

# REQUIREMENTS FOR A LICENSE TO PRACTICE MEDICINE THROUGH A SPECIAL VOLUNTEER LICENSE

## PLEASE DO NOT PROCEED UNTIL YOU HAVE READ THESE INSTRUCTIONS

The North Carolina Medical Board annually processes over two thousand applications for medical licensure. Our process involves the collection of credentials from you, the applicant and from other sources. Once all the application materials have been collected, our staff must review them. After reviews have been done, it may be necessary for the staff to request additional information and/or to return items that need corrections or clarification. You will be notified in writing regarding any deficiencies in your application once it has been reviewed. It is our goal to review materials as quickly as possible, but we must be thorough. 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.

\*\* Questions regarding your application can be e-mailed to [license@ncmedboard.org](mailto:license@ncmedboard.org). \*\*

Please adhere to the following guidelines:

1. Processing time will take longer during the months of March through August, due to the increased number of residents and relocating physicians. We recommend you allow **four to six** months of total processing time if you want a license during these months.
2. You should submit your completed application, fingerprint cards, authority to release form and fee together as soon as possible in order that the background check can be requested. Credentials received prior to your application will be held in our office for 1 year.
3. If you have been named in any malpractice suits or have answered "yes" to any question on your application, anticipate the possibility that additional information and an interview will be requested.
4. It is recommended that you not make practice commitments prematurely.

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State law will only allow us to speak to the applicant regarding the application. Relatives, staff members, future employers or placement services **can not** be informed about the status of your application even if you have signed a release authorizing them to speak with the Board regarding your application.

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Note: The NC Medical Board will be unable to return original or photocopies of application materials once received.

# NORTH CAROLINA MEDICAL BOARD REQUIREMENTS FOR A SPECIAL VOLUNTEER LICENSE

The process outlined below is for applicants NOT using  
The Federation's Credential Verification Service

PO Box 20007, Raleigh, NC 27619  
1203 Front Street, Raleigh, NC 27609 (use this address for express/overnight deliveries)  
(919) 326-1100

## DO NOT SUBMIT PHOTOCOPIES OR FACSIMILIES UNLESS SPECIFICALLY PERMITTED

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 by e-mail at [license@ncmedboard.org](mailto:license@ncmedboard.org).

A volunteer medical license limits its holder to the practice of medicine as follows:

- (1) Practice within the confines of specific locations approved by the Board and;
- (2) Practice with no expectation of payment or compensation or payment to the Special Volunteer license, either director or indirect, monetary, in-kind, or otherwise for a provision of medical services.

Below is a summary of the rules of Chapter 32 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 the Board deems appropriate at the time.

- 1. Completed 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 (form enclosed-photocopy as needed). ATTACH A PHOTOCOPY OF PLAINTIFF'S COMPLAINTS AND SETTLEMENT ORDERS FOR EACH INCIDENT.
  - Sign applicant's oath and have signature NOTARIZED. Make sure the original application form is submitted to the Board.
  - Include name change documentation, if applicable.
  
- 2. One Certified Photograph: An applicant must submit a recent photograph at least 2 inches by 2 inches, head and shoulders shot, taken within the past sixty (60) days, of durable quality, (not a snapshot or home Polaroid) to be certified by your medical school on the Board's Medical School Certification form. This certification must bear the original Signature of the Dean or other Official of your medical school; their official title and the seal of the school must be placed over the photo. THIS REQUIREMENT CANNOT BE WAIVED.
  - (A) Transcripts - If you did not attend one medical school for 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.
  
- 3. Examination Scores - Applicants must have certified scores submitted directly to the Board office. If you successfully completed:
  - Federation Licensing Examination (**FLEX**) or United States Medical Licensing Examination (**USMLE**) visit the Federation of State Medical Boards web site to request scores (<http://www.fsmb.org>). The Board shall not issue a license to practice medicine to any applicant who has failed to receive a passing score of any Step or component thereof, or the USMLE within six (6) attempts unless it is determined in the Board's discretion, that the applicant has successfully completed additional training or education which is approved and accepted by the Board.
  - National Board of Medical Examination (**NBME**) visit the National Board of Medical Examiners web site to request scores (<http://www.nbme.org>).

