IMPORTANT NOTICE

IF YOUR APPLICATION IS IN A PENDING STATUS FOR MORE THAN THREE MONTHS, YOU WILL BE REQUIRED TO PROVIDE UPDATED INFORMATION.

IF THE APPLICATION PROCESS IS NOT COMPLETED WITHIN ONE YEAR OF RECEIPT OF YOUR INITIAL APPLICATION, YOUR APPLICATION AND DOCUMENTS WILL BE DISCARDED. IF YOU WISH TO REAPPLY YOU WILL NEED TO RESUBMIT ALL DOCUMENTS FOR LICENSURE.

HOW TO CHECK THE STATUS OF YOUR APPLICATION

To expedite the processing of applications, the Board asks that you check the status of your application online instead of contacting the office by phone or email. After your application has been received and processed, an email will be sent to you at the email address listed on the application, advising of your individualized PIN, instructions and website address. The information lacking from your application will be listed on the website. As documents are received the website will be updated. Please note, the website updates nightly. If you wish for other individuals to know the status of your application, it will be your responsibility to provide them with your PIN. Board staff will only release the PIN to you. If, during the application process you need to request a duplicate copy of your PIN, please email or fax a written request to the Board office.

Eric R. Greitens
Governor
State of Missouri

Kathleen (Katie) Steele Danner, Division Director
DIVISION OF PROFESSIONAL REGISTRATION

Department of Insurance
Financial Institutions
and Professional Registration
Chlora Lindley-Myers, Acting Director

STATE BOARD OF REGISTRATION FOR THE HEALING ARTS
3605 Missouri Boulevard
P.O. Box 4
Jefferson City, MO 65102-0004
573-751-0098
866-289-5753 TOLL FREE
573-751-3166 FAX
800-735-2966 TTY
website: http://pr.mo.gov/healingarts.asp

Connie Clarkston
Executive Director

Dear Doctor:

Attached are the materials you will need to make an application for licensure to practice the Healing Arts in the State of Missouri. Included in the packet are:

1. Application with specific instructions for completing it;
2. Postgraduate Reference form (if necessary, please make additional copies);
3. Sheet of general information which will help you through the application process;
4. Sheet of Documents and Fees you must provide with your application;
5. Verification of Licensure form (if necessary, make additional copies);
6. Verification of Hospital Affiliation form (if necessary, make additional copies);

It is suggested that you read the General Information sheet before beginning the process. Next, read the statutes and rules that are located on the Board's website at the address listed above. These statutes and rules contain applicant information that governs your professional conduct as a practitioner of the Healing Arts in the State of Missouri.

If you hold current licensure in any state or territory of the United States or the District of Columbia; have actively engaged in the practice of clinical medicine or held a teaching or faculty position in a medical or osteopathic school approved by the AMA or AOA for the five year period immediately preceding your application for licensure; hold current certification in your area of specialty by the ABMS or AOA; and, no license issued to you has been disciplined, you may be exempt from providing some of the documents. These documents will be noted on the enclosed "Documents and Fee Sheet". Please read them carefully because it will expedite the processing of your application.

Applicants who have not actively engaged in the practice of clinical medicine or held a teaching or faculty position in a medical or osteopathic school approved by the AMA, LCME or the AOA for any two years in the three year period immediately preceding the filing of their application for licensure, may be required to complete continuing medical education, additional training, an assessment from a board approved facility, or re-examination.

There are four ways to become licensed in Missouri:

(1) National Board Endorsement;
(2) Reciprocity with a state license which was obtained by a written examination;
(3) Endorsement with the FLEX, USMLE, or LMCC Examination;
(4) Taking the USMLE Step 3 Examination in Missouri.

No application can be considered by the Board until the entire file is complete. **Therefore, you should not make any firm commitment to begin working until you have received notification of licensure in writing from this office.** Proof that a physician has practiced medicine in Missouri before becoming licensed is grounds for denial of licensure.

Please be advised that no application will be processed without a fee. In addition to the material you are required to submit, the Board makes independent inquiries into your professional background. Therefore, you should allow a minimum of 30 days for the processing of your application once you have filed the completed application and the required documents in this office.

A license to practice as a physician and surgeon expires January 31st of every year **regardless of when it is issued**. A renewal application will be mailed to you on or before December 1st of each year. You will be required to pay an additional fee for renewal and confirm on the renewal application that you obtained 50 hours of continuing medical education. The period for completion of the continuing medical education requirements shall be the 24 month period beginning January 1st of each even-numbered year and ending December 31st of each odd-numbered year. For complete information regarding the Board's continuing medical education requirements, please see Rule 20 CSR 2150-2.125. Failure to receive the renewal application does not relieve any person of the duty to register and pay the fee required nor exempt them from the penalties for failure to renew.

Please be reminded that it is unlawful to misrepresent any material fact, in any way, in connection with an application for Missouri licensure. Proof that a physician has misrepresented any material fact is grounds for licensure denial.

If you have any questions during the process which are not answered in the enclosed material, you may contact the Board of Healing Arts Licensure Section for assistance by calling 573-751-0098, or toll free (866) 289-5753 or via email at licensure@pr.mo.gov

Sincerely yours,
Licensure Section

GENERAL INFORMATION - ALL APPLICANTS

Please read the following information very carefully. Often the questions applicants have are covered in this document. **After reviewing,** if you still have questions, please do not hesitate to contact this office.

There are four approved routes to licensure in Missouri: (1) Endorsement from the **National Board of Medical or Osteopathic Examiners**; (2) **Reciprocity** based upon taking and passing a state board examination, and upon receiving a license in that State or Territory of the U.S. or the District of Columbia wherein the physician is licensed to practice in the same manner and to the same extent as physicians and surgeons are authorized to practice in Missouri. (3) **Endorsement** of the FLEX, USMLE or the LMCC examination; (4) Passing the **USMLE Examination** in Missouri.

If you hold current licensure in any state or territory of the United States or the District of Columbia; have actively engaged in the practice of clinical medicine or held a teaching or faculty position in a medical or osteopathic school approved by the AMA or AOA for the five year period immediately preceding your application for licensure; hold current certification in your area of specialty by the ABMS or AOA; and, no license issued to you has been disciplined, you may be exempt from providing some of the documents. These documents will be noted on the enclosed "Documents and Fee Sheet". Please read them carefully because it will expedite the processing of your application.

Applicants who have not actively engaged in the practice of clinical medicine or held a teaching or faculty position in a medical or osteopathic school approved by the AMA, LCME or the AOA for any two years in the three year period immediately preceding the filing of their application for licensure may be required to complete continuing medical education, additional training, an assessment from a Board approved facility or re-examination.

The Board does not grant licensure based upon reciprocity with a State Board examination where the Basic Science subjects were not examined.

All International Medical Graduates must be certified by the Educational Commission for Foreign Medical Graduates (ECFMG) and provide evidence of having completed three years postgraduate training in a program which is approved and accredited to teach post-graduate medical education by the Accreditation Counsel on Graduate Medical Education of the AMA in **one recognized specialty** area of medicine.

All American medical/osteopathic graduates must present evidence of satisfactory completion of one year of postgraduate training in a program which is approved and accredited to teach post-graduate medical education by the Accreditation Counsel on Graduate Medical Education of the AMA or the education committee of the AOA.

Applicant must be a graduate of a medical or osteopathic school that has been approved by the Missouri Board.

INCOMPLETE APPLICATIONS WILL NOT BE CONSIDERED BY THE BOARD. All required documentation must be received in our office before the file will be reviewed. Any file in a pending status for over three months will be required to provide updated information.

Please be advised that **incomplete** applications on file in this office for **one year will be discarded**.

If you have taken a licensing examination more than three times, please refer to Chapter 334.040 RSMo which can be found on the Board's website before proceeding.

USMLE Steps 1, 2 and 3 must be completed within a seven-year period. The seven-year period begins when you take your first Step, either Step 1 or Step 2. Each Step must be passed within three attempts.

Fifth Pathway applicants may satisfy requirements for licensure in Missouri.

ALL LICENSURE FEES ARE NON-REFUNDABLE.

A temporary license may be issued for physicians in AMA/AOA approved training programs in Missouri. Temporary licensure does not provide for the practice of medicine outside the training program.

Please notice that detailed instructions accompany the document entitled APPLICATION. All items on the application are numbered. Individual instructions for each item may be found following the corresponding number in the document entitled INSTRUCTIONS.

THIS OFFICE DOES NOT ACCEPT FAXED DOCUMENTS.

