Regular Mailing Address
STATE BOARD OF MEDICINE
P.O. BOX 2649
HARRISBURG, PA 17105-2649
717-783-1400/717-787-2381
Email: st-medicine@pa.gov

Courier Delivery Address
STATE BOARD OF MEDICINE
2601 NORTH THIRD STREET
HARRISBURG, PA 17110

APPLICATION FOR A GRADUATE MEDICAL TRAINING LICENSE FOR GRADUATES OF ACCREDITED MEDICAL SCHOOLS (SCHOOLS IN THE U.S. AND CANADA)

THIS APPLICATION IS TO BE USED FOR INITIAL GRADUATE TRAINING LICENSE

DO NOT USE TO RENEW

APPLICATION MUST BE SUBMITTED AT LEAST 60 DAYS PRIOR TO THE START OF TRAINING

APPLICANTS MUST COMPLETE THE FOLLOWING:

1.	Submit the $30 fee, check or money order, made payable to the "Commonwealth of Pennsylvania." **FEES ARE NOT REFUNDABLE.** Note: A processing fee of $20 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment. Your cancelled check is your receipt of payment.
2.	Complete pages 1 and 3 of the application. **Note: If you are a graduate of a school outside of the United States or Canada, you may NOT use this form.**
3.	If documents will be submitted to the Board under a name different from your present name, submit a copy of the legal document evidencing the name change (i.e., marriage license, divorce decree, naturalization, etc.).

PLEASE NOTE: If this application is not completed **within six months**, updates of certain sections and/or supporting documents will be required. If the application process has not been completed within one year from the date it was received, applicants will be required to submit a new application (**another application processing fee**) and supporting documents, as necessary.

ATTENTION HOSPITAL: When listing the specialty in which the doctor will be training, list the specialty by the name in which the program is accredited with ACGME. If the Board cannot verify that the program is accredited by ACGME, a discrepancy will occur and could cause a delay in issuing the license.

MEDICAL EDUCATION AND TRAINING

1.	Complete Section 1 of the Verification of Medical Education and forward to your medical school for completion of Section 2. **The school must return the completed verification directly to the Board in an official school envelope. The form may be completed ONLY three months prior to graduation. However, if graduation DOES NOT take place, the school must notify the Board immediately.**
2.	If entering **first year/level in an entry-level specialty**, No additional documents are required.

EXAMINATIONS

1.	If entering **second year/level in an entry level specialty** -- Attach a copy of your unrestricted license/registration card displaying the expiration date OR attach a copy of your scores from one of the following examinations:	
	FLEX	• If taken between June 1968 and December 1984 – A score of 75.0 weighted average in an individual attempt is required. • If taken after December 1984 – A score of 75 on FLEX 1 is required.
	LMCC	Must have been taken in or after May 1970. **The scores must verify the language in which the examination was taken.** If the examination was not taken in English, but is otherwise acceptable, and a passing score was secured, the Board will accept the examination results if the applicant has also secured a passing score (550) on the Test of English as a Foreign Language (TOEFL).
	STATE BOARD	Must have been taken prior to December 1973.
	USMLE	Must have secured a passing score on Steps 1 and 2. **If date of graduation from medical school is on or after June 30, 2005, both the clinical skills and clinical knowledge results will be required.**
	NBME	Must have secured a passing score on Parts I & II.
2.	If entering **third year/level or above** in an entry level specialty or any advanced level subspecialty-- Attach a copy of your unrestricted license/registration card displaying the expiration date OR attach a copy of your scores from one of following examinations:	
	FLEX	• If taken between June 1968 and December 1984 – A score of 75.0 weighted average in an individual attempt. • If taken after December 1984 – A score of 75 on each component.
	LMCC	Must have been taken in or after May 1970. **The scores must verify the language in which the examination was taken.** If the examination was not taken in English, but is otherwise acceptable, and a passing score was secured, the Board will accept the examination results if the applicant has also secured a passing score (550) on the Test of English as a Foreign Language (TOEFL).
	STATE BOARD	Must have been taken prior to December 1973.
	USMLE	Must have secured a passing score on Steps 1, 2 and 3. **If date of graduation from medical school is on or after June 30, 2005, both the clinical skills and clinical knowledge results will be required.**
	NBME	Must have secured a passing score on Parts I, II & III.

