REQUIREMENTS AND INSTRUCTIONS - OSTEOPATHIC PHYSICIAN & SURGEON

Access this form via website at: **cca.hawaii.gov/pvl**

REQUIREMENTS FOR LICENSURE

Pursuant to Section 453-4, Hawaii Revised Statutes, to be eligible for licensure, an applicant must meet the following requirements:

1. Be a graduate of a school or college of osteopathy which is approved by the American Osteopathic Association (AOA);
2. Served an internship of at least one year in a hospital approved by the American Osteopathic Association and the American College of Osteopathic Surgeons, or in a program accredited by the ACGME; and
3. Passed all levels, parts or steps of the: National Board of Osteopathic Medical Examiners examination (NBOME); the COMLEX-USA; the Federation Licensing Examination (FLEX); the United States Medical Licensing Examination (USMLE); or a combination of parts of the FLEX and the USMLE as approved by the Board.

Applicants are subject to requirements in effect at the time of filing.

APPLICATION

Complete the online fillable application form (DOS-01). Type or print **legibly** in dark ink.

- **Failure to provide all the requested information will delay the processing of your application.**

SOCIAL SECURITY NUMBER

Your Social Security Number is used to verify your identity for licensing purposes and for compliance with the below laws. **For a license to be issued, you must provide your Social Security Number or your application will be deemed deficient and will not be processed further.**

The following laws require that you furnish your Social Security Number to our agency:

FEDERAL LAWS:
42 U.S.C.A. §666(a)(13) requires the Social Security Number of any applicant for a professional license or occupational license be recorded on the application for license; and
If you are a licensed health care practitioner, **45 C.F.R., Part 61, Subpart B, §61.7** requires the Social Security Number as part of the mandatory reporting we must do to the Healthcare Integrity and Protection Data Bank (HIPDB), of any final adverse licensing action against a licensed health care practitioner.

HAWAII REVISED STATUTES ("HRS"):
§576D-13(j), HRS requires the Social Security Number of any applicant for a professional license or occupational license be recorded on the application for license; and
§436B-10(4), HRS which states that an applicant for license shall provide the applicant's Social Security Number if the licensing authority is authorized by federal law to require the disclosure (and by the federal cites shown above, we are authorized to require the Social Security Number).

QUESTIONS

In the event the response to any of the questions numbered 4 through 13 is "**YES**", please file a typewritten or legible handwritten detailed explanation as directed on the application.

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FEES

ATTACH check made payable to: COMMERCE & CONSUMER AFFAIRS. (check must be in U.S. dollars and be from a U.S. financial institution.)

Application for licensure without examination:

If licensed from July 1 of an even-numbered year to June 30 of an odd-numbered year, pay $510
(*Application fee - $50* + License fee - $260 + 1/2 Renewal fee - $52 + Compliance Resolution Fund - $148*)

If licensed from July 1 of an odd-numbered year to June 30 of an even-numbered year, pay $384**
(*Application fee - $50* + License fee - $260 + Compliance Resolution Fund - $74*)

**Application fee not refundable*
***Subject to renewal June 30, even-numbered year.*

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.

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.

DOCUMENTS REQUIRED WITH APPLICATION

ATTACH a copy of your:

1. Osteopathic Medical School diploma; and
2. Residency training certificate.

VERIFICATION OF LICENSE

On the application, list **all** the licenses you hold or held, including those for residency training or locum tenens.

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.

NATIONAL PRACTITIONER DATA BANK REPORT

SUBMIT the original "NPDB Response to Self-Query" report from the National Practitioner Data Bank (NPDB). To obtain the report, go to the NPDB website at: **www.npdb.hrsa.gov** and click on **Perform a Self-Query**. If you are unable to go on-line, call NPDB at 1-800-767-6732 for assistance. After you receive this report, send the original report to the Hawaii Medical Board (HMB).

The NPDB is now making your NPDB report available for download. The HMB will accept either the ORIGINAL hard copy that is mailed to you or an electronic version of the report. To send the electronic version, please, save the report as a .pdf file, attach it to the ORIGINAL email from NPDB and email to **medical@dcca.hawaii.gov**.

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AOA PHYSICIAN PROFILE

To order an AOA Physician Profile, please visit the following at: **https://aoaprofiles.org/**. You may complete the payment process via an acceptable credit card or debit card.

