Instructions for Physician Application

Attached are the materials you will need to make application for licensure to practice the healing arts in the state of Missouri. It is suggested that you read these instructions before beginning the process.

Your Application Packet Consists of:

- These instructions;
- Postgraduate Reference Form;
- Malpractice Claim Information Form;
- Application;
- Verification of Hospital Affiliation Form;
- Official Documents Form (International graduates only).

Prior to completing the application, you should read the statutes and rules governing physicians in the state of Missouri. These are located on our website at https://pr.mo.gov/healingarts-rules-statutes.asp.

NOTICE

All persons receiving a license from, or renewing a license with the Division of Professional Registration, are required to have paid all Missouri state income taxes and required to have filed all necessary Missouri state income tax returns for the preceding three years. If you have failed to pay your Missouri taxes or have failed to file your Missouri tax returns, your license will be subject to immediate suspension within 90 days of being notified by the Missouri Department of Revenue of any delinquency or failure to file.

GENERAL INFORMATION

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Processing your application can take approximately four (4) to six (6) weeks. Additional processing time may be required during the months of March through July due to a high volume of incoming applications. Below is information on the application process of the Board. Allowing our staff to process your application and supporting documents without duplicate submissions of documents, emails and telephone inquiries can decrease the processing time. Please know that our goal is to process your application in an efficient manner so that you can begin practicing in the state of Missouri as quickly as possible. Your assistance is greatly appreciated.

- You will be sent an email notifying you that your application and fee have been received, and your application will be put into a queue for processing.
- After your application has been processed, you will be sent another email that assigns a PIN and advises you of procedures to check the status of your application online. You will be able to see what documents are still lacking or need clarification. Feel free to share your PIN with whomever you want to be able to check the status of your application.
- Once all of the supporting documentation has been received, your application will be reviewed within approximately two (2) to four (4) weeks. Some applications may require further review by members of the Board.
- If a license is issued, you will receive an email notification and the hard copy of your license will be mailed to you.
- Should the Chair of the Licensure Committee request your appearance or if your file requires discussion at an upcoming meeting, you will be notified.

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In addition to the materials you are required to submit, the Board makes independent inquiries into your background. Additionally, the Board can request that you appear before them prior to issuing your license.

FEE

The application fee for a Missouri license is $75. Please make checks payable to the **Missouri Board of Healing Arts and please be sure to sign your check.** All checks must be drawn on a United States bank because our bank doesn't accept checks from International banks. The Board cannot accept credit or debit cards for payment of the initial application fee. No application will be processed until the fee and application are received in the Board office. **The Board cannot accept the application and fee submitted electronically. The physical application and fee must be received in the Board office.**

CONFIDENTIALITY

The Board cannot release information about your application (including status) or discuss your application without your permission. If you wish us to discuss your application with anyone, please list that person in item D on the application (Names of individuals with whom the Board is authorized to discuss your file).

DOCUMENTS THAT NEED TO BE SUBMITTED

- **Name Change** – If you have had a name change for any reason, submit a copy of the document evidencing the name change (Marriage Certificate, Divorce Decree, Adoption Order, Court Order, or Naturalization Certificate).
- **Pre-Medical Transcripts –** Official **FINAL** transcripts with school seal affixed and degree awarded, from any pre-professional (undergraduate) program you attended.
- **Medical Transcripts** – Official **FINAL** transcripts with school seal affixed and degree awarded, from any medical or osteopathic school you attended.
- **Medical Diploma** - A copy of your medical diploma (not larger than 8 ½" x 11"). This can be emailed to licensure@pr.mo.gov.

