

APPLICANT'S OATH

I hereby certify under oath that I am the person named in this application for a license to practice medicine in the State of North Carolina, that all statements I have made herein are true, that I am the person named in the various forms and credentials furnished to this Board with my application. The photograph submitted as part of this application process is a true likeness of myself and was taken within sixty days prior to the date of this application.

I further state that by filing this application for a license to practice medicine in the State of North Carolina, I hereby authorize and consent to have an investigation made as to my moral character, professional reputation and fitness for the practice of medicine. I agree to give any further information, which may be required. I understand that I will not receive a copy of any report or know its contents, and I further understand that the contents of any investigative report will be confidential as provided by law.

I authorize and request every person, hospital, clinic community, governmental agency, (local, state, federal or foreign), court, association, institution, or other organization having control of any documents, records and other information pertaining to me to furnish to the North Carolina Medical Board any such information including documents, records regarding charges or complaints filed against me (formal or informal, pending or closed) or any other pertinent data. I further permit the North Carolina Medical Board or any of its agents or representatives to inspect and make copies of such documents, records and other information in connection with this application, subsequent licensure or practice there under.

I hereby release, discharge and exonerate the North Carolina Medical Board, its agents or representatives and any person so furnishing information, from any and all liability for every nature and kind arising out of the furnishing or inspection of such documents, records, other information or the investigation made by the North Carolina Medical Board.

(Printed Name)

(Applicant's Signature)

(Social Security Number)

State: _____ Subscribed and sworn to before me this _____ day of _____ 20__

County: _____ NOTARY PUBLIC _____

My Commission Expires _____

SEAL

CLAIM INFORMATION FORM

NORTH CAROLINA MEDICAL BOARD

Please attach a PHOTOCOPY of the PLAINTIFF'S COMPLAINT AND SETTLEMENT ORDER, if there is one.

The applicant must complete this form for each liability or malpractice claim of which they are aware. Please make as many photocopies of this form as you need. Please use one form for each claim or suit.

1. In addition to copies of the complaint and settlement order, if any, describe below the allegations against you. **A copy of the complaint will not replace a written description by you.** Include, a brief history, comments regarding the examination and care surrounding the allegations. If suits are pending a very brief summary of the allegations or charges must be included regardless of the litigation stage. Simply stating that the charges were dismissed is inadequate. More detail must be provided. Use additional pages if necessary.

Patient's Name: _____

2. Date of the claim: _____

3. If an insurance carrier was involved, list the name, address and telephone:

4. Plaintiff's Attorney & Telephone #: _____

5. Is the claim pending? Yes No

6. Was there a judgment or settlement? Yes No

7. What was the amount and date of the judgment or settlement? _____

8. Comments: _____

I certify that the information that I have provided is correct to the best of my knowledge.

Signature: _____

Date: _____

NORTH CAROLINA MEDICAL BOARD

MEDICAL SCHOOL CERTIFICATION FORM (A)

Form (A) is to be completed by fourth year medical students who have met the requirements for the MD/DO degree, but have not received the degree.

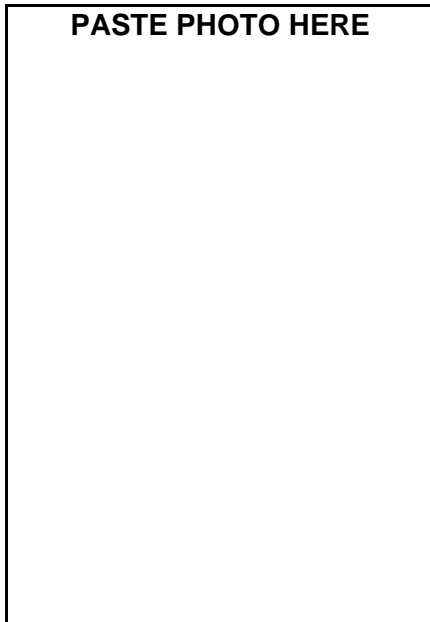
The North Carolina Medical Board requires you complete this form.

Please return to me at the following address:

ORIGINAL SIGNATURE IS REQUIRED - SIGNATURE STAMPS WILL NOT BE ACCEPTED

The Dean or other medical school official must complete the certification and sign. Medical school seal must be affixed over the photograph.

DO NOT ALTER THIS FORM.



