

# REQUIREMENTS FOR NORTH CAROLINA PERFUSIONIST LICENSE

## CORE APPLICATION INCLUDES:

- Instructions
- Biographical information
- Chronology
- Background questions
- Applicant's oath
- Claims Information Form
- Reference Forms
- Criminal history record check
- NPDB & HIPDB reports

<b>Regular Pathway</b> G.S. 90-686	<b>Reciprocity Pathway</b> G.S. 90-687	<b>Provisional Pathway</b> G.S. 90-688
Submit all core application requirements plus education certification form and verification of current CCP certification.	Submit all core application requirements <b>plus</b> verification of license in good standing in another state or US territory and either  1) Evidence laws of that state meet the standards of North Carolina  OR  2) Proof of current certification as a clinical perfusionist	Submit all core application requirements plus education certification and Designation of Supervising Perfusionist Form

**PERFUSIONIST ADVISORY COMMITTEE  
OF THE NORTH CAROLINA MEDICAL BOARD**

**LICENSING OVERVIEW**

Beginning July 1, 2006, all perfusionists in North Carolina must obtain licensure in order to practice perfusion. There are three pathways by which a person may obtain his or her perfusion license. They are: Regular Pathway, Reciprocity Pathway, or Provisional Pathway.

**Regular Pathway:** This pathway is for applicants who have graduated from an approved educational program, have a current certification as a clinical perfusionist, and who do not wish, or may not be qualified, to obtain a license by one of the other pathways.

**Reciprocity Pathway:** This pathway is available for applicants who are licensed, in good standing, as a perfusionist in another state or United States Territory, and who can satisfy one of the following two criteria:

- 1) The state or territory in which he or she is licensed has laws regulating perfusion that are substantially equivalent to the laws of North Carolina\*; or
- 2) The applicant has current certification as a clinical perfusionist.

\* In the event the applicant seeks reciprocity by electing this criteria, the Perfusionist Advisory Committee of the North Carolina Medical Board (PAC) will obtain the laws of the other state and make a determination as to whether such laws are substantially equivalent to those of North Carolina.

**Provisional Pathway:** This pathway is for applicants who do not have certification as a clinical perfusionist but do satisfy the educational requirements for perfusion licensure, and who do not qualify for licensure under the Reciprocity or Grandfather Pathways. A provisional license applicant must be supervised by a licensed perfusionist, and the provisional license may not exceed a period of twelve (12) months. The provisional license applicant must complete a Designation of Supervising Perfusionist Form.

**Converting A Provisional License to a Full License:** A provisional licensed perfusionist who receives certification from the American Board of Cardiovascular Perfusion (ABCP) may request that his or her provisional license be converted to a full license. The provisional licensee must submit a written request for the conversion and proof of certification from the ABCP, and pay the conversion fee. The Perfusionist Advisory Committee may request additional information or conduct an interview of the applicant to determine the applicant's qualifications.

## REQUIREMENTS FOR A LICENSE TO PRACTICE PERFUSION

NORTH CAROLINA MEDICAL BOARD  
P.O. Box 20007, Raleigh, NC 27619  
1203 Front Street, Raleigh, NC 27609  
(919) 326-1100 or (800) 253-9653

### 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 department may be contacted by e-mail at [license@ncmedboard.org](mailto:license@ncmedboard.org).

- 1. Completed application form (applies to all pathways)
  - 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. Submit ORIGINAL Application Form to the Committee.
  - Include name change documentation, if applicable.

- 2. Verification of Education (not required if applying under Reciprocity Pathway)

Verification of education using the Education Certification Form. This certification must bear the original signature of the Dean or other Official of the program; their official title and the seal of the program/school.

- 3. ABCP Certification (applies to Regular pathway and Reciprocity pathway)

Primary source verification of current certification from the American Board of Cardiovascular Perfusion (ABCP). (This verification is not required if applying under the Grandfather or Provisional Pathways. This verification may also be required under the Reciprocity Pathway -- See Licensing Overview for further details)

You may request verification by phone, fax, e-mail, or letter. An authorization for release of information is not necessary. They will respond directly to the Board. Original certification is required.

**Fax number: 601-582-2271**

**E-mail address: [abcp@abcp.org](mailto:abcp@abcp.org)**

**Mailing address: ABCP, 207 North 25th Avenue, Hattiesburg, MS 39401**

- 4. Verification of Other State License (applies to all pathways)

Using the License Biography Form you must secure a report from each state in which you have ever been licensed as a perfusionist, regarding the status of that license. **All licenses, active and/or inactive, must be verified.** Most states charge a fee for this service.

- 5. Two current references (applies to all pathways)

Two professional references, using the provided Reference Forms. References must not be from a relative and must be mailed directly to the Board's office at PO Box 20007, Raleigh, NC 27619-0007.

