NOTE TO APPLICANTS:

This document is NOT a paper version of the licensure application. Some applicants have technical difficulties that prevent them from completing all sections of the online application. This document is intended to provide hard copies of any forms these applicants are unable to complete during the online application process.

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.

VERIFICATION OF MEDICAL EDUCATION

Please return the form to: **NORTH CAROLINA MEDICAL BOARD**
P.O. Box 20007
Raleigh, NC 27619

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

This individual did not receive a medical degree and left the institution 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 is required)

Title: _____

Email address: _____

Date of signature: _____

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.

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

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 ( )

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

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
PHYSICIAN REFERENCE FORM

P.O. Box 20007, Raleigh, NC 27619
or
1203 Front Street, Raleigh, NC 27609

TO APPLICANT: The North Carolina Medical Board requests completion of **TWO** reference forms. These forms must be sent from the reference sources **directly** to the NC Medical Board.

In addition, the forms must meet the following criteria:

a) They must be completed and returned to the Board within six months of the date of your application.
b) They must have an original signature. Signature stamps will not be accepted.
c) They should be completed by physicians who have interacted with you within the past three years and who are knowledgeable about your competence in your intended area of practice.

Please be sure to indicate your name below for identification purposes.

Name of Applicant: _____
(Please Print Clearly)

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

REFERENCE SOURCE: Please complete this form and return to the NC Medical Board. Your response is confidential, pursuant to North Carolina law. **Please print or type all information.**

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

Name _____ MD/DO

Address _____ City _____ State _____ Zip _____

Phone Number _____ Email Address _____

1. How long have you known the applicant? _____

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

_____

If you answer "YES" to questions 3 - 9, you will need to provide an explanation.

3.	Have you ever received reports of poor medical practice by this physician or have you discussed concerns you had about his/her practice with medical staff officers at a hospital?	Yes	No	N/A
4.	Have you ever received reports of poor relationships between this physician and other health care workers?	Yes	No	N/A
5.	Do you know of any derogatory information about this physician with respect to his/her ability to practice medicine?	Yes	No	N/A
6.	Do you know if this physician has had any mental, emotional, or physical illnesses that have interfered with his/her medical practice within the past five (5) years?	Yes	No	N/A
7.	Do you know if this physician has abused alcohol or drugs or shown signs of chemical dependency within the past five (5) years?	Yes	No	N/A
8.	Do you know of any judgments, awards, payments or settlements regarding this physician?	Yes	No	N/A
9.	Do you know of any restrictions, limitations or other disciplinary actions of any nature taken against this physician by a hospital or other health care organization?	Yes	No	N/A

If you answer "NO" to questions 10 - 12, you will need to provide an explanation.

10.	Does this physician understand medical staff and hospital policies and abide by these policies?	Yes	No	N/A
11.	Does this physician enjoy professional respect among his or her colleagues and in the community where this physician practices?	Yes	No	N/A
12.	Do you recommend this physician for unrestricted medical licensure in North Carolina?	Yes	No	N/A
13.	Have you interacted with this physician within the past three years and are you knowledgeable about their competence in their intended area of practice.	Yes	No	N/A

***** Additional comments are encouraged and assist the Board in evaluating the applicant. *****

COMMENTS: _____

_____

_____

_____ _____

Signature **Title**

_____ _____

Name of Hospital (if applicable) **Date**

Revised: 7/2011

NORTH CAROLINA MEDICAL BOARD
PHYSICIAN REFERENCE FORM

P.O. Box 20007, Raleigh, NC 27619
or
1203 Front Street, Raleigh, NC 27609

TO APPLICANT: The North Carolina Medical Board requests completion of **TWO** reference forms. These forms must be sent from the reference sources **directly** to the NC Medical Board.

In addition, the forms must meet the following criteria:

a) They must be completed and returned to the Board within six months of the date of your application.
b) They must have an original signature. Signature stamps will not be accepted.
c) They should be completed by physicians who have interacted with you within the past three years and who are knowledgeable about your competence in your intended area of practice.

Please be sure to indicate your name below for identification purposes.

Name of Applicant: _____
(Please Print Clearly)

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

REFERENCE SOURCE: Please complete this form and return to the NC Medical Board. Your response is confidential, pursuant to North Carolina law. **Please print or type all information.**

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

Name _____ MD/DO

Address _____ City _____ State _____ Zip _____

Phone Number _____ Email Address _____

1. How long have you known the applicant? _____

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

_____

If you answer "YES" to questions 3 - 9, you will need to provide an explanation.