- **Official Examination Scores** - Your examination scores need to be sent directly to the Missouri Board of Healing Arts from one of the below agencies. Please see below for specific instructions regarding the different licensing examinations.
    - **USMLE/FLEX**: Request an official transcript at https://portal.fsmb.org/MyFsmb/. For assistance, call 817-868-4041 or email usmle@fsmb.org.
    - **NBME**: Request your scores at https://www.nbme.org/Cert-tran/Scores-and-transcripts.html. For assistance, call 215-590-9500 or email scores@nbme.org.
    - **NBOME/COMLEX-USA**: Request a certified copy of your official transcript at https://www.nbome.org/exams-assessments/exam-faqs/. For assistance, call 866-479-6828 or email Client Services at clientservices@nbome.org.
    - **State Board Examination**: Request the state board or jurisdiction to send your state exam information directly to the board you are applying to for licensure. Most boards require a fee for this service. A directory of state medical boards is available at https://www.fsmb.org/contact-a-state-medical-board/.
    - **LMCC**: Complete the Service Request form at https://mcc.ca/examinations/. For assistance, call 613-521-6012 or email service@mcc.ca.
- **Postgraduate Reference Letter** –The director of each ACGME/AOA/Canadian Royal College of Physicians and Surgeons postgraduate training program you have participated in must submit a Postgraduate Reference Form or letter directly to the Board. One copy of this form is included in the application packet. Please print/make additional copies as necessary.
- **Verification of Licensure** – If you have ever held a **permanent, temporary or institutional license, permit or certificate in any state, territory or country to practice as a physician, dentist, nurse, physician assistant, or any other professions in which a license, permit or certificate was issued**, the licensing agency **MUST** submit a verification of each to our office. The verification must be submitted directly from the licensing agency to our office. Some licensing agencies use a secure online verification portal however it is your responsibility to contact the licensing agency and advise them you are applying for a Missouri license. The Board accepts verifications from VeriDoc.
- **Hospital Affiliation Form** – Each hospital where you have held *active admitting privileges* in the US or Canada in the last five years must submit this form. This *does not* include training hospitals. Please have the hospital submit the form directly to the Board.
- **Photograph** – A photograph no larger than 3 ½" x 5" must be attached to the application in the space provided. Please do not staple or paperclip.
- **National Practitioner Data Bank Self-Query** – Contact the National Practitioner Data Bank (NPDB) at 1-800-767-6732 or http://www.npdb.hrsa.gov/index.jsp and perform a self-query. **The self-query must be dated within three (3) months of the application.** When you receive your self-query, forward the original information to the Board by email (licensure@pr.mo.gov), fax (573-751-3166) **OR** mail.

INFORMATION TO SUBMIT IF ANY OF THE PERSONAL HISTORY QUESTIONS ARE ANSWERED YES

- **Questions 1-9** - Include a separate statement/letter explaining the circumstances behind your "yes" answer. Documentation supporting your statement, if applicable (i.e. a settlement agreement from another state disciplining your license, documents showing probation in your postgraduate program, etc.) needs to be submitted directly from the state board, hospital, etc.
- **Question 10** - Include a separate statement/letter explaining the circumstances behind your "yes" answer and also **request the court to submit certified copies of the court documents directly to the Board OR have your attorney send the documents directly to the Board**. The Board needs to receive a copy of the complaint/petition and judgment, settlement, or disposition.
- **Question 11** - Include a separate statement/letter explaining the circumstances behind your "yes" answer. A copy of the charge (it may be called a petition, indictment, information, or complaint), and the judgment, sentence, or dismissal order, also needs to be submitted to the Board **directly from your attorney. The Board will also accept certified court copies directly from the court**.
- **Question 12** - Include a separate statement/letter explaining the circumstances behind your "yes" answer and documentation supporting that statement.
- **Question 13** – Please provide details and dates, including the names and addresses of the individuals and facilities which have treated you. Also please submit a letter from your current physician or treatment professional indicating your diagnosis, prognosis, and if your illness or condition affects your ability to practice.
- **Question 14 -** Please complete the Malpractice Claim Information form in its entirety. Additional documentation may be required after review of the information provided. Please also list the number of claims in which you have been named in the space provided.

ACTIVITIES STATEMENT

- Please provide all medical and nonmedical activities since graduation from your medical/doctorate program, or from the past 10 years, whichever is less, to the present date in CHRONOLOGICAL ORDER.
- All dates must be accounted for in the MM/YYYY format.
- Please include complete names and addresses for each activity listed.
- If unemployed or on vacation for at least a month, list your exact activities.