(AOA charges a fee of $25 for non-members. No fee for AOA members. Please note that fees are determined by the AOA and are subject to change. Contact them directly for the most current fees as well as acceptable forms of payment at **https://aoaprofiles.org**.)

EXAMINATION SCORES

Applicants who passed the NBOME or the COMLEX-USA examination:

ARRANGE to have all levels of the NBOME examination scores sent **directly** to the HMB. To do this, call the NBOME at (866) 479-6828 or go to their website at: **www.nbome.org** and click on Transcript Request Form.

Applicants who passed the USMLE or FLEX examination:

ARRANGE to have the Federation send an "Examination and Board Action History Report" (EBAHR) **directly** to the HMB. To do this, call the Federation at (817) 868-4041 or go to their website at: **www.fsmb.org** and click on **Transcript Requests**. (The EBAHR also provides a board action history report.)

CERTIFICATE OF COMPETENCY

ARRANGE to have two (2) osteopathic or allopathic physicians complete the certificate of competency form and send it **directly** to the HMB.

CERTIFICATE OF APPLICANT

Please read the certification at the end of the application and **sign and date it**.

RELEASE OF INFORMATION

If an 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 portion on **Release of Information to Third Party**, sign and date it.

BOARD'S ADDRESS

Application and items are to be:

Mailed to:

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

OR

Delivered to:

335 Merchant Street, Room 301
Honolulu, HI 96813

Phone No.: (808) 586-3000

COMPLETE APPLICATION

We are unable to take action on an application unless it is complete. Therefore, please ensure that we have received all the documents necessary. To do this, you may call (808) 586-3000 to inquire about the status of your application. If an agency is assisting with your application, we will release this information to them when you provide us with written authorization. (See Release of Information).

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ABANDONMENT

Pursuant to HRS §436B-9, your application shall be considered abandoned and will be destroyed, if you fail to complete the license process within one year after filing an application or fail to take and pass the examination after becoming eligible to take the examination.

If an application is deemed abandoned, the applicant shall be required to reapply for licensure and comply with the licensing requirements at the time of the reapplication.

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 (HMB), and must be within 60 days of notification that your application for a license has been denied.

LICENSE RENEWAL

Osteopath licenses expire on June 30 of **each even-numbered year**.

About 2 months before the license expiration date, a renewal application is mailed to all licensees at their address of record. If you do not receive a renewal application approximately one month prior to the license expiration date, contact the Licensing Branch (808-586-3000) for assistance. To ensure that you receive a renewal application, keep the Board informed of your address. Licenses that are not renewed by the deadline are forfeited and the holders of a forfeited license are considered unlicensed and may not practice. After two years of license forfeiture, reapplication is required.

LAWS & RULES

The pertinent laws and rules are posted on our website free of charge at: **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 93, Hawaii Administrative Rules
3. Chapter 436B, Hawaii Revised Statutes

U.S. CITIZEN, U.S. NATIONAL, OR AN ALIEN AUTHORIZED TO WORK IN THE U.S.

Pursuant to section 436B-10, Hawaii Revised Statutes, and federal law, **all applicants are required to be a U.S. citizen, U.S. national, or an alien authorized to work in the United States**. This means that even if an applicant meets the education, training and examination requirements for licensure, that applicant will not be issued a license if that applicant is not a U.S. citizen, U.S. national or an alien authorized to work in the United States.

However, the Board may issue the applicant a conditional approval that signifies that the applicant has met the education, experience and examination requirements for licensure. This conditional approval is not a license to engage in the profession and does not authorize the applicant to work in Hawaii.

To obtain authorization to work in the United States, the applicant may contact the U.S. Citizenship and Immigration Services ("USCIS") at: http://uscis.gov or 1-800-375-5283.

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U.S. CITIZEN, U.S. NATIONAL, OR AN ALIEN AUTHORIZED TO WORK IN THE U.S. (cont'd)

Once the applicant submits evidence to the Board that the USCIS has authorized the applicant to work in the U.S. (without conditions or other encumbrances), provides a Social Security Number and has met all of the licensing requirements, the applicant may be issued a license, provided that there is no change in the applicant's status or the information that was originally submitted. The Board may ask the applicant to submit up-to-date documents to determine whether there have been any changes and whether the applicant still qualifies for licensure.

The conditional approval is valid for two (2) years. An applicant must obtain the appropriate USCIS authorization within this two (2) year period in order to have a license issued. If the applicant is unable to meet this deadline, the applicant may be required to reapply for licensure and meet all of the requirements in effect at that time.