- National Board of Osteopathic Medicine Examination (**NBOME**) visit the National Board of Osteopathic Medical Examiners web site to request scores (<http://www.nbome.org>).
- Pursuant to G.S. 90-9 Osteopathic Physicians who graduated from medical school prior to January 1960 are not eligible for a North Carolina license.
- Comprehensive Osteopathic Medical Licensing Examination (**COMLEX**) visit the National Board of Osteopathic Medical Examiners web site to request scores (<http://www.nbome.org>).
- Licentiate of the Medical Council of Canada (**LMCC**) contact the Licensing Medical Council of Canada to request scores (<http://www.mcc.ca>).
- State Board Written Examination contact the state board in which you took the exam to request scores to be sent directly to our office. **The North Carolina Medical Board does not accept the Puerto Rico state board written examination.**

4. You must secure a report from each state regarding status of licensure. **All licenses, active and/or inactive, must be verified. Training licenses do not need to be verified.** Most licensing agencies charge a fee for this service. The verifications should be sent directly to the NC medical Board

(A) Enclosed is an additional release form for the State of Connecticut. If you have ever been licensed in Connecticut, you must send this form, along with the licensure biography form to the Connecticut Department of Public Health. If you have never been licensed in Connecticut, disregard the form.

5. Two recommendations must be from physicians using the enclosed Physician Reference Forms. Recommendations **cannot** be from a relative. These forms must be sent from the reference source **directly** to the NC Medical Board.

6. **ECFMG:** Graduates of foreign medical schools must have a current ECFMG. You will need to contact ECFMG (<http://www.ecfmq.org/>) and have a certification status report sent to the NC Medical Board.

**Fifth Pathway:** Graduates of a foreign medical school, who have completed a Fifth Pathway program, must furnish verification of passing the ECFMG examination and completion of the 5<sup>th</sup> Pathway Program. You will need to contact ECFMG and have your score transcript forwarded directly to the NC Medical Board. You can obtain a Fifth Pathway Verification Form, by e-mailing our office at [license@ncmedboard.org](mailto:license@ncmedboard.org).

7. Forward the Postgraduate Training form to all US/Canadian training program(s) in which you have participated. Request the Program Director complete the form and return to the NC Medical Board.

\*\* If you left a training program prior to completion provide a detailed explanation regarding the circumstances of your departure. \*\*

(A) U.S. graduates are required to have 1 year postgraduate training in a training program approved by the Accreditation Council on Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA).

(B) Foreign Medical Graduates are required to have 3 years postgraduate training in training programs approved by the ACGME or AOA.

(C) Foreign Medical Graduates who have less than 3 years ACGME or AOA postgraduate training may satisfy the postgraduate training requirement with at least one year of ACGME or AOA approved training in combination with certification by a specialty board recognized by the ABMS or AOA Specialty Boards.

8. If certified or recertified by an American Medical Specialty Board or American Osteopathic Board, send a photocopy of your certificate with your application.

9. In addition to all other requirements for licensure, an applicant who has not met one of the following qualifications within the past 10 years of the date of the application to the Board, must take the SPEX, or other examination as determined by the Board, and attain a score of at least 75:
- a) National Board of Medical Examiners Certification
  - b) FLEX examination
  - c) USMLE examination
  - d) National Osteopathic Board of Medical Examiners Examination or COMLEX.
  - e) SPEX examination with a score of at least 75
  - f) COMVEX examination – Osteopathic examination equivalent to SPEX.
  - g) Certification or recertification by a specialty board recognized by the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA).
  - h) Completion of formal ACGME or AOA post-graduate training
  - i) Received Certificate of Added Qualifications issued by a speciality board recognized by ABMS or AOA.

