

REQUIREMENTS FOR A LIMITED VOLUNTEER LICENSE

NORTH CAROLINA MEDICAL BOARD
PO Box 20007, Raleigh, NC 27619
1203 Front Street, Raleigh, NC 27609 (use this address for express/overnight deliveries)
(919) 326-1100 or (800) 253-9653

DO NOT SUBMIT PHOTOCOPIES UNLESS SPECIFICALLY PERMITTED

An application for license in North Carolina is a confidential matter therefore we are unable to respond to any questions regarding your application from anyone other than you, the applicant. The licensing staff may be contacted by e-mail at license@ncmedboard.org.

Below is a summary of the rules of Chapter 32B of the North Carolina Administrative Code. These are the conditions, which might allow licensure, but the Board reserves the right to make whatever additional demands on the applicant for licensure that the Board deems appropriate at the time.

The Limited Volunteer License is available to physicians who are not licensed in North Carolina but wish to volunteer at indigent clinics. The holder of a limited volunteer license shall practice medicine and surgery within the State of North Carolina for no more than 30 days per calendar year and may not receive compensation for services rendered at clinics specializing in the care of indigent patients.

Application materials and fee are good for 1 year. If you are not issued a license within the year and choose to reapply for a NC license, you will be required to resubmit all application materials and background check fee.

1. Completed application form.
 - CIRCLE the correct answer for all questions and provide DETAILED explanations for affirmative answers.
 - A claim form must be completed for EACH malpractice suit or settlement (form enclosed-photocopy as needed). ATTACH A PHOTOCOPY OF PLAINTIFF'S COMPLAINTS AND SETTLEMENT ORDERS FOR EACH INCIDENT.
 - If your name has changed at any time during your life, you will need to list your prior names and submit a copy of legal documentation (marriage certificate, divorce decree, adoption papers, etc.) supporting the name change.
 - Attach a photograph taken within the past year to the applicant's oath and have the form notarized.
2. Complete the Immigration Status Form and submit with the required documentation.
3. You must secure a report from one state or jurisdiction in which you currently hold an active license, verifying the status of licensure. Most licensing agencies charge a fee for this service. The verification should be sent directly to the NC Medical Board. The NC Medical Board accepts license verifications through the Veridoc service.
 - If you are submitting verification of a Connecticut license as part of this application, you must send the Connecticut release form along with the licensure biography form to the Connecticut Department of Public Health.
4. Applicants must submit two completed fingerprint cards for the purpose of conducting a criminal background check. When possible, have different officials complete each card. It is recommended you have your local law enforcement office perform the fingerprinting. An application is not considered complete until a response has been received from the appropriate agency. Expect a minimum of eight weeks for the report to be received. Fingerprint cards must be submitted with your NCMB application along with the authority to release form. Since rejections are common, the SBI has suggested that applicants use lotion or witch hazel on their hands before being fingerprinted. Fingerprint cards are submitted for processing twice a week upon receipt of your application for a license, fingerprint cards, authority for release of information form and the fingerprinting fee.

The SBI has suggested that using the live scan method, when available, may be a more reliable choice. E-mail fpc@ncmedboard.org to request a set of fingerprint cards.

5. A fee of \$38.00 for the criminal background check fee is to be paid at the time the application is submitted. Checks should be made payable to the NC Medical Board. Checks returned for insufficient funds will require an additional \$20.00 fee. Returned checks must be replaced by a certified check or money order. FEES RECEIVED ARE NOT REFUNDABLE.

6. When all application materials have been received, your file will be forwarded to a staff member for quality assurance review. If the quality assurance review is complete and no additional information is needed, your file will be forwarded to a board member for review to determine whether you will be required to appear for a personal interview. Upon receipt of the board member's decision, your license will be reinstated if a personal interview is not required. **INTERVIEWS SCHEDULED PRIOR TO APPLICANT BEING NOTIFIED BY NCMB STAFF THAT APPLICATION IS COMPLETE MAY BE CANCELED.**

7. If a physician has been away from clinical practice 2 years or longer, they may be required to develop a reentry plan as part of the license application. It is the responsibility of the applicant to be prepared to present a program of re-training or supervision that will establish proof of competency in their chosen area or medicine. Applicants in this category will be required to appear for a personal interview.

RENEWAL – A renewal fee will not be required, however, you will be required to complete the online renewal process with 30 days of your birthday every year.