When your application is received and processed, you will be notified via email of how to check the status of your application online. Completed applications are reviewed on a weekly basis by the Executive Director. The Executive Director may forward the application to the Licensure Chair or Board for further review.

All applications are considered on an individual basis. You may be requested to submit information or documents in addition to the requirements mentioned herein. You may also be requested to appear before the Board's Licensure Committee.

Allow a minimum of 30 days for the processing of your application once you have filed the completed application, fee and the required documents in this office.

The address you have listed on your application as your "current mailing address" will be printed on your certificate.

If you are issued your Missouri license, you will be required by law to pay a licensure renewal fee on or before January 31 of each year and provide proof of having completed 50 hours of continuing medical education every two years.

The Missouri State Board of Healing Arts accepts information from the Federation Credentials Verification Service (FCVS) for any applicant who wishes to use this service. **Please be advised FCVS does not provide all of the documentation required by the Missouri Board.**

If you choose to use FCVS, the following information is included in the FCVS packet and ***NOT*** required to be submitted with your application:

EBAHR
Medical school diploma;
Medical school transcripts;
Postgraduate reference letters;
FLEX/USMLE scores;
NBME scores;
ECFMG Certification (International graduates only).

The following information is required to be submitted ***IN ADDITION TO*** the FCVS packet:

Copy of your Social Security card;
National Practitioner Data Bank;
Pre-Medical transcripts;
Hospital Affiliation Verification(s);
State License Verification(s);
Copy of International Medical License (if applicable).

PLEASE DO NOT DISCARD - REVIEW PRIOR TO COMPLETING APPLICATION.
INSTRUCTIONS FOR COMPLETING YOUR LICENSURE APPLICATION

The Board wishes to stress that you should provide complete details and dates, complete names, addresses and zip codes as required in your application. **Answer all questions.** If you do not, the processing of your application may be delayed indefinitely. Allow 30 days for processing your application after the application, fee and required documents are received. Please type or print your application in **BLACK** ink. The following information is provided to assist you in answering the questions.

ITEM #1 – Please indicate if you are eligible to apply by an expedited licensure method.

ITEM #2 – Please indicate if you are requesting approval to take the USMLE Step 3 exam and/or which examinations you have taken.

ITEM #3 – Print your full name.

ITEM #4 – Provide address to which all licensure material should be sent.

ITEM #5 – Provide current email address.

ITEM #6 – Indicate Month-Day-Year and place of birth.

ITEM #7 – Indicate office, home and cell numbers.

ITEM #8 – Provide Social Security Number.

ITEM #9 – Indicate your medical specialty.

ITEM #10 – (International Medical Graduates Only) Indicate ECFMG number and date it was issued.

ITEM #11 – Indicate the type of practice in which you are currently involved.

ITEM #12 – Indicate intended Missouri practice address. Provide the name of the institution/group, street, city, state and zip. If unknown, please explain.

ITEM #13 – Indicate the type of practice that you intend to be involved with in the State of Missouri.

ITEM #14 – If your answer is “yes”, provide the name of the Specialty Board(s). If your answer is “no”, indicate if you are Board Eligible.

ITEM #15 – List all licenses held, whether active or inactive, permanent, temporary, or institutional, date issued and license number.

ITEM #16 – Indicate any other professional licenses that you hold or have held (other than a license to practice medicine or osteopathic medicine) providing the profession and state or country in which the license, certification or registration was held.

ITEM #17 – If your answer is “yes”, provide complete details on a separate notarized statement. This should include the States, Provinces, or country, dates and reasons. It will also be necessary for the State Board to provide our office with documentation regarding the action taken.

ITEM #18 – If your answer is “yes”, provide the names, addresses, dates and reasons on a separate notarized statement.

ITEM #19 – If your answer is “yes”, provide complete details, names, addresses, etc., on a separate notarized statement. This should include States, Provinces or country, dates and reasons. It will also be necessary for the State Board to provide our office with documentation regarding the action taken.

ITEM #20 – If your answer is “yes”, provide complete details, names, addresses, etc., on a separate notarized statement. This should include States, Provinces or country, dates and reasons. It will also be necessary for the State Board to provide our office with documentation regarding the action taken.

ITEM #21 – If your answer is “yes”, provide complete details on a separate notarized statement. This should include the States, Provinces or country, dates and reasons.

ITEM #22 – If your answer is “yes”, provide complete details on a separate notarized statement. This should include States, Provinces or country, dates and reasons. It will also be necessary for the State Board to provide our office with documentation regarding the action taken.

ITEM #23 – If your answer is “yes”, provide complete details, dates, etc. on a separate notarized statement. If you have ever been a defendant in any legal action, furnish a **Certified Court Copy,** with court seal affixed, of the original complaint, the judgment, the settlement, and/or the disposition of the case. If the case is still pending, your attorney must also submit a letter stating the current status of the case.

ITEM #24 – If your answer is “yes”, provide complete details of the arrest, the dates, places and disposition of the case on a separate notarized statement. Furnish a **Certified Court Copy,** with court seal affixed, of the original charge, the judgment, the sentence and/or the dismissal order, or other such documents which reflects the disposition of the matter.

This does not include any minor traffic or parking violation fines which are under $100. We suggest that if you have ever had an arrest (no matter how minor), you answer the question “yes” on your application and furnish full details of the incident leading up to and including the arrest and disposition of the case.

ITEM #25 – **If you have been involved in two or less cases, and the cases were resolved over five years ago** (from the date of the filing of your licensure application), you are only required to provide a notarized statement. The statement should include a summary of the incident, the date of the incident, the name of the patient and how the case was resolved (i.e. dismissed, jury trial, settled/amount paid, etc.)

If a case(s) is currently pending, it will be necessary for you to provide our office with a copy of the complaint and a notarized statement as described above.

If you have been involved in more than two cases or if cases have been resolved within the five year period immediately preceding the filing of your licensure application, it will be necessary for you to furnish a notarized statement, as described above, and provide a certified court copy of the complaint and the document showing the disposition of the case. If your insurance company paid a claim without a formal case being filed, then include in the written statement the name of the insurance carrier and the date and amount of the settlement.

ITEM #26 – If your answer is “yes”, provide complete details, dates, etc., on a separate notarized statement. This should include the States, Provinces or country, dates and reasons. It will also be necessary for the State Board to provide our office with documentation regarding the action taken.

ITEM #27 – If your answer is “yes”, provide complete details on a separate notarized statement. This should include States, Provinces or country, dates and reasons. It will also be necessary for the State Board to provide our office with documentation regarding the action taken.

ITEM #28-31 – If your answer is “yes”, provide complete details and dates, including the names and addresses of individuals who treated you and any hospitals/institutions where you have been treated on a separate notarized statement. The Board also requires a letter from your treating professional indicating your diagnosis, prognosis and if your illness or condition affects your ability to practice.

ITEM #32 – If your answer is “yes”, provide complete details on a separate notarized statement. This should include why you are required to register, conviction, date and state. The Board also requires a certified copy of the conviction and any court orders (i.e., probation, parole, etc.) requiring registration.

ITEM #33 – List name of school, city and state, month and year of enrollment and graduation.

ITEM #34 – List name of school, city and state, month and year of beginning and ending time year by year. List degrees and dates received from all colleges attended for one semester or longer.

ITEM #35 – List name of school, city and state, beginning date and completion date. If you attended more than one medical school, list each.

ITEM #36 – List the name of your medical school of graduation as it appears on your medical diploma. Indicate month, day and year that you graduated from medical/osteopathic school.

ITEM #37 – (Fifth Pathway Candidates Only) List name of hospital, city, state, dates attended and the name of the Program Director.

ITEM #38 – (Applies to training received in the United States and Canada only.) Indicate the type of training, (i.e. intern, resident, fellow or other), name of hospital, address, and the department/specialty. Provide the beginning and ending dates. Also indicate the name of the Program Director.

ITEM #39 – List all hospitals where you have held active and/or admitting privileges in the U.S. or Canada within the last five years, other than training hospitals. Provide the name of the hospital, address and dates of affiliations. Attach separate listing if more space is needed.

ITEM #40 – List medical and nonmedical activities since the entrance into medical school to present date. This must be in chronological order and account for all dates.

If you hold current licensure in any state or territory of the United States or the District of Columbia; have actively engaged in the practice of clinical medicine or held a teaching or faculty position in a medical or osteopathic school approved by the AMA or AOA for the five year period immediately preceding your application for licensure; hold current certification in your area of specialty by the ABMS or AOA; and, no license issued to you has been disciplined, you are only required to list medical and nonmedical activities for the five year period immediately preceding the filing of your licensure application.

