Nationwide Medical Licensing®

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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 NBDE, 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 dentist 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**