Created: 11/11

APPLICATION FOR LIMITED VOLUNTEER LICENSE

NORTH CAROLINA MEDICAL BOARD

P.O. Box 20007, Raleigh, NC 27619
1203 Front Street, Raleigh, NC 27609

Application for issuance of a license to practice medicine is effective for a period of **1 YEAR** from the date application is notarized, through personal interview. All changes in the answers to these questions must be reported to the Board.

North Carolina General Statute 90-14 A (3) states an application may be denied or revoked if the applicant has made false statements or representations to the Board, or if the applicant has willfully concealed from the board material information in connection with an application for a license.

I hereby make application for a license to practice medicine and surgery of the State of North Carolina and submit the following statement concerning my age, moral character, medical education, and practice.

Full Name: _____
(First) (Middle) (Last) (Suffix) (MD/DO)

Other names you have been known by: _____
(Provide copies of official documents showing name change, i.e., a marriage certificate)

Home Address: _____

Practice Address: _____

Mailing Address (Circle one): Practice or Home

Email Address: _____

Soc. Sec. #: _____ - _____ - _____ Place of Birth: _____ Date of Birth: _____ / _____ / _____
Month Day Year

Current Home Telephone Number: (_____) _____

Current Business Telephone Number: (_____) _____

Current Fax Number: (_____) _____

Current Cell Phone/Beeper: (_____) _____

Medical School: _____ City/State: _____ Year of Graduation: _____

Internship: _____ City/State: _____ Year of Completion: _____

Residency: _____ City/State: _____ Year of Completion: _____

States where you have ever held a license (active or inactive). _____

Current Medical Specialty: _____ Sub Specialty: _____

Please provide a brief description of your practice plans for the State of North Carolina if known. _____

Name: _____
(Printed)

CIRCLE your answer to the following questions. Provide a detailed description of any YES answers. Any changes in your answers to these questions between the time your application is notarized and the time your application is complete must be reported to the Board. The following questions refer to events in any jurisdiction – U.S. or Foreign.

Complaint includes, but is not limited to, any instance where any person or organization has raised a concern regarding your or your practice regardless of the outcome.

Investigation includes, but is not limited to, an inquiry into (in person or otherwise), examination or inspection of, or gathering of evidence or information regarding you or your practice regardless of the outcome.

1. Are you aware of any **complaint or investigation**, ever, regarding you that has been received or conducted by any of the following: YES NO

- professional licensing board or agency
- military service
- medical or professional organization/association
- local, state, federal, or other governmental agency
- private or governmental insurance company or payor
- hospital or other healthcare organization
- professional certifying board

2. Have you ever been denied the privilege of taking an examination by any professional licensing board, agency, or any other organization which provides professional certification or credentialing? YES NO

3. Have you ever: YES NO

- withdrawn a license application
- been denied a license
- surrendered a license
- had a license restricted or limited in any way
- placed a license on inactive status while under investigation

4. In the past five (5) years, have you used or consumed any controlled substance or other prescription drug that you obtained through illegal or improper means? YES NO

5. In the past five (5) years, have you used or consumed any illicit or illegal drugs including, but not limited to cocaine, heroin, ecstasy, LSD, mescaline, psilocybin, PCP and/or marijuana? YES NO

6. In the past five (5) years, have you used alcohol or other substances in a manner that could in any way impair or limit your ability to practice medicine with reasonable skill and safety or have you been told you were impaired by your use of alcohol or other substances in a manner that could impair or limit your ability to practice medicine with reasonable skill and safety? YES NO

7. In the past five (5) years, have you had, or have you been told you have, a mental health or physical condition (not referenced above) which in any way limits or impairs or, if untreated, could limit or impair your ability to practice medicine in a competent or professional manner? YES NO

8. Have you ever had a professional liability policy cancelled or not renewed relating to an accusation of your poor medical care or misconduct? YES NO

9. Have you ever been separated or discharged other than honorably from the US military, foreign military, Veteran's Administration or public health service? YES NO

10. While at any professional school or training program, have you ever: YES NO

- been suspended, placed on scholastic or disciplinary probation, expelled or requested to resign, or
- withdrawn or gone on leave of absence while under investigation or threat of investigation or disciplinary action?

11. Have you ever had an action taken against your privileges by a health care institution, including employers or group practices? If so, list each occurrence and provide documentation. YES NO

Actions include:

- Warnings
- Censures
- Discipline
- Admissions monitored
- Privileges limited, suspended or revoked
- Remediation
- Probation
- Withdrawals/resignations of privileges
- Suspension or termination of employment or a resignation under threat of investigation or disciplinary action or denial of staff membership.

