



Nationwide Medical Licensing®

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Melbourne, FL 32901
Phone: (321) 622-9030
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 (MEDICAL DIPLOMA, 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: <input type="checkbox"/> Home <input type="checkbox"/> Work | Home Phone: () | Preferred Contact Number: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work |
| | Cell Phone: () | |
| | Work Phone: () | |

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 |
|--------------------------|-------------------|----------------------|--------------|--------------|
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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

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: |
| Credit Received: <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

| | | |
|---|-------------|-----------|
| Facility Name: | City/State: | |
| Program Type & Department: | Start Date: | End Date: |
| Credit Received: <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

| | | |
|---|-------------|-----------|
| Facility Name: | City/State: | |
| Program Type & Department: | Start Date: | End Date: |
| Credit Received: <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

| | | |
|---|-------------|-----------|
| Facility Name: | City/State: | |
| Program Type & Department: | Start Date: | End Date: |
| Credit Received: <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

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 |
| | | |
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| 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 |
| | |
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| 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 named 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 | |
|--|--------------------------|
| Carrier/Contact Number/Policy Number | Dates of Coverage |
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