You must provide this office with verification of one of the above. The SPEX requirement may be waived by the Board upon receipt of a **current 3 year** AMA Physician's Recognition Award or equivalent AOA CME. Visit the AMA's web site for CME requirements. If the AMA/PRA is submitted to satisfy this requirement, copies of the CME documentation used to obtain the award must be included as part of your NC medical license application clearly showing the majority of the CME is relevant to your speciality or area of practice.

10. Applicants must request an AMA Physician Profile from the AMA. Visit the AMA's web site (<https://profiles.ama-assn.org/amaprofiles>) to request a profile be mailed directly to the NCMB office from the AMA. If you are a DO, visit the American Osteopathic Association's web site (<https://www.doprofiles.org>) to request a physician profile be sent directly to the NCMB from the AOA. This should be done in addition to the AMA profile.
11. Applicants who did not take FLEX or USMLE must request a Board Action Databank Inquiry form from the Federation of State Medical Boards of the US. (<http://www.fsmb.org>).
12. Applicants must submit a National Practitioner Data Bank (NPDB) and Healthcare Integrity and Protection Data Bank (HIPDB) report as part of their application. The NPDB and HIPDB report must be dated within sixty (60) days of submission of your application to the NCMB. You will need to send the notarized "self - query" form to the National Practitioner Data Bank address. The NPDB will send **you** e-mail notification when the report is available for online viewing. You can access this report online from their web site. You will need to print this report and send to the NCMB. You can e-mail a copy of the report to [license@ncmedboard.org](mailto:license@ncmedboard.org). <http://www.npdb-hipdb.hrsa.gov/welcomesq.html>.
13. 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](mailto:fpc@ncmedboard.org) to request a set of fingerprint cards. A set contains 2 fingerprint cards.

- 14. A fee of \$138.00 U.S. dollars is to be paid at the time the application is submitted. (\$100.00 for the license application fee and \$38.00 for the criminal background check fee). 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 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.
  
- 15. 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. If a personal interview is not required, staff has the authority to issue the full license at that time. Applicants will be notified if a personal interview will be required.
  
- 16. 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 of medicine. Applicants in this category will be required to appear for a license interview.

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

Revised 1/2010





Name: \_\_\_\_\_  
(Printed)

**CIRCLE** your answer to the following questions. Provide a detailed description of any YES answers. Any changes in your answers to these questions between the time your application is notarized and the time your application is complete must be reported to the Board. The following questions refer to events in any jurisdiction – U.S. or Foreign.

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

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

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

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3. Have you ever surrendered any license? YES NO

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

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

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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 when on duty? YES NO

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7. Do you have any medical conditions? If so, please list all your medical conditions. A medical condition is a physical or mental impairment or disorder affecting or interfering with the normal function of any body system. YES NO

Do not use abbreviations in your response. For each condition, please state whether the condition impairs or limits in any way, your ability to practice medicine and provide any helpful, additional information.

NOTE: All information provided in your response to this question is confidential. The Board needs this information so that it can independently determine whether licensees might have a medical condition that could affect their ability to practice safely.

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

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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

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

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

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14. Have you ever had an action taken against you by a health care institution? If so, list each occurrence and provide documentation. YES NO

Actions include terminations, warnings, censures, discipline, admissions monitored, privileges limited, privileges suspended/revoked, remediation, probation, withdrawals/resignations of privileges, or denial of staff membership.

Health care institutions include hospitals, health maintenance organizations, preferred provider organizations, any facility in which you trained or any other provide organizations that issue credentials to physicians.

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**FOR THE PURPOSE OF QUESTIONS 15 AND 16, IF "YES", SUBMIT COPIES OF ALL RELEVANT DOCUMENTATION, SUCH A POLICE REPORTS, CERTIFIED COURT RECORDS AND DISPOSITIONS**

15. 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 offences. "Minor traffic offences" 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.