Health care institutions include:

- Hospitals
- Health maintenance or preferred provider organizations
- Any facility in which you trained
- Any group practice
- Any other organization that issue credentials to physicians

** All final suspensions and revocations will be visible to the public on the Board's website for a period of seven years (from the date of the action).**

FOR THE PURPOSE OF QUESTIONS 12 AND 13, IF “YES”, SUBMIT COPIES OF ALL RELEVANT DOCUMENTATION, SUCH A POLICE REPORTS, CERTIFIED COURT RECORDS AND DISPOSITIONS

12. Have you ever been charged with or convicted of a misdemeanor? If so, list each occurrence. YES NO

Note: You are not required to report minor traffic offenses. “Minor traffic offenses” do not include driving while intoxicated, driving under the influence, careless and reckless driving, or any offence involving serious injury or death.

Charged includes being arrested, indicted or arraigned.

Convicted includes if you pled guilty, were found guilty by a court of competent jurisdiction, or entered a plea of nolo contendere (no contest) or received a prayer for judgment continued (PJC) for a violation of federal, state, or local law.

** Misdemeanor convictions that involve offenses against a person, offenses of moral turpitude, offenses involving the use of drugs or alcohol and violations of public health and safety codes will be visible to the public on the Board’s website for a period of 10 years (from the date of the conviction). If one of the actions reported is determined to be public information, the Board will notify the licensee in writing). **

13. Have you ever been charged with or convicted of a felony? Is so, list each occurrence. YES NO

Charged includes being arrested, indicted or arraigned.

Convicted includes if you pled guilty, were found guilty by a court of competent jurisdiction, or entered a plea of nolo contendere (no contest) or received a prayer for judgment continued (PJC) for a violation of federal, state or local law.

** All felony convictions will be visible to the public on the Board’s website. **

14. Have you ever had an action taken against you by a regulatory board or agency? If so, list each occurrence. YES NO

Action include revocations, suspensions, probations, limitations/restrictions, disciplinary/non-disciplinary actions and fines, including private actions and letters, or the issuance of a license through an order.

Regulatory Board or Agency includes any professional licensing board or agency, the US Food or Drug Administration, the US Drug Enforcement Administration, Medicare, or Medicaid.

** All public actions taken by state medica/regulatory boards will be visible to the public on the Board’s website indefinitely. All actions taken by federal/state agencies such as the US Food and Drug Administration, the US Drug Enforcement Administration, Medicare, and Medicaid will be visible to the public on the Boards website for a period of seven years (from the date of the action). **

15. Have you ever been named in a malpractice lawsuit or a malpractice lawsuit filed against you was resolved – regardless of whether the judgment, award, payment or settlement was made in your name or a malpractice settlement or payment was made, affecting or involving you, where no lawsuit was filed? If so, you will need to complete the “Claims Information Form”. In addition, you are required to provide a copy of the plaintiff’s complaint and if applicable the judgement, award, payment or settlement documents. YES NO

** Not all malpractice payment reports will be published. The NCMB will only publish:

- judgments or awards that occurred within the past seven years, and
- settlements that occurred on or after May 1, 2008 and are \$75,000 or greater.

Please note that the dollar amount of the payment will not be published; nor will any information that might identify a patient. Payments that meet the criteria for public reporting will be visible to the public on the Board’s website for a period of 7 years from the date of payment.

North Carolina Medical Board Applicant's Oath

THIS ENTIRE FORM MUST BE COMPLETED IN THE PRESENCE OF A NOTARY PUBLIC

Applicant's Printed Name

THE FOLLOWING SENTENCE IS TO BE COPIED BY THE APPLICANT IN THE APPLICANT'S USUAL HANDWRITING.

I hereby certify under oath that I am the person named in this application and that all statements I have made or may make are true and complete.

I further certify and acknowledge the following (initial each statement):

- _____ I am the person named in the various forms and credentials furnished with respect to my application and that all documents, forms or copies furnished with respect to my application are true in every aspect.
- _____ If I fail to answer questions truthfully and completely, the NC Medical Board (NCMB) may deny my application or take other disciplinary action and that all license denials are reported to the National Practitioners Data Bank and other state medical boards.
- _____ If I am in doubt about whether to report any information requested, I should fully disclose the information and provide an explanation of the circumstances.
- _____ If someone else completed the application for me, I am responsible to make sure the answers are truthful and complete.