ALL OTHER REQUIREMENTS

1.	Attach a current Curriculum Vitae listing all periods of employment or unemployment (i.e., child rearing, research, etc.) from graduation from medical school to present. The list must be in chronological order, include the month and year, and indicate the state/territory in which the employment occurred.
2.	Applicants may also use the FCVS credentials verification service through the Federation of State Medical Boards to verify their ECFMG certification, medical education, post graduate training and examination scores. **The Board will accept FCVS if primary source verification is provided. However, you will need to meet all Pennsylvania licensure requirements.** Additional documents are required by the Board that are **NOT** included in the FCVS report but are listed in the "All Other Requirements" section of the application instructions. It is the applicant's responsibility to ensure that these additional documents are provided to the Board as outlined in the application instructions.

IMPORTANT INFORMATION	
1.	**PLEASE ALLOW AT LEAST 30-60 DAYS FOR PROCESSING.**
2.	**PLEASE FOLLOW ALL DIRECTIONS. ANY DISCREPANCIES WILL CAUSE A DELAY IN THE ISSUANCE OF A LICENSE. IT IS YOUR RESPONSIBILITY TO CONTACT THE HOSPITAL REGARDING THE STATUS OF YOUR APPLICATION. THE BOARD WILL BE IN DIRECT CORRESPONDENCE WITH THE HOSPITAL.**
3.	**IF THIS APPLICATION IS NOT COMPLETED WITHIN SIX MONTHS, UPDATES OF CERTAIN SECTIONS AND/OR SUPPORTING DOCUMENTS WILL BE REQUIRED.**
4.	**IT IS YOUR RESPONSIBILITY TO MAINTAIN A COPY OF THIS APPLICATION AND ALL DOCUMENTS SUBMITTED TO THE BOARD OR RECEIVED FROM THE BOARD.**
5.	**YOU MAY NOT PRACTICE IN THE COMMONWEALTH OF PENNSYLVANIA UNTIL THE PENNSYLVANIA STATE BOARD OF MEDICINE HAS ISSUED A LICENSE. THE LICENSE IS ONLY VALID FOR THE DATES, SPECIALTY, PGY LEVEL, AND HOSPITAL THAT ARE LISTED ON THE LICENSE.**

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APPLICATION FOR A GRADUATE MEDICAL TRAINING LICENSE FOR GRADUATES OF ACCREDITED MEDICAL SCHOOLS (SCHOOLS IN THE U.S. AND CANADA)

Submit a $30 fee, check or money order, made payable to the "Commonwealth of Pennsylvania." **FEES ARE NOT REFUNDABLE.** Note: A processing fee of $20 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment.

TO BE COMPLETED BY APPLICANT
(Please print or type)

NAME:	Last		First		Middle		
ADDRESS:	Street						
City			State		ZIP		
DATE OF BIRTH:	Month	Day	Year	**SOCIAL SECURITY NUMBER:**			

If your medical/licensure records are listed under another name or names, please list below:

_____

APPLYING USING FCVS (FEDERATION CREDENTIAL VERIFICATION SERVICE):	☐ **YES**	☐ **NO**

NAME & ADDRESS OF MEDICAL SCHOOL

NAME OF MEDICAL SCHOOL:		
ADDRESS OF SCHOOL:		
DATES OF ATTENDANCE:	**From**: Month/Day/Year	**To**: Month/Day/Year
DATE OF GRADUATION:	Month/Day/Year	

PREVIOUS TRAINING HOSPITAL INFORMATION

NAME & ADDRESS OF PREVIOUS TRAINING HOSPITAL(S): **(If applicable)**	DATES OF PREVIOUS TRAINING:	SPECIALTY:

APPLICATION FOR GRADUATE MEDICAL TRAINING LICENSE - AMERICAN

NAME OF APPLICANT:	Last	First	Middle

TO BE COMPLETED BY HOSPITAL LOCATED IN PENNSYLVANIA

ATTENTION HOSPITAL: When listing the specialty in which the doctor will be training, list the specialty by the name in which the program is accredited with ACGME. If the Board cannot verify that the program is accredited by ACGME, a discrepancy will occur and could cause a delay in issuing the license.

NAME OF HOSPITAL:		**HS-_____-L**
HOSPITAL ADDRESS:	Street	
City	State	ZIP

YEAR IN TRAINING:		**ACGME SPECIALTY:**		**LEVEL IN TRAINING-PGY**	

DATES OF TRAINING REQUESTED:	**BEGIN DATE:** Month/Day/Year	**END DATE**: Month/Day/Year

TO BE COMPLETED BY HOSPITAL PROGRAM DIRECTOR

I VERIFY THAT I AM THE PROGRAM DIRECTOR FOR THE HOSPITAL PROGRAM LISTED ABOVE AND THAT THIS IS AN ACGME ACCREDITED PROGRAM AT THIS HOSPITAL

NAME OF PROGRAM DIRECTOR:	
SIGNATURE OF PROGRAM DIRECTOR:	
DATE:	

LEGAL QUESTIONS

You must answer the following questions.

