DCH/LMD-505 (12/04)

Michigan Department of Community Health
**Board of Medicine**
P.O. Box 30192
Lansing, Michigan 48909
(517) 335-0918
www.michigan.gov/healthlicense

# MEDICAL CLINICAL ACADEMIC LIMITED LICENSURE INSTRUCTIONS

Authority: P.A. 368 of 1978, as amended
This form is for information only.

**NOTE**: It is your responsibility to have all required documentation sent to the Board of Medicine. Questions regarding your application can be directed to the Michigan Board of Medicine at (517) 335-0918 three weeks after the date you sent the application. Please allow 4-6 weeks processing time. Applications submitted without the required licensing fee, applicant's signature and date will be returned.

**THE FOLLOWING MUST BE RECEIVED IN THE BOARD OFFICE:**

1. A completed application and a check or money order, drawn on a U.S. financial institution(made payable to the **STATE OF MICHIGAN**, for the appropriate amount. An application accompanied by the appropriate fee is valid for two years. If an applicant fails to complete the requirements for licensure within two years from the date of filing the application, the application is no longer valid.

2. Certification of medical education submitted directly from the medical school to the board on the attached form.

3. The Certification of Appointment to a Michigan Academic Institution form (attached), certifying a teaching or research appointment to a Michigan academic institution as defined in Section 17001 of Public Act 368 of 1978, as amended, must be completed and submitted directly to the Board by the Director of Medical Education of the appointing institution.

4. Official verification of your medical license status submitted directly to the Michigan Board from the state licensing board of EACH state in which you currently hold or have ever held a permanent license. Most states charge a fee for providing license verification.

**If you intend to apply for full licensure under Section 17031(1) of the Michigan Public Health Code, you will also need to submit:**

5. Certification of all postgraduate training, completed on the enclosed form, and submitted directly to the board by the Director of Medical Education of the hospital(s) in which the training was completed.

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**Board of Medicine**
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# APPLICATION FOR CLINICAL ACADEMIC LIMITED LICENSE AND CONTROLLED SUBSTANCE LICENSES

Authority: Public Act 368 of 1978, as amended
If this form is not completed, a license will not be issued.

A controlled substance license is required for every person who prescribes, manufactures, distributes, or dispenses any controlled substance in Michigan as described in Article 7 of Public Act 368 of 1978, as amended. Information on obtaining a Federal controlled substance license may be obtained by contacting the Regional Branch, Drug Enforcement Administration, 431 Howard Street, Detroit, MI 48226 (Telephone 1-800-882-9539).

| Board Use Only |
|---|
| License Number |
| C.S. License Number |
| Date of Licensure |

**Type or Print Only**

## I AM APPLYING FOR THE FOLLOWING:

☐ **Limited Clinical Academic and Controlled Substance Fee: 170.00**
**71-43-01-375705**

Your check or money order drawn on a U.S. financial institution and made payable to the **STATE OF MICHIGAN** must accompany this application. **DO NOT SEND CASH.** Fees are deposited upon receipt and can only be refunded under refund rules promulgated by the Department.

| First Name | Middle Name | Last Name |
|---|---|---|
| U.S. Social Security Number | Date of Birth | Previous MI License Number and Expiration Date, If applicable |
| Daytime Phone Number | All Previous Names and/or Birth Name Used (if applicable) | |
| Have you ever held a health professional license in Michigan? ☐ Yes ☐ No | | |
| Name of Appointing Academic Institution | | |
| Street Address of Academic Institution | | |
| City | State | ZIP Code |

**Check the appropriate answer to each of the following questions. NOTE: Attach a detailed explanation for any Yes answer you check.**

1. **Have you ever been convicted of a felony?** ☐ Yes ☐ No
2. **Have you ever been convicted of a misdemeanor punishable by imprisonment for a maximum term of 2 years?** ☐ Yes ☐ No
3. **Have you ever been convicted of a misdemeanor involving the illegal delivery, possession, or use of alcohol or a controlled substance (including motor vehicle violations)?** ☐ Yes ☐ No
4. **Have you been treated for substance abuse in the past 2 years?** ☐ Yes ☐ No
5. **Have you had 3 or more malpractice settlements, awards, or judgments totaling $200,000 or more in any consecutive 5 year period?** ☐ Yes ☐ No
6. **Have you had one or more malpractice settlements, awards, or judgments totaling $200,000 or more in any consecutive 5 year period?** ☐ Yes ☐ No
7. **Have you ever had a federal or state health professional license or registration revoked, suspended, or otherwise disciplined; been denied a license; or currently have disciplinary action pending against you?** ☐ Yes ☐ No

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

Name

8. Have you ever been censured, or requested to withdraw from a health care facility's staff or had your health care facility staff privileges involuntarily modified? ☐ Yes ☐ No

9. Do you hold or have you held a medical license in any state? If yes, list each state, the license or registration number, the date issued, and how the license was obtained DO NOT LIST TEMPORARY LICENSES. **You must have each state board verify licensure directly to this board office. (Attach additional sheets if necessary.)** ☐ Yes ☐ No

| State | License Number | Date of Issue | How obtained (Endorsement or examination) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Provide a complete chronological record of your educational preparation.**
Attach additional sheets **if necessary**.

| Name and Address of Institution | Dates of Attendance From | To | Degree |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Provide a description of your professional medical experience.**
Attach additional sheets if necessary.

| Name and Address of Employer | Dates of Practice From | To | Duties |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## CERTIFICATION

I understand that it is the policy of this agency to secure a criminal conviction history as part of their pre-licensure screening process. I authorize this agency to use the information provided in this application to obtain a criminal conviction history file search from the Central Records Division of the Michigan Department of State Police or other law enforcement or judicial record-keeping organization.

I further consent to the release of information to this agency regarding any disciplinary investigations conducted by a similar licensure, registration, or specialty certification board of this or any other state, of the United States military, of the federal government, or of another country.

The statements in this application are true and correct. I have not withheld information that might affect the decision to be made on this application. In signing this application, I am aware that a false statement or dishonest answer may be grounds for denial of my application or revocation of my license and that such misrepresentation is punishable by law.

| Signature of Applicant | Date |
|---|---|
| | |

Michigan Department of Community Health
**Board of Medicine**
P.O. Box 30192
Lansing, MI 48909
(517) 335-0918

# CERTIFICATION OF POSTGRADUATE TRAINING (CLINICAL ACADEMIC LIMITED LICENSE)

Authority: Public Act 368 of 1978, as amended
If this form is not completed, a license will not be issued.

## INSTRUCTIONS TO APPLICANT:

**Complete Section I. Type or print your name exactly as it appears on your application. For completion of Section II, send this form to be completed by the Director of Medical Education where you completed your postgraduate training. This certification must be submitted directly to the Michigan Board of Medicine by the Director of Medical Education.**

## SECTION I - APPLICANT INFORMATION

| First Name | Middle Name | Last Name |
|---|---|---|
| Social Security Number | Date of Birth | |
| Street Address | | |
| City | State | ZIP Code |
| Daytime Telephone Number | All Previous Names and/or Birth Name Used (if applicable) | |

| Signature of Applicant | Date |
|---|---|

**APPLICANT: UPON COMPLETION OF SECTION I, SEND THIS FORM TO THE DIRECTOR OF MEDICAL EDUCATION FOR COMPLETION OF SECTION II.**

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

| Name |
|---|
| |

## TO BE COMPLETED BY THE DIRECTOR OF MEDICAL EDUCATION

### INSTRUCTIONS FOR COMPLETING SECTION II:

**Please complete the following information. Return this completed certification directly to the Michigan Board of Medicine at the address shown on Page 1 of this form.**

### SECTION II - CERTIFICATION OF POSTGRADUATE TRAINING

| Name of Hospital | | |
|---|---|---|
| Street Address of Hospital | | |
| City | State | ZIP Code |
| Identify all medical schools affiliated with the training hospital: | | |

**I certify that** _____ **a graduate of the**
(Applicant's Name)

_____ **medical school, has successfully completed postgraduate**

**clinical training offered by the hospital named above from** _____ **to** _____
(Month/Day/Year) (Month/Day/Year)

**in the clinical area of** _____ .

_____ _____
Signature of Director of Medical Education Date of Signature

_____ **(S E A L)**
Print or Type Name of Director of Medical Education

If hospital has no seal, please indicate

**NOTE: Certification of postgraduate training will not be accepted if certified and submitted more than 15 days prior to actual completion.**

DCH/LMD-097 (03/04)

Michigan Department of Community Health
**Board of Medicine**
P.O. Box 30192
Lansing, MI 48909
(517) 335-0918

# CERTIFICATION OF APPOINTMENT TO A MICHIGAN ACADEMIC INSTITUTION

Authority: Public Act 368 of 1978, as amended
If this form is not completed, a license will not be issued.

**Please complete the following information. Return this completed certification directly to the Michigan Board of Medicine at the address shown above.**

| Name of Institution | | |
|---|---|---|
| Street Address of Institution | | |
| City | State | ZIP Code |

**I certify that** _____ **has been duly**
(Applicant's Name)

**appointed to this academic institution in the clinical area of** _____

_____

**beginning** _____ **and ending** _____.
(Month/Day/Year) (Month/Day/Year)

**The applicant is appointed to the following position:**

☐ **Medical school faculty**

☐ **Research**

**I further certify that the above-named academic institution meets all of the following requirements:**

A. **Was the sole sponsor or a cosponsor, with either a medical school approved by the Michigan Board of Medicine or a hospital owned by the federal government and directly operated by the United States Department of Veterans' Affairs, of not less than four residency programs accredited by the Accreditation Council for Graduate Medical Education for not less than three years immediately preceding the date of my signature below.**

B. **Has spent not less than $2,000,000 for medical education during each of the three years immediately preceding the date of my signature below (As used in this statement, "medical education" means the education of physicians and candidates for degrees or licenses to become physicians, including physician staff, residents, interns and medical students).**

_____ _____
Signature of Director of Medical Education Date of Signature

(S E A L)

_____
Print or Type Name of Director of Medical Education

If school has no seal, please indicate

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

Michigan Department of Community Health
**Board of Medicine**
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(517) 335-0918



# CERTIFICATION OF MEDICAL EDUCATION FOR GRADUATES OF FOREIGN MEDICAL SCHOOL GRADUATES

Authority: Public Act 368 of 1978, as amended
If this form is not completed, a license will not be issued.

## INSTRUCTIONS TO APPLICANT:

**Complete Section I. Type or print your name exactly as it appears on your application. For completion of Section II, send this form to the Dean of the medical school you attended. This certification must be submitted directly to the Michigan Board of Medicine by the medical school.**

## SECTION I - APPLICANT INFORMATION

| First Name | Middle Name | Last Name |
|---|---|---|
| Social Security Number | Date of Birth | |
| Street Address | | |
| City | State | ZIP Code |
| Daytime Telephone Number | All Previous Names and/or Birth Name Used (if applicable) | |
| Date of Admission | | Date of Graduation |

| Signature of Applicant | Date |
|---|---|

## APPLICANT: UPON COMPLETION OF SECTION I, SEND THIS FORM TO THE DEAN OF YOUR MEDICAL SCHOOL FOR COMPLETION OF SECTION II.

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

Name

## TO BE COMPLETED BY THE DEAN OR REGISTRAR OF THE MEDICAL SCHOOL

### INSTRUCTIONS FOR COMPLETING SECTION II:

Please complete the following information. Return this completed certification directly to the Michigan Board of Medicine at the address shown on Page 1 of this form.

### SECTION II - CERTIFICATION OF MEDICAL EDUCATION

| Name of Medical School | | |
|---|---|---|
| Street Address of Medical School | | |
| City | State | ZIP Code |

I certify that _____ attended the
(Applicant's Name)

medical school named above from _____ to _____ ,
(Month/Day/Year) (Month/Day/Year)

and was granted the degree of _____ on

_____ .
(Month/Day/Year)

I also certify that the medical education program from which the applicant graduated was not less than 130 weeks and does not award credit for any courses taken by correspondence. I further certify that this medical education program included basic science courses in anatomy; physiology; biochemistry; microbiology; pathology; pharmacology and therapeutics; preventive medicine; and clinical sciences clerkships in the following subject areas completed at the hospitals or institutions listed below.

| Clinical Sciences | Name and Address of Hospital | Teaching Hospital |
|---|---|---|
| Internal Medicine | | ☐ Yes ☐ No |
| General Surgery | | ☐ Yes ☐ No |
| Pediatrics | | ☐ Yes ☐ No |
| Obstetrics and Gynecology | | ☐ Yes ☐ No |
| Psychiatry | | ☐ Yes ☐ No |

_____
Signature of Dean or Registrar

_____
Date of Signature

_____
Print or Type Name of Dean or Registrar

(S E A L)

If school has no seal, please indicate

* Teaching hospital means that the hospital or institution offers a postgraduate clinical training program in the same content area of the clerkship.