I waive confidentiality, authorize and request every person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me to furnish to the NCMB any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, my examination grades, or any other pertinent data and to permit the NCMB or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application that can subsequently be

provided to professional licensing boards, hospitals and other entities when I apply for licensure, staff membership, employment or other privileges.

I hereby release, discharge and exonerate the NCMB, its agents or representatives and any person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the NCMB.

I will immediately notify the NCMB in writing of any changes to the answers to any questions contained in this application if such a change occurs at any time prior to a decision by the NCMB regarding my application.

Applicant's Signature

Applicant's Soc. Sec. Number

Applicant's Printed Name

Applicant's Date of Birth

Date of Signature

NOTARY PUBLIC

State of _____, County of _____.

SUBSCRIBED AND SWORN TO before me this _____ day of _____, 20 _____.

My commission expires: _____

Notary Public

I certify that on the date set forth above the individual named above did appear personally before me and that I: (a) did identify this applicant by comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) did witness this applicant complete this form including the handwritten statement above.

NOTE: NOTARY SEAL MUST BE PARTIALLY OVER THE APPLICANT'S PHOTOGRAPH.

Applicant's Photograph
Securely tape or glue in this square a current, front-view, 2" X 2" passport-type color photograph of yourself on photo quality paper.

LIMITED VOLUNTEER LICENSE

By my signature below, I certify that I understand the Limited Volunteer License allows me to practice medicine and surgery only at clinics that specialize in the treatment of indigent patients and I will receive no compensation for services rendered at clinics specializing in the care of indigent patients.

The holder of a Limited Volunteer License shall practice medicine and surgery no more than 30 days per calendar year.

Printed Name

Signature

Date

**NC MEDICAL BOARD
IMMIGRATION STATUS FORM**

PO Box 20007
Raleigh, NC 27619

Physician Name: _____

Social Security Number: _____

1. If you are not physically present in the United States of America or a United States Territory and have no plans to enter the United States of America or a United States Territory, please check below and then continue to the next page.

I am not physically present and I have no plans to enter the United States of America or a United States Territory.

*If you do enter the United States of America or a United States Territory and practice as a licensee of the North Carolina Medical Board, you must notify the Legal Department at the North Carolina Medical Board immediately.

2. Are you a citizen of the United States of America?

Yes

No

If you answered "Yes," you must provide a copy of **one** of the following documents:

- a. Birth certificate indicating birth in the United States of America or a United States Territory.
- b. Valid and unexpired United States of America passport.
- c. Other appropriate documentation of United States of America citizenship deemed acceptable by the North Carolina Medical Board, which may include:
 1. Report of Birth Abroad of a United States of America citizen (FS-240)
 2. Certification of Report of Birth (DS-1350 or FS-545)
 3. Certificate of United States of America Citizenship (N-561)
 4. United States of America Citizen Identification Card (I-197)

If you answered "No," you must provide:

- a. A statement defining and specifying your immigration and alien status:

AND

- b. A copy of a document indicating your immigration and alien status deemed acceptable by the North Carolina Medical Board, which may include one of the following documents:
1. Alien Registration Card or Green Card (Form I-551)
 2. Employment Authorization Document (Form I-688B or Form I-766)
 3. Certification of Report of Birth (DS-1350)
 4. Arrival-Departure Record (Form I-94)
 5. Other documentation providing lawful status in the United States of America.

NORTH CAROLINA MEDICAL BOARD

LICENSE VERIFICATION FORM

Applicant: Complete the top portion of this form and forward one copy to each licensing board in all the states where you **have held OR currently hold** a medical license. Training licenses do not need to be verified. This form should be mailed directly to the North Carolina Medical Board from the state licensing board. Most states require a fee for processing. The fee is the applicant's responsibility. The NC Medical Board accepts license verifications through the VeriDoc service.

Licensing Board: The North Carolina Board requires information regarding my license. This is my request for you to respond to the questions below and also gives you authority to release any information, favorable or otherwise, to the North Carolina Medical Board.

I am applying for a North Carolina medical license. I was granted license number _____ on _____ by the State of _____.

Name: _____

Signature: _____

Soc. Sec. #: _____

Address: _____

Date of Birth: _____

This is to certify that the records of the _____ State Licensing Board indicate that _____ physician was issued license number _____ on _____ to practice medicine in the State of _____,

Respond to the following questions:

- 1. Is this license current? _____ YES NO
- 2. Is this license in good standing? _____ YES NO
- 3. Has any public or private action been taken against this physician? _____ YES NO
- 4. Are there any pending investigations against this physician? _____ YES NO

If YES answered to questions 2 and 3, attach an explanation.