- 6. Fee (applies to all pathways)

A fee of \$397.50 U.S. dollars is to be paid at the time the application is submitted (\$350.00 for the license application fee, \$9.50 for the NPDB/HIPDB report, and \$38.00 for the criminal background check fee). If you request a provisional license, a fee of \$222.50 is required (\$175.00 for the provisional license application fee, \$9.50 for the NPDB/HIPDB report, 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 the application fee has been received.

- 7. Data Bank Query (applies to all pathways)

NCMB staff will request a current report from the National Practitioner Data Bank (NPDB) **AND** the Healthcare Integrity Practitioner Data Bank (HIPDB) (applies to all pathways)

- 8. Background Check (applies to all pathways)

Applicants must submit two completed fingerprint cards for the purpose of conducting a criminal background check. 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 upon receipt of your application for a license, fingerprint cards, authority for release of information form and the fingerprinting fee. The SBI has suggested that using live scan when available may be a more reliable choice.

- 9. Personal Interview

A personal interview with the Committee may be required. Applicants will be advised by mail regarding the necessity of a personal interview once all application materials are received. Each application is considered on an individual basis to determine whether an interview is required. If an interview is required, a license will not be issued before the interview has been conducted.

- 10. Designation of Supervising Perfusionist using the Designation of Supervising Perfusionist form (applies only to Provisional Pathway)

**REGISTRATION - NORTH CAROLINA LAW REQUIRES LICENSED PERFUSIONISTS TO REGISTER WITH THE BOARD TWO YEARS AFTER THE DATE THE LICENSE WAS ISSUED. NOTICE OF EXPIRATION WILL BE SENT TO EACH LICENSEE AT HIS OR HER LAST KNOWN ADDRESS AT LEAST 30 DAYS PRIOR TO THE EXPIRATION OF THE LICENSE. APPLICANTS FOR RENEWAL OF UNEXPIRED LICENSES SHALL BE ACCOMPANIED BY PROOF THAT THE APPLICANT HAS COMPLETED THE CONTINUING EDUCATION REQUIREMENTS THAT HAVE BEEN ESTABLISHED. IT IS THE APPLICANT'S RESPONSIBILITY TO KEEP THE BOARD INFORMED OF ADDRESS CHANGES.**

## APPLICATION FOR LICENSE TO PRACTICE PERFUSION

Perfusionist Advisory Committee  
North Carolina Medical Board  
P.O. Box 20007, Raleigh, NC 27619  
1203 Front Street, Raleigh, NC 27609

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.

*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 perfusion in the State of North Carolina and submit the following statement concerning my age, moral character, medical education, and work history.**

**Please select which pathway you will be applying under:**

- Regular Pathway
- Reciprocity Pathway
- Provisional Pathway

Full Name: \_\_\_\_\_  
(First) (Middle) (Last) (Suffix)

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

E-mail 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: (\_\_\_\_) \_\_\_\_\_

Educational Institution that issued your degree: \_\_\_\_\_

City/State: \_\_\_\_\_ Year of Graduation: \_\_\_\_\_

American Board of Cardiovascular Perfusion Examination Taken:

- Yes
- No

State(s) where Perfusion licenses are currently held: \_\_\_\_\_

State(s) where Perfusion licensure is expired: \_\_\_\_\_



**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

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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

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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

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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

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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

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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 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

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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

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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

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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. 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?

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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).\*\*

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**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). \*\*

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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. \*\*

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

Action includes 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). \*\*

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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.

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# North Carolina Medical Board Affidavit, Release, and Authorization

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

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.*

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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.

**NOTE: NOTARY SEAL MUST BE PARTIALLY OVER THE APPLICANT'S PHOTO AND SIGNATURE**

\_\_\_\_\_  
Applicant's Printed Name

\_\_\_\_\_  
Applicant's Social Security Number

\_\_\_\_\_  
Applicant's Date of Birth

**Applicant 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.

\_\_\_\_\_  
**Applicant's Signature**

\_\_\_\_\_  
**Date of Signature**

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**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.**



**NC MEDICAL BOARD  
IMMIGRATION STATUS FORM**

PO Box 20007  
Raleigh, NC 27619

Perfusionist 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:

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**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.

**VERIFICATION OF EDUCATION**

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

Name of Perfusionist: \_\_\_\_\_

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 school for a total of  
(Perfusionist's name)

\_\_\_\_\_ weeks of education on the following dates (mm/dd/yy):

From \_\_\_\_\_ to \_\_\_\_\_

This institution's minimum attendance requirement is \_\_\_\_\_ weeks.

