

# 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.

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

\_\_\_\_\_  
Applicant's Printed Name

\_\_\_\_\_  
Applicant's Social Security Number

\_\_\_\_\_  
Applicant's Date of Birth

**Applicant 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.

\_\_\_\_\_  
**Applicant's Signature**

\_\_\_\_\_  
**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.

**NORTH CAROLINA MEDICAL BOARD**

**LICENSE VERIFICATION FORM  
PA EXPEDITED LICENSURE**

**Applicant:** Complete the top portion of this form and forward to the licensing board in one state, US territory or Canadian province where you currently hold a full unrestricted active license for the previous five years immediately preceding this application. 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/Country of \_\_\_\_\_.

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Soc. Sec. #: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

\_\_\_\_\_

\*\*\*\*\*

This is to certify that the records of the \_\_\_\_\_ State/Country Licensing Board indicate that \_\_\_\_\_ physician was issued license number \_\_\_\_\_ on \_\_\_\_\_ to practice medicine in the State/Country of \_\_\_\_\_.

Respond to the following questions:

- 1. Is this license current and in good standing? \_\_\_\_\_ YES NO
- 2. Has any public or private action been taken against this physician? \_\_\_\_\_ YES NO
- 3. 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 # BOME0000 – NORTH CAROLINA MEDICAL BOARD**

# 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.**

## 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)

<b>APPLICANT</b>	LEAVE BLANK	TYPE OR PRINT ALL INFORMATION IN BLACK						ED1	LEAVE BLANK		
		LAST NAME <u>NAM</u>	FIRST NAME	MIDDLE NAME							
SIGNATURE OF PERSON FINGERPRINTED <b>2</b>		ALIASES <u>AKA</u> <b>3</b>		O R I	<u>NCBCT0000</u> <u>ST BU OF INV</u> <u>RALEIGH, NC</u>			DATE OF BIRTH <u>DOB</u> Month <u>4</u> Day <u>  </u> Year <u>  </u>			
RESIDENCE OF PERSON FINGERPRINTED <b>5</b>		CITIZENSHIP <u>CTZ</u>		SEX	RACE	HAIR	EYES	EAR	PLACE OF BIRTH <u>POB</u>		
DATE <u>13</u>	SIGNATURE OF OFFICIAL TAKING FINGERPRINTS <u>14</u>		YOUR NO. <u>OCA</u>		<u>6</u>	<u>7</u>	<u>8</u>	<u>9</u>	<u>10</u>	<u>11</u>	<u>12</u>
EMPLOYER AND ADDRESS <u>North Carolina Medical Board</u> <u>PO Box 20007</u> <u>Raleigh, NC 27619-0007</u>		FBI NO. <u>EBJ</u>		SOCIAL SECURITY NO. <u>SOC</u> <u>15</u>		LEAVE BLANK					
REASON FINGERPRINTED <u>Medical License Applicant</u> <u>State and Federal</u> <u>NCCGS 90-11</u>		ARMED FORCES NO. <u>MNU</u>		MISCELLANEOUS NO. <u>MNU</u>		CLASS _____					
						REF _____					
<p><b>This is a SAMPLE CARD</b></p> <p><b>Do <u>NOT</u> put prints on this card</b></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					

**To request cards be mailed to you, please e-mail: [fpc@ncmedboard.org](mailto:fpc@ncmedboard.org)**



## Request and Authorization for Release of Information

Please type or print information to send to third party. Scores are automatically sent to PA. Duplicate as needed.

### Section 1: Identification

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Daytime Telephone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Social Security No.: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

### Section 2: Exam Information

Indicate for which exam and examination period you're requesting information. (Only one request per form.)

- PANCE (Physician Assistant National Certifying Exam)
- PANRE (Physician Assistant National Recertifying Exam)
- Pathway II
- Surgery Exam

Year: \_\_\_\_\_

### Section 3: Information Request

Indicate the nature of this request and the person or agency to whom it should be sent.

- Eligibility letter, verifying that you are eligible for and registered to take the above exam
- Exam results

(Complete only if different from above.)

Name: \_\_\_\_\_

Agency: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Want us to send the information via fax? If so, please provide the fax number here: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

### Section 4: Signature and Authorization

*Each state licensing authority sets its own rules and regulations. NCCPA strives to stay up-to-date on individual state regulations. We will send the required information, which may consist of current scores and/or score history, to the agency listed above in accordance with the information on state requirements on file with NCCPA.*

I acknowledge that I have read and understand the above statement and authorize NCCPA to release all information required by the agency listed above.

\_\_\_\_\_  
(signature)

\_\_\_\_\_  
(date)