(Board Seal)

Authorized Signature

Date

PLEASE COMPLETE AND RETURN THIS FORM DIRECTLY TO THE NORTH CAROLINA MEDICAL BOARD, P.O. Box 20007, RALEIGH, NC 27619.

State of Connecticut

Department of Public Health and Addiction Services
Bureau of Health System Regulation
Division of Medical Quality Assurance

Consent for Release of Confidential Disciplinary Records

This is to certify that I hereby give my consent and authorizes the Department of Public Health and Addiction Services, Division of Medical Quality Assurance, to confirm the existence of any pending petitions and to release any records of disciplinary action maintained by that Division (with the exception of any documents identified below) to:

NC Medical Board
PO Box 20007
Raleigh, NC 27619-0007

I understand that these records are confidential pursuant to the provisions of Connecticut General Statute §20-13e and may not be disclosed without my permission. This information will only be disclosed when this release is executed by me. I also understand that if I am a participant in a rehabilitation program sponsored by a County Medical Association or by the Connecticut State Medical Society that I have the right to contact the Association or Society prior to signing this release.

Documents the Department is Not Authorized to Release:

Signature

Date

Name (Printed or Typed)

Conn. Medical License Number

Date of Birth

Expiration Date

For office use only
Petition under investigation (see attached)
Confidential action (see attached)
No confidential action

Initials-Date

DBB:

0241Q

**AUTHORITY FOR RELEASE OF INFORMATION
State and Federal Record Check**

I authorize the North Carolina Department of Justice through the State Bureau of Investigation, Division of Support Services to perform a fingerprint search of the State's criminal history record file and a fingerprint search of the Federal Bureau of Investigation's files for a national criminal history record check in connection with my application for a medical license with the North Carolina Medical Board pursuant to N.C.G.S. 90-11(HB 1638).

Please print or type the following information:

Name: _____
 Last First Middle Maiden

Soc Sec #: _____ Date of Birth: _____

Sex: _____ Race: _____

I understand that the North Carolina State Bureau of Investigation, Division of Support Services, and its officials and employees shall not be held legally accountable in any way for providing this information to the North Carolina Medical Board, and I hereby release said agency and persons from any and all liability which may be incurred as a result of furnishing such information. I further understand that the North Carolina Medical Board cannot provide a **hard copy** of the results of this criminal history record check to me.

Applicant's Signature:

Date:

ORI # BOME00000 – NORTH CAROLINA MEDICAL BOARD

Photocopy of a Sample Fingerprint Card

Each numbered block on this SAMPLE must be completed on the actual fingerprint cards. Follow the *Instruction Sheet for Completing the Fingerprint Cards* to ensure you are completing each block on the actual fingerprint cards with the correct information and in the proper format.

(The actual card must be white with blue writing)

APPLICANT	LEAVE BLANK	TYPE OR PRINT ALL INFORMATION IN BLACK						EBI	LEAVE BLANK
		LAST NAME <u>NAM</u>	FIRST NAME	MIDDLE NAME					
		1							
SIGNATURE OF PERSON FINGERPRINTED 2		ALIASES <u>AKA</u> 3	O R I	NCBCI0000 ST BU OF INV RALEIGH, NC					DATE OF BIRTH <u>DOB</u> Month <u>4</u> Day Year
RESIDENCE OF PERSON FINGERPRINTED 5		CITIZENSHIP <u>CIZ</u>							PLACE OF BIRTH <u>POB</u> 12
DATE 13	SIGNATURE OF OFFICIAL TAKING FINGERPRINTS 14	YOUR NO. <u>OCA</u>	SEX <u>6</u>	RACE <u>7</u>	HGT. <u>8</u>	WGHT. <u>9</u>	EYES <u>10</u>	HAR <u>11</u>	
EMPLOYER AND ADDRESS North Carolina Medical Board PO Box 20007 Raleigh, NC 27619-0007		FBI NO. <u>ERJ</u>	LEAVE BLANK						
REASON FINGERPRINTED Medical License Applicant State and Federal NCGS 90-11		ARMED FORCES NO. <u>MNU</u>	CLASS _____						
		SOCIAL SECURITY NO. <u>SOC</u> 15	REF _____						
		MISCELLANEOUS NO. <u>MNU</u>							
<p>This is a SAMPLE CARD</p> <p>Do <u>NOT</u> put prints on this card</p>									
1. R. THUMB	2. R. INDEX	3. R. MIDDLE	4. R. RING	5. R. LITTLE					
6. L. THUMB	7. L. INDEX	8. L. MIDDLE	9. L. RING	10. L. LITTLE					
LEFT FOUR FINGERS TAKEN SIMULTANEOUSLY			11. THUMB	12. THUMB	RIGHT FOUR FINGERS TAKEN SIMULTANEOUSLY				
<p>To request cards be mailed to you, please e-mail: fpc@ncmedboard.org</p>									