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16. 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.

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

Action include revocations, suspensions, probations, limitations/restrictions, disciplinary/non-disciplinary actions and fines, 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.

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18. Have 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? Is 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

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**APPLICANT'S OATH**

I hereby certify under oath that I am the person named in this application for a license to practice medicine in the State of North Carolina, that all statements I have made herein are true, that I am the person named in the various forms and credentials furnished to this Board with my application. The photograph submitted as part of this application process is a true likeness of myself and was taken within sixty days prior to the date of this application.

I further state that by filing this application for a license to practice medicine in the State of North Carolina, I hereby authorize and consent to have an investigation made as to my moral character, professional reputation and fitness for the practice of medicine. I agree to give any further information, which may be required. I understand that I will not receive a copy of any report or know its contents, and I further understand that the contents of any investigative report will be confidential as provided by law.

I authorize and request every person, hospital, clinic community, governmental agency, (local, state, federal or foreign), court, association, institution, or other organization having control of any documents, records and other information pertaining to me to furnish to the North Carolina Medical Board any such information including documents, records regarding charges or complaints filed against me (formal or informal, pending or closed) or any other pertinent data. I further permit the North Carolina Medical Board or any of its agents or representatives to inspect and make copies of such documents, records and other information in connection with this application, subsequent licensure or practice there under.

I hereby release, discharge and exonerate the North Carolina Medical Board, its agents or representatives and any person so furnishing information, from any and all liability for every nature and kind arising out of the furnishing or inspection of such documents, records, other information or the investigation made by the North Carolina Medical Board.

\_\_\_\_\_  
**(Printed Name)**

\_\_\_\_\_  
**(Applicant's Signature)**

\_\_\_\_\_  
**(Social Security Number)**

State: \_\_\_\_\_

Subscribed and sworn to before me this \_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_

County: \_\_\_\_\_

NOTARY PUBLIC \_\_\_\_\_

My Commission Expires \_\_\_\_\_

SEAL



## STATEMENT OF APPLICANT FOR SPECIAL VOLUNTEER LICENSE

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

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

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\_\_\_\_\_  
Full Name (Printed)

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**NORTH CAROLINA MEDICAL BOARD**  
**MEDICAL SCHOOL CERTIFICATION FORM**

Please return the form to the following address:

NC Medical Board  
PO Box 20007  
Raleigh, NC 27619

**ORIGINAL SIGNATURE IS REQUIRED - SIGNATURE STAMPS WILL NOT BE ACCEPTED**

The Dean or another medical school official must complete the certification and sign. Medical School seal must be affixed over the photograph. Photo must be of photo paper weight quality.

**PASTE PHOTO HERE**

(School seal must be affixed over the photo)

My signature below certifies that this is a true likeness of

\_\_\_\_\_

who received the MD/DO degree from

\_\_\_\_\_

on \_\_\_\_\_, \_\_\_\_\_.

Signature of Certifying Official:

\_\_\_\_\_

(Original signature is required – stamps not accepted)

Title \_\_\_\_\_

Date: \_\_\_\_\_

Address of Medical School:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**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) Recent (no older than six months)
- b) Original signature. Signature stamps will not be accepted.
- c) Two forms completed by physicians who have observed your work in a clinical environment within the past 3 years.

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. \*\***

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**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? \_\_\_\_\_

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**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 |
| 4. Have you ever received reports of poor relationships between this physician and other members of hospital medical staff?   | Yes | No |
| 5. Do you know of any derogatory information about this physician with respect to his/her ability to practice medicine?   | Yes | No |
| 6. Do you know if this physician has or has this physician had in the past, any mental or physical illnesses or personal problems that interfere with his/her medical practice?       | Yes | No |
| 7. Do you know if this physician has ever abused alcohol or drugs or shown signs of chemical dependency?  | Yes | No |
| 8. Do you know of any lawsuits having to do with this physician's medical practice that this physician has either lost or settled out of court?                                       | Yes | No |
| 9. Do you know of any restrictions, limitations or other actions of any nature taken against this physician by a hospital or other health related entity?                             | Yes | No |

