REQUIREMENTS FOR SPECIAL PURPOSE 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

The Special Purpose License is for physicians who wish to come to North Carolina for a limited time, scope and purpose, such as to demonstrate or learn a new technique, procedure or piece of equipment, or to educate physicians or medical students in an emerging disease or public health issue.

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 via e-mail at license@ncmedboard.org.

These are the requirements for licensure, but the Board reserves the right to make whatever additional demands it deems appropriate (at the time.)

Application credentials 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 credentials and the application fee.

1. Completed application form
   - Circle the correct answer for all questions and provide a detailed explanation for all affirmative answers.
   - A claim form must be completed for EACH malpractice suit or settlement (photocopy as needed). ATTACH A PHOTOCOPY OF PLAINTIFF'S COMPLAINTS AND SETTLEMENT ORDERS FOR EACH INCIDENT.
   - Attach a photograph taken within the past year to the applicant's oath and have the form notarized.
   - 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.
   - Copy of your Curriculum Vitae (CV).

2. Verification from local facility/group to participate in a learning/teaching procedure giving details stating the name of local facility/group where the procedure(s) will be performed, length of time of the procedure(s), type of procedure, what the procedure(s) will include and the name of the physician responsible for overseeing the procedure(s).

3. Applicants must have verification of a full, unrestricted medical license mailed directly to the Board from one licensing jurisdiction. Most licensing agencies charge a fee for this 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 verification form to the Connecticut Department of Public Health.

4. Complete the Immigration Status form and provide supporting documentation.

5. Examination Score Transcripts must be sent from the examination source. If you took:

   1 – USMLE – visit the Federation of State Medical Board's website www.fsmb.org and have your transcripts sent to us electronically.

   2 – COMLEX – visit the National Board of Osteopathic Examiners website www.nbome.org and request to have your transcripts forwarded to us.

6. Criminal Background Check

   Applicants outside North Carolina

   Request a set of fingerprint cards to be mailed to you at fpc@ncmedboard.org. You will need to send in the authority to release form and fingerprint cards to the NCMB.

   Applicants in North Carolina

   Live scan is available to those applicants who are in NC. You will need to go to your local law enforcement office to have this completed. You will need to take the Applicant Information form with you. The Electronic Authority to Release form will need to be sent to the NCMB.

   The authority to release forms can be emailed to license@ncmedboard.org.

7. A fee of $388.00 U.S. dollars is to be paid at the time the application is submitted. ($350.00 for the license application fee and $38.00 for the criminal background check fee). Check 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. Applications will not be processed until application fee has been received.

8. When all applications 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. You will be notified regarding the board member's decision.

RENEWAL - NORTH CAROLINA LAW REQUIRES LICENSED PHYSICIANS TO RENEW WITH THE BOARD WITHIN 30 DAYS OF THEIR BIRTH DATE, EVERY YEAR, NO MATTER WHEN THE LICENSE IS ISSUED. A RENEWAL FEE IS REQUIRED.

Revised: 8/14

APPLICATION FOR NORTH CAROLINA SPECIAL PERMIT

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. ____________________
____
____

CHRONOLOGY: List in chronological order EVERYTHING you have done since high school. This would include places of employment, hospitals, teaching institutions, private practice, corporations, military assignments, government agencies and Locum Tenens assignments. The Board requires you to account for any and all time. They will not allow any time gaps. You will need to label any unemployed time as "vacation" or "sabbatical" (give details) or "moving" (whatever is appropriate). A CV will NOT replace completing this section of the application.

From	To	At Place of Institution or Employment	Geographical Location	Type of Employment, Intern, or Residency, etc.
From ________	To ________	At		
From ________	To ________	At		
From ________	To ________	At		
From ________	To ________	At		
From ________	To ________	At		
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From ________	To ________	At		
From ________	To ________	At		
From ________	To ________	At		
From ________	To ________	At		

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 of 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

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___

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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

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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

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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).**

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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). **

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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. **

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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, 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). **

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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.

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North Carolina Medical Board
PO Box 20007
Raleigh, NC 27619

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 did witness this applicant complete this form including the handwritten statement above.

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.

NORTH CAROLINA MEDICAL BOARD

CLAIMS INFORMATION FORM

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. Is the claim pending? Yes No

5. Was there a judgment or settlement? Yes No

6. What was the amount and date of the judgment or settlement? ______________________________

7. Comments: ______________________________

   ____

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

Signature: ______________________________ Date: ______________

Printed Name: ______________________________ Social Security Number: ______________

VERIFICATION OF ACTIVITIES IN CONNECTION WITH THE ISSUANCE OF A NORTH CAROLINA SPECIAL PERMIT

A Special Permit issued by the North Carolina Medical Board allows a physician not otherwise licensed to practice medicine in North Carolina to come into the state for a limited time to perform medical or surgical acts for certain purposes such as teaching or learning medical or surgical procedures or techniques.

PHYSICIANS NAME

____

NAME OF LOCAL AND ADDRESS OF FACILITY OR GROUP WHERE PROCEDURE WILL BE PERFORMED:

____

____

____

BEGINNING AND ENDING DATE OF ACTIVITY:

____

TYPE OF PROCEDURE:

____

DETAILS OF PROCEDURE:

____

____

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____

____

NAME OF NORTH CAROLINA LICENSED PHYSICIAN RESPONSIBLE FOR OVERSEEING PERFORMANCE OF PROCEDURE(S) AND THE TRAINING OR EDUCATIONAL ACTIVITIES:

____

____

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:

____

____

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____

____

____

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 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.