Instruction Sheet for Completing the Fingerprint Cards

The NC Medical Board requires 2 fingerprint cards for processing. Failure to submit 2 fingerprint cards will delay your application if the first card is rejected.

1. The complete name of the subject is to be listed as indicated: Last name, First name, and Middle name. Please ensure the name is legible if written.
2. Signature of the subject being fingerprinted is written here.
3. List any and all alias names or nicknames, maiden name or any other married names.
4. List the date of birth numerically – month, day, and year.

Example: May 11, 1948, should be shown as 05111948; October 15, 1930, should be shown as 10151930
5. Current residence of subject fingerprinted is written here.
6. Sex is to be listed M for male, and F for female, or U for Unknown.
7. Race is to be listed by placing an individual into one (1) of the following categories by writing the appropriate letter in the space provided:

W White
B Black
I American Indian or Alaskan Native
A Asian or Pacific Islander
U Unknown if unsure or unable to determine
8. Indicate the subject's height in feet and inches using all numerics.

Example: 6'01" = 601, 6'11" = 611, 6' = 600
9. Indicate the subject's weight in pounds using all numerics.

Example: 186 or 098, etc.
10. List the subject's eye color by placing one (1) of the following eye color codes in the space provided:

BLK – Black GRY – Gray MAR – Maroon
BLU – Blue GRN – Green PNK – Pink
BRO – Brown HAZ – Hazel XXX – Unknown
11. Color of hair should be indicated by writing one (1) of the following color codes in the space provided:

BAL – Bald (When subject has lost most of his hair or is hairless)
BLK – Black
BLN – Blond or Strawberry
BRO – Brown
GRY – Gray or partially
RED – Red or Auburn
SDY – Sandy
12. Indicate, if possible, the city and state where the subject was born. The state should be indicated by the two-digit abbreviation.
13. Indicate the date of the fingerprinting.
14. Signature of Official taking fingerprints.
15. Write the Social Security number in this space. The Social Security number is a very important identifier.

Due to the volume of fingerprints that get rejected, please read the following in order to obtain the best possible set of prints.

SBI FINGERPRINT REJECTION POLICY

The quality of ten-print fingerprint image submissions accepted by the North Carolina State Bureau of Investigation has deteriorated in the last few years. Poor quality fingerprint images result in decreased reliability for both ten-print and latent searches. Low quality fingerprint data are frequently the result of poor rolling practices as opposed to poor image scanning of the rolled prints. For records to be maintained in both the State and Federal level, fingerprints must be rolled from the tip to below the first joint, and nail to nail. Ridge characteristic must be distinct and fingerprint impressions must be in sequential order. We request that all law enforcement agencies and non-criminal justice agencies submit fingerprints that are of good quality.

The following is the SBI/Identification Section Fingerprint Rejection Policy implemented February 2, 2004:

1. Every criminal and applicant fingerprint card must have all ten fingerprint images of good quality. The ten fingerprint images of the plain impressions/slaps must be completely discernable thereby allowing comparison between the plain impressions and rolled impressions.

NOTE: If a fingerprint in the plain impressions has been cut off (either too low or too high) the FBI cannot compare the rolled images to the plain images, and they will reject the card.

2. The exception to this is amputated, bandaged or deformed fingers. If one of these three notations is in a rolled impression block, there should be **NO** fingerprint in the plain impression/slaps.
3. Fingerprint cards submitted with the following will be rejected:
 - Hands out of sequence, or
 - Fingerprints out of sequence, or
 - Hand printed twice, or
 - Fingerprints printed twice, or
 - Fingerprints missing with no reason given

The definition of a good quality fingerprint is an image that provides sufficient data to accurately identify and locate principal fingerprint features. These features include minutia, cores and delta, and ridges. The image should cover sufficient area to allow examiners to identify fingerprint patterns and to compare the prints with those in the database.

If cards are rejected a new set must be submitted within 90 days of being notified of the rejection. If not received within 90 days the process must be restarted.