ITEM #41 – Application Information Release Authorization – In the space provided please list the name of one other person with whom we may discuss your file. To expedite the processing of your application, we will only discuss your application with you and one other person.

ITEM #42 – All applicants for medical licensure in Missouri are required to pass the Missouri Medical Jurisprudence Examination. Answers are readily available in the statutes and rules.

ITEM #43 – You must sign this oath before a Notary Public. The Notary Public must complete their portion and sign, date and seal your signature. You should also attach a recent photograph no larger than 3" x 5" in the space provided. Copies of photographs and magazine clippings are not acceptable.

PLEASE BE ADVISED THAT ALL QUESTIONS MUST BE ANSWERED OR THE APPLICATION WILL BE RETURNED.

PLEASE BE ADVISED THAT YOU SHOULD NOT MAKE ANY FIRM COMMITMENT TO ACTUALLY BEGIN PRACTICING UNTIL YOU HAVE RECEIVED NOTIFICATION OF LICENSURE IN WRITING FROM THIS OFFICE.

ANY FILE IN A PENDING STATUS FOR OVER THREE MONTHS WILL BE REQUIRED TO PROVIDE UPDATED INFORMATION.

INCOMPLETE APPLICATIONS ON FILE FOR ONE YEAR WILL BE DISCARDED.

AMERICAN AND CANADIAN GRADUATES
DOCUMENTS AND FEE YOU MUST FURNISH
WITH YOUR APPLICATION

1. **FEES** – Please submit a fee in the amount of $75 to this office in the form of a **MONEY ORDER OR CASHIER'S CHECK** payable on or through a United States bank. All fees should be paid to the order of the Missouri Board for the Healing Arts. **FEES WILL NOT BE REFUNDED**.

2. **NOTARIZATIONS** – Notarizations should be completed as follows:

   a. Affidavits and statements should be notarized as "Subscribed and Sworn to" before the Notary Public. The Notary Public must sign, date and affix their notary seal to the document. Notary seal must show date of expiration.
   b. Canadian documents may be stamped, dated, and signed by the Commissioner of the appropriate Providence if a Notary Public is not available.
   c. The Board will also accept a notarization by the American Embassy.

3. **MEDICAL DIPLOMA** – I**f the Missouri license will be your first permanent license,** you must furnish a copy, no larger than 8½" x 11", of your original Professional Diploma (Doctor of Medicine/Doctor of Osteopathy). **If you hold an active permanent license in another state(s) you are not required to provide a copy of your diploma.**

4. **NATIONAL BOARD CANDIDATES** – If you are applying for licensure by endorsement from the National Board, please have the National Board forward a certified copy of your scores directly to this office. Forms can be obtained on the National Board of Medical Examiners website at http://www.nbme.org/ or the National Board of Osteopathic Medical Examiners website at http://www.nbome.org/.

5. **STATE BOARD EXAMINATION** – If applying for licensure based on an examination given by a State Medical Board, please have the Medical Board forward a certified copy of your scores directly to this office.

6. **FEDERATION HISTORY REQUEST FORM (EBAHR)** – Unless you are applying using FCVS, **all applicants** who apply for a license in Missouri, regardless of what exam you have taken, are required to contact the Federation of State Medical Boards at www.fsmb.org or by calling (817)-868-4041 and request the online EBAHR reporting form. It not only informs us if you have taken the FLEX or USMLE exam, but also if any disciplinary action has been taken against you in any state.

7. **VERIFICATION OF LICENSURE** – If you have ever held a permanent, temporary or institutional license in any State or territory to practice as a physician, dentist, nurse physician assistant, speech pathologist or any other profession, the enclosed form must be mailed to each licensing agency in which you are now or have ever been licensed to practice. You may copy this form for additional copies. It is the applicant's responsibility to provide this form directly to the State Board(s) or territory(s). The State Board(s) or territory(s) must complete the form and return it directly to this office.

8. **PHOTOGRAPH** – Please attach a recent photograph no larger than 3" x 5" in the space provided on the application. **(Please do not staple.)** Copies of photographs are not acceptable.

9. **PRE-MEDICAL TRANSCRIPTS** – I**f the Missouri license will be your first permanent license,** you must furnish a certified, with school seal affixed, pre-medical transcript of grades from all colleges or universities attended for one semester or longer. I**f you hold an active permanent license in another state, you are not required to provide pre-medical transcripts.**

10. **MEDICAL** – All applicants are required to submit certified, with school seal affixed, medical/osteopathic transcripts of your grades during professional school. If these credits were obtained from more than one university, you will be required to submit transcripts from each.

11. **POSTGRADUATE REFERERNCE FORM** – You will be responsible for mailing Postgraduate Reference Forms to each supervisor or director of your training program(s). If more than one reference form is needed, please make additional copies. When the reference forms have been completed by the appropriate individuals, it will be necessary for the forms to be **forwarded directly from the training hospital to our office.** All postgraduate references must be on our form. We will not accept letters of recommendation. These forms must be sent from ALL training programs. Incomplete forms may hold up your file indefinitely.

    If you hold current licensure in any state or territory of the United States or the District of Columbia; have actively engaged in the practice of clinical medicine or held a teaching or faculty position in a medical or osteopathic school approved by the AMA or AOA for the five year period immediately preceding your application for licensure; hold current certification in your area of specialty by the ABMS or AOA; and, no license issued to you has been disciplined, you are exempt from providing postgraduate reference forms.

    *If using FCVS, this document should be included in the FCVS packet. If it is not included, the postgraduate reference form will need to be completed and returned directly to our office.

12. **NATIONAL PRACTITIONER DATA BANK FORM** – It will be necessary for you to contact the National Practitioner Data Bank at 1-800-767-6732 or http://www.npdb-hipdb.hrsa.gov/ and advise them that you wish to do a self query. They will provide you with the

appropriate documents to perform this self query. When you receive the response from the data bank to your query, please forward the **original** information to our office as soon as possible inasmuch as your application will not be considered complete until we receive this information. You may keep a copy for your records.

13. **HOSPITAL AFFILIATION FORM** – You will be responsible for mailing Hospital Affiliation forms to each hospital where you have held active and/or admitting privileges in the U.S. or Canada within the past five years. **This does not include your training hospitals.** You may copy this form as needed. After these forms have been completed by the appropriate hospitals, they must be forwarded directly from the hospital to our office. All hospital affiliations must be completed on our form. Incomplete forms may hold up your file indefinitely.

14. **NAME CHANGE** – If your name has changed, you will be required to submit one of the following documents:

    Marriage – Furnish a **Copy** no larger than 8½" x 11" of your marriage certificate.

    Divorce Decree – Furnish a **Copy** no larger than 8½" x 11" of your divorce decree.

    Adoption – Furnish a **Copy** no larger than 8½" x 11" of your adoption order.

    Court Order – Furnish a certified court copy of the name change document.

    Naturalization – If you have had a name change by naturalization, you will be required to hand carry your original Naturalization Certificate to this office for inspection, since it is unlawful to copy that particular document.

15. **SOCIAL SECURITY CARD** – Furnish a copy of your Social Security card. (Do NOT fax) A citizen of an international country applying for licensure in Missouri, who does not hold a United States Social Security number, shall submit his/her Visa or Passport in lieu of the Social Security card.

PLEASE BE ADVISED THAT YOU SHOULD NOT MAKE ANY FIRM COMMITMENT TO ACTUALLY BEGIN PRACTICING UNTIL YOU HAVE RECEIVED NOTIFICATION OF LICENSURE IN WRITING FROM THIS OFFICE.

ANY FILE IN A PENDING STATUS FOR OVER THREE MONTHS WILL BE REQUIRED TO PROVIDE UPDATED INFORMATION.

INCOMPLETE APPLICATIONS ON FILE FOR ONE YEAR WILL BE DISCARDED.

INTERNATIONAL MEDICAL GRADUATES
DOCUMENTS AND FEE YOU MUST FURNISH
WITH YOUR LICENSURE APPLICATION

1. **FEES** – Please submit a fee in the amount of $75 to this office in the form of a **MONEY ORDER OR CASHIER'S CHECK** payable on or through a United States bank. All fees should be paid to the order of the Missouri Board for the Healing Arts. **FEES WILL NOT BE REFUNDED.**

2. **NOTARIZATIONS** – Notarizations should be done as follows:

   a. Must be done in the United States or Canada.
   b. Affidavits and statements should be notarized as "Subscribed and Sworn to" before the Notary Public. The Notary Public must sign, date and affix their notary seal to the document. Notary seal must show date of expiration.
   c. The Board will also accept a notarization done in an international country if it has "Apostile" stamped on it.