Michigan Department of Community Health
**Board of Medicine**
P.O. Box 30192
Lansing, MI 48909
(517) 335-0918

# CERTIFICATION OF MEDICAL EDUCATION FOR GRADUATES OF MEDICAL SCHOOLS LOCATED IN THE UNITED STATES, ITS TERRITORIES, THE DISTRICT OF COLUMBIA, OR THE DOMINION OF CANADA

Authority: Public Act 368 of 1978, as amended
If this form is not completed, a license will not be issued.

## INSTRUCTIONS TO APPLICANT:

**Complete Section I. Type or print your name exactly as it appears on your application. For completion of Section II, send this form to the Dean of the medical school you attended. This certification must be submitted directly to the Michigan Board of Medicine by the medical school.**

## SECTION I - APPLICANT INFORMATION

| First Name | Middle Name | Last Name |
|---|---|---|
| Social Security Number | Date of Birth | |
| Street Address | | |
| City | State | ZIP Code |
| Daytime Telephone Number | All Previous Names and/or Birth Name Used (if applicable) | |
| Date of Admission | | Date of Graduation |

| Signature of Applicant | Date |
|---|---|

## APPLICANT: UPON COMPLETION OF SECTION I, SEND THIS FORM TO THE DEAN OF YOUR MEDICAL SCHOOL FOR COMPLETION OF SECTION II.

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

Name

## TO BE COMPLETED BY THE DEAN OR REGISTRAR OF THE MEDICAL SCHOOL

### INSTRUCTIONS FOR COMPLETING SECTION II:

**Please complete the following information. Return this completed certification directly to the Michigan Board of Medicine at the address shown on Page 1 of this form.**

### SECTION II - CERTIFICATION OF MEDICAL EDUCATION

**Name of Medical School**

**Street Address of Medical School**

**City, State and ZIP Code**

**I certify that** _____ **attended the**
(Applicant's Name)

**medical school named above from** _____ **, to** _____ **,**
Month/Day/Year Month/Day/Year

**and was/will be granted the degree of** _____ **on**

_____ .
Month/Day/Year

_____
Signature of Dean or Registrar

_____
Date of Signature

(S E A L)

_____
Print or Type Name of Dean or Registrar

If school has no seal, please indicate

OHS/HLD-001 (01/04)

Michigan Department of Community Health
**Bureau of Health Professions**
P.O. Box 30670
Lansing, MI 48909

# VERIFICATION OF LICENSURE OR REGISTRATION IN ANOTHER STATE

Authority: Public Act 368 of 1978, as amended.

**PART I: To be completed by the applicant and forwarded to the appropriate State Licensing Board for completion.**

**Check the profession for which you are requesting verification.**

- ☐ **Chiropractic**
- ☐ **Counseling**
- ☐ **Dentistry**
- ☐ **Marriage & Family Therapy**
- ☐ **Medicine**
- ☐ **Nursing**
- ☐ **Nursing Home Adm.**
- ☐ **Occupational Therapy**
- ☐ **Optometry**
- ☐ **Osteopathy**
- ☐ **Pharmacy**
- ☐ **Physical Therapy**
- ☐ **Physician's Assistants**
- ☐ **Podiatry**
- ☐ **Psychology**
- ☐ **Sanitarians**
- ☐ **Social Work**
- ☐ **Veterinary**

| First Name | Middle Name | Last Name |
|---|---|---|
| Previous Names Used | Date of Birth | U. S. Social Security Number |
| State Board | License Number | Date of Issue |

The applicant listed above has applied for licensure in Michigan and has indicated licensure in your State.
Please complete Part II of this form and return it to the appropriate Michigan Board at the address shown above.

**PART II: To be completed by the State Licensing Board.**

| Basis for Issuance of License: | | Type of License: |
|---|---|---|
| ☐ Examination - Please indicate type of exam (National, Regional, State, etc.) | ☐ Endorsement - Please indicate name of state | |
| License Status<br>☐ Current ☐ Lapsed ☐ Inactive | Original Issue Date | Expiration Date |

Has the applicant incurred any formal or informal actions in your State?

☐ No ☐ Yes - If Yes, Please attach certified copies of any actions.

| Are formal or informal actions pending? | Has the applicant's license ever been limited, denied, surrendered, reprimanded, suspended or revoked? |
|---|---|
| ☐ No ☐ Yes | ☐ No ☐ Yes |

## CERTIFICATION

**I hereby verify, to the best of my knowledge, the information above is true to the records of this Board.**

**Signature** _____ **Date** _____

**Type or Print Name** _____

(S E A L)

**Title** _____

**Full Name of Licensing Board** _____

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