

North Carolina Medical Board Applicant's Oath

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

Applicant's Printed Name

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

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

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

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

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

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

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

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

Applicant's Signature

Applicant's Soc. Sec. Number

Applicant's Printed Name

Applicant's Date of Birth

Date of Signature

NOTARY PUBLIC

State of _____, County of _____.

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

My commission expires: _____

Notary Public

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

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

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

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

VERIFICATION OF MEDICAL EDUCATION FORM A
DO NOT ALTER

THIS FORM IS FOR MEDICAL STUDENTS WHO HAVE COMPLETED THE REQUIREMENTS FOR THE MEDICAL DEGREE BUT HAVE NOT YET RECEIVED THE DEGREE.

Please return the form to: _____

Name of Applicant: _____

Name of Medical School: _____

Medical School Address: _____

City: _____ State: _____ Zip: _____

Country: _____

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

Enrollment and Participation:

Our records indicate _____ **has** completed the requirements for the MD/DO degree.
(Applicants name)

This institution's minimum attendance requirement is _____ weeks.

This individual is **anticipated** to receive the MD or DO degree on _____
month/year

The Dean or other medical school official must complete the certification and sign.

Certification: By my signature, I _____,
(Print Name)

certify that the above information is an accurate account of the above named individual's office records maintained in this and is true and correct to my knowledge.



Signature of certifying official: _____
(Original Signature Required)

Title: _____

Date of signature: _____

Email address: _____

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. Please check the appropriate response and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation (attach additional pages as necessary).

1. Does this individual's official records reflect (an) interruption(s) or extension(s) in his/her medical education? Yes () No ()

If YES, select the reasons(s) for, indicate the dates of the interruption(s) or extensions(s) and check whether the interruption/extension was approved or unapproved.

	<u>From Mo/Yr</u>	<u>To Mo/Yr</u>	<u>Approved</u>	<u>Unapproved</u>
<u>Personal/Family</u>	()	()	()	()
<u>Academic remediation</u>	()	()	()	()
<u>Health</u>	()	()	()	()
<u>Financial</u>	()	()	()	()
<u>Participation in joint degree program</u>	()	()	()	()
<u>Participation in non-research special study (e.g., fellowship, international experience)</u>	()	()	()	()
<u>Participation in non-degree research</u>	()	()	()	()
<u>Other</u>	()	()	()	()

Please specify _____

2. Does this applicant's official record reflect he/she was ever placed on academic or disciplinary probation during his/her medical education? Yes () No ()

	<u>From Mo/Yr</u>	<u>To Mo/Yr</u>
<u>Academic Probation</u>		
<u>Probation for unprofessional conduct/behavior</u>		
<u>Probation for other reason</u>		

Please specify reason: _____

3. Does this applicant's official records reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? Yes () No ()

If YES, provide detailed documentation/information about the circumstances and outcomes(s):

4. Does this applicant's official records reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medial school or parent university? Yes () No ()

If YES, provide detailed documentation/information about the circumstances and outcomes(s):

5. Does this applicant's official records reflect that there were any limitations or special requirements imposed on the physician because of questions of academic incompetence, disciplinary problems, or any other reason? Yes () No ()

If YES, provide detailed documentation/information about the circumstances and outcomes(s):

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:

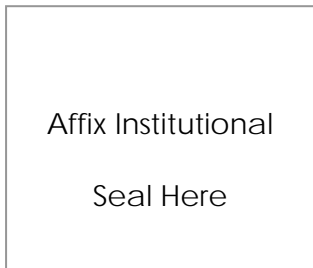
Type of Clinical Rotation	Dates Attended (Month/Day/Year)		Number of Weeks Credit
	From	To	
	/ /	/ /	
	/ /	/ /	
	/ /	/ /	
	/ /	/ /	

<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

VERIFICATION OF MEDICAL EDUCATION FORM B
DO NOT ALTER

Please return the form to: _____

Form should be sent to your GME office _____

Name of Physician: _____

Name of Institution: _____

Institution Address: _____

City: _____ State: _____ Zip: _____

Country: _____

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

Enrollment and Participation:

Our records indicate _____ attended our medical school for a total of _____
(Physicians name)

_____ weeks of medical education on the following dates (mm/dd/yy):

From _____ to _____

This institution's minimum attendance requirement is _____ weeks.

This individual was awarded the medical degree on _____
month/year

The Dean or other medical school official must complete the certification and sign.

