Eligibility Requirements for Medical School Faculty Limited License

The Medical School Faculty License is limited to physicians who do not meet the requirements for physician licensure but do have expertise which can be used to help educate North Carolina medical students, post-graduate residents and fellows.

If you are a graduate from a medical or osteopathic school approved by the LCME, CACMS or COCA and have the following, you are not eligible for the Medical School Faculty Limited License.

1. Completed at least one year of graduate medical education approved by ACGME, CFPC, RCPSC or AOA.

2. Passed (a state board licensing examination; NBME; USMLE; FLEX, COMLEX, NBOME, MCCQE or their successors).

   Each step of the USMLE or COMLEX must be passed within three attempts. However, the Board shall waive this requirement if the applicant has been certified or recertified by an ABMS, CCFP, FRCP, FRCS or AOA approved specialty board within the past 10 years.

3. Have completed a minimum of 130 weeks of medical school.

4. An applicant must have obtained one of the following with the past 10 years:
   (A) passed an exam listed in NC G.S. 90-10.1 (a state board licensing examination; NBOME; USMLE; COMLEX; or MCCQE or their successors; or
   (B) passed SPEX (with a score of 75 or higher); or
   (C) passed COMVEX (with a score of 75 or higher); or
   (D) within the past 10 years obtained certification or recertification or CAQ by a specialty board recognized by the ABMS, CCFP, FRCP, FRCS or AOA.
   (E) within the past 10 years completed GME approved by ACGME, CFPC, RCPSC or AOA; or
   (F) within the past three years completed CME as required by 21 NCAC 32R .0101(a), .0101(b), and .0102.

If you are a graduate of a medical school other than those approved by LCME, COCA or CACMS (International Medical Schools) and have the following, you are not eligible for the Medical School Faculty License:

1. Current valid certification of the ECFMG or has passed the ECFMG examination and completed an approved Fifth Pathway Program.

2. Satisfactory completed three years of graduate medical education approved by ACGME, CFPC, RCPSC or AOA.

3. Passed (a state board licensing examination; NBME; USMLE; FLEX, COMLEX, NBOME, MCCQE or their successors).

   Each step of the USMLE and COMLEX must be passed within three attempts. However, the Board shall waive this requirement if the applicant has been certified or recertified by an ABMS, CCFP, FRCP, FRCS or AOA approved specialty board within the past 10 years.

4. Have completed a minimum of 130 weeks of medical school.

5. An applicant must have obtained one of the following within the past 10 years:
   (A) passed an exam listed in G.S. 90-10.1 (a state board licensing examination; NBOME; USMLE; COMLEX; or MCCQE or their successors; or
   (B) passed SPEX (with a score of 75 or higher); or
   (C) passed COMVEX (with a score of 75 or higher); or
   (D) within the past 10 years obtained certification or recertification or CAQ by a specialty board recognized by the ABMS, CCFP, FRCP, FRCS or AOA.
   (E) within the past 10 years completed GME approved by ACGME, CFPC, RCPSC or AOA; or
   (F) within the past three years completed CME as required by 21 NCAC 32R .0101(a), .0101(b), and .0102.

I hereby certify that I do meet the eligibility requirements for a faculty limited license.

Signature: _____ Date: _____

Social Security Number: _____

REQUIREMENTS FOR APPLICATION FOR MEDICAL SCHOOL FACULTY 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 Medical School Faculty License is limited to physicians who have expertise which can be used to help educate North Carolina medical students, postgraduate residents and fellows who do not meet the requirements for physician licensure.

A physician holding a Medical School Faculty Limited License may practice only within the confines of the medical school or its affiliates. "Affiliates" means the primary medical school hospital(s) and clinic(s), as designated by the ACGME.

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. You should not expect the entire process to take less than **4 months** from the time your application is received by the NC Medical Board.

Below is a summary of the rules of Chapter 32B.1502 of the North Carolina Administrative Code. These are the conditions, which might allow licensure, but the Board reserves the right to make whatever additional demands on the applicant for licensure that the Board deems appropriate at the time.

1. Complete application form.
   - Circle the correct answer for all questions.
   - Provide detailed explanations for affirmative answers.
   - A claim form must be completed for each malpractice suit or settlement Attach a photocopy of plaintiff's complaint and settlement orders for each incident.
   - 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.

2. Attach a photograph on photo quality paper taken within the past year to the applicant's oath. Complete the form and have the form notarized.

3. Sign and return the Eligibility Requirements form to the NCMB.

4. Verification of Faculty Appointment form. Forward form to the medical school where you will hold your appointment.

5. Verification of medical education: Forward form to your medical school for completion.

   (A) Transcripts - If you attended one medical school for less or more than the standard four years, OR if you attended more than 1 medical school, you must submit original medical school transcript(s), translated into English, if applicable.

6. Complete the Immigration Status Form and submit required documentation.

7. Two recommendations must be from physicians using the physician reference forms. Recommendations **cannot** be from a relative. These forms must be sent from the reference source directly to the NC Medical Board.