3. **OFFICIAL TRANSLATIONS** – If any of your documents, transcripts, etc. are in an international language, the Board requires you to furnish an **ORIGINAL,** official, word-for-word translation along with a **NOTARIZED TRUE COPY** of the translation.

   AN OFFICIAL TRANSLATION IS:
   1. One which is done by a government official in the United States.
   2. One which is done by an official translation service in the United States.
   3. One which is done by a professor of a language department in a college or university located in the United States.
   4. One which is done by an Official of the American Embassy in a foreign country. This document must be translated by the American Embassy not just certified as a true copy and must have the Embassy seal placed on it.

   THE TRANSLATOR MUST:
   1. Certify that the document is a true translation to the best of their knowledge, that they are fluent in the language, and qualified to translate.
   2. Sign the translation and have their signature certified by a Notary Public.
   3. Print their name and title under the signature.
   4. Translate on official letterhead.

4. **PRE-MEDICAL SCHOOL TRANSCRIPTS** – **If the Missouri license will be your first permanent license,** you must furnish a certified, with school seal affixed, pre-medical transcript of grades from all colleges or universities attended for one semester or longer. **If you hold an active permanent license in another state, you are not required to provide pre-medical transcripts.**

5. **MEDICAL SCHOOL TRANSCRIPTS** – All applicants are required to submit Certified, with school seal affixed, medical transcripts/mark sheets. If these credits were obtained from more than one university, you will be required to provide transcripts from each.

   SUBMIT ORIGINALS **AND** COPIES OF ALL MEDICAL AND PRE-MEDICAL DOCUMENTS, INCLUDING TRANSLATIONS.

   ORIGINALS WILL BE RETURNED PER REQUEST AND SUBMISSION OF THE "ORIGINAL DOCUMENTS" FORM.

6. **MEDICAL DIPLOMA** – **If the Missouri license will be your first permanent license**, you must furnish a copy no larger than 8½" x 11" of your original professional diploma. **If you hold an active permanent license in another state, you are not required to provide a copy of your diploma.**

7. **VERIFICATION FOR LICENSURE IN NATION OF GRADUATION** – Provide proof of eligibility to practice medicine in the country that you graduated from medical school by furnishing a **Copy** no larger than 8½" x 11" of the document. (Does not apply to Fifth Pathway Applicants.)

   IF THE MEDICAL DIPLOMA OR LICENSE TO PRACTICE IN COUNTRY OF GRADUATION ARE IN ANOTHER LANGUAGE THEY MUST BE TRANSLATED (SEE #3). YOU MUST SUBMIT THE ORIGINAL TRANSLATION ALONG WITH A NOTARIZED TRUE COPY OF THE TRANSLATION.

8. **ECFMG VERIFICATION FORM** – Complete a "Request for Status Report of ECFMG Certification" by accessing the form on ECFMG's website at www.ecfmg.org. ECFMG must complete and return it directly to our office. Fifth Pathway applicants should submit a notarized "True Copy" of the ECFMG Interim Letter. Canadian graduates are not required to submit an ECFMG Certificate.

9. **VERIFICATION OF LICENSURE** – If you have ever held a permanent, temporary or institutional license in any State or territory to practice as a physician, dentist, nurse, physician assistant, speech pathologist or any other profession, the enclosed form must be mailed to each licensing agency in which you are now or have ever been licensed to practice. You may copy this form as needed. It is the applicant's responsibility to provide this form directly to the State Board(s) or territory(s). The State Board(s) must complete the form and return it directly to the Board's office. This will be the only form we will accept. Faxes are not acceptable.

10. **POSTGRADUATE REFERENCE FORM** – You will be responsible for mailing Postgraduate Reference Forms to each supervisor/director of each of your training programs in the U.S. and Canada. You may copy this form as needed.

After these forms have been completed by the appropriate training program, they must be **forwarded directly from the program to our office**. All postgraduate references **must be on our form to be acceptable**. Letters of recommendation will not be accepted in lieu of this form. Incomplete forms may hold up your file indefinitely.

*If using FCVS, this document should be included in the FCVS packet. If it is not included, the postgraduate reference form should be completed and returned to our office by the program or director.

If you hold current licensure in any state or territory of the United States or the District of Columbia; have actively engaged in the practice of clinical medicine or held a teaching or faculty position in a medical or osteopathic school approved by the AMA or AOA for the five year period immediately preceding your application for licensure; hold current certification in your area of specialty by the ABMS or AOA; and, no license issued to you has been disciplined, you are exempt from providing postgraduate reference forms.

11. **HOSPITAL AFFILIATION FORM** – You will be responsible for mailing Hospital Affiliation forms to each hospital where you have held staff and/or admitting privileges in the U.S. or Canada within the past five years. **(This does not include your training hospitals.)** You may copy this form as needed. After these forms have been completed by the appropriate hospitals, they must be forwarded directly from the hospital to our office. All hospital affiliations must be completed on our form. Incomplete forms may hold up your file indefinitely.

12. **PHOTOGRAPH** – Please attach a recent photograph no larger than 3" x 5" in the space provided on the application. (Do not staple.) Copies of photographs are not acceptable.

13. **FIFTH PATHWAY APPLICANTS** – Must have the training institution where the Fifth Pathway Program was completed furnish a Postgraduate Reference Form completed by the director of the program, sent directly to our office.

14. **NAME CHANGE** – If your name has changed, you will be required to submit one of the following documents:

    a. Marriage – Furnish a **Copy** no larger than 8½" x 11" of your marriage certificate.

    b. Divorce Decree – Furnish a **Copy** no larger than 8½" x 11" of your divorce decree.

    c. Adoption – Furnish a **Copy** no larger than 8½" x 11" of your adoption order.

    d. Court Order – Furnish a certified court copy of the name change document.

    e. Naturalization – If you have had a name change by naturalization, you will be required to hand carry your original Naturalization Certificate to this office for inspection, since it is unlawful to copy that particular document.

15. **NATIONAL PRACTITIONER DATA BANK** – It will be necessary for you to contact the National Practitioner Data Bank at 1-800-767-6732 or http://www.npdb-hipdb.hrsa.gov/ and advise them that you wish to do a self query. They will provide you with the appropriate documents to perform this self query. When you receive the response from the data bank to your query, please forward all the **original** information to our office as soon as possible inasmuch as your application will not be considered complete until we receive this information. You may keep a copy for your records.

16. **ORIGINAL DOCUMENTS FORM** – Must be fully completed and enclosed with original documents, to be submitted with application.

17. **FEDERATION HISTORY REQUEST FORM (EBAHR) -** Unless you are applying using FCVS, **all applicants** who apply for a license in Missouri, regardless of what exam you have taken, are required to contact the Federation of State Medical Boards at www.fsmb.org or by calling (817)-868-4041 and request the online EBAHR reporting form. It not only informs us if you have taken the FLEX or USMLE exam, but also if any disciplinary action has been taken against you in any state.

18. **SOCIAL SECURITY CARD** – Furnish a copy of your Social Security card. (Do NOT fax) A citizen of an international country applying for licensure in Missouri, who does not hold a United States Social Security number, shall submit his/her Visa or Passport in lieu of the Social Security card.

PLEASE BE ADVISED THAT YOU SHOULD NOT MAKE ANY FIRM COMMITMENT TO ACTUALLY BEGIN PRACTICING UNITL YOU HAVE RECEIVED NOTIFICATION OF LICENSURE IN WRITING FROM THIS OFFICE.

ANY FILE IN A PENDING STATUS FOR OVER THREE MONTHS WILL BE REQUIRED TO PROVIDE UPDATED INFORMATION.

INCOMPLETE APPLICATIONS ON FILE FOR ONE YEAR WILL BE DISCARDED.

