

REQUIREMENTS FOR SPECIAL PURPOSE LICENSE

NORTH CAROLINA MEDICAL BOARD

PO Box 20007, Raleigh, NC 27619

1203 Front Street, Raleigh, NC 27609 (use this address for express/overnight deliveries)

(919) 326-1100 or (800) 253-9653

DO NOT SUBMIT PHOTOCOPIES UNLESS SPECIFICALLY PERMITTED

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

An application for license in North Carolina is a confidential matter therefore we are unable to respond to any questions regarding your application from anyone other than you, the applicant. The licensing staff may be contacted via e-mail at license@ncmedboard.org.

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

Application credentials and fee are good for 1 year. If you are not issued a license within the year and choose to reapply for a NC license, you will be required to resubmit all application credentials and the application fee.

1. Completed application form
 - Circle the correct answer for all questions and provide a detailed explanation for all affirmative answers.
 - A claim form must be completed for EACH malpractice suit or settlement (photocopy as needed). ATTACH A PHOTOCOPY OF PLAINTIFF'S COMPLAINTS AND SETTLEMENT ORDERS FOR EACH INCIDENT.
 - Attach a photograph taken within the past year to the applicant's oath and have the form notarized.
 - If your name has changed at any time during your life, you will need to list your prior names and submit a copy of legal documentation (marriage certificate, divorce decree, adoption papers, etc.) supporting the name change.
 - Copy of your Curriculum Vitae (CV).
2. Verification from local facility/group to participate in a learning/teaching procedure giving details stating the name of local facility/group where the procedure(s) will be performed, length of time of the procedure(s), type of procedure, what the procedure(s) will include and the name of the physician responsible for overseeing the procedure(s).
3. Applicants must have verification of a full, unrestricted medical license mailed directly to the Board from one licensing jurisdiction. Most licensing agencies charge a fee for this service.
 - If you are submitting verification of a Connecticut license as part of this application, you must send the Connecticut release form along with the licensure verification form to the Connecticut Department of Public Health.
4. Complete the Immigration Status form and provide supporting documentation.

5. Examination Score Transcripts must be sent from the examination source. If you took:
 - 1 – USMLE – visit the Federation of State Medical Board's website www.fsmb.org and have your transcripts sent to us electronically.
 - 2 – COMLEX – visit the National Board of Osteopathic Examiners website www.nbome.org and request to have your transcripts forwarded to us.
6. 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.
7. A fee of \$388.00 U.S. dollars is to be paid at the time the application is submitted. (\$350.00 for the license application fee and \$38.00 for the criminal background check fee). Check should be made payable to the NC Medical Board. Checks returned for insufficient funds will require an additional \$20.00 fee. Returned checks must be replaced by a certified check or money order. **FEES RECEIVED ARE NOT REFUNDABLE.** Applications will not be processed until application fee has been received.
8. When all applications materials have been received, your file will be forwarded to a staff member for quality assurance review. If the quality assurance review is complete and no additional information is needed, your file will be forwarded to a board member for review to determine whether you will be required to appear for a personal interview. You will be notified regarding the board member's decision.

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

APPLICATION FOR NORTH CAROLINA SPECIAL PURPOSE 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). _____

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.

[illegible]

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
	<ul style="list-style-type: none">• professional licensing board or agency (including, but not limited to, the North Carolina Medical Board)• 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		
	<hr/> <hr/> <hr/>		
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
	<hr/> <hr/> <hr/>		
3.	Have you ever:	YES	NO
	<ul style="list-style-type: none">• 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		
	<hr/> <hr/> <hr/>		
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
	<hr/> <hr/> <hr/>		
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
	<hr/> <hr/> <hr/>		
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
	<hr/> <hr/> <hr/>		

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, arrested for or convicted of a misdemeanor including, but not limited to, Driving Under the Influence ("DUI") or Driving While Impaired ("DWI") and any other violation of the law involving the operation of some means of transportation while under the influence of drugs or alcohol? If so, you must list every misdemeanor charge, arrest and conviction. YES NO

Definitions:

You have been charged if you have been arrested, indicted or arraigned for a criminal act, even if the charge was later dismissed.