My signature below certifies that this is a true likeness of

who has met the requirements for the MD/DO degree and is **anticipated to receive** the MD or DO degree from the

on _____, _____

Signature of Certifying Official:

(Original signature is required – stamps not accepted)

Printed Name: _____

Title: _____

Date: _____

Address of Medical School:

NORTH CAROLINA MEDICAL BOARD

MEDICAL SCHOOL CERTIFICATION FORM (B)

Form (B) is to be completed by physicians who have **graduated and received** a medical degree.

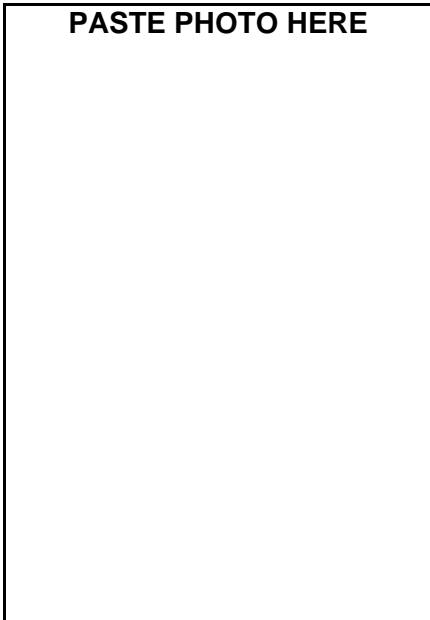
The North Carolina Medical Board requires you complete this form.

Please return to me at the following address:

ORIGINAL SIGNATURE IS REQUIRED - SIGNATURE STAMPS WILL NOT BE ACCEPTED

The Dean or another medical school official must complete the certification and sign. Medical school seal must be affixed over the photograph.

DO NOT ALTER THIS FORM.



(School seal must be affixed over the photo)

My signature below certifies that this is a true likeness of

who received the MD/DO degree from

on _____, _____.

Signature of Certifying Official:

(Original signature is required – stamps not accepted)

Printed Name: _____

Title: _____

Date: _____

Address of Medical School:

FIFTH PATHWAY VERIFICATION FORM

North Carolina Medical Board

PO Box 20007

Raleigh, NC 27619

Instructions to the applicant:

Complete the following section of this form and forward to all Fifth Pathway program(s) in which you have participated. Make copies of the form as necessary. Request the Program Director complete the form and return it to the NC Medical Board's office.

Full Name: _____

Social Security Number: _____ Date of Birth: _____

Instructions to the Program Director:

The individual above has authorized your institution to provide the North Carolina Medical Board any and all information pertaining to their Fifth Pathway program at your institution. **Please complete this form and forward it, together with an official copy of the individual's record (indicating rotations, dates, and hours of training, scores, grades or evaluations), directly to the NC Medical Board.**

Fifth Pathway History

Name of Institution: _____

Complete Address: _____

Street Address

City

State

Zip Code

If name of institution was different when this individual attended, please note this name below:

Enrollment and Participation:

According to our records: _____

Print individual's full name: First, Middle, Last, Suffix

_____ Was enrolled in this institution from ____/____/____ to ____/____/____

_____ Was NOT enrolled with this institution

Our records also indicate that this individual (check one of the following):

_____ Will receive a certificate of completion on: ____/____/____

_____ Received a certificate of completion on: ____/____/____

_____ Withdrew on: ____/____/____

_____ Was dismissed on: ____/____/____

Please attach an explanation

Verification of Fifth Pathway (continued):

Rotations: Our records indicate that this individual participated in the following rotations:

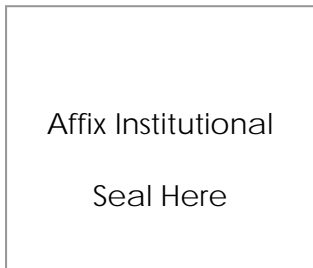
Type of Clinical Rotation	Dates Attended (Month/Day/Year)		Number of Weeks Credit
	From	To	
	/ /	/ /	
	/ /	/ /	
	/ /	/ /	
	/ /	/ /	

<p>Unusual Circumstances:</p> <p><u>Circle the correct response. Omitted responses require written explanation.</u></p> <p>If necessary, you may continue your explanation on a separate sheet of paper.</p>	<p>Did this individual ever take a leave of absence or break from his/her training?</p> <p>Yes No</p>
	<p>Was this individual ever placed on probation?</p> <p>Yes No</p>
	<p>Was this individual ever disciplined or placed under investigation?</p> <p>Yes No</p>
	<p>Did instructors ever file any negative reports on this individual?</p> <p>Yes No</p>
	<p>Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reasons?</p> <p style="text-align: center;"><u>Please explain any 'Yes' responses from above:</u></p> <p>_____</p> <p>_____</p> <p>_____</p>

ENCLOSE A COPY OF THIS INDIVIDUAL'S OFFICIAL TRANSCRIPT OR EQUIVALENT DOCUMENT

Certification: By my signature below, I, _____, certify that the information contained in this report is an accurate account of the above named individual's official records maintained by this institution and is true and correct to my knowledge.