BOARD OF REGISTRATION FOR THE HEALING ARTS
P.O. BOX 4
JEFFERSON CITY, MISSOURI 65102
FOR OVERNIGHT DELIVERIES:
3605 MISSOURI BLVD.
JEFFERSON CITY, MISSOURI 65109
TELEPHONE (573) 751-0177
TOLL FREE (866) 439-3897
FAX (573) 751-3166
TTY (800) 735-2966

STATE OF MISSOURI
DIVISION OF PROFESSIONAL REGISTRATION
STATE BOARD OF REGISTRATION FOR THE HEALING ARTS

APPLICATION FOR MISSOURI LICENSURE - PHYSICIAN

SEE INSTRUCTIONS FIRST

Pursuant to Section 324.010 RSMo:

☐ **CHECK THIS BOX ONLY IF IN ALL OF THE LAST THREE (3) YEARS: YOU WERE NOT A MISSOURI RESIDENT, YOU DID NOT HAVE ANY MISSOURI INCOME, AND YOU ARE NOT SUBJECT TO ANY TYPE OF MISSOURI INCOME TAX.**

False statements are subject to criminal penalties and/or license discipline. **If you have any questions regarding taxes contact the Department of Revenue at 573-751-7200 or e-mail income@dor.mo.gov.**

1. I hereby certify that:

YES	NO	
☐	☐	I hold current licensure in a state or territory of the United States or the District of Columbia;
☐	☐	I have actively engaged in the practice of clinical medicine or held a teaching or faculty position in a medical or osteopathic school approved by the AMA or AOA for the five year period immediately preceding my application for licensure;
☐	☐	I hold current certification in my area of specialty by the ABMS or AOA; and
☐	☐	Any license issued to me has not been disciplined.

2. Are you requesting approval to take the USMLE Step 3 through the Missouri Board of Healing Arts?

☐ YES ☐ NO

IF NO, PLEASE MARK WHICH EXAMINATIONS YOU HAVE TAKEN:

☐ USMLE ☐ NATIONAL BOARD OF MEDICAL EXAMINERS ☐ FLEX
☐ COMLEX/NBOME ☐ STATE BOARD EXAMINATION ☐ LMCC

3. LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX	☐ M.D. ☐ D.O.

MAIDEN NAME	OTHER NAMES USED	4. CURRENT MAILING ADDRESS (STREET, CITY, STATE, ZIP)

5. APPLICANT EMAIL ADDRESS	6. DATE OF BIRTH	PLACE OF BIRTH	7. OFFICE PHONE ▶ HOME PHONE ▶ CELL PHONE ▶

8. SOCIAL SECURITY NUMBER*	9. MEDICAL SPECIALTY	10. ECFMG NUMBER AND ISSUE DATE

11. TYPE OF PRACTICE YOU ARE CURRENTLY INVOLVED IN (CHECK ON)

☐ INTERN ☐ RESIDENT ☐ PRIVATE ☐ FACULTY
☐ OTHER (PLEASE EXPLAIN) ▶

FEE RECEIVED DATE

12. PROPOSED MISSOURI PRACTICE ADDRESS (INSTITUTION/GROUP, STREET, CITY, STATE, ZIP) (IF UNKNOWN, PLEASE EXPLAIN)

FOR OFFICE USE ONLY

13. TYPE OF PRACTICE THAT YOU WILL BE INVOLVED IN IF MISSOURI LICENSE IS GRANTED

☐ INTERN ☐ RESIDENT ☐ PRIVATE ☐ FACULTY
☐ OTHER (PLEASE EXPLAIN) ▶

14. ARE YOU A DIPLOMATE OF ANY AMERICAN BOARD OF MEDICAL SPECIALTIES OR THE AOA? IF YES, PLEASE LIST EACH ☐ YES ☐ NO

IF NO, ARE YOU BOARD ELIGIBLE? ☐ YES ☐ NO

15. List all of the states, territories or international countries in which you hold or have ever held a permanent, temporary or institutional license to practice medicine, in order of attainment.

A.	B.	C.	D.	E.
F.	G.	H.	I.	J.

* USED FOR IDENTIFICATION PURPOSES ONLY

16. List all **other** professional licenses or certifications (e.g. Physician Assistant, Registered Nurse, Chiropractor, etc.) you now hold or have ever held, excluding a license to practice medicine or osteopathic medicine. (Indicate the profession and state in which you are or have been licensed, certified or registered.)

A.	B.
C.	D.

PLEASE ANSWER THE FOLLOWING QUESTIONS WITH THE APPROPRIATE CHECKMARK. IF ANY ARE ANSWERED YES, SEE SEPARATE INSTRUCTIONS.

	YES	NO
17. Have you, or any license or right to practice held by you, been restricted or disciplined, such disciplinary action to include, but not be limited to, revocation, suspension, probation, censure, or reprimand, whether voluntarily agreed to or not, by any U.S. state, territory, federal agency, Canadian province or foreign country?	☐	☐
18. Have you had any disciplinary or corrective action taken against you, or had your right to practice restricted, by any professional medical or osteopathic association or society, or by any licensed hospital or medical staff of a hospital including being placed on probation while in a post graduate training program?	☐	☐
19. Have you surrendered a license issued to you by any U.S. state or any Canadian provincial licensing agency for reasons other than failure to renew?	☐	☐
20. Have any charges or complaints been filed against you with the federal government, any federal agency or any U.S. state or Canadian provincial licensing or disciplinary agency?	☐	☐
21. Have you been denied or surrendered a controlled substance license, registration, certificate or authority issued by the Drug Enforcement Administration (DEA) or any state bureau of narcotics or other agency concerned with controlled substances, or had such license, registration, certificate or authority restricted or disciplined, such disciplinary action to include, but not be limited to, revocation, suspension, probation, censure, or reprimand, whether voluntarily agreed to or not?	☐	☐
22. Has any disciplinary action been taken against you, or has your authority to practice been restricted, by any federal or state agency including, but not limited to, Medicare or Medicaid?	☐	☐
23. Have you forfeited collateral for breach or violation of any law, police regulation or ordinance whatsoever, been summoned into court as a defendant, or has any law suit (other than malpractice) been filed against you?	☐	☐
24. Have you been arrested, charged, indicted, found guilty, or entered a plea of guilty or nolo contendere, in a criminal prosecution under the laws of any state or of the United States whether or not sentence was imposed, including suspended imposition of sentence or suspended execution of sentence?	☐	☐
25. Have you been a defendant in a legal action involving professional liability (malpractice) or had a professional liability claim paid in your behalf or paid such a claim yourself?	☐	☐
26. Have you been denied a license to practice medicine or denied the privilege of taking an examination administered by a U.S. state and/or Canadian provincial licensing agency?	☐	☐
27. Have you ever made application for licensure in another state and subsequently withdrawn said application?	☐	☐
28. Are you currently addicted to or dependent upon narcotics, intoxicating liquors, or other substances?	☐	☐
29. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism, or other sexual behavior disorder?	☐	☐
30. Have you in the last ten years or since the age of 18 been treated for or hospitalized for bipolar disorder, schizophrenia, paranoia or any other psychotic disorder?	☐	☐
31. Are you currently experiencing any medical condition or disorder that limits or impairs your judgment or that otherwise affects your ability to practice medicine in a safe and competent manner?	☐	☐
32. Are you now or have you ever been required by federal law or the law of any state to register as a sex offender?	☐	☐

33. HIGH SCHOOL NAME

LOCATION	DATES ATTENDED

34. PREPROFESSIONAL EDUCATION (LIST ALL UNIVERSITIES/COLLEGES ATTENDED FOR ONE SEMESTER OR LONGER)

FROM (MO/YR)	TO (MO/YR)	NAME & ADDRESS OF SCHOOL	DEGREE & DATE RECEIVED

35. PROFESSIONAL EDUCATION (LIST ALL UNIVERSITIES/COLLEGES ATTENDED FOR ONE SEMESTER OR LONGER)

FROM (MO/YR)	TO (MO/YR)	NAME & ADDRESS OF SCHOOL	DEGREE & DATE RECEIVED

36. MEDICAL SCHOOL OF GRADUATION (PRINT SCHOOL NAME AS IT APPEARS ON YOUR DIPLOMA)

LOCATION	DATE OF GRADUATION

FIFTH PATHWAY CANDIDATES ONLY

37. CLINICAL CLERKSHIP (FIFTH PATHWAY) HOSPITAL

ADDRESS		
PROGRAM DIRECTOR	TERM STARTED	COMPLETED

38. POST DEGREE EXPERIENCE (U.S. & CANADIAN ONLY)

A.

☐ INTERN ☐ RESIDENT ☐ FELLOW ☐ OTHER (PLEASE EXPLAIN) ▶

NAME OF TRAINING HOSPITAL	DEPARTMENT/SPECIALTY	
ADDRESS (STREET, CITY, STATE, ZIP)		
PROGRAM DIRECTOR	TERM STARTED	COMPLETED

B.

☐ INTERN ☐ RESIDENT ☐ FELLOW ☐ OTHER (PLEASE EXPLAIN) ▶

NAME OF TRAINING HOSPITAL	DEPARTMENT/SPECIALTY	
ADDRESS (STREET, CITY, STATE, ZIP)		
PROGRAM DIRECTOR	TERM STARTED	COMPLETED

C.