You have been convicted if you pleaded guilty, were found guilty by a court, 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.

Instructions:

Failure to report may result in denial of licensure, fines or other public disciplinary action. **You must report all charges, arrests and convictions for** driving while intoxicated, driving under the influence, careless and reckless driving and any offenses involving serious injury or death. Minor traffic offenses are not required to be reported.

Expungements:

Do not report expunged charges or convictions for which you possess written documentary proof of expungement. **Do not assume** any previous charge, arrest or conviction has been expunged unless you have in your possession an official written court order or document, signed by a judge, which explicitly orders the charge, arrest or conviction sealed and/or expunged.

The Board will notify you prior to publishing your misdemeanor conviction on the website.

13. Have you **ever** been charged with, arrested for or convicted of a felony including, but not limited to, Driving Under the Influence ("DUI") or Driving While Impaired ("DWI") and any other violation of the law involving the operation of some means of transportation while under the influence of drugs or alcohol? If so, you must list every felony charge, arrest and conviction below. YES NO

Definitions:

You have been charged if you have been arrested, indicted or arraigned for a criminal act, even if the charge was later dismissed.

You have been convicted if you pleaded guilty, were found guilty by a court, 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.

Instructions:

Failure to report may result in denial of licensure, fines or other public disciplinary action. **You must report all charges, arrests and convictions for** driving while intoxicated, driving under the influence, careless and reckless driving and any offenses involving serious injury or death. Minor traffic offenses are not required to be reported.

Expungements:

Do not report expunged charges or convictions for which you possess written documentary proof of expungement. **Do not assume** any previous charge, arrest or conviction has been expunged unless you have in your possession an official written court order or document, signed by a judge, which explicitly orders the charge, arrest or conviction sealed and/or expunged.

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

Definitions:

Actions include, but are not limited to:

- *Revocations*
- *Suspensions*
- *Probations*
- *Limitations/restrictions*
- *Disciplinary/non-disciplinary actions and fines*
- *Private actions and letters*
- *Issuance of a license through an order*
- *License denials*

Regulatory board or agency includes:

- *Any professional licensing board or agency*
- *The U.S. Food and Drug Administration*
- *The U.S. Drug Enforcement Administration*
- *Medicare or Medicaid*

You must supply all supporting documents.

All public actions taken by state medical/regulatory boards will be visible to the public on the Board's website indefinitely. All actions taken by federal/state agencies such as the U.S. Food and Drug Administration, the U.S. Drug Enforcement Administration, Medicare, and Medicaid will be visible to the public on the Board's website for a period of seven years (from the date of the action).

15. List all relevant information for any of the three scenarios below that apply to you on the claims information form. YES NO

1. You were named in a malpractice lawsuit.
2. A malpractice lawsuit filed against you was resolved with a judgment (regardless of appeal), award, payment, or settlement regardless of whether the payment or settlement was in your name.
3. A malpractice settlement or payment was made, affecting or involving you, where no lawsuit was filed.

Malpractice payment information is requested for two reasons: (1) internal investigation, and (2) public reporting.

Internal Investigation: The NCMB investigates all malpractice payment reports to determine if disciplinary or remedial action is necessary.

Public Reporting: 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.

16. Have you ever taken USMLE or COMLEX? If so, you will need to have those scores sent directly to the NCMB from the original source.

YES NO

**North Carolina Medical Board
PO Box 20007
Raleigh, NC 27619**

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

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.

NOTARY PUBLIC

I certify that on the date set forth above the individual named above did appear personally before me and that I did witness this applicant complete this form including the handwritten statement above.

State of _____, County of _____.

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

(Official Notary Seal)

Official Signature of Notary

Notary's Printed Name

My Commission Expires: _____

NORTH CAROLINA MEDICAL BOARD

CLAIMS INFORMATION FORM

Please attach a PHOTOCOPY of the PLAINTIFF'S COMPLAINT AND SETTLEMENT ORDER, if there is one.