8. Submit proof on the postgraduate training verification form of completion of at least (1) one year of GME approved by one of the following:

   - ACGME (Accreditation Council on Graduate Medical Education);
   - AOA (American Osteopathic Association);
   - CFPC (College of Family Physicians of Canada);
   - RCPSC (Royal College of Physicians and Surgeons of Canada;

   or evidence of other education, training or experience, to be determined by the Board as equivalent.

9. You must secure a report from each state, Canadian province or US territory regarding status of licensure. **All licenses, active and/or inactive, must be verified**. Most licensing agencies charge a fee for this service. The verifications should be sent directly to the NC Medical Board. The NCMB accept license verification through the veridoc service.

   - If you have ever been licensed in Connecticut, you must send the consent for release of confidential disciplinary records form, along with the NC licensure verification form to the Connecticut Department of Public Health. If you have never been licensed in Connecticut, disregard the form.

10. The NC Medical Board staff will request the following documentation on behalf of the applicant. If staff is unable to obtain this information, the applicant will be contacted and expected to have this information forwarded to the NC Medical Board.

    - AMA physician profile.
    - AOA physician profile.
    - FSMB Board Action Data Bank report.
    - NPDB/HIPDB report.

11. Applicants must submit two completed fingerprint cards for the purpose of conducting a criminal background check. When possible, have different officials complete each card. It is recommended you have your local law enforcement office complete the fingerprinting. An application is not considered complete until results of the background check have been received. Expect a minimum of 8 weeks for the report to be received. Since rejections are common, the SBI has suggested that applicants use lotion or witch hazel on their hands before being fingerprinted. Fingerprint cards are submitted for processing twice a week. The SBI has suggested that using live scan when available may be a more reliable choice. **When using live scan, prints must be printed on fingerprint cards and be submitted to the NC Medical Board. They cannot be submitted electronically.** See detailed instructions for completing cards. E-mail fpc@ncmedboard.org to request a set of fingerprint cards. A set contains 2 fingerprint cards.

12. Fee of $397.50 US dollars ($350.00 application fee, $38.00 background check fee and $9.50 NPDB/HIPDB report fee) is to be paid at the time the application is submitted. Personal checks made payable to the NC Medical Board are acceptable. Checks returned for insufficient funds will require an additional $20.00 fee. Returned checks will have to be replaced by a certified check. FEES RECEIVED ARE NOT REFUNDABLE.

13. When all application 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, you file will be forwarded to a board member for review to determine whether you will be required to appear for a personal interview. Upon receipt of the Board members' decision, your license will be issued if a personal interview is not required.

14. If a physician has been away from clinical practice 2 years or longer, they may be required to develop a reentry plan as part of the license application. It is the responsibility of the applicant to be prepared to present a program of re-training or supervision that will establish proof of competency in their chosen area or medicine. Applicants in this category will be required to appear for a personal interview.

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: 7/11

APPLICATION FOR LICENSE TO PRACTICE MEDICINE
THROUGH FACULTY LIMITED LICENSE

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). _____
_____

NC Institution where you received a faculty appointment _____

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.

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

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

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

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).**

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). **

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. **

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

Actions include revocations, suspensions, probations, limitations/restrictions, disciplinary/non-disciplinary actions and fines, including private actions and letters, 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). **

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.

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.

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: _____

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:

_____
_____
_____
_____
_____
_____

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. A copy of your application for an H-1 B Visa.
    6. Other documentation providing lawful status in the United States of America.

NORTH CAROLINA MEDICAL BOARD
PO BOX 20007
RALEIGH, NC 27619

MEDICAL SCHOOL FACULTY LIMITED LICENSE
VERIFICATION OF APPOINTMENT

This form is to be completed by the Dean of the Medical school or his appointed representative.

This will confirm Dr. _____

has received a full time appointment at _____School

of Medicine to begin work on _____ as one of the following:

Please select one:

( ) Lecturer

( ) Assistant Professor

( ) Associate Professor

( ) Full Professor

_____
Original signature

_____
Title of certifying official

_____
Date

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

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 - 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

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? _____ YES NO
2. Is this license in good standing? _____ YES NO
3. Has any public or private action been taken against this physician? _____ YES NO
4. 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: 11//11

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

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

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

2 SIGNATURE OF PERSON FINGERPRINTED

3 ALIASES AKA

ORI NCBCI0000
ST BU OF INV
RALEIGH, NC

5 RESIDENCE OF PERSON FINGERPRINTED

4 DATE OF BIRTH DOB Month Day Year

13 DATE | 14 SIGNATURE OF OFFICIAL TAKING FINGERPRINTS

CTZ CITIZENSHIP

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

OCA YOUR NO.
BOME00000

LEAVE BLANK

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

FBI NO. FBI

CLASS

ARMED FORCES NO. MNU

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

15 SOCIAL SECURITY NO. SOC

MISCELLANEOUS NO. MNU

REF

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

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

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.