



# Board of Physicians

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Damean W.E. Freas, D.O., Chair

## **State Addendum Instruction for Online Maryland Licensure Application**

In addition to completing the UA online, all applicants must complete the following:

### **1. English Language Requirement**

All applicants applying for licensure in Maryland must demonstrate verbal and written competency in the English language by any of the following criteria noted below.

- A. Documentation of graduation from an English-speaking high school or undergraduate school after at least three years of enrollment
- B. Documentation of graduation from an English-speaking professional medical school
- C. Documentation of receiving a passing score of a least 26 on the “Speaking Section” and 79 on the written part of the Test of English as Foreign Language (TOEFL)
- D. Documentation of receiving a passing score of Advanced or higher on the Oral Proficiency Interview (OPI)

### **2. Criminal History Records Checks (CHRC) (See CHRC Instructions)**

Maryland requires a criminal background check. The Board may not issue a new license to any applicant if the Board has not received criminal history record information. To complete a CHRC please contact the Maryland Department of Public Safety and Correctional Services-Criminal Justice Information System (CJIS).

The Board recommends you do not submit your fingerprints for a CHRC earlier than 6 weeks before the date you intend to submit your initial UA application. The Board is only authorized to retain CHRC information for 90 days. If the CHRC is over 90 days, the applicant will be required to complete a new CHRC.

### **3. Military or Veteran Status:**

The Veterans Full Employment Act of 2013 expedites the licensing process for veterans, military spouses, or active duty service members in the armed forces, reserves, or the National Guard.

### **4. Documentation Confirming Change of Name:**

If your name differs from the application or on any supporting documentation submitted to the Board, provide documentation noting the name change as applicable.

# MARYLAND BOARD OF PHYSICIANS

Baltimore, Maryland

[www.mbp.state.md.us](http://www.mbp.state.md.us)

*Use this online application only if you have never been licensed as a physician in Maryland.*

## ONLINE APPLICATION FOR INITIAL MEDICAL LICENSURE

Dear Applicant:

The non-refundable initial license processing fee for **American Medical Graduates** is **\$310** or **\$410** for **Foreign Medical Graduates**. If your application is approved, there will be an additional license fee of up to \$480, based on last name (A-L or M-Z) and prorated at \$20 per month until expiration of initial license as stated in COMAR 10.32.01.12.

Online application payment is made using **credit card only** with Visa, MasterCard, or Discover.

Applications are processed in the order they are received. Board staff will make every effort to process your application as quickly as possible. Incomplete applications and/or failure to submit the required information will delay the processing of your application.

**The Board does not confirm receipt of the application and payment. Once the application has been reviewed, applicants will be notified via e-mail with the status of the application. Please do not call the Board to check on the status of your application, as constant interruptions slow down the process.**

Supporting documents must come directly from the source. For example, verification of education must come directly from your school.

The Board will keep your online application open for 120 days from the original date of receipt. All requirements for licensure must be met within the 120-day period. If the requirements are not met, your application will be closed, and a new application and full licensure fee will be required.

We look forward to reviewing your completed application and will process it as quickly as possible.

Thank you,

The Licensure Division  
Maryland Board of Physicians

# MARYLAND BOARD OF PHYSICIANS

P.O. Box 2571

Baltimore, Maryland 21215

Telephone: 410-764-4777 or 800-492-6836

[www.mbp.state.md.us](http://www.mbp.state.md.us)

## ONLINE APPLICATION FOR INITIAL MEDICAL LICENSURE INSTRUCTIONS AND IMPORTANT INFORMATION

The nonrefundable initial license processing fee for American Medical Graduates is \$310 and \$410 for Foreign Medical Graduates. If your application is approved, there will be an additional license fee of up to \$480, based on last name (A-L or M-Z) and prorated at \$20 per month until expiration of initial license as stated in COMAR 10.32.01.12.

