REQUIREMENTS AND INSTRUCTIONS - PHYSICIAN (MD) LICENSE BY ENDORSEMENT

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

This application is to be used by physicians seeking a permanent physicians (MD) license by endorsement. Physicians seeking a limited and temporary license for education/teaching, sponsorship, or emergency/shortage are directed to use the "Limited and Temporary License - Physician" application form.

****

MD LICENSE

This is a full, regular license that expires on January 31 of each even-numbered year.

REQUIREMENTS MD LICENSE *(U.S. and Canadian* Medical Graduates*)*

U.S. and Canadian Medical School Graduates

- MD degree from an LCME-accredited medical school in the U.S. or Canada.
- One year of residency training in an ACGME-accredited program in the U.S. **OR**
  One year of residency training in a RCPSC or CFPC-accredited program in Canada.
- Satisfactory completion of the NBME, FLEX, USMLE, MCCQE (Qualifying Exam of LMCC) **OR**
  Satisfactory completion, prior to 2000, of an acceptable combination of the NBME, FLEX and USMLE **OR**
  Satisfactory completion of the SPEX, provided that the physician was licensed in another state by virtue of having passed a state-produced examination.
- Holds a current, unencumbered, active license in a jurisdiction that requires substantially equivalent to or greater than the qualifications for licensure in this State.
- Has actively practiced medicine in another jurisdiction for at least two of the immediate preceding five years.
- Has no disciplinary action taken by a medical licensing authority.
- Has not been the subject of adverse judgements or settlements resulting from the practice of medicine that the Board determines constitute evidence of a pattern of negligence or incompetence.

Items/documents required when applying:

- Application form
- Fees
- Verification of licensure
- Evidence of MD degree
- Evidence of residency training
- National Practitioner Data Bank report
- AMA Profile
- Federation report
- Examination scores

REQUIREMENTS MD LICENSE *(Foreign* Medical Graduates*)*

Foreign Medical School Graduates (FMG)

There are two alternative pathways for FMG applicants.

Those who served in an ACGME-accredited residency program in the U.S., or an RCPSC or CFPC-accredited residency program in Canada, should refer to the **first pathway** for the licensure requirements.

All other applicants should refer to the **second pathway** for the licensure requirements.

(CONTINUED ON PAGE 2)

REQUIREMENTS MD LICENSE *(Foreign* Medical Graduates*)* (Cont'd.)

FIRST PATHWAY:

- MD degree from a foreign medical school.
- Two years of residency training in an ACGME-accredited program in the U.S. **OR**
  Two years of residency training in an RCPSC or CFPC-accredited program in Canada
- Satisfactory completion of the NBME, FLEX, USMLE, MCCQE (Qualifying exam of LMCC) **OR**
  Satisfactory completion, prior to 2000, of an acceptable combination of the NBME, FLEX and USMLE **OR**
  Satisfactory completion of the SPEX, provided that the physician was licensed in another state by virtue of having passed a state-produced examination.
- ECFMG Certificate or MCCEE (Evaluating Exam of LMCC) **OR**
  Fifth Pathway Certificate.

Items/documents required when applying:

- Application form
- Fees
- Verification of licensure
- Evidence of MD degree
- Evidence of residency training
- Verification of ECFMG or Fifth Pathway Certificate or MCCEE
- National Practitioner Data Bank report
- AMA Profile
- Federation report
- Examination scores

SECOND PATHWAY:

- MD degree from a foreign medical school.
- Three years of medical training or experience in a hospital approved by the AMA's Council on Medical Education and Hospitals for internship or residency.
- Satisfactory completion of the FLEX or USMLE **OR**
  Satisfactory completion, prior to 2000, of an acceptable combination of these examinations.
- Passed the VISA Qualifying Examination of Educational Commission for Foreign Medical Graduates prior to 1984.

Items/documents required when applying:

- Application form
- Fees
- Verification of licensure
- Evidence of MD degree
- Evidence of medical training or experience approved by the AMA's Council on Medical Education and Hospitals for internship or residency
- Verification of VISA qualifying examination of the ECFMG prior to 1984

(CONTINUED ON PAGE 3)

REQUIREMENTS MD LICENSE *(Foreign* Medical Graduates*)* (Cont'd.)

- National Practitioner Data Bank report
- AMA Profile
- Federation report
- Examination scores

INSTRUCTIONS FOR FILING AN APPLICATION AND SUBMITTING THE REQUIRED ITEMS

Complete on-line fillable application or print legibly in dark ink. Most items on the form are self-explanatory. Those that need explanation are discussed below.