☐ INTERN ☐ RESIDENT ☐ FELLOW ☐ OTHER (PLEASE EXPLAIN) ▶

NAME OF TRAINING HOSPITAL	DEPARTMENT/SPECIALTY	
ADDRESS (STREET, CITY, STATE, ZIP)		
PROGRAM DIRECTOR	TERM STARTED	COMPLETED

D.

☐ INTERN ☐ RESIDENT ☐ FELLOW ☐ OTHER (PLEASE EXPLAIN) ▶

NAME OF TRAINING HOSPITAL	DEPARTMENT/SPECIALTY	
ADDRESS (STREET, CITY, STATE, ZIP)		
PROGRAM DIRECTOR	TERM STARTED	COMPLETED

39. LIST ALL OF YOUR HOSPITAL AFFILIATIONS (OTHER THAN TRAINING HOSPITALS) FOR THE LAST FIVE YEARS.

HOSPITAL	ADDRESS	DATE OF PRIVILEGES	
		FROM (MO/YR)	TO (MO/YR)
A.			
B.			
C.			
D.			
E.			

40. ACTIVITIES STATEMENT

INSTRUCTIONS

Provide a chronological listing of medical and nonmedical activities since the entrance into medical school to the present date.

All dates must be accounted for including all beginning and ending, months and years. In CHRONOLOGICAL ORDER, **list the position you held, complete names, addresses and zip codes of employers. If unemployed or on vacation for more than one month, list your exact activities and locations**. Please include any summer breaks over 90 days while in medical school.

DATES				ACTIVITIES
BEGINNING		ENDING		
MO	YEAR	MO	YEAR	

40. ACTIVITIES STATEMENT (CONTINUED)

DATES				ACTIVITIES
BEGINNING		ENDING		
MO	YEAR	MO	YEAR	

41. APPLICATION INFORMATION RELEASE AUTHORIZATION

I hereby authorize the State Board of Registration for the Healing Arts, its Directors or designee, to release and/or discuss information contained in my application for permanent licensure in the State of Missouri to the following individual. List the name of one individual with whom we may discuss your file other than yourself. If name is not listed we will not speak to them about your file.

NAME OF INDIVIDUAL WITH WHOM THE BOARD IS AUTHORIZED TO DISCUSS YOUR FILE

42. JURISPRUDENCE EXAMINATION

INSTRUCTIONS

Completion of the jurisprudence examination and achieving a score of 75% or higher is a requirement of the Missouri State Board of Registration for the Healing Arts. Each of the twenty true and false questions is given a weight of five percentage points. All the answers are readily available to you in the statutes and rules that are located on the Board's website at http://pr.mo.gov/healingarts.asp.

JURISPRUDENCE EXAMINATION

SCORE ▸

1. T F Missouri law requires all physician applicants to be graduates of a medical or osteopathic college that enforces requirements of a curriculum which contains four terms of thirty-two weeks of actual instruction in each term.
2. T F Missouri law permits the granting of a temporary license for private clinic practice.
3. T F Chapter 334 requires satisfactory evidence of completion of pre-professional education consisting of a minimum of sixty semester hours of college credits in acceptable subjects leading towards the degree of bachelor of arts or bachelor of science from an accredited college or university to be eligible for a Missouri license.
4. T F Missouri law states that anyone who has been denied a license, permit or certificate to practice in another state shall automatically be denied a license to practice in this state.
5. T F Patient records remaining under the care, custody and control of the licensee shall be maintained by the licensee of the board, or the licensee's designee, for a minimum of seven years from the date of when the last professional service was provided.
6. T F All physician permanent licenses expire on January 31st of each year regardless of the date that the license is issued.
7. T F Section 334.100 RSMo, provides the grounds for denial, suspension or revocation of a physician's license.
8. T F Disciplinary action may be taken against a physician's license for willfully and continually performing inappropriate or unnecessary treatment, diagnostic tests or medical or surgical services.
9. T F Persons who report incidents of suspected misconduct to the Board shall not be subject to an action for civil damages.
10. T F A physician located outside of the state of Missouri shall not be required to obtain a license when the physician licensed in Missouri retains ultimate authority and responsibility for the diagnosis or diagnoses and treatment in the care of the patient located within this state.
11. T F The Missouri Board of Healing Arts shall at least quarterly, publish a list of all persons whose licenses have been suspended, revoked, surrendered, restricted, denied or withheld.
12. T F Missouri law requires that a physician notify the Board within fifteen days of any address change.
13. T F If a physician does not receive a notice to renew his/her registration, he/she is exempt from paying the fee for the next year.
14. T F Fees of any kind must be refunded by the Board at the written request of any applicant.
15. T F Conviction of a felony offense is not grounds for revocation.
16. T F A licensee under this chapter shall, in any letter, business card, advertisement, prescription blank, sign, or public listing or display of any nature whatsoever, designate the degree to which he/she is entitled by reason of his/her diploma.
17. T F A physician's license may be disciplined for delegating professional responsibilities to a person who is not qualified by training, skill, competency, age, experience or licensure to perform such responsibilities.
18. T F A physician may require, as a condition of the physician/patient relationship, that the patient only receive drugs dispensed directly from the physician's office.
19. T F The Board shall not renew any certificate of registration unless the licensee provides satisfactory evidence that he/she has complied with the Board's minimum requirement for continuing education.
20. T F Practicing medicine in Missouri without a current registration is a violation of Missouri law.

ALL APPLICANTS MUST PLACE A PHOTOGRAPH IN SPACE PROVIDED. ▶	PHOTO

43. APPLICANT'S OATH

State/Province of _____ County/Parish of _____

I, _____ , hereby certify under oath that I am the person named in this application for a license to practice medicine in the State of Missouri; that all statements I have made herein are true and that I have personally read, reviewed and answered each of these questions; that all documents submitted with this application or as part of the application process that are original, or duplicated copies of the originals, have not been altered in any fashion whatsoever; that I am the original and lawful possessor of and person named in the various documents and credentials furnished to the Board in connection with this application.

I acknowledge and state that I have read Chapter 334 (statutes and rules), RSMo, which contains the Statutes, Rules and Regulations governing the practice of medicine, that can be located on the Board's website; I have answered all questions truthfully and in compliance with the instructions provided; and I understand that the application fee submitted with this application is non-refundable and cannot be transferred to another application.

I further state that by filing this application for a license to practice medicine in the State of Missouri, I hereby authorize and consent to have an investigation made as to my moral character, professional reputation and fitness for the practice of medicine, when in the opinion of the Missouri Board such an investigation is deemed necessary. I agree to give any further information which may be required in reference to my past record.

I authorize and request every person, hospital, clinic, community, governmental agency (local, state, federal or international), court, association, institution, or other organization having control of any documents, records, and other information pertaining to me to furnish to the Missouri State Board of Healing Arts any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Missouri State Board of Healing Arts or any of its agents or representatives to inspect and make copies of such documents, records, and other information, in connection with this application.

MUST BE SIGNED IN PRESENCE OF NOTARY	APPLICANT'S SIGNATURE ▶

NOTARIZATION AND NOTARY INFORMATION

STATE	COUNTY

The applicant identified him/herself with a government issued photographic identification and bearing true likeness to the above photograph subscribed and swore to the truthfulness of this application before me, this _____ day of _____ , _____ .	USE A RUBBER STAMP IN CLEAR AREA BELOW

NOTARY PUBLIC SIGNATURE	COMMISSION EXPIRES	NOTARY PUBLIC EMBOSSER SEAL
NOTARY PUBLIC PRINTED NAME		

EXECUTIVE DIRECTOR'S DECISION:

APPROVE _____ LICENSURE CHAIRMAN _____

LICENSE NUMBER	DATE ISSUED	EXAM TAKEN	DATE OF EXAM	SCORES RECEIVED

STATE OF MISSOURI
DIVISION OF PROFESSIONAL REGISTRATION
STATE BOARD OF REGISTRATION FOR THE HEALING ARTS

BOARD OF REGISTRATION FOR THE HEALING ARTS
P.O. BOX 4
JEFFERSON CITY, MO 65102
TELEPHONE (573) 751-0177
TOLL FREE (866) 439-3897

CERTIFICATION

During the period of time in which the Board is processing my application and determining whether to issue me a license, I will inform the Board of any change in information included in my application for licensure, including but not limited to malpractice suits, discipline imposed by another state, administrative agency, hospital or other entity, arrests, and criminal convictions. I understand that failure to disclose this information could result in discipline pursuant to section 334.100.2(11).