1. **Name:** If the name on the application form differs from the name on any of your supporting documentation, you must submit a copy of a marriage license, divorce decree, or a court order authorizing the name change. The Board of Physicians (the Board) must be notified of any change in your name on a timely basis.
2. **Public Address:** The public (business) address is your address of record, available to the public, and will be posted on your Practitioner Profile on the Board's Website. **If you change your address prior to being licensed, immediately notify the Board in writing by mail.**
3. **Non-Public Address:** The non-public (home) address will be the location to which the Board directs all correspondence. This is where you live. This address is confidential. Do not use your practice address. **If you change your address prior to being licensed, immediately notify the Board in writing by mail.**
4. **Contact Information (Telephone Numbers and E-mail Address):** The Board will contact you using the information provided.
5. **Date of Birth:** Health Occupations Article §14-307(c), Annotated Code of Maryland, requires applicants to be at least 18 years old. Date of birth also will be used for identification and criminal background checks.
6. **Gender:** Disclosure of gender is not a requirement of licensure. The information provided will be used for identification purposes and for criminal background checks only.
7. **Race and Ethnicity:** Disclosure of race and ethnicity is not a requirement of licensure. The information provided will be used for identification purposes and for criminal background checks only.
8. **Social Security Number:** Maryland law requires the Board to collect U.S. social security numbers (SSN) from all persons applying for professional licenses or certificates. Disclosure of your SSN is mandatory. The Board is permitted by State or Federal law or regulation to use the SSN for the following purposes:
  - A. Verification of identity with respect to actions related to your license (COMAR 10.32.01);
  - B. Administration of the Child Support Enforcement Program (Family Law Article, §10-119.3);
  - C. Identification by the Department of Assessments and Taxation of new businesses in Maryland (Health Occupations Article, §1-210);
  - D. Verification by the Maryland Medicaid program of licensure and sanctions for providers participating in Medicaid [42 U.S.C. §1396a(a)(49); 42 U.S.C. §1396r-2; 42 U.S.C. §1320a-7].
9. **Federation Credentials Verification Service (FCVS):** The FCVS can assist applicants with the credentialing process. Maryland is one of many states that accepts credentials verified by FCVS. For further information, contact FCVS at 817-868-5000, 888-275-3287, or [www.fsmb.org](http://www.fsmb.org). Please be aware that the **FCVS profile does not include the Record of Scores from the National Board of Medical Examiners (NBME) or the verification of medical licenses in other states. Applicants who use FCVS will need to arrange for these verifications to be sent to the Board.** If you plan to use FCVS services, please begin the process at least two months prior to submitting your application to the Board and check the box in Part 1 on the application indicating that you are using the FCVS.

**APPLICATION FOR INITIAL MEDICAL LICENSURE  
INSTRUCTIONS AND IMPORTANT INFORMATION (CONTINUED)**

10. **Chronology of Activities:** Beginning with the date you completed medical school and continuing through the present, list chronologically all of your activities, including hospital privileges. Account for all periods of time including each postgraduate training program you attended, regardless of whether or not you completed the program; each job you held, regardless of whether or not it was medically related or you were compensated; and any period of unemployment.
11. **Verification of Professional Education:** Complete Part 1 of the **Verification of Education and English Language Instruction form (IML 2)** and forward it to the institution which issued your medical degree. *The school must return the form directly to the Board at the address listed on the top of the form. (Omit if using FCVS.)*
12. **Oral and Written Competency in English:** Demonstrate verbal and written competency in the English language by any of the following:
- Documentation of graduation from an English-speaking high school or undergraduate school after at least three years of enrollment;
  - Documentation of graduation from an English-speaking professional (medical) school;
  - Documentation of receiving a passing score of at least 26 on the “Speaking Section” and 79 on the written part of the Test of English as Foreign Language (TOEFL)\*;
  - Documentation of receiving a passing score of Advanced or higher on the Oral Proficiency Interview (OPI)\*.

**\*Information about TOEFL and OPI**

**TOEFL:** To schedule the test or obtain score reports for the TOEFL, contact the Educational Testing Services at <http://www.ets.org/toefl/contact/region1>. You will be asked to provide a PDF copy of your score report.

**OPI:** For information about the OPI, contact Language Testing International (LTI) at [www.language-testing.com](http://www.language-testing.com) or at 914-963-7110. LTI will provide information, including how to make the payment for testing. LTI can schedule an interview within 24-72 hours after receiving payment. They will arrange a specific date and time for your telephone interview.