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).

FEES

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

MD License issued between February 1, even-numbered year,
to January 31, odd-numbered year, pay $392
*(Application fee - $50**, License - $97, Compliance Resolution Fund - $148, 1/2 Renewal - $97)*

MD License issued between February 1, odd-numbered year,
to January 31, even-numbered year, pay $221*
*(Application fee - $50**, License - $97, Compliance Resolution Fund - $74)*

* Subject to renewal January 31, even-numbered years - regardless of issue date.
** Application fee is not refundable.

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.

QUESTIONS

In the event the response to any of the questions numbered 7 through 16 is **"YES"**, please file a typewritten or a legible handwritten detailed explanation and supplemental information as directed on the application.

(CONTINUED ON PAGE 4)

EVIDENCE OF MD DEGREE

ATTACH a copy of your MD diploma, medical school transcripts or letter from the dean of the medical school, which provides the date of your graduation from medical school. If your documents are in a foreign language, an accurate translation must be attached from the medical school or other organization that provides translating services. Translations may not be provided by the applicant.

EVIDENCE OF RESIDENCY TRAINING

The following applicants are to provide evidence of residency training:

- All U.S. and Canadian medical school graduates
- FMG applicants for MD license through 1st pathway

ATTACH a copy of your residency certificate or letter from the program director of your residency training, which provides the dates of successful completion of residency training.

EVIDENCE OF TRAINING OR EXPERIENCE

FMG applicants for MD license through 2nd pathway are to provide evidence of medical training or experience:

ARRANGE to have the hospital in which you received at least 3 years of medical training or experience send evidence of this **directly** to the Hawaii Medical Board (HMB). To do this, contact the hospital and request that they provide:

- hospital's name and address
- dates of your training or experience
- verification that the hospital has been approved by the AMA's Council on Medical Education and Hospitals for internship or residency

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.

SYNOPSIS OF MEDICAL PRACTICE

Provide a synopsis of your medical practice from the time you completed residency training to the present. If there have been breaks in your practice, please provide an explanation. Attach additional sheets if necessary. Alternatively, you may attach your curriculum vitae or resume.

EVIDENCE OF ECFMG OR FIFTH PATHWAY CERTIFICATE

The following applicants are to provide evidence of the ECFMG or Fifth Pathway Certificate:

- FMG applicants for MD license through 1st pathway.

ECFMG Certificate

ARRANGE to have the Status Report of ECFMG Certification sent **directly** to the HMB. To do this, contact ECFMG at (215) 386-5900 or go to: **www.ecfmg.org**.

OR

Fifth Pathway

ARRANGE to have verification of completion of your AMA Fifth Pathway sent **directly** to the HMB. To do this, contact AMA at: **www.ama-assn.org** or call (312) 464-5199 for assistance.

(CONTINUED ON PAGE 5)

VISA QUALIFYING EXAMINATION

FMG applicants for MD license through 2nd pathway are to provide evidence of medical training or experience:

ARRANGE to have ECFMG send the score of the VISA qualifying examination passed prior to 1984, sent **directly** to the HMB. To do this, contact ECFMG at (215) 386-5900 or go to: **www.ecfmg.org**.

NATIONAL PRACTITIONER DATA BANK REPORT

ATTACH the original "SELF-QUERY RESPONSE" 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 the NPDB at 1-800-767-6732 for assistance.

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 the NPDB and email to: **medical@dcca.hawaii.gov**.

AMA PROFILE

ARRANGE to have the American Medical Association (AMA) Profile sent **directly** to the HMB by going to the AMA website at: **https://commerce.ama-assn.org/store/**. If you are unable to go on-line, call AMA at (312) 464-5199 for assistance. An AMA Profile is required of all physicians, including those who are not members of AMA.

FEDERATION REPORT

Applicants who passed the NBME, state examination, MCCQE or MCCEE:

ARRANGE to have the Federation Discipline Report sent **directly** to the Hawaii Medical Board (HMB). Email the "Federation Discipline Report" form (MD-07) to the Federation of State Medical Boards (Federation - **boardinquiry@fsmb.org**) and request that they send the form **directly** to the HMB.

Applicants who passed the USMLE, FLEX, SPEX 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 USMLE, FLEX, and SPEX examination scores.)