Applicant Signature	Applicant Printed Name	Date

BOARD OF REGISTRATION FOR THE HEALING ARTS
P.O. BOX 4
JEFFERSON CITY, MISSOURI 65102
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TTY (800) 735-2966

STATE OF MISSOURI
DIVISION OF PROFESSIONAL REGISTRATION
STATE BOARD OF REGISTRATION FOR THE HEALING ARTS

POSTGRADUATE REFERENCE LETTER

NAME OF APPLICANT (PLEASE PRINT FULL NAME)	DATE

The physician named above has applied for licensure in the State of Missouri. The Missouri State Board of Registration for the Healing Arts requires a Postgraduate Reference Letter from the program director of each US or Canadian approved postgraduate training program the applicant has been in or is currently enrolled in.

Please provide **all** of the information requested on this two page form and send the form directly to the Missouri State Board of Registration for the Healing Arts, P.O. Box 4, Jefferson City, MO 65102. **This form must have a hospital seal affixed or be notarized to be acceptable. We will not accept letters of recommendation in lieu of this form. IF ANY PORTION OF THE FORM IS INCOMPLETE IT WILL HOLD UP THE APPLICANT'S FILE AND IT WILL BE RETURNED FOR COMPLETION**.

This information will become part of the permanent records maintained in this office. Please note that the candidate cannot receive final consideration without your cooperation.

Please type or print this form in **BLACK** ink.

I hereby authorize the hospital listed below, its staff or representative, to provide to the Missouri State Board of Registration for the Healing Arts any and all information requested below, whether such information is favorable or unfavorable, and I hereby release any and all liability against the listed institution and/or person for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice. Further, I request that this completed form be sent directly to the Missouri State Board of Registration for the Healing Arts, P.O. Box 4, Jefferson City, MO 65102. I understand that completed forms returned to me will not be accepted by the Missouri State Board of Registration for the Healing Arts for verification purposes.

SIGNATURE	DATE OF BIRTH	SOCIAL SECURITY NUMBER*

PROGRAM DIRECTOR	EMAIL ADDRESS

NAME OF TRAINING HOSPITAL

ADDRESS OF TRAINING HOSPITAL

AREA IN WHICH YOU ARE BEING CALLED UPON AS A REFERENCE

	NAME OF DEPARTMENT
☐ CLINICAL CLERKSHIP (FIFTH PATHWAY)	
☐ INTERNSHIP	
☐ RESIDENCY	
☐ FELLOWSHIP	

DATES APPLICANT WAS IN TRAINING

_____

(PLEASE FILL IN THE BLANK)

The physician satisfactorily completed _____ months of training here.

BRIEFLY DESCRIBE THE DUTIES THIS CANDIDATE PERFORMED WHILE UNDER YOUR SUPERVISION AND BRIEFLY DESCRIBE THE NATURE AND TYPE OF SUPERVISION YOU PROVIDED.

PLEASE READ THE FOLLOWING AND INDICATE YOUR ANSWER BY A CHECK MARK IN THE APPROPRIATE BOX. (IF ANY ANSWERS ARE "YES", PLEASE GIVE FULL DETAILS ON A SEPARATE SHEET.)

1. During the time this physician was in your training program has he/she ever been subject to any disciplinary action, such as imposition of consultation requirements, suspension, or termination or probation? ☐ Yes ☐ No
2. At the time the physician left your institution, were any actions instituted, in process or pending against him/her? ☐ Yes ☐ No
3. Do you have knowledge of any drug or alcohol dependency or abuse by the applicant during the previous ten years or know of any emotional, mental, behavioral or nervous afflictions? ☐ Yes ☐ No

INDICATE YOUR EVALUATION OF THE FOLLOWING ELEMENTS BY A CHECK MARK IN THE APPROPRIATE COLUMN AT THE RIGHT, BASED UPON YOUR PERSONAL KNOWLEDGE OR RECORDS MAINTAINED BY YOUR HOSPITAL:

	UNABLE TO EVALUATE	NOT ACCEPTABLE	AVERAGE	ABOVE AVERAGE
Basic Medical Knowledge				
Professional Judgment				
Sense of Responsibility				
Clinical Competence				
Technical Skill				
Cooperativeness, Ability to Work with Others				
Medical Record Currency				
Quality of Medical Records				
Patient Management				
Physician-Patient Relationship				
I would rate this applicant's overall performance under my supervision, or based on hospital records, as				

BRIEFLY EXPLAIN THE REASON FOR ANY CHECK MARKS IN THE COLUMN ENTITLED NOT ACCEPTABLE OR UNABLE TO EVALUATE.

PLEASE READ THE FOLLOWING RECOMMENDATIONS CAREFULLY AND MARK THE APPROPRIATE ONE.

☐ I recommend this candidate for licensure to practice medicine and surgery without any reservation.
☐ I recommend this candidate for licensure to practice medicine and surgery with reservation.
☐ I do not recommend this candidate for licensure to practice medicine and surgery.

IF YOU DO NOT RECOMMEND THIS INDIVIDUAL FOR LICENSURE OR RECOMMEND HIM/HER WITH RESERVATIONS, PLEASE EXPLAIN WHY.

PLEASE LIST THE NAMES AND ADDRESSES OF ANY OTHER PHYSICIANS ON A SEPARATE SHEET OF PAPER, WHO, IN YOUR OPINION, SHOULD BE CONTACTED REGARDING THIS CANDIDATE AND THE REASON FOR CONTACTING THEM.

I ATTEST THAT THE FOREGOING INFORMATION WHICH I SUPPLIED IS TRUE IN EVERY RESPECT.

NAME (PLEASE PRINT OR TYPE)	TITLE	TELEPHONE NUMBER

SIGNATURE

▶

BOARD OF REGISTRATION FOR THE HEALING ARTS
P.O. BOX 4
JEFFERSON CITY, MISSOURI 65102
FOR OVERNIGHT DELIVERIES:
3605 MISSOURI BLVD.
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STATE OF MISSOURI
DIVISION OF PROFESSIONAL REGISTRATION
STATE BOARD OF REGISTRATION FOR THE HEALING ARTS

VERIFICATION OF LICENSURE

Please print or type in **BLACK** ink.

I, _____ , hereby authorize and request the state
NAME OF APPLICANT (PLEASE PRINT)

board of _____ having control of any documents, records and other information pertaining to me to furnish to the MISSOURI STATE BOARD FOR THE HEALING ARTS, information including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent information.

SIGNATURE OF APPLICANT	LICENSE NUMBER	ISSUE DATE
NAME IN FULL (PLEASE PRINT)	**DATE OF BIRTH**	**SOCIAL SECURITY NO. (identification purposes)**
OTHER NAMES USED IN OBTAINING LICENSURE		
CURRENT ADDRESS (street, city, state and zip code)		

THE FOLLOWING SECTION MUST BE COMPLETED BY AN OFFICIAL OF THE STATE BOARD AND RETURNED DIRECTLY TO THE MISSOURI BOARD OF HEALING ARTS.

STATE, TERRITORY OR FOREIGN COUNTRY OF:	FULL NAME OF LICENSEE	
LICENSE NUMBER	**ISSUE DATE**	**EXPIRATION DATE**

	YES	NO
1. HAS THE APPLICANT EVER BEEN NOTIFIED OR REQUESTED TO APPEAR BEFORE ANY LICENSING OR DISCIPLINARY AUTHORITY IN YOUR STATE? **IF YES, ATTACH DETAILS.**	☐	☐
2. HAS APPLICANT EVER BEEN THE SUBJECT OF COMPLAINTS OR CHARGES RECEIVED BY A DISCIPLINARY AUTHORITY IN YOUR STATE? **IF YES, ATTACH DETAILS.**	☐	☐
3. HAS THE APPLICANT EVER BEEN WARNED, CENSURED OR DISCIPLINED IN ANY MANNER BY A LICENSING OR DISCIPLINARY AUTHORITY IN YOUR STATE? **IF YES, ATTACH DETAILS.**	☐	☐
4. HAS ANY APPLICATION FOR INITIAL LICENSURE OR REINSTATEMENT EVER BEEN DENIED? **IF YES, ATTACH DETAILS.**	☐	☐

COMMENTS, IF ANY

BOARD SEAL	SIGNATURE AND TITLE	DATE
	▶	
	STATE BOARD	

BOARD OF REGISTRATION FOR THE HEALING ARTS
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STATE OF MISSOURI
DIVISION OF PROFESSIONAL REGISTRATION
STATE BOARD OF REGISTRATION FOR THE HEALING ARTS

VERIFICATION OF HOSPITAL AFFILIATION - ADMITTING PRIVILEGES

Please type or print form in **BLACK** ink.