*Applicants must have an application on file with the Board before scheduling an interview with LTI.*

13. **Postgraduate Training:** Complete this section and complete Part 1 of the **Verification of Postgraduate Medical Education form (IML 3)** and send it to each postgraduate training program you attended. American Medical Graduates must have successfully completed at least one year of Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) accredited postgraduate training or equivalent training as determined by the Board. Foreign Medical Graduates must have successfully completed at least two years of ACGME or AOA accredited postgraduate training or equivalent training as determined by the Board. *(Omit the IML3 if using FCVS.)*

**NOTE:** On a case by case basis, the Board may consider **full-time teaching in an LCME-accredited medical school in the United States** as an alternative to the accredited postgraduate clinical medical education required in the Code of Maryland Regulations (COMAR) 10.32.01.03E. Applicants who intend to request consideration of teaching experience as an alternative to accredited postgraduate clinical medical education should contact the Board’s Licensure Unit for further information.

## APPLICATION FOR INITIAL MEDICAL LICENSURE INSTRUCTIONS AND IMPORTANT INFORMATION (*CONTINUED*)

14. **Medical Licensing Examination:** Applicants applying for a medical license must provide documentation of having passed a medical licensing examination, e.g., USMLE, NBME, NBOME, COMLEX, FLEX, State Board, or LMCC. Written or electronic documentation of passing a medical licensing exam must be sent directly to the Board, by e-mail or mail, from the agency that administered the examination. Mail documentation of passage to: *P.O. Box 2571, Baltimore, MD 21215*. Electronic verification of passage may be e-mailed to: [mdh.mbpcredentials@maryland.gov](mailto:mdh.mbpcredentials@maryland.gov) (*Omit if using FCVS*).

Exam	Contact
USMLE, FLEX	Federation of State Medical Boards— <a href="http://www.fsmb.org">www.fsmb.org</a>
NBME	National Board of Medical Examiners— <a href="http://www.nbme.org">www.nbme.org</a>
NBOME/COMLEX	National Board of Osteopathic Medical Examiners— <a href="http://www.nbome.org">www.nbome.org</a>
LMCC	Medical Council of Canada— <a href="https://mcc.ca/services/file-transfer-and-access-service/">https://mcc.ca/services/file-transfer-and-access-service/</a>
State Board	Contact the appropriate state medical board

### Notice to Applicants Who Failed Any Part, Step, Level, or Component of an Exam Three or More Times

An applicant who passes any of the required exams after having failed any part, step, level, or component three or more times must meet the requirements in numbers 1-3 or 4 below. If you meet the requirements in numbers 1-3, complete the **Verification of Clinical Practice form (IML 4)**. If you meet the requirements in number 4, the Board will verify your Board certification.

1. No disciplinary action pending and no disciplinary action taken against the applicant that would be grounds for discipline under Health Occupations Article, §14-404, Annotated Code of Maryland; **and**
2. Successful completion of 2 or more years of an ACGME or AOA-accredited residency or fellowship; **and**
3. A minimum of 5 years of clinical medicine experience in the U.S., its territories, or in Canada under a full unrestricted medical license with at least 3 of the 5 years having occurred within 5 years of the date\* of the application; **or**
4. Board certification.

\* *This is the date the Applicant electronically signs the IML application.*

15. **Licensure in Other States:** If you have ever held a license to practice medicine as a physician in any state or jurisdiction, please request a license verification from the state in which you were licensed. All verifications can be sent electronically via VeriDoc to [mdh.mbpcredentials@maryland.gov](mailto:mdh.mbpcredentials@maryland.gov). **Please do not send copies of your licenses to the Board.**
16. **Character and Fitness Questions:** Answer the Character and Fitness questions “YES” or “NO.” If you answer “YES” to any question, please provide a detailed explanation. If more information is needed, you will be contacted.

