

APPLICATION FOR LIMITED VOLUNTEER LICENSE

Application for retired physicians who are working at clinics specializing in the treatment of indigent patients.

Enclosed is an application for you to submit to the Board pursuant to your desire for a Limited Volunteer License. The law permits the Board to issue a Limited Volunteer License, authorizing the holder to practice medicine and surgery **ONLY** at clinics, which specialize in the treatment of indigent patients. This license may be issued to an applicant who is a retired physician and has allowed his or her license to practice medicine and surgery in this State or another State to become inactive. If you have never held a North Carolina medical license, you must have the Licensing Board for each state where you have held a license complete the enclosed Licensure Biography form and return to this Board. You will need to complete the AMA Physician Profile Order Form and forward to the American Medical Association. You are also requested to provide documentation of continuing medical education you have received since placing your NC medical license in an inactive status (if applicable).

You shall not receive or accept any compensation or payment, direct, monetary, in-kind, or otherwise, for the provision of medical services pursuant to the Special Volunteer License. You will be required to comply with Continuing Medical Education requirements as required by NC General Statute 90-14 (a)(15).

We ask that you provide the additional information requested in the enclosed application so that our files can be complete and so that we may contact you as the need might arise. No **application fee** is required. However, every physician who holds a license is required to register that license within 30 days of their date of birth each year. A registration notice will be sent to the mailing address on file in the Board's office. An annual registration fee is required.

If we can be of further assistance, please contact us.

Please visit the Board's website www.ncmedboard.org for details regarding CME requirements.

STATEMENT OF APPLICANT FOR RETIRED VOLUNTEER LICENSE

By my signature below, I certify that I have no expectation of payment or compensation for any medical services I render pursuant to the Limited Volunteer License, if granted by the Board. I certify that I shall not receive or accept any compensation or payment, direct, monetary, in-kind, or otherwise, for the provision of medical services pursuant to the Limited Volunteer License. I understand I will be required to comply with Continuing Medical Education requirements as required by NC General Statute 90-14 (a)(15). I understand the Limited Volunteer License allows me to practice medicine and surgery only at clinics that specialize in the treatment of indigent patients.

I propose to practice in the following location(s):

Full Name (Printed)

Social Security Number

Signature

Date

**APPLICATION FOR LICENSE TO PRACTICE MEDICINE THROUGH A
LIMITED VOLUNTEER LICENSE-INDIGENT CLINICS**

**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: _____

Inactive North Carolina License Number: _____

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

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

Current Medical Specialty: _____ Sub Specialty: _____

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.

For the purpose of questions 1-5, you should answer the question affirmatively if you know of any complaint or investigation that has been made, regardless of whether you consider the complaint or investigation frivolous or groundless and regardless of the disposition.

1. Are you aware of any complaint or investigation, past or present, regarding you that has been received or conducted by any governmental agency or any professional licensing board or agency? YES NO

2. Have you ever been denied a license or the privilege of taking an examination by any professional licensing board or agency or withdrawn an application made to any professional licensing board or agency? YES NO

3. Have you ever surrendered any license? YES NO

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

Actions include revocations, suspensions, probations, limitations/restrictions, disciplinary/non-disciplinary actions, fines, or the issuance of a license through a public/private consent order.

Regulatory board or agency includes any professional licensing board or agency, the U.S. Food and Drug Administration, the U.S. Drug Enforcement Administration, Medicare, or Medicaid.

5. Have you ever been investigated by or met with or been requested to appear before any professional licensing board or agency, military or federal agency, medical society, or any representative of such organizations? YES NO

6. Have you ever been warned, censured, disciplined, had admissions monitored, had privileges limited, had privileges suspended, been put on probation, or been requested to withdraw or resign privileges, or been denied staff membership by any facility in which you have trained or been a staff member? YES NO

7. Has a registration issued to you by the U.S. Drug Enforcement Administration or a state equivalent, been revoked, suspended, had probationary terms placed against it, been limited or restricted, or had other disciplinary action placed against it? YES NO

FOR THE PURPOSE OF QUESTIONS 8 & 9, IF "YES", SUBMIT COPIES OF ALL RELEVANT DOCUMENTATION, SUCH AS POLICE REPORTS, CERTIFIED COURT RECORDS AND DISPOSITIONS.