Print Form

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 - OSTEOPATHIC PHYSICIAN & SURGEON

Access this form via website at: **cca.hawaii.gov/pvl**

Read Requirements and Instructions before completing this application.

Legal Name (First, Middle)	(Last)
Other Names Used (previous surnames, maiden name, etc.)	
Residence Address (include apt. no., city, state and zip code)	
Mailing Address (**ONLY** if different from above)	
Social Security Number	Phone No. (days)
PERSONAL E-Mail Address	Date of Birth
Date NPDB Requested	Date AOA Profile Requested

FOR BOARD USE ONLY

Approved ☐ Denied ☐ Initials/Date: Effective Date:

License No. DOS -

Check Exam Taken:

☐ NBOME ☐ FLEX ☐ USMLE

☐ COMLEX-USA ☐ COMBINATION OF FLEX & USMLE

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

Check answers and <u>provide details</u> as directed for any "YES" response to the questions below:

3. Have you ever held a license in Hawaii? ..... ☐ YES ☐ NO

If response is "YES", specify type of license and dates below:

4. 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 <u>each</u> 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.)

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Appl	464	$50		1/2 Ren	460	$52	
Lic	466	$260		CRF	467	$74/$148	
				Service Charge	BCF	$25	

Print Name of Physician: _____ Date: _____

5. With regard to any medical training program or facility, including, but not limited to medical school, residency, or fellowship training programs:

   a) Have you ever been subject to adverse or disciplinary actions (e.g. any remediation, restriction, removal from patient care, probation, suspension, termination, extra training requirement, etc.)? ☐ 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 withdrawn or resigned (voluntary or otherwise)? ☐ YES ☐ NO

   e) Have you ever been issued a notice of contract termination, non-renewal or non-promotion? ☐ 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 reason for such action.

6. With regard to any state, federal, or local controlled substance agency:

   a) Have you ever been subject to disciplinary or adverse actions? ☐ 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? ☐ YES ☐ NO

   e) Have you ever been issued a notice of non-renewal or termination? ☐ 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 reason for such action.

7. With regard to any federal or military professional or disciplinary body:

   a) Have you ever been subject to disciplinary or adverse actions? ☐ 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? ☐ YES ☐ NO

   e) Have you ever been issued a notice of non-renewal or termination? ☐ 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 reason for such action.

8. With regard to any hospital privileging or credentialing body, grievance committee or any other medical group:

   a) Have you ever been subject to disciplinary or adverse actions (e.g. any remediation, proctorship, restriction, removal from patient care, probation, suspension, etc.)? ☐ 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, been terminated or failed to renew your privileges or membership? ☐ YES ☐ NO

   e) Have you ever been issued a notice of non-renewal or termination? ☐ 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 reason for such action.

9. With regard to any medical societies or specialty boards:

   a) Have you ever been subject to disciplinary or adverse actions? ☐ YES ☐ NO

   b) Is any disciplinary or adverse action pending against you? ☐ YES ☐ NO

(CONTINUED ON PAGE 3)

Print Name of Physician: _____ Date: _____

c) Are you presently being investigated? ..... ☐ YES ☐ NO

d) Have you ever been denied or withdrawn an application for membership, or have you ever resigned, surrendered, been terminated or failed to renew your membership? ..... ☐ YES ☐ NO

e) Have you ever been issued a notice of non-renewal or termination? ..... ☐ 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 reason for such action.

10. 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, date and action taken.***

11. 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.

12. 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.

13. 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 conditions for each sentence.

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

	Name of Residency Program	Location (City/State or Country)	Dates (mo/yr) From	To
INTERNSHIP, RESIDENCY & FELLOWSHIP				

(CONTINUED ON PAGE 4)

Print Name of Physician: _____ Date: _____

SYNOPSIS	Osteopathic Medical Practice (Attach additional sheets if necessary)				Dates (mo/yr) From	To
LICENSES	Name of Jurisdiction (Attach additional sheets if necessary)	Date Issued	Expiration Date	License Number	Date Verification Requested	

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 93.

_____ _____

Signature of Applicant Date

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 third party:

Name of Individual who is assisting you: _____

Name of Organization: _____

Address of Organization: _____ Phone Number: _____

_____

_____

_____ _____

Signature of Applicant Date

Print Form

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