**APPLICATION FOR INITIAL MEDICAL LICENSURE  
INSTRUCTIONS AND IMPORTANT INFORMATION (CONTINUED)**

**17. Special Purpose Exam (SPEX) or Comprehensive Osteopathic Medical Variable-Purpose Exam (COMVEX):**

The Board will require an applicant to pass the SPEX or COMVEX if the applicant:

- a. Passed a medical licensing exam more than 15 years before submitting the application for licensure;
- b. Never passed a specialty board certification exam or passed a specialty board certification exam given by a member board of the American Board of Medical Specialties or the AOA Bureau of Osteopathic Specialists more than ten years before submitting the application;
- c. Has not had a full, unrestricted medical license in at least one state of the U.S., its territories, or Canada within the ten-year period before submitting the application; and
- d. Has not actively practiced clinical medicine in the U.S., its territories, or Canada for at least seven of the ten years before submitting the application.

**Contact Information for the SPEX and COMVEX**

SPEX: Contact the Federation of State Medical Boards at [http://www.fsmb.org/licensure/spex\\_plas/](http://www.fsmb.org/licensure/spex_plas/).

COMVEX: Contact the National Board of Osteopathic Medical Examiners - Client Services Department at [clientservices@nbome.org](mailto:clientservices@nbome.org) or (866) 479-6828. The Website address is <http://www.nbome.org/comvex.asp>.

18. **Release:** Electronically sign and date the online application. You are giving the Board permission to request additional information to support your application for licensure.
19. **Optional Third Party Release:** Board staff will not disclose the status of your application to any party unless you have completed the optional Third Party Release on Part 8 of the application. Please complete the third party release if you want the status of your application disclosed to another party, including family members, friends, and future employers, etc.
20. **Cooperation in an Investigation:** You are expected to cooperate fully with any request for information related to your application for initial medical licensure.
21. **Written Certification Affidavit:** Sign and date the certification in the presence of a notary public. Both you and the notary should sign the application on the same day. Electronic notarizations are accepted.

**IMPORTANT: Criminal History Records Check (CHRC)**

By law, effective October 1, 2016, a full criminal history records check (CHRC) is a requirement for all applicants applying for licensure. There are **NO EXCEPTIONS**. A CHRC includes both State and FBI checks. The Department of Public Safety and Correction Services, Criminal Justice Information Services (CJIS), oversees CHRCs, which are conducted using fingerprints. **The Board cannot issue a license until the CHRC information has been received and reviewed.**

*Please print a copy of your online application for your records.*

**APPLICATION FOR INITIAL MEDICAL LICENSURE  
INSTRUCTIONS AND IMPORTANT INFORMATION (CONTINUED)**

**Statutes and Regulations**

The law governing the practice of medicine in Maryland (Health Occupations Article, Title 14, §§14-101 to 14-702) and the Board's regulations, Code of Maryland Regulations (COMAR) 10.32.01 *et seq.*, may be accessed at the Board's Website at [www.mbp.state.md.us](http://www.mbp.state.md.us).

**PRACTICING AS A PHYSICIAN:** A person may not practice, attempt to practice, or offer to practice as a physician in Maryland unless licensed to practice medicine by the Board. Individuals practicing without a license may be fined up to \$50,000.

# UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE CHECK LIST

After completing the online application, you are responsible for submitting certain documents. There are two checklists below; one to use if you are using the Federation Credentials Verification Service (FCVS) and one to use if you are not using FCVS. Please use the checklist that applies to you.

	NOT using FCVS to verify credentials	Using FCVS to verify credentials
Completed online Uniform Application.	<input type="checkbox"/>	<input type="checkbox"/>
Completed State Addendums and all related documentation mailed to the Board.	<input type="checkbox"/>	<input type="checkbox"/>
Criminal History Records Check Required.	<input type="checkbox"/>	<input type="checkbox"/>
Completed "Written Certification Affidavit" sent to the Board.	<input type="checkbox"/>	<input type="checkbox"/>
Verification of Clinical Practice form sent to the Board.	<input type="checkbox"/>	<input type="checkbox"/>
Completed Verification of Education and English Language Instructions.	<input type="checkbox"/>	Completed via FCVS
Postgraduate Training Verification form sent to the Board from all programs you attended.	<input type="checkbox"/>	Completed via FCVS
Examination Transcripts sent to the Board.	<input type="checkbox"/>	Completed via FCVS
Notarized copy of birth certificate or current, valid passport sent to the Board.	<input type="checkbox"/>	Completed via FCVS
Supporting documentation of any legal name change sent to the Board.	<input type="checkbox"/>	Completed via FCVS





# Board of Physicians

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Damean W.E. Freas, D.O., Chair

## Notice: Criminal History Records Check Required

Dear Applicant for Initial License or Reinstatement of License:

A full Criminal History Records Check (CHRC) is a qualification of licensure. The Board may not reinstate or issue a new license to any applicant, physician, or allied health practitioner, if the Board has not received criminal history record information.

