

- 1) Submit fee of \$221.00 payable to: COMMERCE AND CONSUMER AFFAIRS  
(Application fee - \$50\*, License fee - \$97 + Compliance Resolution Fund - \$74)
- 2) **ATTACH** a summary of your medical, educational and professional background.
- 3) On the application, list **all** the licenses you hold or held, including those for residency training or locum tenes.

**ARRANGE** to have verification of licensure sent **directly** to the HMB. To do this, contact all the jurisdictions that you are/were licensed in and request that they send a verification of licensure **directly** to the HMB.

**NOTE:** Some state licensing agencies charge a fee for this service. Contact the licensing agencies for charges.

- 4) **ATTACH** a letter signed by the chief of service of a clinical department of a hospital attesting that the chief of service is a licensed physician in this State and is requesting to sponsor and monitor the applicant while the person is engaged in educational or teaching activities for the hospital.

**\* Application fee is not refundable.**

**MAILING  
ADDRESS**

Mail to:

Hawaii Medical Board  
DCCA, PVL Licensing Branch  
P.O. Box 3469  
Honolulu, HI 96801

**OR**

Deliver to office location at:

335 Merchant St., Rm 301  
Honolulu, HI 96813  
Phone: (808) 586-3000

*NOTE: One of the numerous legal requirements that you must meet in order for your new license to be issued is the payment of fees as set forth in this application. You may be sent a license certificate before the payment you sent us for your required fees is honored by your bank. If your payment is dishonored, you will have failed to pay the required licensing fee and your license will not be valid, and you **may not** do business under that license. Also, a \$25.00 service charge shall be assessed for payments that are dishonored for any reason.*

(CONTINUED ON PAGE 2)

**LICENSE  
DENIAL**

If for any reason you are denied the license you are applying for, you may be entitled to a hearing as provided by Title 16, Chapter 201, Hawaii Administrative Rules, and/or Chapter 91, Hawaii Revised Statutes. Your written request for a hearing must be directed to the agency that denied your application, and must be made within 60 days of notification that your application for a license has been denied.

**LAWS AND RULES**

The pertinent laws and rules are posted on our website free of charge at: [cca.hawaii.gov/pvl](http://cca.hawaii.gov/pvl). Click on **Medical and Osteopathy**.

Alternatively, you may obtain copies by sending a written request to: Licensing Branch, PVL, P.O. Box 3469, Honolulu, HI 96801.

1. Chapter 453, Hawaii Revised Statutes
2. Chapter 85, Hawaii Administrative Rules
3. Chapter 436B, Hawaii Revised Statutes

**EMPLOYMENT**

Information regarding employment and hospital facilities are not available through the Hawaii Medical Board.

**ABANDONMENT  
OF APPLICATION**

Pursuant to HRS §436B-9 your application shall be considered abandoned and shall be destroyed if you fail to provide evidence of continued efforts to complete the licensing process for two consecutive years. The failure to provide evidence of continued efforts includes but is not limited to: (1) failure to submit any required information and documents requested by the licensing authority within two consecutive years from the last date the documents and information were requested, or (2) failure to complete any additional requirements for licensure that remain after approval of your application, such as attempting to complete an exam requirement, within two consecutive years from the date your application was approved, or (3) failure to provide the licensing authority with any written communication during two consecutive years indicating that you are attempting to complete the licensing process. If an application is deemed abandoned the applicant shall be required to reapply for licensure and comply with the licensing requirements in effect at the time of the reapplication.

This material can be made available for individuals with special needs. Please call the Licensing Branch Manager at (808) 586-3000 to submit your request.

**Application for License - Limited and Temporary License  
PHYSICIAN (Educational/Teaching - MDT)**

Access this form via website at: [cca.hawaii.gov/pvl](http://cca.hawaii.gov/pvl)

**Read "Instructions and Requirements" before completing this form.**

Legal Name (First, Middle)		(LAST)
Residence Address Required (Include apt. no., city, state and zip code)		
Mailing Address (ONLY if different from residence)		
Social Security No.	Phone No. (Days)	Birthdate
Other Names Used:		

**FOR BOARD USE ONLY**

Approved: <input type="checkbox"/>	Initials/Date:
Denied: <input type="checkbox"/>	
<input type="checkbox"/> \$221	
<input type="checkbox"/> Other state/country Lic(s): _____	(Must have 1 current)
<input type="checkbox"/> Resume	
<input type="checkbox"/> Letter/Chief of Staff (licensed physician, Osteo of a clinical dept of a hospital)	
Effective Date:	License No. MDT -

**Check answers:**

- 1) Are you at least 18 years of age? .....  Yes  No
- 2) Are you a U.S. citizen, a U.S. national, or an alien authorized to work in the U.S.? .....  Yes  No
- 3) Are you a graduate of a **U.S. or Canadian** medical school? .....  Yes  No
- 4) Are you a graduate of a **Foreign** medical school (**FMG**)? .....  Yes  No

**Check answers and provide details as directed for any "Yes" response to the questions below:**

- 5) Have you ever held a license in Hawaii? .....  Yes  No

**If response is "Yes", specify type of license and dates:** \_\_\_\_\_

- 6) With regard to any medical license to practice in any state or country:
  - a) Has it ever been revoked, suspended, placed on probation, surrendered, reprimanded, admonished, or otherwise subject to disciplinary action; or have you ever been issued a letter of concern; or have you ever entered into a consent order or settlement agreement? .....  Yes  No
  - b) Is any disciplinary action pending against you? .....  Yes  No
  - c) Are you presently being investigated? .....  Yes  No
  - d) Have you ever been denied a license or withdrawn an application for licensure? .....  Yes  No