(Print name)



Signature: _____

Title: _____

Date of Signature: _____

Phone Number: _____

**NORTH CAROLINA MEDICAL BOARD
PHYSICIAN/MEDICAL STUDENT REFERENCE FORM**

TO APPLICANT: The North Carolina Medical Board requests completion of two reference forms. These forms must be sent from the reference sources directly to the applicant in sealed envelopes with the sources signature affixed across the seal.

In addition, the forms must meet the following criteria:

- a) Recent. (no older than six months)
- b) Original signature.
- c) **Two** forms completed by physicians who have observed your work in a clinical environment.

Please be sure to indicate the physician's name below for identification purposes.

NAME OF APPLICANT : _____

**** On the application form, the applicant has agreed to release, discharge and exonerate any person furnishing information from any and all liability of every nature and kind arising out of this furnishing or inspection of such documents, records, other information or the investigation made by the North Carolina Board. ****

REFERENCE SOURCE: Please complete this form, sign, and return to the applicant in a sealed envelope. Your response is confidential, pursuant to North Carolina law. **Please print or type all information.**

IMPORTANT: The processing time for licensure directly depends on timely receipt of critical forms such as this.

Name MD/DO

Address

City, State, Zip

Phone Number E-Mail Address

1. How long have you known the applicant? _____

2. In what capacity are you acquainted with him/her? _____

NOTE: IF YOU ANSWER "YES" TO ANY OF THE FOLLOWING QUESTIONS PLEASE GIVE AN EXPLANATION.

- | | | |
|---|-----|----|
| 3. Have you ever received reports of poor medical practice by this physician/medical student or have you discussed concerns you had about his/her practice with medical staff officers at a hospital? | Yes | No |
| 4. Have you ever received reports of poor relationships between this physician/medical student and other members of hospital medical staff? | Yes | No |
| 5. Do you know of any derogatory information about this physician/medical student with respect to his/her ability to practice medicine? | Yes | No |
| 6. Do you know if this physician/medical student has or has this physician/medical student had in the past, any mental or physical illnesses or personal problems that interfere with his/her medical practice? | Yes | No |
| 7. Do you know if this physician/medical student has ever abused alcohol or drugs or shown signs of chemical dependency? | Yes | No |
| 8. Do you know of any lawsuits having to do with this physician/medical student's medical practice that this physician/medical student has either lost or settled out of court? | Yes | No |
| 9. Do you know of any restrictions, limitations or other actions of any nature taken against this physician/medical student by a hospital or other health related entity? | Yes | No |

NOTE: IF YOU ANSWER "NO" TO QUESTION 10, 11, or 12, PLEASE GIVE AN EXPLANATION.

- | | | |
|---|-----|----|
| 10. Does this physician/medical student accept medical staff and hospital policies and function willingly according to these policies? | Yes | No |
| 11. Does this physician/medical student enjoy professional respect among his or her colleagues and in the community where this physician practices? | Yes | No |
| 12. Do you recommend this physician/medical student for resident training medical licensure in North Carolina? | Yes | No |

COMMENTS: _____

Original signature

Title

Name of Hospital (if applicable)

Date

NORTH CAROLINA MEDICAL BOARD

LICENSE VERIFICATION FORM

Applicant: Complete the top portion of this form and forward one copy to each licensing agency in all the states where you **have held OR currently hold** a medical license. Licenses held for the purpose of training do not need to be verified. This form should be mailed directly to the North Carolina Medical 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/Agency: 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: _____

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

This is to certify that the records of the _____ Professional Licensing Board/Licensing Agency indicate that _____ physician was issued license number _____ on _____ to practice _____ 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. Have any charges ever been filed against this professional? _____ YES NO
4. Do you know of any information that may discredit this professional? _____ YES NO
5. Do your files indicate any derogatory information? _____ YES NO
6. Have you received any complaints against this professional? _____ YES NO
7. Has this professional been investigated by your Board? _____ YES NO
8. Are you aware of any information about this professional submitted to the _____ YES NO
National Practitioner Data Bank?