A CHRC will include both a State and national criminal history records check conducted by the Maryland Department of Public Safety and Correctional Services, Criminal Justice Information System (CJIS) and will be maintained in the Maryland and FBI database for further identification purposes. Applicants have the right to challenge their records, which is discussed in more detail in the FBI NonCriminal Justice Applicant's Privacy Rights notice ([https://www.mbp.state.md.us/forms/fbi\\_privacy\\_rights.pdf](https://www.mbp.state.md.us/forms/fbi_privacy_rights.pdf)). An applicant for initial licensure or reinstatement shall apply to CJIS for a CHRC and the application shall include:

1. Two complete sets of legible fingerprints taken on forms approved by CJIS and the FBI; and
2. Payment of the required fees.

### Timing of CHRCs

The Board recommends that applicants do not submit fingerprints earlier than 6 weeks before the date the applicant/licensee intends to complete the initial license or reinstatement application. The Board is only authorized to retain CHRC information for 90 days. If the CHRC is over 90 days, the applicant will be required to complete a new CHRC.

### Fingerprints

#### **A. For Initial Applicants and Reinstatements**

All applicants for licensure in Maryland will be required to submit fingerprints for the CHRC. In order to be fingerprinted, the fingerprinting entity will need the following Board specific information:

- CJIS Authorization #: 1600000743
- FBI ORI #: MD 920522Z
- Reason Fingerprinted: Professional License
- Type of Check: Governmental Licensing/ Certification

## 1. Within Maryland

- a. Go to an authorized location to be fingerprinted prior to mailing in your application to the Board. For a list of electronic fingerprinting locations go to the following website: <https://www.dpscs.state.md.us/publicservs/fingerprint.shtml>. The Board is not responsible for the list. If there are any concerns about a fingerprinting location, please contact CJIS directly.
- b. Provide the fingerprinting entity the CJIS Authorization number and FBI ORI # provided on page 1 of this letter.
- c. Pay the appropriate fee to the fingerprinting entity.

Once the Board receives the results of the CHRCs, the application process will be completed in accordance to Board regulations and policies.

## 2. Outside of Maryland

- a. Out of state applicants have the option of using a Maryland location for fingerprinting. If a Maryland location is used, follow the instructions above for applicants within Maryland. If a location outside of Maryland is used, follow the instructions below.
- b. Either:
  - i. Write to CJIS-Central Repository at P.O Box 32708, Pikesville, Maryland 21282-2708, or
  - ii. Call the Central Repository in Baltimore City at 410-764-4501 or toll free number 1-888-795-0011 to request fingerprint cards.
- c. Have CJIS Authorization and FBI ORI Board #'s available to complete your submission.
- d. Mail the fingerprint card and associated fee to CJIS-Central Repository, P.O Box 32708, Pikesville, Maryland 21282-2708, or overnight the fingerprint card to 6776 Reisterstown Road, Suite 102, Baltimore Maryland 21215.
- e. Please include a check or cashier's check made out to "CJIS Central Repository".

Once the Board received the results of the CHRCs, the application process will be completed in accordance to the Board regulations and policies.

### **Timing of CHRCs**

The Board recommends that applicants do not submit fingerprints earlier than 6 weeks before the date the applicant/licensee intends to complete the initial license or reinstatement application. The Board is only authorized to retain CHRC information for 90 days. If the CHRC is over 90 days, the applicant will be required to complete a new CHRC.

### **Fees:**

Fees are required for CJIS to process each criminal background record check request. All fees must be paid by credit card, check or cashier's check in United States currency. The Central Repository cannot accept cash.