8. Have you ever been charged with (arrested, indicted or arraigned), convicted of, pled guilty to, pled no contest to, or received a prayer for judgment continued (PJC) for a violation of federal, state or local law, excluding minor traffic violations? YES NO

Name: _____
(Printed)

9. Have you ever been ARRESTED FOR OR CHARGED WITH driving under the influence or driving while impaired? YES NO

10. In the past five (5) years have you used or consumed any controlled substances or other prescription drugs other than those lawfully prescribed for you, by another authorized healthcare professional or have you used illegal drugs? "Used illegal drugs" means the use of controlled substances obtained illegally, such as, but not limited to heroin or cocaine, as well as the use of controlled substances that are not obtained pursuant to a valid prescription or not taken in accordance with the direction of a licensed healthcare practitioner. YES NO

11. 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 when on duty? YES NO

12. Do you have any medical conditions? (Do not use abbreviations in your response). ("Medical conditions" include physiologic, psychiatric, psychologic conditions or disorders including but not limited to orthopedic, ophthalmologic, neuromuscular problems, speech and hearing impairment or infectious disease). YES NO

13. Have you ever been named as a defendant or as an agent of a hospital that provides sovereign immunity, in a legal action involving professional liability (malpractice)? If yes, complete the claims information form for each claim including the following information; patient name, date of incident, date and amount of payment. Please provide the name of insurance company and their address. In addition to information provided above you must submit a photocopy of the plaintiffs' complaint and settlement order if available. Provide 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. YES NO

14. Have you ever had a professional liability policy cancelled or not renewed? YES NO

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

16. Have you ever been suspended from, placed on scholastic or disciplinary probation, expelled or requested to resign from any school, including medical school? YES NO

17. Are you aware of any reports made about you to the National Practitioner's Data Bank (NPDB) or the Healthcare Integrity & Protection Data Bank (HIPDB)? YES NO

Name: _____
(Printed)

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

AMA Physician Profile Unit
515 North State St
Chicago, IL 60610

Telephone: 312 464-5199
Fax: 312 464-5900

AMA Physician Profile Order Form -- Physician Use Only

Complete and send this form to the American Medical Association (AMA) at the above address. Profiles also can be ordered online through **AMA ePhysician Profiles** located at <http://www.ama-assn.org/AMAPhysicianProfiles>. AMA Customer Service is available for ordering assistance at 800-665-2882 or 312-464-5199, Monday through Friday, 8:30am - 4:45pm CT.

*****Join or renew your AMA membership today---call 800-AMA-3211*****

Indicate AMA Membership Status: _____ Member Physician _____ Nonmember Physician

Membership Type	Standard Mail Service* (within 10 business days)	Express Service* (within 5 business days)
AMA Member Physician	No charge	\$6 per profile
Nonmember Physician	\$26 per profile	Not available

***Prices are subject to change without advance notice.**

Credit card payment is accepted. Checks should be made payable to the American Medical Association, Remittance Control Area/PPS, Accounting Department, PO Box 109054, Chicago, IL 60610. Orders faxed to the AMA must include credit card information for billing purposes.

___ VISA ___ American Express ___ MasterCard Charge Amount: \$ _____

Credit Card Number _____

Expiration Date: ____/____/____

Name on Credit Card: _____

Billing Address: _____

Approval Signature _____ Daytime Telephone: _____

Part 1: AMA Physician Profile Delivery Information

Please send my profile to the following state licensing or medical specialty board:

Board Name: _____

NOTE: When requesting delivery to a state licensing board, indicate MD or DO profession type.

Part 2: Physician Information

Physician Name (first, middle, last, suffix) _____

Place of Birth _____

_____/_____/_____
Date of Birth

Social Security Number

E-mail Address _____

Medical Education Number (optional)

Preferred Mailing Address _____

City, State, Zip Code _____ (____)_____-_____

Telephone Number _____

The above address is my OFFICE ___ HOME ___ OTHER ___

If address is home or other, please complete this section.

Primary Office Address _____

City _____

State _____

Zip Code _____

(____)_____-_____
Office Telephone Number

American Medical Association

Physicians dedicated to the health of America



Part 3: Medical Education and Other Information

Medical School of Graduation

Year of Graduation

DEA Number

ECFMG Number

Residency Training

Residency Training (institution/hospital name, location, and years)

Hospital Admitting Privileges

Hospital Name

City/State

Group Practice Affiliation(s)

Group Practice Name

City/State

Physician Agreement

Agreement must be signed in order to process your request.