If YES answered to any questions 3-8, attach an explanation.

(Board Seal)

Authorized Signature

Date

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

North Carolina Medical Board - Postgraduate Training Verification Form

Please mail completed forms to:
 (Your GME's address should be used)

Verification For:	Full Name: _____ SSN: _____ DOB: _____												
Institution: _____ Address: _____ _____		Attention: Program Director Affiliated University: _____ _____											
Program Participation: Report incomplete postgraduate years (PGY) separate from those that were successfully completed. If the postgraduate year is currently in progress report the expected completion date in the 'To' field.	PGY: _____ _____ Internship _____ Residency _____ Chief Residency _____ Fellowship _____ Research	Specialty/Subspecialty: _____ From: _____ To: _____ Successfully Completed: _____ Yes _____ No _____ In Progress Accredited By: _____ ACGME _____ AOA _____ Other: _____ (Specify)											
	PGY: _____ _____ Internship _____ Residency _____ Chief Residency _____ Fellowship _____ Research	Specialty/Subspecialty: _____ From: _____ To: _____ Successfully Completed: _____ Yes _____ No _____ In Progress Accredited By: _____ ACGME _____ AOA _____ Other: _____ (Specify)											
	PGY: _____ _____ Internship _____ Residency _____ Chief Residency _____ Fellowship _____ Research	Specialty/Subspecialty: _____ From: _____ To: _____ Successfully Completed: _____ Yes _____ No _____ In Progress Accredited By: _____ ACGME _____ AOA _____ Other: _____ (Specify)											
Unusual Circumstances: Circle the correct response. Omitted responses require written explanation. If necessary, you may continue your explanation on a separate sheet of paper.	<ol style="list-style-type: none"> 1) Did this individual ever take a leave of absence or break from his/her training? 2) Was this individual ever placed on probation? 3) Was this individual ever disciplined or placed under investigation? 4) Were any negative reports for behavioral reasons ever filed by instructors? 5) Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? <p>Please explain any 'Yes' responses above:</p> _____ _____		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; text-align: center;">Yes</td> <td style="width: 50%; text-align: center;">No</td> </tr> <tr> <td style="text-align: center;">Yes</td> <td style="text-align: center;">No</td> </tr> <tr> <td style="text-align: center;">Yes</td> <td style="text-align: center;">No</td> </tr> <tr> <td style="text-align: center;">Yes</td> <td style="text-align: center;">No</td> </tr> <tr> <td style="text-align: center;">Yes</td> <td style="text-align: center;">No</td> </tr> </table>	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Yes	No												
Yes	No												
Yes	No												
Yes	No												
Yes	No												
Certification: Affix your institutional seal in this space. If no seal is available, you must have this form notarized.	Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. The signature line must contain the original signature of the program director (M.D./D.O. only). Name: _____ Title: _____ Signature: _____ Date: _____ Telephone: _____ Email: _____												

NORTH CAROLINA MEDICAL BOARD
ROTATION APPOINTMENT FORM

If this rotation is part of a training program you are currently enrolled in, in another state, the program director/chairman of your current training program must complete this form.

Name: _____

is approved to complete a rotation in (specialty) _____

at (institution) _____

North Carolina from _____ to _____
(mm/dd/yyyy) (mm/dd/yyyy)

This rotation is part of an ACGME or AOA approved training program.

Name of current training program: _____

Address: _____

“Original” signature of current program director/chairman:

Printed Name: _____

Title: _____

Date: _____

Instruction Sheet for Completing the Fingerprint Card

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.

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>					SEX <u>6</u>	RACE <u>7</u>	HGT. <u>8</u>
DATE 13	SIGNATURE OF OFFICIAL TAKING FINGERPRINTS 14	YOUR NO. <u>OCA</u>	LEAVE BLANK						
EMPLOYER AND ADDRESS North Carolina Medical Board PO Box 20007 Raleigh, NC 27619-0007		FBI NO. <u>ERJ</u>	CLASS _____						
REASON FINGERPRINTED Medical License Applicant State and Federal NCGS 90-11		ARMED FORCES NO. <u>MNU</u>	REF _____						
		SOCIAL SECURITY NO. <u>SOC</u> 15							
		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>									