NAME OF APPLICANT (LAST, FIRST, MIDDLE)	DATE
HOSPITAL NAME	DATE FULL PRIVILEGES WERE HELD
HOSPITAL ADDRESS (STREET, CITY, STATE & ZIP CODE)	DATES TEMPORARY PRIVILEGES WERE HELD

I hereby authorize the above-named hospital, its staff or representative, to provide to the Missouri State Board of Registration for the Healing Arts any and all information requested below, whether such information is favorable or unfavorable, and I hereby release any and all liability against the above-named institution and/or person for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice. Further, I request that this completed form be sent directly to the Missouri State Board of Registration for the Healing Arts, P.O. Box 4, Jefferson City, MO 65102. I understand that completed forms returned to me will not be accepted by the Missouri State Board of Registration for the Healing Arts for verification purposes.

SIGNATURE ▶	DATE OF BIRTH	SOCIAL SECURITY NUMBER *

HOSPITAL ADMINISTRATOR SECTION

This section must be completed by the hospital administrator or his/her representative and returned to the Missouri State Board of Registration for the Healing Arts. **No substitutes will be accepted in lieu of this form.** Verifications returned to the applicant will not be accepted. **THIS FORM MUST HAVE A HOSPITAL SEAL AFFIXED OR BE NOTARIZED TO BE ACCEPTABLE.**

1. The above-named physician is/has been affiliated with our hospital from _____ to _____ .
2. Based on past performance, would you recommend this physician for medical staff reappointment at this hospital? ☐ YES ☐ NO
3. During the stated period of time, were the practice privileges of this individual restricted, limited, suspended, or revoked as a result of disciplinary action? ☐ YES ☐ NO
4. **Please submit an explanation if question 2 is answered "no" and/or 3 is answered "yes."**

COMMENTS, IF ANY

_____

I SOLEMNLY SWEAR THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

PRINT FULL NAME OF ADMINISTRATOR/REPRESENTATIVE	
TITLE	EMAIL ADDRESS
SIGNATURE OF HOSPITAL ADMINISTRATOR/REPRESENTATIVE ▶	TELEPHONE NUMBER

THIS FORM MUST HAVE A HOSPITAL SEAL AFFIXED OR BE NOTARIZED.

HOSPITAL SEAL **OR** ▶	STATE	COUNTY
	The individual who signed above identified him/herself with a government issued photographic identification and subscribed and swore to the truthfulness of this application before me, this _____ day of _____ , _____ .	USE A RUBBER STAMP IN CLEAR AREA BELOW
	NOTARY PUBLIC SIGNATURE	COMMISSION EXPIRES / NOTARY PUBLIC EMBOSSER SEAL
	NOTARY PUBLIC PRINTED NAME	

* VERIFICATION PURPOSES ONLY

BOARD OF REGISTRATION FOR THE HEALING ARTS
P.O. BOX 4
JEFFERSON CITY, MISSOURI 65102
FOR OVERNIGHT DELIVERIES:
3605 MISSOURI BLVD.
JEFFERSON CITY, MISSOURI 65109
TELEPHONE (573) 751-0177
TOLL FREE (866) 439-3897
FAX (573) 751-3166
TTY (800) 735-2966

STATE OF MISSOURI
DIVISION OF PROFESSIONAL REGISTRATION
STATE BOARD OF REGISTRATION FOR THE HEALING ARTS

ORIGINAL DOCUMENTS - INTERNATIONAL GRADUATES ONLY

INSTRUCTIONS

You are required to provide our office with all original professional and preprofessional transcripts, marks, translations and other documents requested by the Board. Please type or print in **BLACK** ink.

1. NAME AS SHOWN ON APPLICATION (LAST, FIRST, MIDDLE)	DATE

2. NAME SHOWN ON DOCUMENTS IF DIFFERENT FROM APPLICATION (LAST, FIRST, MIDDLE)

3. ADDRESS (STREET, CITY, STATE, ZIP) PLEASE NOTIFY BOARD OFFICE OF ANY ADDRESS CHANGE(S)

4. LIST EACH ORIGINAL DOCUMENT ENCLOSED	NO. OF PAGES	NOTARIZED COPIES ENCLOSED (✓) YES	NO. OF PAGES

5. LIST ORIGINAL TRANSLATIONS ENCLOSED	NO. OF PAGES	NOTARIZED COPIES ENCLOSED (✓) YES	NO. OF PAGES

NOTARIZED COPIES MUST ACCOMPANY ALL ORIGINALS. ALL COPIES MUST BE NOTARIZED AS TRUE COPIES OF THE ORIGINAL.

STATE OFFICE USE ONLY			
DATE RECEIVED	NUMBER OF ORIGINALS RECEIVED	DATE RETURNED	NUMBER OF ORIGINALS RETURNED
CERTIFIED NUMBER	RETURN ADDRESS IF NOT SAME AS LISTED ABOVE		

STATE BOARD OF REGISTRATION FOR THE HEALING ARTS
P.O. BOX 4
JEFFERSON CITY, MO 65102
FOR OVERNIGHT DELIVERIES:
3605 MISSOURI BLVD.
JEFFERSON CITY, MO 65109
(573) 751-0177
TOLL FREE (866) 439-3897

STATE OF MISSOURI
DIVISION OF PROFESSIONAL REGISTRATION
STATE BOARD OF REGISTRATION FOR THE HEALING ARTS

APPLICATION FOR MISSOURI LICENSURE - PHYSICIAN - CHECKLIST

Please place a checkmark in the appropriate boxes and return to the Missouri Board of Healing Arts with your application. PLEASE SEE DOCUMENT AND FEE SECTION OF THE APPLICATION TO DETERMINE IF ALL OF THE DOCUMENTS LISTED BELOW ARE REQUIRED TO BE SUBMITTED.

SENT/ REQUESTED	N/A	
☐	☐	COMPLETED APPLICATION FORM (including activities statement, jurisprudence examination, and photograph)
☐	☐	FEE - $75 (in the form of a cashier's check or money order)
☐	☐	COPY OF MEDICAL DIPLOMA
☐	☐	COPY OF SOCIAL SECURITY CARD (copy of Visa or Passport may be submitted in lieu of the Social Security card ONLY IF applicant does not hold a United States Social Security Number)
☐	☐	PRE-MEDICAL and MEDICAL TRANSCRIPTS (all transcripts must be official copies, in sealed envelopes from school/university)
☐	☐	NATIONAL PRACTITIONER DATA BANK; we require the **original** response from both the NPDB and HIPDB. Please be sure to open the envelope and make copies for your records prior to forwarding to the Board office.
☐	☐	NAME CHANGE DOCUMENT (only if you have had a name change through marriage, adoption, divorce, court order, or naturalization)

THE FOLLOWING DOCUMENTS MUST BE SENT DIRECTLY FROM EACH RESPECTIVE ENTITY:

☐	☐	SCORE REPORT (i.e. NBME; NBOME; COMLEX; LMCC)
☐	☐	STATE BOARD EXAMINATION SCORES (Only applicable if applying for licensure based on an examination given by a State Medical Board)
☐	☐	FEDERATION HISTORY REQUEST FORM (EBAHR)
☐	☐	VERIFICATION OF LICENSURE (verifications should include investigative/disciplinary information, if applicable, as well as licensure information)
☐	☐	POSTGRADUATE REFERENCE LETTER FORM (from each training program)
☐	☐	VERIFICATION OF HOSPITAL AFFILIATION (from each hospital where applicant has held staff privileges within the past five (5) years)

IN ADDITION TO THE ABOVE, THE FOLLOWING MUST BE SUBMITTED TO THE MISSOURI BOARD OF HEALING ARTS IF YOU ARE AN INTERNATIONAL MEDICAL GRADUATE:

☐	☐	ECFMG VERIFICATION FORM (must be received directly from ECFMG office)
☐	☐	COPY OF INTERNATIONAL MEDICAL LICENSE (does not apply to Fifth Pathway applicants)
☐	☐	ORIGINAL TRANSLATIONS (see application instructions on acceptable translations)
☐	☐	COMPLETED ORIGINAL DOCUMENTS SHEET (this form must be completed and accompany all original documents submitted)

SIGNATURE	DATE

WE ENCOURAGE YOU TO RETAIN COPIES OF YOUR APPLICATION AND SUPPORTING DOCUMENTS.