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

**Affix Institutional Seal
Here**

Signature of certifying official: _____
(original signature required)

Title: _____

Date of signature: _____

Verification of Medical Education
Page 2 of 2

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the physician's medical education. Please check the appropriate response and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation (attach additional pages as necessary).

1. Does this individual's official records reflect (an) interruption(s) or extension(s) in his/her medical education? Yes () No ()

If YES, select the reasons(s) for, indicate the dates of the interruption(s) or extensions(s) and check whether the interruption/extension was approved or unapproved.

	<u>From Mo/Yr</u>	<u>To Mo/Yr</u>	<u>Approved</u>	<u>Unapproved</u>
<u>Personal/Family</u>	()	()	()	()
<u>Academic remediation</u>	()	()	()	()
<u>Health</u>	()	()	()	()
<u>Financial</u>	()	()	()	()
<u>Participation in joint degree program</u>	()	()	()	()
<u>Participation in non-research special study (e.g., fellowship, international experience)</u>	()	()	()	()
<u>Participation in non-degree research</u>	()	()	()	()
<u>Other</u>	()	()	()	()

Please specify _____

2. Does this physician's official record reflect he/she was ever placed on academic or disciplinary probation during his/her medical education? Yes () No ()

	<u>From Mo/Yr</u>	<u>To Mo/Yr</u>
<u>Academic Probation</u>		
<u>Probation for unprofessional conduct/behavior</u>		
<u>Probation for other reason</u>		

Please specify reason: _____

3. Does this physician's official records reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? Yes () No ()

If YES, provide detailed documentation/information about the circumstances and outcomes(s):

4. Does this physician's official records reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medial school or parent university? Yes () No ()

If YES, provide detailed documentation/information about the circumstances and outcomes(s):

5. Does this physician's official records reflect that there were any limitations or special requirements imposed on the physician because of questions of academic incompetence, disciplinary problems, or any other reason? Yes () No ()

If YES, provide detailed documentation/information about the circumstances and outcomes(s):

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, US territories or Canadian provinces 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.

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: _____		Attention: Program Director		
Address: _____		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: _____ <input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Chief Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Research	Specialty/Subspecialty: _____ From: _____ To: _____ Successfully Completed: ___ Yes ___ No ___ In Progress Accredited By: ___ ACGME ___ AOA ___ CFPC ___ ___ RCPSC Other: _____ (Specify)		
	PGY: _____ <input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Chief Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Research	Specialty/Subspecialty: _____ From: _____ To: _____ Successfully Completed: ___ Yes ___ No ___ In Progress Accredited By: ___ ACGME ___ AOA ___ CFPC ___ ___ RCPSC 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> <p>_____</p> <p>_____</p> <p>_____</p>		Yes Yes Yes Yes Yes	No No No No 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: _____			

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

County: _____ NOTARY PUBLIC _____

My Commission Expires _____

NOTARY SEAL

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 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.

Fingerprint cards should be taken to your local law enforcement agency. Be aware the law enforcement agency may require photo identification and a fee for performing the fingerprinting.

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	
SIGNATURE OF PERSON FINGERPRINTED 2		LAST NAME NAM		FIRST NAME 1		MIDDLE NAME			
RESIDENCE OF PERSON FINGERPRINTED 5		ALIASES AKA 3	O R I	NCBCI0000 ST BU OF INV RALEIGH, NC			DATE OF BIRTH DOB Month 4 Day Year		
DATE 13		CITIZENSHIP CIZ					SEX 6	RACE 7	HGT. 8
SIGNATURE OF OFFICIAL TAKING FINGERPRINTS 14		YOUR NO. OCA		LEAVE BLANK					
EMPLOYER AND ADDRESS North Carolina Medical Board PO Box 20007 Raleigh, NC 27619-0007		FBI NO. ERJ							
REASON FINGERPRINTED Medical License Applicant State and Federal NCGS 90-11		ARMED FORCES NO. MNU							
		SOCIAL SECURITY NO. SOC 15							
		MISCELLANEOUS NO. MNU		CLASS _____					
				REF _____					
<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	
<p>To request cards be mailed to you, please e-mail: fpc@ncmedboard.org</p>									
LEFT FOUR FINGERS TAKEN SIMULTANEOUSLY				L. THUMB		R. THUMB		RIGHT FOUR FINGERS TAKEN SIMULTANEOUSLY	