The applicant must complete this form for **each** liability or malpractice claim of which they are aware. Please make as many photocopies of this form as you need. Please use one form for each claim or suit.

1. In addition to copies of the complaint and settlement order, if any, describe below the allegations against you. **A copy of the complaint will not replace a written description by you.** Include, a brief history, comments regarding the examination and care surrounding the allegations. If suits are pending a very brief summary of the allegations or charges must be included regardless of the litigation stage. Simply stating that the charges were dismissed is inadequate. More detail must be provided. Use additional pages if necessary.

Patient's Name: _____

2. Date of the claim:

3. If an insurance carrier was involved, list the name, address and telephone:

4. Is the claim pending? Yes No

5. Was there a judgment or settlement? Yes No

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

7. Comments:

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

Signature: _____

Date: _____

Printed Name: Social Security Number:

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

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

PHYSICIANS NAME

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

BEGINNING AND ENDING DATE OF ACTIVITY:

TYPE OF PROCEDURE:

DETAILS OF PROCEDURE:

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

Signature

Date

NC MEDICAL BOARD
IMMIGRATION STATUS FORM
PO Box 20007
Raleigh, NC 27619

Physician Name: _____

Social Security Number: _____

1. If you are not physically present in the United States of America or a United States Territory and have no plans to enter the United States of America or a United States Territory, please check below and then continue to the next page.

☐ I am not physically present and I have no plans to enter the United States of America or a United States Territory.

*If you do enter the United States of America or a United States Territory and practice as a licensee of the North Carolina Medical Board, you must notify the Legal Department at the North Carolina Medical Board immediately.

2. Are you a citizen of the United States of America?

Yes ☐

No ☐

If you answered "Yes," you must provide a copy of **one** of the following documents:

- a. Birth certificate indicating birth in the United States of America or a United States Territory.
- b. Valid and unexpired United States of America passport.
- c. Other appropriate documentation of United States of America citizenship deemed acceptable by the North Carolina Medical Board, which may include:
 1. Report of Birth Abroad of a United States of America citizen (FS-240)
 2. Certification of Report of Birth (DS-1350 or FS-545)
 3. Certificate of United States of America Citizenship (N-561)
 4. United States of America Citizen Identification Card (I-197)

If you answered "No," you must provide:

- a. A statement defining and specifying your immigration and alien status:

AND

- b. A copy of a document indicating your immigration and alien status deemed acceptable by the North Carolina Medical Board, which may include one of the following documents:
1. Alien Registration Card or Green Card (Form I-551)
 2. Employment Authorization Document (Form I-688B or Form I-766)
 3. Certification of Report of Birth (DS-1350)
 4. Arrival-Departure Record (Form I-94)
 5. Other documentation providing lawful status in the United States of America.

NORTH CAROLINA MEDICAL BOARD

LICENSE VERIFICATION FORM

Applicant: Complete the top portion of this form and forward one copy to each licensing board in all the states where you **have held OR currently hold** a medical license. Training licenses do not need to be verified. This form should be mailed directly to the North Carolina Medical Board from the state licensing board. Most states require a fee for processing. The fee is the applicant's responsibility. The NC Medical Board accepts license verifications through the VeriDoc service.

Licensing Board: The North Carolina Board requires information regarding my license. This is my request for you to respond to the questions below and also gives you authority to release any information, favorable or otherwise, to the North Carolina Medical Board.

I am applying for a North Carolina medical license. I was granted license number _____ on _____ by the State of _____.

Name: _____

Signature: _____

Soc. Sec. #: _____

Address: _____

Date of Birth: _____

This is to certify that the records of the _____ State Licensing Board indicate that _____ physician was issued license number _____ on _____ to practice medicine in the State of _____,

Respond to the following questions:

1. Is this license current and in good standing? _____ YES NO
2. Has any public or private action been taken against this physician? _____ YES NO
3. Are there any pending investigations against this physician? _____ YES NO

If YES answered to questions 2 and 3, attach an explanation.

(Board Seal)

Authorized Signature

Date

PLEASE COMPLETE AND RETURN THIS FORM DIRECTLY TO THE NORTH CAROLINA MEDICAL BOARD, P.O. Box 20007, RALEIGH, NC 27619.