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

- |   |     |    |
|---|-----|----|
| 10. Does this physician accept medical staff and hospital policies and function willingly according to these policies?              | Yes | No |
| 11. Does this physician enjoy professional respect among his or her colleagues and in the community where this physician practices? | Yes | No |
| 12. Do you recommend this physician for unrestricted medical licensure in North Carolina?   | Yes | No |

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

**COMMENTS:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Title**

\_\_\_\_\_  
**Name of Hospital (if applicable)**

\_\_\_\_\_  
**Date**

**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) Recent (no older than six months)
- b) Original signature. Signature stamps will not be accepted.
- c) Two forms completed by physicians who have observed your work in a clinical environment within the past 3 years.

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. \*\***

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**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? \_\_\_\_\_

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**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 |
| 4. Have you ever received reports of poor relationships between this physician and other members of hospital medical staff?   | Yes | No |
| 5. Do you know of any derogatory information about this physician with respect to his/her ability to practice medicine?   | Yes | No |
| 6. Do you know if this physician has or has this physician had in the past, any mental or physical illnesses or personal problems that interfere with his/her medical practice?       | Yes | No |
| 7. Do you know if this physician has ever abused alcohol or drugs or shown signs of chemical dependency?  | Yes | No |
| 8. Do you know of any lawsuits having to do with this physician's medical practice that this physician has either lost or settled out of court?                                       | Yes | No |
| 9. Do you know of any restrictions, limitations or other actions of any nature taken against this physician by a hospital or other health related entity?                             | Yes | No |

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

- |   |     |    |
|---|-----|----|
| 10. Does this physician accept medical staff and hospital policies and function willingly according to these policies?              | Yes | No |
| 11. Does this physician enjoy professional respect among his or her colleagues and in the community where this physician practices? | Yes | No |
| 12. Do you recommend this physician for unrestricted medical licensure in North Carolina?   | Yes | No |

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

**COMMENTS:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Title**

\_\_\_\_\_  
**Name of Hospital (if applicable)**

\_\_\_\_\_  
**Date**

# NORTH CAROLINA MEDICAL BOARD

## LICENSE VERIFICATION FORM

**Applicant:** Complete the top portion of this form and forward one copy to each licensing agency 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: \_\_\_\_\_

\_\_\_\_\_

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

This is to certify that the records of the \_\_\_\_\_ Professional 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. Have any charges ever been filed against this physician? \_\_\_\_\_ YES NO
4. Do you know of any information that may discredit this physician? \_\_\_\_\_ YES NO
5. Do your files indicate any derogatory information? \_\_\_\_\_ YES NO
6. Have you received any complaints against this physician? \_\_\_\_\_ YES NO
7. Has this physician been investigated by your Board? \_\_\_\_\_ YES NO

**If YES answered to any questions 3-7, attach an explanation.**

(Board Seal)

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Date

**State of Connecticut**

Department of Public Health and Addiction Services  
Bureau of Health System Regulation  
Division of Medical Quality Assurance

**Consent for Release of Confidential Disciplinary Records**

This is to certify that I hereby give my consent and authorizes the Department of Public Health and Addiction Services, Division of Medical Quality Assurance, to confirm the existence of any pending petitions and to release any records of disciplinary action maintained by that Division (with the exception of any documents identified below) to:

NC Medical Board  
PO Box 20007  
Raleigh, NC 27619-0007

I understand that these records are confidential pursuant to the provisions of Connecticut General Statute §20-13e and may not be disclosed without my permission. This information will only be disclosed when this release is executed by me. I also understand that if I am a participant in a rehabilitation program sponsored by a County Medical Association or by the Connecticut State Medical Society that I have the right to contact the Association or Society prior to signing this release.