Note: if there are dates not accounted for, you will be contacted by the Board to account for those dates.

FCVS - The Board accepts information from the Federation Credentials Verification Service (FCVS) for any applicant who wishes to use this service. **The FCVS does NOT provide all of the documentation required for licensure.** If you choose to use FCVS,

the following information is usually included in the FCVS packet and ***NOT*** required to be submitted with your application as long as they are included in the FCVS:

- Medical school diploma;
- Medical school transcripts;
- Postgraduate reference letters;
- Official examination scores;
- Name change documentation;
- ECFMG Certification (International graduates only).

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

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

ADDITIONAL INFORMATION FOR INTERNATIONAL GRADUATES

- Missouri law (section 324.024, RSMo) requires submission of your social security number. If you are a citizen of a foreign country and do not have a social security number, you are required to submit your visa or passport number in lieu of the social security number. This same law requires a social security number in order to renew your Missouri license.
- If you are sending original documents and need them to be returned, please fill out the "Official Documents Form."
- **International Medical License:** Provide a copy of your license from the country you graduated from unless you were in a Fifth Pathway program.
- **ECFMG Certification Status Report**: Request a Status Report to be sent to the board you are applying to for licensure at https://cvsonline2.ecfmg.org/. For assistance, call 215-386-5900 or email credentials@ecfmg.org. Canadian graduates are not required to submit an ECFMG Certification Status Report.
- Fifth Pathway Applicants – The training institute where the Fifth Pathway Program was completed must furnish a Postgraduate Reference Letter directly to this office.
- Transcripts and other documents must be translated into English by:
  - A professor of a language department in a college or university in the United States, or
  - The United States Embassy or Consulate in a foreign country.

  THE TRANSLATOR MUST INCLUDE DOCUMENTATION CERTIFYING THAT:

  - The document is a true translation to the best of their knowledge, and
  - They are fluent in the original language and qualified to translate the document into English.
  - The translator must sign the translation and print their name and address on the translation.

All physician licenses expire on January 31. Please remember this date so you can allow time for your renewal to be processed. Information on renewing your license will be mailed to you on or before December 1 of each year to the last known address on file. Failure to receive the renewal application does not relieve any person of the duty to register and pay the fee required for renewal nor exempt them from the penalties for failure to renew. **Therefore it is imperative that you notify the Board of any address change as soon as it occurs.** If your license expires, you cannot practice in Missouri until your renewal is granted.

BOARD CONTACT INFORMATION

Missouri Board of Healing Arts
PO Box 4. Jefferson City, MO 65102
OVERNIGHT DELIVERY ADDRESS
3605 Missouri Blvd., Jefferson City, MO 65109
Phone 573-751-0098
Toll Free 866-289-5753
Fax 573-751-3166
Email licensure@pr.mo.gov

Save Print Reset

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
TELEPHONE (573) 751-0098
TOLL FREE (866) 289-5753
FAX (573) 751-3166

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

APPLICATION FOR PHYSICIAN LICENSURE

INSTRUCTIONS

Complete each section by providing complete details in black ink or by typed responses. Failure to answer all questions could result in delayed processing of your application. If additional responses are necessary, submit in a separate statement.

A. MISSOURI TAX COMPLIANCE

☐ Check this box if in all of the last three 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.

Pursuant to Section 324.010 RSMo, all persons applying for and renewing a license with the Division of Professional Registration are required to have paid all Missouri state taxes and are also required to have filed Missouri state income tax returns for the last three years. If such licensee is delinquent on any Missouri state taxes or has failed to file Missouri state income tax returns in the last three years, your license will be subject to suspension within 90 days after being notified by the Missouri Department of Revenue of such delinquency or failure to file.

False statements are subject to criminal penalties and/or license discipline. For tax questions, please contact the Department of Revenue at (573) 751-7200 or email at income@dor.mo.gov.

B. IDENTIFYING INFORMATION

Print your full name, mailing address, and personal information.

