REQUIREMENTS AND INSTRUCTIONS FOR FILING - Limited and Temporary License PHYSICIANS

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

This application is to be used when applying for the following types of limited and temporary licenses: **shortage or absence; sponsorship; or public emergency.**

- Applicants for a limited and temporary license for government employment must use the application for physician employed by Hawaii State or County government.
- Applicants for a limited and temporary license for residency training must use the application for residence/specialty training.

The following are required of **ALL** applicants:

FEES

ATTACH a check, money order or cashier's check payable to: ***Commerce and Consumer Affairs***. (check must be in U.S. dollars and be from a U.S. financial institution.)

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).

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 Hawaii Medical Board (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.

HOSPITAL FORM

On the application, list all the hospitals where (in the **last 3 years**) you:

- have held or applied for consultation, teaching appointments, privileges or locum tenens positions; or
- serve/served in an internship or residency program.

ARRANGE to have hospital forms sent **directly** to the HMB. To do this, send copies of the "Hospital" form (MD-08) to the hospitals and request that they send the forms **directly** to the HMB.

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 an RCPSC or CFPC-accredited program in Canada.

(CONTINUED ON PAGE 2)

(cont'd) U.S. AND CANADIAN MEDICAL GRADUATES

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

- 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.

(Note: All three steps of the USMLE must be passed within seven years.)

FOREIGN MEDICAL SCHOOL GRADUATES (FMG)

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.

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)

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 Certificate.

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.

(Note: All three steps of the USMLE must be passed within seven years.)

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.
- (As an alternative to the ECFMG Certificate), satisfactory completion, prior to 1984, of the VISA qualifying examination of the ECFMG.

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.

(Note: All three steps of the USMLE must be passed within seven years.)

(CONTINUED ON PAGE 3)

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**.

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 HMB. To do this, send the *"Federation Discipline Report"* form (MD-07) to the Federation of State Medical Boards (Federation) and request that they send the form **directly** to the HMB.

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 Request**. (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) 590-9700 or go to their website at: www.nbme.org/cert-tran/certification.html.

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 a board action history report.)

Note: All three steps of the USMLE must be passed within seven years.

Applicants who passed a state-developed 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 HMB.

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.

CERTIFICATION OF APPLICANT

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

IN ADDITION TO THE ABOVE, ATTACH THE FEES, DOCUMENT/VERIFICATION SPECIFIED BELOW FOR THE LICENSE FOR WHICH YOU ARE APPLYING FOR.

ABSENCE OR SHORTAGE LICENSE (A/S)

This temporary license may be issued to those who are licensed through written examination in another state or territory of the U.S. and will practice only in a particular locality which has an absence or shortage of licensed physicians and no other. The license is subject to approval by the HMB at its regular monthly meeting, may be issued up to 18 months, and is **NOT** renewable.

(CONTINUED ON PAGE 4)

(cont'd) ABSENCE OR SHORTAGE LICENSE (A/S)

1) **Submit** fee of $164.00 *(Application fee-$25*, license fee-$65 + Compliance Resolution Fund-$74)*
2) **ATTACH** a letter signed by an official of the respective county medical society attesting to the absence or shortage.

*** Application fee is not refundable.**

SPONSORSHIP LICENSE (S)

This temporary license may be issued to those who will be practicing medicine under the direction of a Hawaii licensed physician and:

1) Are licensed in another state by having passed a state produced exam and intend to take the Special Purpose Examination (SPEX) within the next 18 months; OR
2) Intend to take the USMLE within the next 18 months.

This license may be valid for 18 months unless extended by the board for 6 months and is **NOT** renewable.

1) **Submit** fee of $164.00 *(Application fee-$25*, license fee-$65 + Compliance Resolution Fund-$74)*
2) **Submit** a statement of your intent to take the USMLE/SPEX sometime during the 18-month period of licensure;
3) For individuals taking the SPEX, **submit** verification of passing a state-developed examination; and
4) **ATTACH** a completed *"Sponsor Statement-MD"* form (MD-12), which contains the affidavit of the sponsor.

*** Application fee is not refundable.**

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).

PUBLIC EMERGENCY LICENSE (E)

This temporary license may be issued to those who are licensed through written examination in another state or territory of the U.S. and will practice during a public emergency (to be determined by the HMB). License is subject to approval by the HMB at its regular monthly meeting and is valid only during the period of public emergency.

1) **Submit** fee of $131.00 *(Application fee-$25*, license fee-$32 + Compliance Resolution Fund-$74)*
2) **ATTACH** a statement describing the nature of the emergency and the period of time involved.

*** 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.

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 of **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:

335 Merchant Street, Room 301
Honolulu, HI 96813

Phone: (808) 586-3000

(CONTINUED ON PAGE 5)

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.

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.

LAWS AND RULES

The pertinent laws and rules are posted on our website 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

EMPLOYMENT

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

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 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 - Limited and Temporary License PHYSICIAN

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

Read "Requirements and Instructions" 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)	Birth date
Other Names Used:		Email Address:

FOR BOARD USE ONLY

Approved: ☐ Initials/Date:

Denied: ☐

Effective Date: License No.:

Check type of Limited and Temporary LICENSE CATEGORY you are applying for:

☐ **ABSENCE OR SHORTAGE (MDA)** ☐ **SPONSORSHIP (MDS)**

☐ **PUBLIC EMERGENCY (MDE)**

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: _____

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 <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.)

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

(CONTINUED ON PAGE 2)

Appl.	323.	$25
Lic.	312.	$32/$65
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.

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

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

(CONTINUED ON PAGE 3)

Print Name of Applicant: _____ Date: _____

INTERNSHIP, RESIDENCY, & FELLOWSHIP

Name of Residency Program	Location (City/State or Country)	Dates (mo/yr) From	Dates (mo/yr) To

SYNOPSIS

Medical Practice (Attach additional sheets if necessary)	Dates (mo/yr) From	Dates (mo/yr) To

LICENSES

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

HOSPITAL

Name of Hospital (last 3 years) **(If none, state "None")**	Location (City/State or Country)	Dates (mo/yr) From	Dates (mo/yr) To	Date Form Requested

AFFIDAVIT OF APPLICANT:

The applicant, _____ being first duly sworn upon his oath deposes and says: that he/she is the person
(Name in Full)

herein named subscribing to this application; that he/she has read the complete application, knows the full content thereof, and declares that all of the information contained herein and evidence or other credentials submitted herewith are true and correct and that there are no material omissions; that he/she is the lawful holder of the degree of Doctor of Medicine, that the same was procured without fraud or misrepresentation or any mistake of which the applicant is aware and that the applicant is the lawful holder thereof. Further, I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present) all government agencies (local, state, federal or foreign) to release to the Hawaii Medical Board or its successors any information, files or records requested by that Board in connection with this application. I further authorize the Hawaii Medical Board or its successors to release to the organizations, individuals or groups listed above any information which is material to this application or any subsequent licensure. I further acknowledge that falsification of any item or response on this application is adequate to deny the same or to hold a hearing to revoke the same, if issued.

I understand that any misrepresentation or breach of this certificate are grounds for refusal or subsequent revocation and is a misdemeanor (Section 710-1017, Sections 436B-19 and 453-8, Hawaii Revised Statutes).

_____ _____
Signature of Applicant Date

(CONTINUED ON PAGE 4)

Print Name 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:

Name of Individual you are authorizing: _____

Name of Organization: _____

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.