Do not send any payment to the Board, as it does not conduct CHRCs. For additional information contact CJIS at 410-764-4501 or visit <https://www.dpscs.state.md.us/publicservs/fingerprint.shtml>.

### Questions?

Should you have any questions, concerns, or to check the status of a criminal history record information request, please contact the **CJIS Call Center at 410-764-4501 or 1-888-795-0011**, Monday-Friday 8:00 a.m. - 5:00 p.m. The Board cannot assist you in this regard.

**\*Please do not contact the Board to verify receipt or submit receipts. The Board will receive the electronic CHRC notifications within 3 – 14 days.**

MARYLAND BOARD OF PHYSICIANS

Written Certification Affidavit

Online Application ID:

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**Certification:** To be completed by the applicant in the presence of a notary public.

I certify that I have personally reviewed all the responses to Parts 1-8 of this application and that the information I have given is true and accurate to the best of my knowledge. I understand and agree that I may not practice, attempt to practice, or offer to practice medicine in Maryland unless licensed by the Board. I also certify that I am thoroughly familiar with the Statute (Title 14) and Code of Maryland Regulations (COMAR) 10.32.01 *et seq.* which govern the practice of medicine in Maryland.

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

Date \_\_\_\_\_

STATE OF \_\_\_\_\_, CITY/COUNTY OF \_\_\_\_\_, I HEREBY CERTIFY that on this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_, before me, a Notary Public of the State and City/County aforesaid, personally appeared the Applicant, \_\_\_\_\_, who has made oath in due form of law to be the individual referenced in  
(print applicant's name)  
the above application for license to practice medicine and surgery in Maryland, and to have stated the truth in all statements made in this application.

AS WITNESS my hand and notarial seal. \_\_\_\_\_  
Notary Public

My Commission expires: \_\_\_\_\_

SEAL

*The date the applicant and the notary sign the application must be the same.*

Mail all required documents to:  
Maryland Board of Physicians  
P.O. Box 2571  
Baltimore, Maryland 21215

**VERIFICATION OF EDUCATION AND ENGLISH LANGUAGE INSTRUCTION**

*This form is not needed if using the Federation Credentials Verification Service (FCVS) with your Maryland license application.*

**Part 1**

**APPLICANT:** Complete Part 1 and send this form to the institution which issued your medical degree. If you satisfied Maryland's English language competency requirements somewhere other than your medical school, also send a copy of this form to that institution and ask the institution to return the completed form directly to the Board.

Online Application ID:

**Name:**

Print last name and generational indicator (Jr., Sr., II, III, etc.)

First name

Middle name

**Date of Birth:**      Month      Day      Year

**Social Security Number:**  -  -

**School Attended** \_\_\_\_\_  
Only medical school, undergraduate school, or high school

**Affiliated with** (if applicable): \_\_\_\_\_  
Name of institution that conferred your degree, if different from medical college attended

**Attended from:** \_\_\_\_\_ **to** \_\_\_\_\_ **Date of Graduation:** \_\_\_\_\_

**Part 2**

**REGISTRAR, DEAN, PRINCIPAL or OTHER AUTHORIZED OFFICIAL:** Please complete this form and mail it to the above address.

**I hereby certify that the above-named individual attended this institution during the inclusive dates from**

Month      Day      Year      to      Month      Day      Year  
       

; that all academic studies were taught in the  
language(s) of \_\_\_\_\_ ; that all clinical clerkships were taught in the  
language(s) of \_\_\_\_\_ ; and that he/she was conferred the degree of

☐ M.D.    ☐ D.O.    ☐ M.D./Ph.D.    ☐ M.B.B.S.    ☐ M.B.B.Ch    ☐ Other: \_\_\_\_\_  
(specify)

on      Month      Day      Year  
   after he/she had satisfied all prerequisite obligations.

Print Name of Authorized Official

Name of Institution

Title of Authorized Official

Telephone Number

Fax Number

Signature of Authorized Official

Date

**SEAL  
OF THE  
INSTITUTION**

VERIFICATION OF POSTGRADUATE MEDICAL EDUCATION

*This form is not needed if using the Federation Credentials Verification Service (FCVS) with your Maryland license application.*

**Part 1**

**APPLICANT:** Complete Part 1 and sign where indicated in the Part 2 instructions. Print your name on top of the reverse page, and send a form to the director of each postgraduate training program you attended. Be sure to copy both sides.