3.	Have you ever received reports of poor medical practice by this physician or have you discussed concerns you had about his/her practice with medical staff officers at a hospital?	Yes	No	N/A
4.	Have you ever received reports of poor relationships between this physician and other health care workers?	Yes	No	N/A
5.	Do you know of any derogatory information about this physician with respect to his/her ability to practice medicine?	Yes	No	N/A
6.	Do you know if this physician has had any mental, emotional, or physical illnesses that have interfered with his/her medical practice within the past five (5) years?	Yes	No	N/A
7.	Do you know if this physician has abused alcohol or drugs or shown signs of chemical dependency within the past five (5) years?	Yes	No	N/A
8.	Do you know of any judgments, awards, payments or settlements regarding this physician?	Yes	No	N/A
9.	Do you know of any restrictions, limitations or other disciplinary actions of any nature taken against this physician by a hospital or other health care organization?	Yes	No	N/A

If you answer "NO" to questions 10 - 12, you will need to provide an explanation.

10.	Does this physician understand medical staff and hospital policies and abide by these policies?	Yes	No	N/A
11.	Does this physician enjoy professional respect among his or her colleagues and in the community where this physician practices?	Yes	No	N/A
12.	Do you recommend this physician for unrestricted medical licensure in North Carolina?	Yes	No	N/A
13.	Have you interacted with this physician within the past three years and are you knowledgeable about their competence in their intended area of practice.	Yes	No	N/A

***** Additional comments are encouraged and assist the Board in evaluating the applicant. *****

COMMENTS: _____

_____

_____

_____ _____

Signature **Title**

_____ _____

Name of Hospital (if applicable) **Date**

Revised: 7/2011

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 - Postgraduate Training Verification Form

Please mail completed forms to: **NC Medical Board**
PO Box 20007
Raleigh, NC 27619

Verification For:	**Full Name:** **SSN:**	**DOB:**
Institution: _____ **Address:** _____ _____	**Attention: Program Director** **Affiliated University:** _____ _____	
Program Participation: Report incomplete postgraduate years (PGY) separate from those that were successfully completed. If the postgraduate year is currently in progress report the expected completion date in the 'To' field.	**PGY**: _____ _____ Internship _____ Residency _____ Chief Residency _____ Fellowship _____ Research	**Specialty/Subspecialty:** _____ **From:** _____ **To:** _____ **Successfully Completed:** _____ Yes _____ No _____ In Progress **Accredited By:** _____ACGME _____ AOA _____CFPC _____ _____RCPSC Other: _____ (Specify)
	PGY: _____ _____ Internship _____ Residency _____ Chief Residency _____ Fellowship _____ 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.	**1)** Did this individual ever take a leave of absence or break from his/her training?	Yes	No
	2) Was this individual ever placed on probation?	Yes	No
	3) Was this individual ever disciplined or placed under investigation?	Yes	No
	4) Were any negative reports for behavioral reasons ever filed by instructors?	Yes	No
	5) Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason?	Yes	No
	Please explain any 'Yes' responses above: _____ _____ _____		

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

VERIFICATION OF FIFTH PATHWAY

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: _____
First Middle Last Suffix

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) From	To	Number of Weeks Credit
	/ /	/ /	
	/ /	/ /	
	/ /	/ /	
	/ /	/ /	

Unusual Circumstances:

Circle the correct response. Omitted responses require written explanation.

If necessary, you may continue your explanation on a separate sheet of paper.

Did this individual ever take a leave of absence or break from his/her training?	Yes	No
Was this individual ever placed on probation?	Yes	No
Was this individual ever disciplined or placed under investigation?	Yes	No
Did instructors ever file any negative reports on this individual?	Yes	No
Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reasons?	Yes	No

Please explain any 'Yes' responses from above:

_____

_____

_____

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

Certification: By my signature below, I, _____ (Print name), 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.

Affix Institutional Seal Here

(If your institution does not have an official seal, this form must be notarized)

Signature: _____

Title: _____

Date of Signature: _____

Phone Number: _____

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

Instruction Sheet for Completing the Fingerprint Cards

The NC Medical Board requires 2 fingerprint cards for processing. Failure to submit 2 fingerprint cards will delay your application if the first card is rejected.

1. The complete name of the subject is to be listed as indicated: Last name, First name, and Middle name. Please ensure the name is legible if written.