LAST NAME	FIRST NAME	MIDDLE NAME	MAIDEN NAME	SUFFIX	☐ MD ☐ DO

OTHER NAMES USED	CONTACT TELEPHONE NUMBER	BUSINESS PHONE NUMBER	EMAIL ADDRESS

STREET ADDRESS	CITY	STATE	ZIP CODE

DATE OF BIRTH	PLACE OF BIRTH	SSN	GENDER

C. PRACTICE INFORMATION

TYPE OF PRACTICE YOU ARE CURRENTLY INVOLVED IN

☐ Intern ☐ Resident ☐ Private ☐ Faculty ☐ Other _____

ANTICIPATED MISSOURI PRACTICE ADDRESS IF UNKNOWN, CHECK THIS BOX ☐

NAME OF BUSINESS	ADDRESS	CITY	STATE	ZIP

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

☐ Intern ☐ Resident ☐ Private ☐ Faculty ☐ Other _____

ARE YOU A DIPLOMATE OF ANY AMERICAN BOARD OF MEDICAL SPECIALTIES OR THE AOA?

☐ YES ☐ NO IF YES, PLEASE LIST EACH

IF NO, ARE YOU BOARD ELIGIBLE?

☐ YES ☐ NO

D. NAMES OF INDIVIDUALS WITH WHOM THE BOARD IS AUTHORIZED TO DISCUSS YOUR FILE

CONTACT #1 NAME	CONTACT #1 EMAIL	CONTACT #1 TELEPHONE NUMBER

CONTACT #2 NAME	CONTACT #2 EMAIL	CONTACT #2 TELEPHONE NUMBER

ISSUANCE OF A MISSOURI LICENSE IS REQUIRED PRIOR TO PRACTICING IN THE STATE OF MISSOURI.

Approximate date that a Missouri license is needed: _____ The Board will process your application as quickly as possible but be advised that your application, fee and supporting documentation needs to be received and approved prior to issuing a Missouri license. Sometimes applications require additional review by Board members and this can delay the decision on whether or not a Missouri license is issued.

E. PREMEDICAL EDUCATION

List the name of each school, location, dates of attendance, degree awarded and dates degree was awarded from all colleges attended.

NAME OF SCHOOL	CITY/STATE	DATES ATTENDED				DEGREE AWARDED	DATE AWARDED
		FROM		TO			
		MONTH	YEAR	MONTH	YEAR		

F. MEDICAL/DOCTORATE EDUCATION

List the name of each school, location, dates of attendance, degree awarded and dates degree awarded from all colleges attended. If it took longer than four years to complete medical school, please explain.

NAME OF SCHOOL	CITY/STATE	DATES ATTENDED				DEGREE AWARDED	DATE AWARDED
		FROM		TO			
		MONTH	YEAR	MONTH	YEAR		

G. EXAMINATION

PLEASE INDICATE WHICH EXAMINATION YOU HAVE TAKEN.

USMLE ☐ Yes ☐ No FLEX ☐ Yes ☐ No NBME ☐ Yes ☐ No

NBOME/COMLEX-USA ☐ Yes ☐ No STATE BOARD EXAMINATION ☐ Yes ☐ No LMCC ☐ Yes ☐ No

If Yes, indicate the number of times you have taken each portion of the examination and the dates they were taken in the space below.

Part 1/Step 1/Level 1	Part 2/Step 2(CK)/Level 2(CE)	Part 2/Step 2(CS)/Level 2(PE)	Part 3/Step 3/Level 3	Component 1	Component 2

Section 334.040.2 requires each step of the examination to be taken and passed within three attempts, and steps one, two and three of the USMLE to be taken within a seven year period. If it took more than three attempts or more than seven years to pass the exam, please explain the circumstances:

H. ACGME/AOA/CANADIAN ROYAL COLLEGE OF PHYSICIANS AND SURGEONS POSTGRADUATE EXPERIENCE

List ACGME/AOA/Canadian Royal College of Physicians and Surgeons postgraduate training received in the United States and Canada by indicating the type of training received, name of hospital, address and the department/specialty, beginning and ending dates, and program director.

1.HOSPITAL NAME	☐ Intern ☐ Resident ☐ Fellow ☐ Research ☐ Other	
ADDRESS	CITY, STATE, ZIP	
DEPARTMENT/SPECIALTY	DATE STARTED (MONTH/YEAR)	DATE COMPLETED (MONTH/YEAR)
PROGRAM DIRECTOR NAME	ACCREDITED BY ☐ ACGME ☐ AOA ☐ Royal College ☐ Other _____	

2.HOSPITAL NAME	☐ Intern ☐ Resident ☐ Fellow ☐ Research ☐ Other	
ADDRESS	CITY, STATE, ZIP	
DEPARTMENT/SPECIALTY	DATE STARTED (MONTH/YEAR)	DATE COMPLETED (MONTH/YEAR)
PROGRAM DIRECTOR NAME	ACCREDITED BY ☐ ACGME ☐ AOA ☐ Royal College ☐ Other _____	

ACGME/AOA/CANADIAN ROYAL COLLEGE OF PHYSICIANS AND SURGEONS POSTGRADUATE EXPERIENCE (continued)

3.HOSPITAL NAME	☐ Intern ☐ Resident ☐ Fellow ☐ Research ☐ Other	
ADDRESS	CITY, STATE, ZIP	
DEPARTMENT/SPECIALTY	DATE STARTED (MONTH/YEAR)	DATE COMPLETED (MONTH/YEAR)
PROGRAM DIRECTOR NAME	ACCREDITED BY ☐ ACGME ☐ AOA ☐ Royal College ☐ Other _____	

I. FIFTH PATHWAY EDUCATION

List name and location of hospital, dates attended and Program Director information.

HOSPITAL NAME	ADDRESS	CITY, STATE, ZIP
TERM STARTED (MONTH/YEAR)	DATE COMPLETED (MONTH/YEAR)	
PROGRAM DIRECTOR NAME		

J. ECFMG CERTIFICATION

Indicate ECFMG Number and date of issuance.

ECFMG CERTIFICATE NUMBER	DATE ISSUED

K. MEDICAL LICENSURE HISTORY

List all of the states, territories and countries in which you currently hold or have ever held a license, permit or certificate to practice medicine. This includes training licenses and previous Missouri licenses. **If you have held an International medical license, please list it here.**

STATE	STATE	STATE	STATE	STATE

L. OTHER PROFESSIONAL LICENSES HISTORY

List all other professional licenses, permits, registrations or certifications you now hold or have ever held (e.g. Physician Assistant, Registered Nurse, etc.)

PROFESSION	STATE IN WHICH HELD	PROFESSION	STATE IN WHICH HELD

M. HOSPITAL AFFILIATION ADMITTING PRIVILEGES ONLY

Have you had admitting privileges at any United States or Canadian hospital within the last five years? ☐ Yes ☐ No

If yes, please complete the information in M. If not, please move on to N.

List all United States and/or Canadian Hospitals in which you had **admitting privileges for the last five (5) years.** Indicate the name, address and dates of privileges, excluding all training programs. If you have additional hospitals, please list them separately.

HOSPITAL NAME	ADDRESS	CITY AND STATE	DATES OF PRIVILEGES	
			DATE STARTED	DATE COMPLETED
			(MONTH/YEAR)	(MONTH/YEAR)
			(MONTH/YEAR)	(MONTH/YEAR)
			(MONTH/YEAR)	(MONTH/YEAR)
			(MONTH/YEAR)	(MONTH/YEAR)
			MONTH/YEAR)	MONTH/YEAR)
			MONTH/YEAR)	MONTH/YEAR)

N. PERSONAL HISTORY

Answer the following questions with the appropriate checkmark. **If any are answered yes, see the Instruction Sheet for specific information and documentation needed for review.**

1. Have you been denied a license, registration or certificate to practice as a physician or any other profession or been denied the privilege of taking an examination administered by a U.S. state, Canadian provincial or international licensing agency? ☐ Yes ☐ No