Online Application ID:

**a. Applicant's Name:**

\_\_\_\_\_  
Last Name and Generational Indicator (Jr., Sr., II, III, etc.)

\_\_\_\_\_  
First Name

\_\_\_\_\_  
Middle Name

Address: \_\_\_\_\_

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

Date of Birth:

Social Security Number:  -  -

**b. Name of Institution:** \_\_\_\_\_

Department and Area of Training: \_\_\_\_\_

Complete Address: \_\_\_\_\_

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

FROM:   TO

**Part 2**

**POSTGRADUATE TRAINING AUTHORIZED OFFICIAL:** Please complete Part 2 according to the records available and send directly to the Maryland Board of Physicians at the above address. Please do not send original or copies to the applicant.

Applicant's Signature: \_\_\_\_\_

1. Did the applicant participate in postgraduate training in your department during the period listed above?\*

☐ YES ☐ NO If "No," please enter exact dates: \_\_\_\_\_ to \_\_\_\_\_

Program Specialty: \_\_\_\_\_

\*If training was part-time, please explain the training schedule after item 8 of this form.

2. During the time of the applicant's participation, was the postgraduate training program accredited? ☐ YES ☐ NO

Accredited by: ☐ ACGME: Program # \_\_\_\_\_ ☐ AOA: ID #: \_\_\_\_\_ ☐ RCPSC

3. Did the applicant participate in all of the components of the training as required by the accrediting body?

☐ YES ☐ NO Comments (attach signed and dated additions as needed): \_\_\_\_\_

4. Did the applicant successfully complete all requirements of each year of training?

☐ YES ☐ NO Comments (attach signed and dated additions as needed): \_\_\_\_\_

(Continued on next page)

MARYLAND BOARD OF PHYSICIANS  
VERIFICATION OF POSTGRADUATE MEDICAL EDUCATION

Side B

Online Application ID:

Applicant's Name (print): \_\_\_\_\_

5. During the applicant's year(s) of training, did the applicant have any break in training?

☐

YES

☐

NO

Comments (attach signed and dated additions as needed): \_\_\_\_\_

6. Did the applicant have any condition or impairment that affected the applicant's ability to practice medicine during the period of training?

☐

YES

☐

NO

If "Yes," please give a detailed explanation\* \_\_\_\_\_

7. During the period of training, was any action taken against the applicant by any training program, hospital, medical board, licensing authority, or court? Such actions include, but are not limited to investigations, limitations of privileges or special conditions, requirements imposed for academic incompetence, disciplinary actions, probationary actions, etc.

☐

YES

☐

NO

If "Yes," please give a detailed explanation\* \_\_\_\_\_

8. In each year of training, did the applicant demonstrate sufficient academic and clinical ability to qualify for advancement without conditional or probationary status to the next year and next progressive level of responsibility in a designated specialty program?

☐

YES

☐

NO

Comments:\* \_\_\_\_\_

\* If the space is not sufficient, please attach an additional signed and dated sheet.

**Attestation:** I attest that the information I have provided regarding the applicant is true, accurate, and complete according to all available records.

\_\_\_\_\_  
Printed Name of Authorized Official

\_\_\_\_\_  
Title of Authorized Official

\_\_\_\_\_  
Hospital

\_\_\_\_\_  
Address

\_\_\_\_\_  
Department

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Signature of Authorized Official

\_\_\_\_\_  
Date

Maryland Board of Physicians  
P.O. Box 2571  
Baltimore, Maryland 21215  
Telephone: (410) 764-4777 or 800-492-6836  
E-mail: [mbpmail@rcn.com](mailto:mbpmail@rcn.com)

**Application for Initial Medical Licensure  
VERIFICATION OF CLINICAL PRACTICE**

**General Instructions and Important Information**

The Verification of Clinical Practice form is required if an otherwise qualified applicant passes the examination required for licensure, after having failed any part, step, level, or component three or more times. Under these circumstances, in accordance with Health Occupations Article, §14-307(g), Annotated Code of Maryland and Code of Maryland Regulations (COMAR) 10.32.01.03G(3), the Board may consider clinical practice experience.