2. Signature of the subject being fingerprinted is written here.

3. List any and all alias names or nicknames, maiden name or any other married names.

4. List the date of birth numerically – month, day, and year.

   Example: May 11, 1948, should be shown as 05111948; October 15, 1930, should be shown as 10151930

5. Current residence of subject fingerprinted is written here.

6. Sex is to be listed M for male, and F for female, or U for Unknown.

7. Race is to be listed by placing an individual into one (1) of the following categories by writing the appropriate letter in the space provided:

W	White
B	Black
I	American Indian or Alaskan Native
A	Asian or Pacific Islander
U	Unknown if unsure or unable to determine

8. Indicate the subject's height in feet and inches using all numerics.

   Example: 6'01" = 601, 6'11" = 611, 6' = 600

9. Indicate the subject's weight in pounds using all numerics.

   Example: 186 or 098, etc.

10. List the subject's eye color by placing one (1) of the following eye color codes in the space provided:

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

11. Color of hair should be indicated by writing one (1) of the following color codes in the space provided:

    BAL – Bald (When subject has lost most of his hair or is hairless)
    BLK – Black
    BLN – Blond or Strawberry
    BRO – Brown
    GRY – Gray or partially
    RED – Red or Auburn
    SDY – Sandy

12. Indicate, if possible, the city and state where the subject was born. The state should be indicated by the two-digit abbreviation.

13. Indicate the date of the fingerprinting.

14. Signature of Official taking fingerprints.

15. Write the Social Security number in this space. The Social Security number is a very important identifier.

Due to the volume of fingerprints that get rejected, please read the following in order to obtain the best possible set of prints.

SBI FINGERPRINT REJECTION POLICY

The quality of ten-print fingerprint image submissions accepted by the North Carolina State Bureau of Investigation has deteriorated in the last few years. Poor quality fingerprint images result in decreased reliability for both ten-print and latent searches. Low quality fingerprint data are frequently the result of poor rolling practices as opposed to poor image scanning of the rolled prints. For records to be maintained in both the State and Federal level, fingerprints must be rolled from the tip to below the first joint, and nail to nail. Ridge characteristic must be distinct and fingerprint impressions must be in sequential order. We request that all law enforcement agencies and non-criminal justice agencies submit fingerprints that are of good quality.

The following is the SBI/Identification Section Fingerprint Rejection Policy implemented February 2, 2004:

1. Every criminal and applicant fingerprint card must have all ten fingerprint images of good quality. The ten fingerprint images of the plain impressions/slaps must be completely discernable thereby allowing comparison between the plain impressions and rolled impressions.

   NOTE: If a fingerprint in the plain impressions has been cut off (either too low or too high) the FBI cannot compare the rolled images to the plain images, and they will reject the card.

2. The exception to this is amputated, bandaged or deformed fingers. If one of these three notations is in a rolled impression block, there should be **NO** fingerprint in the plain impression/slaps.

3. Fingerprint cards submitted with the following will be rejected:

   - Hands out of sequence, or
   - Fingerprints out of sequence, or
   - Hand printed twice, or
   - Fingerprints printed twice, or
   - Fingerprints missing with no reason given