Documents the Department is Not Authorized to Release:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name (Printed or Typed)

\_\_\_\_\_  
Conn. Medical License Number

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Expiration Date

For office use only  
Petition under investigation (see attached)  
Confidential action (see attached)  
No confidential action

Initials-Date  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

DBB:

0241Q

## North Carolina Medical Board - Postgraduate Training Verification Form

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

<b>Verification For:</b>	<b>Full Name:</b> _____												
	<b>SSN:</b> _____	<b>DOB:</b> _____											
<b>Institution:</b> _____		<b>Attention: Program Director</b>											
<b>Address:</b> _____		<b>Affiliated University:</b> _____											
<p><b>Program Participation:</b></p> <p>Report incomplete postgraduate years (PGY) separate from those that were successfully completed.</p> <p>If the postgraduate year is currently in progress report the expected completion date in the 'To' field.</p> <p>Report internships, residencies, and fellowships separately.</p> <p>Use one section per department/specialty if the dept/specialty is rotating or transitional.</p>	<p><b>PGY:</b> _____</p> <p><input type="checkbox"/> Internship  <input type="checkbox"/> Residency  <input type="checkbox"/> Chief Residency  <input type="checkbox"/> Fellowship  <input type="checkbox"/> Research</p>	<p><b>Specialty/Subspecialty:</b> _____</p> <p><b>From:</b> _____ <b>To:</b> _____</p> <p><b>Successfully Completed:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress</p> <p><b>Accredited By:</b> <input type="checkbox"/> ACGME <input type="checkbox"/> AOA <input type="checkbox"/> CFPC _____  <input type="checkbox"/> RCPSC <input type="checkbox"/> Other: _____  <small>(Specify)</small></p>											
	<p><b>PGY:</b> _____</p> <p><input type="checkbox"/> Internship  <input type="checkbox"/> Residency  <input type="checkbox"/> Chief Residency  <input type="checkbox"/> Fellowship  <input type="checkbox"/> Research</p>	<p><b>Specialty/Subspecialty:</b> _____</p> <p><b>From:</b> _____ <b>To:</b> _____</p> <p><b>Successfully Completed:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress</p> <p><b>Accredited By:</b> <input type="checkbox"/> ACGME <input type="checkbox"/> AOA <input type="checkbox"/> CFPC _____  <input type="checkbox"/> RCPSC <input type="checkbox"/> Other: _____  <small>(Specify)</small></p>											
	<p><b>PGY:</b> _____</p> <p><input type="checkbox"/> Internship  <input type="checkbox"/> Residency  <input type="checkbox"/> Chief Residency  <input type="checkbox"/> Fellowship  <input type="checkbox"/> Research</p>	<p><b>Specialty/Subspecialty:</b> _____</p> <p><b>From:</b> _____ <b>To:</b> _____</p> <p><b>Successfully Completed:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress</p> <p><b>Accredited By:</b> <input type="checkbox"/> ACGME <input type="checkbox"/> AOA <input type="checkbox"/> CFPC _____  <input type="checkbox"/> RCPSC <input type="checkbox"/> Other: _____  <small>(Specify)</small></p>											
<p><b>Unusual Circumstances:</b></p> <p>Circle the correct response. Omitted responses require written explanation.</p> <p>If necessary, you may continue your explanation on a separate sheet of paper.</p>	<p>1) Did this individual ever take a leave of absence or break from his/her training?                  2) Was this individual ever placed on probation?                  3) Was this individual ever disciplined or placed under investigation?                  4) Were any negative reports for behavioral reasons ever filed by instructors?                  5) Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason?</p> <p><b>Please explain any 'Yes' responses above:</b></p> <p>_____</p> <p>_____</p>		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Yes</td> <td style="width: 50%;">No</td> </tr> <tr> <td>Yes</td> <td>No</td> </tr> <tr> <td>Yes</td> <td>No</td> </tr> <tr> <td>Yes</td> <td>No</td> </tr> <tr> <td>Yes</td> <td>No</td> </tr> </table>	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Yes	No												
Yes	No												
Yes	No												
Yes	No												
Yes	No												
<p><b>Certification:</b></p> <p>This form will need to be notarized by a notary public.</p>	<p>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 <b>must</b> contain the original signature of the program director (M.D./D.O. only).</p> <p>Name: _____ Title: _____</p> <p>Signature: _____ Date: _____</p> <p>Telephone: _____ Email: _____</p>												