Complete this form only if you have passed any of the required exams after having failed it three or more times and meet the requirements below.

1. No disciplinary action pending and no disciplinary action taken against the applicant that would be grounds for discipline under Health Occupations Article, §14-404, Annotated Code of Maryland; **and**
2. Successful completion of 2 or more years of an ACGME or AOA-accredited residency or fellowship; **and**
3. A minimum of 5 years of clinical medicine experience in the U.S. or in Canada under a full unrestricted medical license, with at least 3 of the 5 years having occurred within 5 years of the date of the application.

**Instructions for the Applicant:**

1. Complete Part I.
2. Parts II, III, and signature section must be completed by an employer/former employer, Departmental Chair, Chief Medical Officer, supervising physician, or professional colleague with knowledge of your clinical practice. Upon completion, the forms must be sent directly to the Board.

**NOTE:** You may send copies of the form with Section I completed to all individuals necessary to verify that you have a minimum of 5 years clinical practice with at least 3 of the 5 years having occurred within 5 years of the date of the application. The date\* in Section I is the date of the application.

**Instructions for the Person Completing Parts II, III, and signature section:**

1. Parts II and III must be completed by the employer/former employer, Departmental Chair, Chief Medical Officer, supervising physician, or professional colleague with personal knowledge of the applicant's clinical practice.
2. The person completing Parts II and III must send the completed form directly to:

Maryland Board of Physicians  
Licensure Unit  
P.O. Box 2571  
Baltimore, MD 21215

3. ***Do not return the form to the applicant.***



VERIFICATION OF CLINICAL PRACTICE FORM

**Part 1**

**APPLICANT:** Complete Part 1. Send the form to the employer, former employer, Departmental Chair, Chief Medical Officer, or supervising physician with personal knowledge of the applicant's clinical practice to complete Parts 2 and 3 and the signature section.

Online Application ID:

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Applicant's Name:

\_\_\_\_\_  
Last Name and Generational Indicator (Jr., Sr., II, III, etc.)

\_\_\_\_\_  
First Name

\_\_\_\_\_  
Middle Name

Address: \_\_\_\_\_

City: \_\_\_\_\_

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

Zip code: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Telephone number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Date of Birth:

Month	Day	Year						
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Applicant's signature: \_\_\_\_\_

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

**Part 2**

**CLINICAL PRACTICE VERIFICATION:** To be completed by the current/former employer, Departmental Chair, Chief Medical Officer, or supervising physician with personal knowledge of the applicant's clinical practice.

Name of Practice or Employer: \_\_\_\_\_

Practice/Employer Address: \_\_\_\_\_

City: \_\_\_\_\_

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

Zip code: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Practice or Employment Dates: From: \_\_\_\_\_

to: \_\_\_\_\_

Job Title/Position Held: \_\_\_\_\_

Check the box that applies:

☐

Clinical Practice

☐

Non-clinical practice

If clinical practice is checked, complete Part 3.

**Part 3**

**DATES OF CLINICAL PRACTICE AND SIGNATURE:** To be completed by the current/former employer, Departmental Chair, Chief Medical Officer, or supervising physician with personal knowledge of the applicant's clinical practice.

Did the applicant have 5 years of clinical practice of medicine? ☐ YES ☐ NO

Dates: From: \_\_\_\_\_ to: \_\_\_\_\_

Was the clinical practice of medicine in the United States or Canada? ☐ YES ☐ NO

Did at least 3 years of the clinical practice of medicine occur within 5 years of the date\* of the application? ☐ YES ☐ NO

Dates of 3 years of clinical practice of medicine occurring within 5 years of the date\* of the application? Dates: From: \_\_\_\_\_ to: \_\_\_\_\_

Additional Comments: \_\_\_\_\_

*\* This is the date the Applicant signs the IML application, not this form.*

Print Name:

Title:

Capacity in which you worked with the applicant:

E-mail address:

Signature:

Date: