

Regular Mailing Address
State Board of Medicine
P.O. Box 2649
Harrisburg, PA 17105-2649
717-783-1400 OR 717-787-2381
Email: st-medicine@state.pa.us

Courier Delivery Address
State Board of Medicine
2601 North Third Street
Harrisburg, PA 17110

**APPLICATION FOR A GRADUATE LICENSE FOR GRADUATES OF UNACCREDITED
MEDICAL SCHOOLS (SCHOOLS OUTSIDE OF THE U.S. AND CANADA)**

- THIS APPLICATION IS TO BE USED FOR INITIAL GRADUATE LICENSE – DO NOT USE TO RENEW**
• THIS APPLICATION MUST BE SUBMITTED AT LEAST 60 DAYS PRIOR TO THE START OF TRAINING

ALL APPLICANTS ARE REQUIRED TO: (Check when completed)

- _____ Complete pages 1 and 2 of the application.
- _____ 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.).
- _____ Attach **\$85.00** check or money order made payable to "Commonwealth of PA." **Fees are not refundable. Check or money order must be drawn on a US bank. No foreign fees can be accepted, even if marked US Funds.** ***NOTE: A processing fee of \$20.00 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment.***

PLEASE NOTE: If the application process has not been completed within one year from the date it was received, applicants will be required to submit an updated application (**another application processing fee**) and supporting documents, as necessary.

_____ Medical Education-The following verification methods are accepted by the Board:

A. **The following documents must be received directly from their respective agencies:**

1. Proof of the following must be provided **DIRECTLY** from your Medical School (**The school must return the completed verification directly to the Board in official school envelope.**):
 - a. Verification of Medical Education Form
 - b. Certified copy of Diploma
 - c. Transcript – **If the official transcript does not provide detailed information regarding the courses attended from which the applicant's eligibility is determined, the Board retains the right to request a copy of the medical school curriculum from the applicant.**

NOTE: If you attended more than one medical school, documents must be received directly from **ALL** schools. All documents must be in **ENGLISH** or an official translation must be submitted to the Board from an official translation agency or professor of the language.

2. Request verification of your ECFMG Certification. **Your certification must be current and valid.** To obtain the form from ECFMG, please visit www.ecfm.org. The name of the State Medical Board that the Status Report should be sent to is **Pennsylvania State Board of Medicine-State Code: 039**. The State Board Contact is **Tammy Radel, Administrative Officer**. The telephone number is **717-783-1400**.
3. If you completed an approved Fifth Pathway Program, submit a notarized copy of the Fifth Pathway Certificate.
4. a) If entering first year/level in an entry-level specialty – No additional documents are required.

- b) 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 I | 75.0 passing score |
| FLEX | 75.0 weighted average in an individual attempt
(Must have been taken between June 1968 and December 1984) |
| 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 score of 550 on the Test of English as a Foreign Language (TOEFL). |
| State Board | (Must have been taken prior to December, 1973) |
| USMLE | Part I of the National Boards or Step 1 of the USMLE plus Part II of the National Boards or Step 2 of the USMLE. *If USMLE Step 2 was taken on or after June 14, 2004, both the clinical skills and clinical knowledge results will be required. |
- c) 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 I and II | 75.0 passing score in both components |
| FLEX | 75.0 weighted average in an individual attempt (Must have been taken between June 1968 and December 1984) |
| 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 score of 550 on the Test of English as a Foreign Language (TOEFL). |
| State Board | (Must have been taken prior to December, 1973) |
| USMLE | Part I of the National Boards or Step 1 of the USMLE plus Part II of the National Boards or Step 2 of the USMLE plus Part III of the National Boards or Step 3 of the USMLE OR Part I of the National Boards or Step 1 of the USMLE plus Part II of the National Boards or Step 2 of the USMLE plus FLEX II OR FLEX I plus Step 3 of the USMLE. |

NOTE: Since the Medical Practice Act recognizes only ACGME accredited graduate training, any applicant requesting advanced level training who does not have the accumulative accredited training leading up to the level of training requested, must apply for a waiver of the prior accredited training.

OR

- B. Credential Verification from FCVS at www.fsmb.org or (817) 868-4000. **The Board will accept FCVS as primary source verification. However, you will need to meet all Pennsylvania licensure requirements. Further documents may be required at the discretion of the Board.** Additional documents are required by the Board that are **NOT** included in the FCVS report. It is the applicant's responsibility to ensure that these additional documents are provided to the Board as outlined in the application instructions.

____ Attach a current Curriculum Vitae listing **all** periods of employment or unemployment (i.e., childrearing, 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.

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.

IMPORTANT INFORMATION

IF THE APPLICATION IS SUBMITTED DURING APRIL, MAY, JUNE, JULY OR AUGUST, ALLOW AT LEAST 60 DAYS FOR PROCESSING.

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.

IF THIS APPLICATION IS NOT COMPLETED WITHIN SIX MONTHS, UPDATES OF CERTAIN SECTIONS WILL BE REQUIRED.

IT IS YOUR RESPONSIBILITY TO MAINTAIN A COPY OF THIS APPLICATION AND ALL DOCUMENTS SUBMITTED TO THE BOARD OR RECEIVED FROM THE BOARD.

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.

Regular Mailing Address
State Board of Medicine
P.O. Box 2649
Harrisburg, PA 17105-2649
Phone: 717-783-1400 or 717-787-2381
Email: st-medicine@state.pa.us

Courier Delivery Address
State Board of Medicine
2601 North Third Street
Harrisburg, PA 17110

HOSPITAL USE ONLY

TO BE COMPLETED FOR BULK CHECK USAGE

Hospital Name: _____

HS # _____

Receipt # _____

APPLICATION FOR A GRADUATE LICENSE FOR GRADUATES OF UNACCREDITED MEDICAL SCHOOLS (SCHOOLS OUTSIDE OF THE U.S. AND CANADA)

Application Fee: \$85.00 not refundable. Make check payable to the "Commonwealth of Pennsylvania." Note: A processing fee of \$20.00 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 Code

SOCIAL SECURITY # _____ DATE OF BIRTH: _____
MM/DD/YYYY

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

Are you applying using credentials verification from FCVS? YES NO

NAME & ADDRESS OF MEDICAL SCHOOL	DATES OF ATTENDANCE	DATE OF GRADUATION
_____	_____	_____
_____	_____	_____

NAME & ADDRESS OF HOSPITAL(S)	DATES OF PREVIOUS TRAINING	SPECIALTY
_____	_____	_____
_____	_____	_____

TO BE COMPLETED BY HOSPITAL LOCATED IN PENNSYLVANIA:

NAME OF HOSPITAL: _____ HS-- _____ --L

ADDRESS OF HOSPITAL: _____

YEAR IN TRAINING: _____ ACGME SPECIALTY: _____ LEVEL IN TRAINING (PGY) _____

DATES OF TRAINING REQUESTED: _____ TO _____
BEGINNING DATE-(MM/DD/YYYY) ENDING DATE-(MM/DD/YYYY)

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 (Print): _____

SIGNATURE OF PROGRAM DIRECTOR: _____

Answer the following questions. If "YES" is answered to Questions #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 another 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, pleaded guilty or entered a plea of nolo contendere, or received probation without verdict, accelerated rehabilitative disposition (ARD) or received any other disposition (excluding acquittal or dismissal) of any criminal charges, felony or misdemeanor, including any DUI/DWI, drug law violations, or are there any criminal charges pending and unresolved in any state or jurisdiction?		
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 Board's 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. 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

**VERIFICATION OF MEDICAL EDUCATION
For Graduates of Unaccredited Medical Schools**

1. Submit this Verification of Medical Education Form to all medical schools attended.
 2. School(s) must attach certified copy of diploma and transcripts.
 3. Upon completion, school must return this form, certified copy of diploma, and transcripts directly to the Board in an official school envelope.
-

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 YOUR SCHOOL TO 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 student: _____
Last First Middle

Date student began to attend this medical school: _____
MM/DD/YYYY

Total number of academic years completed in this medical school: _____

Total number of weeks of academic instruction completed: _____

Total number of weeks of clinical instruction completed: _____

Name of Medical School: _____

Date of graduation: _____
MM/DD/YYYY

[Seal of School]

I certify that all of the above information is correct.

Signature of Dean or Registrar:

Date: _____

Upon completion, school must return this completed form directly to the Pennsylvania State Board of Medicine in an official school envelope. **DO NOT RETURN TO APPLICANT**

Regular Mailing Address
State Board of Medicine
P.O. Box 2649
Harrisburg, PA 17105-2649
U.S.A.

Courier Delivery Address
State Board of Medicine
2601 North Third Street
Harrisburg, PA 17110
U.S.A.