EXAMINATION SCORES

Applicants who passed the NBME examination:

ARRANGE to have the NBME examination scores sent **directly** to the HMB. To do this, call the NBME Examinee Records office at (215) 590-9500 or go to their website at: **www.nbme.org/**.

Applicants who passed the USMLE, FLEX, or SPEX 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.)

Applicants who passed a state-produced examination:

ARRANGE to have the state (where you took the examination) send the scores **directly** to the HMB. In addition, proof of satisfactory completion of the SPEX examination must be sent to the Board.

Applicants who passed the MCCQE or MCCEE:

ARRANGE to have the Medical Council of Canada (MCC) send the scores or marks of the MCCQE or MCCEE **directly** to the HMB. To do this, call the MCC at (613) 521-6012 or go to their website at: **www.mcc.ca**.

TO APPLY FOR EXAMINATION

TO APPLY FOR THE USMLE OR SPEX call the Federation at (817) 868-4041 or go to their website at: **www.fsmb.org**. USMLE applicants click on "**USMLE"**. SPEX applicants click on "**Post-licensure Assessment",** then "**Special Purpose Examination"** (SPEX).

(CONTINUED ON PAGE 6)

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.

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 the time.

CERTIFICATION 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.

MAILING 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:
Hawaii Medical Board
DCCA, PVL Licensing Branch
335 Merchant Street, Room 301
Honolulu, HI 96813
Phone: (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).

ABANDONMENT OF APPLICATION

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.

(CONTINUED ON PAGE 7)

LICENSE RENEWAL

MD LICENSES expire on January 31 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 at (808) 586-300 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 license forfeiture, reapplication is required.

LAWS AND 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 85, Hawaii Administrative Rules
3. Chapter 436B, Hawaii Revised Statutes

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 - PHYSICIAN (MD)
LICENSE BY ENDORSEMENT

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

Read Requirements and Instructions before completing this application.

FOR BOARD USE ONLY		
Approved ☐ Denied ☐	Initials/Date:	Effective Date:
License No. MD -		

Legal Name (First, Middle)	(Last)
Other Names Used	
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	Birth date

Check Exam Taken:

☐ NBME ☐ FLEX ☐ USMLE
☐ MCCQE ☐ STATE-PRODUCED & SPEX
☐ COMBINATION OF NBME, 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
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 <u>provide details</u> 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 below:

   _____

6. Have you actively practiced medicine in another jurisdiction for at least two of the immediate preceding five years? ☐ YES ☐ NO
7. 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.)

(CONTINUED ON PAGE 2)

MD: Appl/Lic ..... 323/312 ..... $50/$97
CRF ..... 324 ..... $74/$148
1/2 Ren ..... 300 ..... $97
Service Charge ..... BCF $25

Print Name of Physician: _____ Date: _____

8. 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.

9. 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.

10. 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.

11. 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.

12. 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.

13. 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.***

14. 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.

15. 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 and if a participant/participated in a physician health program, attach your contract and status report.

16. 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 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: _____

	Medical Practice (Attach additional sheets (if necessary), a CV, or resume)	Dates (mo/yr) From	To
SYNOPSIS			

	Name of Jurisdiction (Attach additional sheets if necessary)	Date Issued	Expiration Date	License Number	Date Verification Requested
LICENSES					

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

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: _____

_____

_____

Email Address of Organization: _____

_____ _____

Signature of Applicant Date

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.

FEDERATION DISCIPLINE REPORT - PHYSICIAN

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

TO THE APPLICANT: All applicants who passed the NBME state examination, MCCQE, or MCCE are required to provide completion of this report by the Federation of State Medical Boards.

Complete the APPLICANT section and email this form to the Federation of State Medical Boards at: **boardinquiry@fsmb.org**

APPLICANT

NAME (First, Middle)	NAME (Last)	Social Security No.	Birthdate

Medical School of Graduation & Branch Location	Date of Graduation

I authorize the Federation of State Medical Boards to indicate on this form if there is any previous or pending disciplinary action against my licenses in any state.

Signature of Applicant _____ Date _____

FEDERATION

TO THE FEDERATION: Please indicate below if there is any previous or pending disciplinary action against any licenses of the above-named individual.

Signature: _____

Title: _____

Date: _____

PLEASE RETURN THIS FORM **DIRECTLY** TO THE HAWAII MEDICAL BOARD AT THE ADDRESS BELOW:

Print Form

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