



Nationwide Medical Licensing

20 Renn Lane
Palm Coast, FL 32164
Phone: (386) 437-8300

PLEASE COMPLETE EACH SECTION OF THIS PACKET THOROUGHLY. ANY OMITTED INFORMATION CAN CAUSE DELAYS IN PROCESSING YOUR APPLICATION. ATTACH ANY SUPPORTING DOCUMENTS YOU THINK MAY BE USEFUL (MEDICAL DIPLOMA, TRAINING CERTIFICATES) PLEASE BE SURE TO MAIL 3 PASSPORT STYLE PHOTOS TO OUR OFFICE AT THE ADDRESS LISTED ABOVE. PROVIDING THESE DOCUMENTS AND PHOTOS AHEAD OF TIME WILL REDUCE ANY DELAY IN REQUESTING YOUR VERIFICATIONS.

Full Name:

Have you ever used any other name? YES NO

Married Single

If YES, provide name and date of change:

Current address:

Work address:

Preferred Mailing Address:

Home Work

Home Phone: ()

Cell Phone: ()

Work Phone ()

Preferred Contact Number:

Home

Cell

Work

Email Address:

Social Security Number:

Are you a U.S. Citizen? YES NO

Date of Birth:

Place of Birth:

(MM/DD/YY)

(City, State, Country)

Naturalization Date (if applicable):

PHYSICAL DATA:

Height:

Weight:

Gender:

Eye Color:

Hair Color:

Race:

Physical Marks:

Location of Marks:

Have you ever been in the Military? YES NO

If Yes, list branch of service, rank, and dates of service. Indicate if discharge was honorable.

Branch:

Rank:

Type of Discharge:

Start Date:

End Date:

DEA Number:

Issuing State:

EDUCATION

List education in chronological order, beginning with High School

<u>School/University</u>	<u>City/State</u>	<u>Course/Degree</u>	<u>MM/YY</u>	<u>MM/YY</u>

Date of Graduation from Medical School:

Did you attend a fifth pathway Program? Yes No

If yes, did you complete any clinical clerkship in a country other than where your medical school is located? Yes No

POSTGRADUATE TRAINING

List in order of chronology from date of graduation from medical school to present, all postgraduate training. (Internship, Residency, Fellowship)

Facility Name:	City/State:	
Program Type & Department:	Start Date:	End Date:

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Program type & Department:	Start Date:	End Date:

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Program type & Department:	Start Date:	End Date:

PRACTICE/EMPLOYMENT

List in chronological order from date of completion of postgraduate training to present, all employment (including staff affiliations) or non-employment activities. Please include month/year and contact number. Be sure to address ALL gaps of employment larger than one month.

Employer:	Type of Employment:
City/State:	Contact Number ()
DATES: (MM/YY) From:	TO:

Employer:	Type of Employment:
City/State:	Contact Number ()
DATES: (MM/YY) From:	TO:

Employer:	Type of Employment:
City/State:	Contact Number ()
DATES: (MM/YY) From:	TO:

Employer:	Type of Employment:
City/State:	Contact Number ()
DATES: (MM/YY) From:	TO:

MEDICAL SOCIETY/ASSOCIATION MEMBERSHIPS		
<u>Society</u>	<u>City/State</u>	<u>Dates of Affiliation</u>

PERSONAL REFERENCES Please Provide Four Personal References		
<u>Name/Title</u>	<u>Mailing Address</u>	<u>Phone Number</u>

THIRD PARTY RELEASE INFORMATION Please list any and all names of individuals you wish Nationwide Medical Licensing to discuss the application and or any other personal information with on your behalf. If no party is listed, NML will ONLY speak directly with the physician during the application process.	
<u>Name/Title</u>	<u>Contact Number</u>

ADVERSE ACTIONS / MALPRACTICE
<p>Have you ever been treated or hospitalized for any mental illness, drug or alcohol abuse or do you have any condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:</p>
<p>Have you ever had any adverse actions taken by a medical school, hospital, licensing board, or have you ever been charged with or found guilty of a violation of any national, federal, state, or local statute? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:</p>
<p>Have you ever taken a leave of absence from Medical School or Postgraduate training program? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:</p>
<p>Have you ever been names in a malpractice suit? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain: (in addition, please be prepared to provide a copy of the complaint and settlement for each suit.)</p>

MALPRACTICE INSURANCE Please provide the names and contact numbers for ALL malpractice carriers since graduation of Medical School	
<u>Carrier/Contact Number</u>	<u>Dates of Coverage</u>



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ACQUISITION AGREEMENT

I hereby acknowledge that I have attained the services of Nationwide Medical Licensing, LLC for assistance with licensure in the state (s) of: (please list all states requested)

I understand that the fee for this service is \$475.00 per state, (\$400.00 for Resident and Physician) and \$135.00 for FCVS applications. This includes the cost of Nationwide Medical Licensing administrating and processing of my License Application (s) and related documents. It does not include the fees charged by the regulatory board, various agencies that charge for direct source documentation, or postage/delivery fees. I further understand that if I have chosen the Rush Service, this in no way effects the time in which the Medical Board will process my application but only refers to Nationwide Medical Licensing "IN-HOUSE" Rush. The Rush Service does not guarantee licensure by any specific date.

Total Payment Enclosed: \$ _____

Method of Payment:

- I paid online via Google Checkout
 Company/Personal check or money order
 Credit Card
 Visa
 MasterCard
 American Express
 Discover

Cardholder Name: _____ Account Number _____
(As it appears on the Card)

Security Number (CCV) _____ Expiration Date _____

Billing Address: _____

Signature

Date



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Shipping Agreement

Nationwide Medical Licensing uses USPS shipping method. In order for us to insure that your package gets to you on time and is delivered safely to you, we request that you sign for your delivery. This is the safest way for your personal information to arrive to you and we strongly advise that you use this method of shipment. However, we do understand that there may be other circumstances that prevent you from being able to sign for your package. Therefore, please complete the following and select from the options below. Please understand that Nationwide Medical Licensing cannot be responsible for those packages that are not signed for when delivered. This form must be filled out and returned before we are able to mail out any packages to you. Thank you.

Please check your option for shipping:

- I prefer to have my application with instructions emailed to me at this email address:

- I would like my package delivered to my home or office with no signature required. I understand that Nationwide Medical Licensing is not liable for said package after it has been noted in the USPS tracking system that it has been delivered.
- I request that my package be delivered to my local USPS location, which will be disclosed to me by Nationwide Medical Licensing at the time of shipment for pick up at my convenience.
- I prefer my package to be delivered with signature required. I understand that I must sign for this package at the time of delivery.

Signature

Date