AMA endeavors to maintain its physicians' records with information that is complete, current, and timely; however, because of possible reporting and processing delays, no representations or warranties as to the accuracy or completeness can be or is made. In consideration of the receipt of your physician record provided by AMA, hereby release AMA, its agents and servants from any and all liability whatsoever for inaccurate or incomplete information in such physician record. Submission of this form and payment of fee (if applicable) shall be conclusive evidence of your understanding and agreement to the above stated terms and conditions.

X _____
Signature

_____/_____/_____
Date

LICENSE VERIFICATION FORM

Applicant: If you have ever held a license in one of the following professions: medical (other than a training license), dental, nursing, and/or law, complete the top portion of this form and forward one copy to each licensing board in the state(s) where you have held OR currently hold a professional license. This form should be returned to you to be enclosed with your license application. Most states require a fee for processing. The fee is the applicant's responsibility.

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 TO THE PHYSICIAN AT THE ADDRESS INDICATED ABOVE.

This is to certify that the records of the _____ Professional Licensing Board/Board of Medical Examiners indicate that _____ MD/DO 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.

IF ANY ADVERSE INFORMATION IS AVAILABLE, PLEASE MAIL DIRECTLY TO THE NORTH CAROLINA MEDICAL BOARD, P.O. Box 20007, RALEIGH, NC 27619.

(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

CRIMINAL BACKGROUND CHECK INSTRUCTIONS

Effective February 1, 2003, pursuant to N.C. G.S. 90-11 (b) and 21 N.C.A.C. 32B.0104, applicants for licensure by this Board must provide fingerprints as set forth in the above-referenced rule in order for the Board to conduct a state and federal criminal history record check.

To ensure the proper finger print card is used you should email the North Carolina Medical Board's License Department at license@ncmedboard.org and request a set of cards be sent to you. On the card containing your fingerprints, you must fill in the information in each block that is checked on the example. Be aware that photo identification and a fee may be required by the law enforcement agency performing this service. Fingerprints of poor quality will be rejected and new prints will be required. If this occurs there will be a delay in processing your application. Once the cards are rejected new cards must be submitted within 90 days of being notified or the process will have to be restarted. Enclosed is a sample fingerprint card with instructions. It takes approximately 8-12 weeks to process, but on occasion may take longer.

Send the properly completed fingerprint cards, the form entitled "Authority For Release of Information" completed by you, and a check in the amount of \$38.00 payable to the North Carolina Medical Board. Checks made payable to the State Bureau of Investigation will not be accepted. The fee of \$38.00 will be paid by the North Carolina Medical Board to the North Carolina State Bureau of Investigation in accordance with the statute for the record check. You may pay the fingerprint and application fees in one check.

Any questions regarding this procedure can be submitted by email to the license department at license@ncmedboard.org.

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						LEAVE BLANK	LEAVE BLANK	
		LAST NAME <u>NAM</u>	FIRST NAME	MIDDLE NAME						
SIGNATURE OF PERSON FINGERPRINTED <u>2</u>		ALIASES <u>AKA</u> <u>3</u>		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 <u>5</u>		CITIZENSHIP <u>CTZ</u>		SEX <u>6</u>	RACE <u>7</u>	HGT. <u>8</u>	WGT. <u>9</u>	EYES <u>10</u>	HAIR <u>11</u>	PLACE OF BIRTH <u>POB</u> <u>12</u>
DATE <u>13</u>	SIGNATURE OF OFFICIAL TAKING FINGERPRINTS <u>14</u>		YOUR NO. <u>OCA</u> <u>BOME00000</u>		LEAVE BLANK					
EMPLOYER AND ADDRESS North Carolina Medical Board PO Box 20007 Raleigh, NC 27619-0007			FBI NO. <u>FBJ</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> <u>15</u>							
			MISCELLANEOUS NO. <u>MNU</u>							

This is a SAMPLE CARD

**Do NOT put prints on
this card**

1. R. THUMB

2. R. INDEX

4. R. RING

5. R. LITTLE

6. L. THUMB

7. L. INDEX

8. L. MIDDLE

9. L. RING

10. L. LITTLE

To request cards to mailed to you please email: license@ncmedboard.org

LEFT FOUR FINGERS TAKEN SIMULTANEOUSLY

L. THUMB

R. THUMB

RIGHT FOUR FINGERS TAKEN SIMULTANEOUSLY

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.

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: _____