This individual was awarded the \_\_\_\_\_ degree on \_\_\_\_\_  
month/year

**The Dean or other 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 – stamps not accepted)

Title: \_\_\_\_\_

Date of signature: \_\_\_\_\_

**Verification of Education**  
**Page 2 of 2**

**Unusual Circumstances:** The following questions apply to unusual circumstances that occurred during any part of the perfusionist's 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 education? Yes ( ) No ( )

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

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

Please specify \_\_\_\_\_

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

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

Please specify reason: \_\_\_\_\_

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

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

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

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

5. Does this perfusionist's official records reflect that there were any limitations or special requirements imposed on the perfusionist 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  
PERFUSIONIST 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 professionals who have interacted with you within the past three years and who are knowledgeable about your competence in the practice of perfusion.

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

\_\_\_\_\_  
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 perfusionist 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 perfusionist and other health care workers?   | Yes | No | N/A |
| 5. Do you know of any derogatory information about this perfusionist with respect to his/her ability to practice?  | Yes | No | N/A |
| 6. Do you know if this perfusionist has had any mental, emotional, or physical illnesses that have interfered with his/her practice as a perfusionist within the past five (5) years?    | Yes | No | N/A |
| 7. Do you know if this perfusionist 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 perfusionist?  | Yes | No | N/A |
| 9. Do you know of any restrictions, limitations or other disciplinary actions of any nature taken against this perfusionist 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 perfusionist understand medical staff and hospital policies and abide by these policies?                                    | Yes | No | N/A |
| 11. Does this perfusionist enjoy professional respect among his or her colleagues and in the community where this perfusionist practices? | Yes | No | N/A |
| 12. Do you recommend this perfusionist for unrestricted licensure in North Carolina?  | 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**

**NORTH CAROLINA MEDICAL BOARD  
PERFUSIONIST 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 professionals who have interacted with you within the past three years and who are knowledgeable about your competence in the practice of perfusion.

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

\_\_\_\_\_  
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 perfusionist 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 perfusionist and other health care workers?   | Yes | No | N/A |
| 5. Do you know of any derogatory information about this perfusionist with respect to his/her ability to practice?  | Yes | No | N/A |
| 6. Do you know if this perfusionist has had any mental, emotional, or physical illnesses that have interfered with his/her practice as a perfusionist within the past five (5) years?    | Yes | No | N/A |
| 7. Do you know if this perfusionist 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 perfusionist?  | Yes | No | N/A |
| 9. Do you know of any restrictions, limitations or other disciplinary actions of any nature taken against this perfusionist 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 perfusionist understand medical staff and hospital policies and abide by these policies?                                    | Yes | No | N/A |
| 11. Does this perfusionist enjoy professional respect among his or her colleagues and in the community where this perfusionist practices? | Yes | No | N/A |
| 12. Do you recommend this perfusionist for unrestricted licensure in North Carolina?  | 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**

# 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 \_\_\_\_\_ perfusionist was issued license number \_\_\_\_\_ on \_\_\_\_\_ to practice perfusion 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 perfusionist? \_\_\_\_\_ YES NO
3. Are there any pending investigations against this perfusionist? \_\_\_\_\_ 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.**

## 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.

**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/perfusionist 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**

**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:

Perfusionist Advisory Committee of the  
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

## CRIMINAL BACKGROUND CHECK INSTRUCTIONS

Effective February 1, 2003, pursuant to N.C. G.S. 90-11 (b) and 21 N.C.A.C. 32B.0104, applicants for licensure by this Committee must provide fingerprints as set forth in the above-referenced rule in order for the Committee to conduct a state and federal criminal history record check.

**To ensure the proper finger print card is used you should email the North Carolina Medical Board's License Department at [license@ncmedboard.org](mailto:license@ncmedboard.org) and request a set of cards be sent to you.** On the card containing your fingerprints, you must fill in the information in each block that is checked on the example. Be aware that photo identification and a fee may be required by the law enforcement agency performing this service. Fingerprints of poor quality will be rejected and new prints will be required. If this occurs there will be a delay in processing your application. Once the cards are rejected new cards must be submitted within 90 days of being notified or the process will have to be restarted. Enclosed is a sample fingerprint card with instructions. The background check will take several weeks to process so it is important that you begin this as soon as possible.

Send the properly completed fingerprint cards, the form entitled "Authority For Release of Information" completed by you, and a check in the amount of \$38.00 payable to the North Carolina Medical Board. Checks made payable to the State Bureau of Investigation will not be accepted. The fee of \$38.00 will be paid by the North Carolina Medical Board to the North Carolina State Bureau of Investigation in accordance with the statute for the record check. You may pay the fingerprint and application fees in one check.

Any questions regarding this procedure can be submitted by email to the license department at [license@ncmedboard.org](mailto:license@ncmedboard.org).



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.**