**Verification of Fifth Pathway (continued):**

Rotations: Our records indicate that this individual participated in the following rotations:

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

<p><b>Unusual Circumstances:</b></p> <p>Circle the correct response. Omitted responses require written explanation.</p> <p>If necessary, you may continue your explanation on a separate sheet of paper.</p>	<p>Did this individual ever take a leave of absence or break from his/her training?      Yes    No</p> <p>Was this individual ever placed on probation?      Yes    No</p> <p>Was this individual ever disciplined or placed under investigation?      Yes    No</p> <p>Did instructors ever file any negative reports on this individual?      Yes    No</p> <p>Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reasons?      Yes    No</p> <p>Please explain any 'Yes' responses from above:</p> <p>_____</p> <p>_____</p> <p>_____</p>
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**ENCLOSE A COPY OF THIS INDIVIDUAL'S OFFICIAL TRANSCRIPT OR EQUIVALENT DOCUMENT**

**Certification:** By my signature below, I, \_\_\_\_\_, certify that the information contained in this report is an accurate account of the above named individual's official records maintained by this institution and is true and correct to my knowledge.

(Print name)

**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).

(Print or Type)

Last Name	First	Middle	Maiden
_____	_____	_____	_____

Social Security Number	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**

01-132-10  
North Carolina Medical Board  
November 2002

# 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)

<b>APPLICANT</b>	LEAVE BLANK	TYPE OR PRINT ALL INFORMATION IN BLACK					FBI	LEAVE BLANK	
		LAST NAME <u>NAM</u>	FIRST NAME	MIDDLE NAME					
SIGNATURE OF PERSON FINGERPRINTED <u>2</u>		ALIASES <u>AKA</u>		O R I	<u>1</u> NCBCI0000 ST BU OF INV RALEIGH, NC				
RESIDENCE OF PERSON FINGERPRINTED <u>5</u>		<u>3</u>					DATE OF BIRTH <u>DOB</u> Month <u>4</u> Day Year		
DATE <u>13</u>	SIGNATURE OF OFFICIAL TAKING FINGERPRINTS <u>14</u>		CITIZENSHIP <u>CTZ</u>	SEX <u>6</u>	RACE <u>7</u>	HGT. <u>8</u>	WGT. <u>9</u>	EYES <u>10</u>	
EMPLOYER AND ADDRESS North Carolina Medical Board PO Box 20007 Raleigh, NC 27619-0007		YOUR NO. <u>OCA</u> <u>BOME00000</u>		HAIR <u>11</u>					PLACE OF BIRTH <u>POB</u> <u>12</u>
		FBI NO. <u>FBI</u>		LEAVE BLANK					
		ARMED FORCES NO. <u>MNU</u>		CLASS _____					
		SOCIAL SECURITY NO. <u>SOC</u> <u>15</u>		REF _____					
REASON FINGERPRINTED Medical License Applicant State and Federal NCGS 90-11		MISCELLANEOUS NO. <u>MNU</u>							
1. R. THUMB	2. R. INDEX	3. R. MIDDLE	4. R. RING						
<b>This is a SAMPLE CARD</b>									
<b>Do <u>NOT</u> put prints on this card</b>									
6. L. THUMB	7. L. INDEX	8. L. MIDDLE	9. L. RING						
LEFT FOUR FINGERS TAKEN SIMULTANEOUSLY			THUMB	R. THUMB	RIGHT FOUR FINGERS TAKEN SIMULTANEOUSLY				