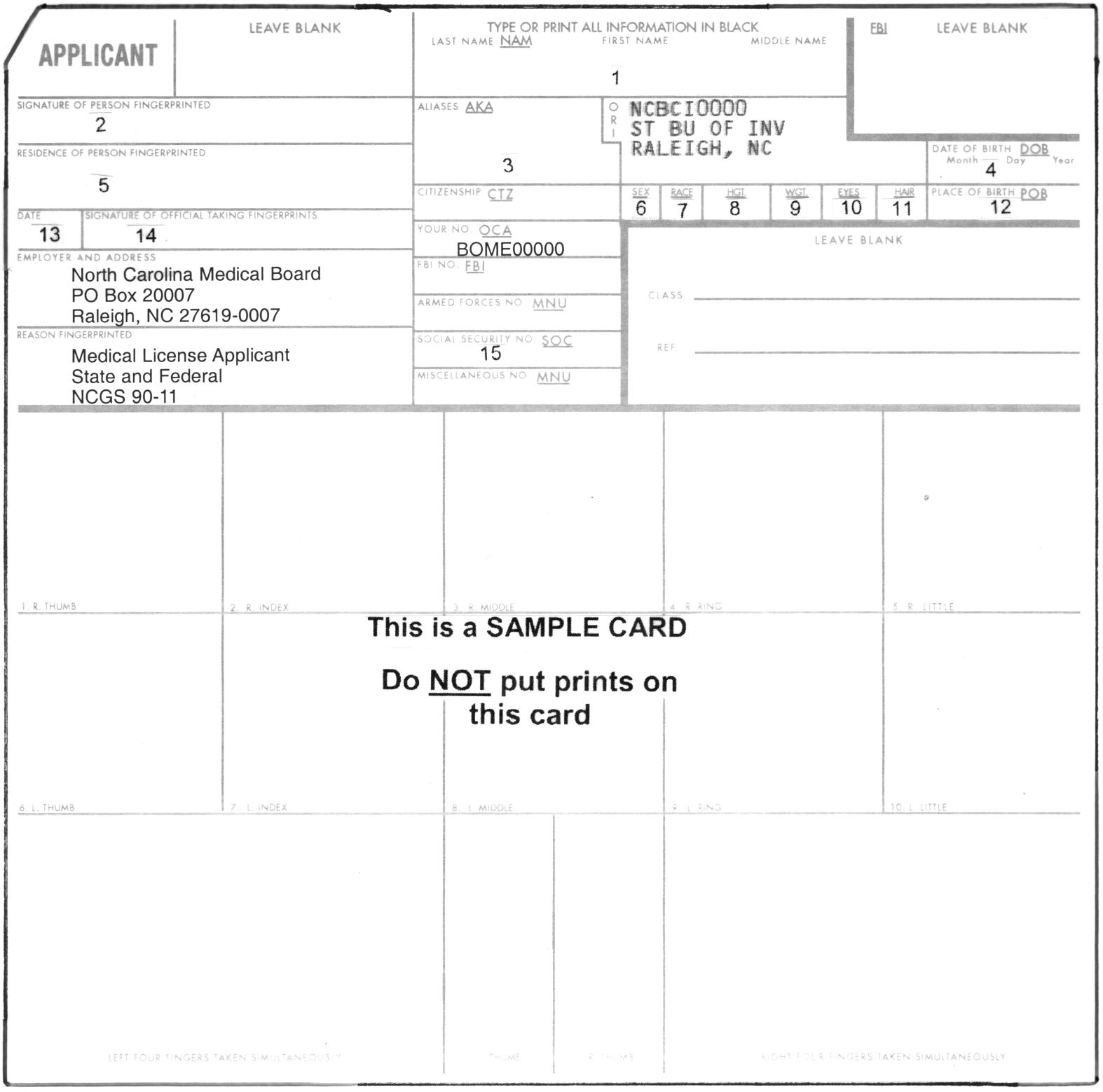
The definition of a good quality fingerprint is an image that provides sufficient data to accurately identify and locate principal fingerprint features. These features include minutia, cores and delta, and ridges. The image should cover sufficient area to allow examiners to identify fingerprint patterns and to compare the prints with those in the database.

If cards are rejected a new set must be submitted within 90 days of being notified of the rejection. If not received within 90 days the process must be restarted.

Photocopy of a Sample Fingerprint Card

Each numbered block on this SAMPLE must be completed on the actual fingerprint cards. Follow the *Instruction Sheet for Completing the Fingerprint Cards* to ensure you are completing each block on the actual fingerprint cards with the correct information and in the proper format.

(The actual card must be white with blue writing)



Name:_____
Social Security #: _____

North Carolina Medical Board
Continuing Medical Education Record Form

You may use this form to record your relevant CME, either Credit 1 or 2. Use as many of the forms as needed.
The Board may request documentation of entries.

CME Activity • **I**f provided by an accredited sponsor (Credit 1), enter sponsor's name and location, note type/nature of activity [*eg, St Swithin's Hospital, Anytown, NC – Seminar.*] • If NOT provided by an accredited sponsor (NC Credit 2), note type/nature of activity [*eg, Self-Study, article in* JAMA*, Vol 285, #4.*]	**Practice-Relevant Subject**	**Date(s)**	**Hour Value**	**Credit (1 or 2)**

Credit 1 hours listed on this page: _____ Credit 2 hours listed on this page: _____
(Must total at least 150 hours in 3 years, with at least 60 hours of Credit 1.)
(Refer to the Board's *Brief Guide to CME Requirements* and the *CME Rule* for further details.)

☐ **Check box if you have <u>not</u> received any CME in the past 3 years.** **Signature: _____**