Nationwide Medical Licensing®

P.O. Box 1208
Melbourne, FL 32901
Phone: (888) 992-9933
Fax: (866) 437-8771

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 (MEDICALDIPLOMA, TRAINING CERTIFICATES) PROVIDING THESE DOCUMENTS AHEAD OF TIME WILL REDUCE ANY DELAY IN REQUESTING YOUR VERIFICATIONS.

Full Name: (First, Middle, Last)		
Have you ever used any other name? [ ] YES [ ] NO If YES, provide name and date of change:		
Current Address:		
Most Recent Previous 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: (MM/DD/YY)	Place of Birth: (City, State, Country)	
Drivers License Number and State:		
Mother's Maiden Name: (last name only)		

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

School/University	City/State	Course/Degree	MM/YY	MM/YY

Date of Graduation from Medical School: (Month/Day/Year)
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

EXAMINATIONS List all licensing examinations you have ever taken. These may include FLEX, USMLE, SPEX, NBME, NBOME. LMCC, SBME.			
Exam	**Date Taken (MM/YY)**	**State**	**Number of Attempts**
ECFMG Certificate Number:		**Issue Date:**	

CERTIFICATION		
Are you certified by any Specialty Board? [ ] Yes [ ] No		
Name of Specialty Board	**Certification Specialty/ Sub-Specialty**	**Date Certified/Re-certified**

LICENSES Please list ALL active and inactive professional licenses that you have EVER held.			
State	**License Number**	**Issue Date**	**Expiration Date**

MEMBERSHIPS (IF APPLICABLE)		
Affiliation	**User Name**	**Password**
AMA		
USMLE		
FCVS (FSMB)		

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: Credit Received: [ ] Yes [ ] No	Start Date:	End Date:

Facility Name:	City/State:	
Program Type & Department: Credit Received: [ ] Yes [ ] No	Start Date:	End Date:

Facility Name:	City/State:	
Program Type & Department: Credit Received: [ ] Yes [ ] No	Start Date:	End Date:

Facility Name:	City/State:	
Program Type & Department: Credit Received: [ ] Yes [ ] No	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:
Address:	Contact Number ( )
DATES: (MM/D/YY) From:	TO:

Employer:	Type of Employment:
Address:	Contact Number ( )
DATES: (MM/D/YY) From:	TO:

Employer:	Type of Employment:
Address:	Contact Number ( )
DATES: (MM/D/YY) From:	TO:

Employer:	Type of Employment:
Address:	Contact Number ( )
DATES: (MM/D/YY) From:	TO:

PERSONAL REFERENCES Please Provide Four Personal References		
Name/Title	**Mailing Address**	**Phone Number/Email**

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.	
Name/Title	**Contact Number**

ADVERSE ACTIONS / MALPRACTICE
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? [ ] Yes [ ] No If yes, please explain:
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? [ ] Yes [ ] No If yes, please explain:
Have you ever taken a leave of absence from Medical School or Postgraduate training program? [ ] Yes [ ] No If yes, please explain:
Have you ever been named in a malpractice suit? [ ] Yes [ ] No If yes, please explain: (in addition, please be prepared to provide a copy of the complaint and settlement for each suit.)

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

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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 $600.00 per state, (exception AR and MA licensure is $700.00 per state) ($500.00 for Resident). I understand that 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. The direct source documentation fees will be invoiced upon completion and approval of my application(s) and will be charged to the credit card listed below. 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. I waive any right to pursue any damages against NML. If there are any damages resulting from services provided by NML, such damages may only be pursued by client pursuant to the terms of the contract between client and NML. By signing this agreement, you acknowledge that you have read and understand the company policies outlined on our website and refund policy outlined below.

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

NML's Refund Policy: After application withdrawal: 50% of initial fee. After verification withdrawal: 25% of initial fee. After follow up no refund will be issued. If the client is denied a license because of our error: 100% of initial fee. * Any refund issued by NML will be in the form of a credit toward future licensing services (excluding shipping and handling fees). All applications are subject to a processing fee prior to receiving a refund.

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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 and you only, 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 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 I has been delivered.

☐ 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