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

PO BOX 20007
Raleigh, NC 27619

AUTHORITY FOR RELEASE OF INFORMATION

State and Federal Record Check

I authorize the North Carolina Department of Justice through the State Bureau of Investigation, Division of Support Services to perform a fingerprint search of the State's criminal history record file and a fingerprint search of the Federal Bureau of Investigation's files for a national criminal history record check in connection with my application for a medical license with the North Carolina Medical Board pursuant to N.C.G.S. 90-11(HB 1638).

Please print or type the following information:

Name: _____
Last First Middle Maiden

Soc Sec #: _____ Date of Birth: _____

Sex: _____ Race: _____

I understand that the North Carolina State Bureau of Investigation, Division of Support Services, and its officials and employees shall not be held legally accountable in any way for providing this information to the North Carolina Medical Board, and I hereby release said agency and persons from any and all liability which may be incurred as a result of furnishing such information. I further understand that the North Carolina Medical Board cannot provide a **hard copy** of the results of this criminal history record check to me.

Applicant's Signature:

Date:

ORI # BOME00000 – NORTH CAROLINA MEDICAL BOARD

Instruction Sheet for Completing the Fingerprint Card

1. The complete name of the subject is to be listed as indicated: Last name, First name, and Middle name. Please ensure the name is legible if written.
2. Signature of the subject being fingerprinted is written here.
3. List any and all alias names or nicknames, maiden name or any other married names.
4. List the date of birth numerically – month, day, and year.

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

5. Current residence of subject fingerprinted is written here.
6. Sex is to be listed M for male, and F for female, or U for Unknown.
7. Race is to be listed by placing an individual into one (1) of the following categories by writing the appropriate letter in the space provided:

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

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

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

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

Example: 186 or 098, etc.

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

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

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

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

12. Indicate, if possible, the city and state where the subject was born. The state should be indicated by the two-digit abbreviation.
13. Indicate the date of the fingerprinting.
14. Signature of Official taking fingerprints.
15. Write the Social Security number in this space. The Social Security number is a very important identifier.

Photocopy of a Sample Fingerprint Card

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

(The actual card must be white with blue writing)

APPLICANT		LEAVE BLANK		TYPE OR PRINT ALL INFORMATION IN BLACK LAST NAME <u>NAM</u> FIRST NAME <u>1</u> MIDDLE NAME						ED1 LEAVE BLANK	
SIGNATURE OF PERSON FINGERPRINTED <u>2</u>		ALIASES <u>AKA</u> <u>3</u>		OR I NCBCI0000 ST BU OF INV RALEIGH, NC						DATE OF BIRTH DOB Month <u>4</u> Day Year	
RESIDENCE OF PERSON FINGERPRINTED <u>5</u>		CITIZENSHIP <u>CIZ</u>								SEX <u>6</u> RACE <u>7</u> HGT <u>8</u> WGT <u>9</u> EYES <u>10</u> HAIR <u>11</u>	
DATE <u>13</u>	SIGNATURE OF OFFICIAL TAKING FINGERPRINTS <u>14</u>	YOUR NO. <u>OCA</u> <u>BOME00000</u>		LEAVE BLANK							
EMPLOYER AND ADDRESS North Carolina Medical Board PO Box 20007 Raleigh, NC 27619-0007		FBI NO. <u>ERJ</u>									
REASON FINGERPRINTED Medical License Applicant State and Federal NCGS 90-11		ARMED FORCES NO. <u>MNU</u>									
		SOCIAL SECURITY NO. <u>SOC</u> <u>15</u>		CLASS _____							
		MISCELLANEOUS NO. <u>MNU</u>		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. PINKY		6. L. THUMB		7. L. INDEX		8. L. MIDDLE		9. L. RING		10. L. PINKY	
<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			

NORTH CAROLINA MEDICAL BOARD

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

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

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

Name: _____
(Printed)

_____-_____-_____
Social Security No.

Name: _____
(Signature)

Date: _____