**If response is "Yes", attach a detailed explanation on a separate sheet, which includes state or country where action is pending or took place, relevant dates, action taken and reasons for such action. Arrange to have certified documents from each state in which disciplinary action was taken or is pending or being investigated sent directly to the Board. (Include Findings of Fact, Conclusion of Law, Recommended Order, Final Order and whether you have been reinstated. If reinstated, date and conditions of license.)**

**\*\*\*SIGNATURE REQUIRED ON PAGE 3\*\*\***

(CONTINUED ON PAGE 2)

Appl .....	323 .....	\$50
Lic .....	312 .....	\$97
CRF .....	324 .....	\$74
Service Charge ....	BCF .....	\$25

Print Name of Applicant: \_\_\_\_\_

Date: \_\_\_\_\_

- 7) With regard to any educational training program or facility, state/federal controlled substance agency, local, state, federal or military professional or disciplinary body or any hospital privileging or credentialing body, grievance committee or any other medical group, including medical societies and specialty boards:
- a) Have you ever been subject to disciplinary or adverse actions or entered into an agreement? .....  Yes  No
  - b) Is any disciplinary or adverse action pending against you? .....  Yes  No
  - c) Are you presently being investigated? .....  Yes  No
  - d) Have you ever been denied or withdrawn an application for privileges or membership, or have you ever resigned, surrendered or failed to renew your privileges or membership? .....  Yes  No
  - e) Have you ever been issued a notice of contract non-renewal? .....  Yes  No
- If response is "Yes", attach a detailed explanation on a separate sheet, which includes the bodies of jurisdiction or organizations involved, relevant dates, action taken and reasons for such action.**
- 8) With regard to professional liability:
- a) Have any claims of malpractice ever been filed against you? .....  Yes  No
  - b) Has any insurance carrier ever denied, conditioned, curtailed, limited, suspended, or revoked your coverage? .....  Yes  No
- If response is "Yes", attach a detailed explanation on a separate sheet, which:**
- includes the date of the case (month/year), jurisdiction (State, etc.) nature of the case, allegations, and amount paid on your behalf. Information is to be provided on all settlements, judgments, awards, and claims (including those for which no money was paid); and/or
  - provides the name and address of your insurance carrier, specific circumstances, dates and action taken.
- 9) With regard to participation in any health plan or Federal or State health care program:
- a) Have you ever relinquished participation or certification, or been denied, terminated, sanctioned, penalized, decertified or otherwise excluded from participation? .....  Yes  No
  - b) Have you ever been convicted of insurance fraud? .....  Yes  No
- If response is "Yes", attach a detailed explanation on a separate sheet, which includes the bodies of jurisdiction relevant dates, allegations, charges, disposition, action taken and reasons for such action.**
- 10) In the past five years, have you been addicted to, dependent on, or a habitual user of alcohol or of a narcotic, barbiturate, amphetamine, hallucinogen, or other drug having similar effects? .....  Yes  No
- If response is "Yes", attach a detailed explanation on a separate sheet.**
- 11) Have you ever been convicted of a crime in any jurisdiction that has not been annulled or expunged? .....  Yes  No
- Explain "Yes" response on a separate sheet with detailed information and attach certified court documentation on the date, place, violation of each conviction and fulfillment of each sentence.**

EDUCATION	Name of Medical School	Location (City/State or Country)	Degree Earned	Dates (mo/yr)	
				From	To

\*\*\*SIGNATURE REQUIRED ON PAGE 3\*\*\*

(CONTINUED ON PAGE 3)

Print Name of Applicant: \_\_\_\_\_

Date: \_\_\_\_\_

<b>INTERNSHIP, RESIDENCY, &amp; FELLOWSHIP</b>	Name of Residency Program		Location (City/State or Country)		Dates (mo/yr)		
					From	To	
<b>SYNOPSIS</b>	Medical Practice (Attach additional sheets if necessary)					Dates (mo/yr)	
						From	To
<b>LICENSES</b>	Name of Jurisdiction (Attach additional sheets if necessary)		Date Issued	Expiration Date	License No.	Date Verification Requested	
<b>HOSPITAL</b>	Name of Hospital (last 3 years only) <b>(If none, state "None")</b>		Location (City/State or Country)		Dates (mo/yr)		Date Form Requested
					From	To	

**CERTIFICATION OF APPLICANT:**

I certify that the statements, answers, and representations made in this application and in the documents attached are true and correct. I understand that this certification and any misrepresentation are grounds for the denial, refusal or subsequent revocation of license and is a misdemeanor (Section 710-1017, and Sections 436B-19, and 453-8, Hawaii Revised Statutes). I further certify that I have read and will abide by the provisions of Chapter 453 and Chapter 85.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

(CONTINUED ON PAGE 4)

Print Name of Applicant: \_\_\_\_\_

Date: \_\_\_\_\_

**RELEASE OF INFORMATION**

If any agency or individual is assisting you with the licensure process, we will not be able to release any information to them unless you provide us with authorization. If you wish to do so, please complete the **Release of Information to Third Party** below, sign and date it.

**Release of Information to Third Party:**

To assist me in the licensing process, I authorize the HMB and staff to release any and all information regarding my application (including but not limited to, application status, examination scores, disciplinary or criminal history, National Practitioner Data Bank Report, AMA profile) to the following:

Name of Individual you are authorizing: \_\_\_\_\_

Name of Organization: \_\_\_\_\_

Address of Organization: \_\_\_\_\_

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

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