Revised: 4/10

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	Initials-Date
Petition under investigation (see attached)	________
Confidential action (see attached)	________
No confidential action	________

DBB:

0241Q

NORTH CAROLINA MEDICAL BOARD

PO BOX 20007
Raleigh, NC 27619

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

APPLICANT INFORMATION

Last Name: ______________________ **Date of Birth:** __________________

First Name: _____________________ **Place of Birth** __________________

Middle Name: ____________________ **Residence:** ____________________

Maiden Name: ____________________ ______________________________

Aliases: ________________________
____

Employer and Address:
NC Medical Board
PO Box 20007 Raleigh, NC 27619

Sex: Male _______ **Female** ________

Reason Fingerprinted:

NCGS 90-11- State and Federal

Race: ________________________
(write the appropriate letter in the space provided)

W – White, B – Black, I – American Indian,
A – Asian or Pacific Islander, U - Unknown

Social Security Number: __________
(*Optional)

Your Case No. (OCA): **BOME00000**

Height: _________________________

Type of Transaction: **__NFUF________**
Non fed-User Fee

Weight: _________________________

NC FP Card Type: **_ _BOME_______**

Eye Color: ______________________
(write the appropriate letters in the space provided)

BLK – Black GRY – Gray MAR – Maroon
BLU – Blue BRO – Brown GRN – Green
HAZ – Hazel PNK – Pink XXX – Unknown

Hair Color: ______________________
(write the appropriate letters in the space provided)

BAL – Bald BLK – Black BLN – Blonde or Strawberry
BRO – Brown GRY – Gray or partially
RED – Red or Auburn SDY - Sandy

*Disclosure of social security number is entirely voluntary and not required. If disclosed, the social security number will be utilized to assist with accurate identification/exclusion of possible criminal history records.

ROY COOPER
ATTORNEY GENERAL

NORTH CAROLINA
STATE BUREAU OF INVESTIGATION
DEPARTMENT OF JUSTICE
3320 GARNER ROAD
PO BOX 29500
RALEIGH, NC 27626-0500
(919) 662-4500
FAX: (919) 662-4523

GREGORY S. MCLEOD
DIRECTOR

ELECTRONIC FINGERPRINT SUBMISSION RELEASE OF INFORMATION

I authorize the North Carolina Department of Justice through the State Bureau of Investigation, Criminal Information and Identification Section, to perform a national criminal history record check in connection with my application for licensure with NC Medical Board pursuant to NCGS 90-11.

I understand that the North Carolina State Bureau of Investigation, Criminal Information and Identification Section, the Federal Bureau of Investigation, and its officials and employees shall not be held legally accountable in any way for providing this information to the above named agency, 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 understand that the above named agency cannot provide a hard copy of the results of this criminal history record check to me.

______________________________ ____________________
Applicant/Licensee's Signature Date

I authorize the above named subject to be fingerprinted and have the fingerprints submitted to the SBI electronically.

05/22/2013

______________________________ ____________________
Agency Authorized Official's Signature Date

Agency Contact Information
Joy Cooke
NC Medical Board
PO Box 20007
Raleigh, NC 27619
919-326-1100
license@ncmedboard.org

I certify that I have taken the fingerprints of the above named subject and forwarded them electronically to the State Bureau of Investigation.

______________________________ ____________________
Signature of Official Taking Fingerprints Date

Agency Seal/Certification ____

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.

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
LAST NAME NAM FIRST NAME MIDDLE NAME
1

FBI LEAVE BLANK

SIGNATURE OF PERSON FINGERPRINTED
2

ALIASES AKA
3

ORI
NCBCI0000
ST BU OF INV
RALEIGH, NC

RESIDENCE OF PERSON FINGERPRINTED
5

DATE OF BIRTH DOB
Month Day Year
4

CITIZENSHIP CTZ

SEX	RACE	HGT.	WGT.	EYES	HAIR	PLACE OF BIRTH POB
6	7	8	9	10	11	12

DATE
13

SIGNATURE OF OFFICIAL TAKING FINGERPRINTS
14

YOUR NO. OCA
BOME00000

LEAVE BLANK

EMPLOYER AND ADDRESS
North Carolina Medical Board
PO Box 20007
Raleigh, NC 27619-0007

FBI NO. FBI

ARMED FORCES NO. MNU

CLASS

REF

REASON FINGERPRINTED
Medical License Applicant
State and Federal
NCGS 90-11

SOCIAL SECURITY NO. SOC
15

MISCELLANEOUS NO. MNU

This is a SAMPLE CARD

Do NOT put prints on this card

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

To request cards be mailed to you, please e-mail: fpc@ncmedboard.org

LEFT FOUR FINGERS TAKEN SIMULTANEOUSLY
L. THUMB
R. THUMB
RIGHT FOUR FINGERS TAKEN SIMULTANEOUSLY

NORTH CAROLINA MEDICAL BOARD

1203 Front Street
Raleigh, NC 27609
(919) 326-1100

Applicants for North Carolina medical license are required to complete this form and return to the North Carolina Medical Board with your application form.

I acknowledge it is my responsibility to be familiar with the North Carolina Medical Practice Act and the North Carolina Medical Board's rules and position statements. These can be found on the Board's web site at www.ncmedboard.org.

Name: ______________________________ (Printed)

_____-_____-_____ Social Security No.

Name: ______________________________ (Signature)

Date: ____________________