If you answer "YES" to #2 through #9, provide complete details on a separate sheet as well as certified copies of relevant documents. **Sign and date below**.

		Yes	No
1.	Do you hold or have you ever held an unrestricted license, certification, or registration (active or inactive, current or expired) to practice medicine and/or surgery in any state or jurisdiction? **If yes, list the jurisdiction(s) here**: _____		
2.	Have you withdrawn an application for a license, certificate or registration, had an application for a license denied or refused, or for any disciplinary reason agreed not to reapply for a license, certificate or registration in any profession in any state or jurisdiction?		
3.	Have you had disciplinary action taken against your license, certificate or registration issued to you in any profession in any other state or jurisdiction?		
4.	Have you been convicted, found guilty or pleaded nolo contendere, or received probation without verdict or accelerated rehabilitative disposition (ARD) as to any felony or misdemeanor, including any drug law violations, or do you have any criminal charges pending and unresolved in any state or jurisdiction? You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.		
5.	Since May 19, 2002, have you been arrested for criminal homicide, aggravated assault, sexual offenses or drug offenses in any state, territory or country?		
6.	Have you had practice privileges denied, revoked or restricted in a hospital or other health care facility, or have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?		
7.	Have you had your DEA registration denied, revoked or restricted or have you had your provider privileges terminated by any medical assistance agency for cause?		
8.	Are you, or have you ever been, addicted to the intemperate use of alcohol or to the habitual use of narcotics or other habit-forming drugs? **Note: You may answer "NO" if you are currently a participant in or have successfully completed the requirements of the Pennsylvania Department of State Professional Health Monitoring Program.**		
9.	Since May 19, 2002, have any malpractice complaints been filed against you? If yes, the Board requires that you submit a copy of the **entire Civil Complaint** which must include the **docket number**, **filing date,** and the **date you were served.**		

SIGNED STATEMENT

Note that disclosing your social security number on this application is mandatory in order for the State Board of Medicine to comply with the requirements of the federal Social Security Act pertaining to child support enforcement, as implemented in the Commonwealth of Pennsylvania at 23 Pa. C.S. 4304.1(a). In order to enforce domestic child support orders, the Commonwealth's licensing boards must provide to the Department of Public Welfare information prescribed by DPW about the licensee, including the social security number. Additionally, disclosing the number is mandatory in order for this board to comply with the reporting requirements of the federal National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank. Reports to the NPDB/HIPDB must include the licensee's social security number.

I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa. C.S. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my license or certificate. I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Pennsylvania State Board of Medicine any information, files or records requested by the Board.

_____ _____

Signature of Applicant Date

_____

Printed Name of Applicant

PENNSYLVANIA STATE BOARD OF MEDICINE

VERIFICATION OF MEDICAL EDUCATION
(For Graduates of Accredited Medical Schools)

SECTION 1 – TO BE COMPLETED BY APPLICANT

NAME:	Last	First	Middle
NAME OF MEDICAL SCHOOL:			
LOCATION:			

Submit the verification of medical education form to your medical school and request the school return the completed form directly to the board in an official school envelope.

SECTION 2 – TO BE COMPLETED BY DEAN OR REGISTRAR OF MEDICAL SCHOOL

NAME OF MEDICAL SCHOOL:				
NAME OF MEDICAL STUDENT:	Last	First		Middle
DATE STUDENT BEGAN TO ATTEND THIS MEDICAL SCHOOL:		Month	Day	Year
DATE OF GRADUATION:		Month	Day	Year

I CERTIFY THAT ALL OF THE INFORMATION LISTED ABOVE IS CORRECT

SIGNATURE OF DEAN/REGISTRAR:				
DATE:	Month	Day	Year	This form may be completed **ONLY three months prior to graduation**. Upon completion, school must return this completed form directly to the Pennsylvania State Board of Medicine in an official school envelope.
(Seal of School)				****** IF GRADUATION DOES NOT TAKE PLACE, NOTIFY THE BOARD IMMEDIATELY******
				DO NOT RETURN THIS FORM TO THE APPLICANT

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