2. Have you made application for licensure, registration or certification in another state, province or country and subsequently withdrawn said application? ☐ Yes ☐ No

3. Has any license or right to practice held by you been disciplined, including but not limited to restriction, 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? ☐ Yes ☐ No

4. 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 postgraduate training program? ☐ Yes ☐ No

5. Have you ever been restricted, suspended, terminated, requested to voluntarily resign, placed on probation, counseled, received a warning or been subject to any remedial or disciplinary action during medical school or a postgraduate training program? ☐ Yes ☐ No

6. Have you surrendered a license issued to you by any U.S. state or any Canadian provincial licensing agency for any reason, other than failure to renew, retirement or relocating to another state? ☐ Yes ☐ No

7. 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? ☐ Yes ☐ No

8. 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, including, but not limited to, revocation, suspension, probation, censure, or reprimand, whether voluntarily agreed to or not? ☐ Yes ☐ No

9. 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? ☐ Yes ☐ No

10. 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 lawsuit (other than malpractice) been filed against you? ☐ Yes ☐ No

11. Have you been arrested, charged, indicted, found guilty, or entered a plea of guilty, an alford, no contest plea or plea of nolo contendere, in a criminal prosecution in any state, federal, or municipal court whether or not sentence was imposed, including suspended imposition of sentence or suspended execution of sentence, except for minor traffic violations? Alcohol related traffic violations must be reported. ☐ Yes ☐ No

12. Have you been required by federal law or the law of any state to register as a sex offender? ☐ Yes ☐ No

13. Do you currently have any condition or impairment which in any way affects your ability to practice in a professional, competent and safe manner, including but not limited to: (1) a mental, emotional, nervous or sexual disorder, (2) an alcohol or substance abuse disorder or (3) a physical disease or condition? ☐ Yes ☐ No

14. 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? ☐ Yes ☐ No

    14a. If your answer is yes, please indicate how many claims in which you have been named. _____

O. ACTIVITIES

Chronologically list all medical and nonmedical activities since graduation from your medical/doctorate program or from the last ten (10) years, whichever is less, to the present date. Please account for all months.

DATES		ACTIVITY	ENTITY NAME & ADDRESS	CITY & STATE	COUNTRY
BEGINNING MONTH/YEAR	ENDING MONTH/YEAR				
6/2011	6/2011	Vacation/Summer Brea		City, State	
7/2011	6/2014	Internship/Residency	Name of Hospital Address	City, State	
7/2014	present	Private Practice	Name of Practice, Address	City, State	

P. APPLICANT'S OATH

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 address updates, 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.

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 hereby authorize the Missouri State Board of Healing Arts, its Director or designee, to release and/or discuss information contained in my application for licensure in the State of Missouri to the individuals indicated on the 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.

I further certify that I understand that I cannot practice my profession in the state of Missouri unless and until a license has been granted by the Missouri Board of Healing Arts.

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

Q. NOTARIZATION

STATE	COUNTY

The applicant identified him/herself with a government issued photographic identification and bearing true likeness to the attached photograph subscribed and swore to the truthfulness of this application before me, this _____ day of _____ , _____ .

NOTARY PUBLIC RUBBER STAMP

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

PLEASE GLUE OR TAPE YOUR PHOTO TO THE APPLICATION.

DO NOT STAPLE OR PAPER CLIP PHOTO.

PHOTO

JURISPRUDENCE EXAMINATION

INSTRUCTIONS

Completion of the jurisprudence examination and achieving a score of 75% or higher is a requirement for licensure by the Missouri State Board of Registration for the Healing Arts (Board). Each of the twenty "True (T) or False (F)" 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 https://pr.mo.gov/healingarts-rules-statutes.asp.

JURISPRUDENCE EXAMINATION

SCORE ▸

1. T F A physician located outside of the state of Missouri is not required to hold a license in this state if a collaborating Missouri licensed physician retains ultimate authority and responsibility for the diagnosis and treatment of the care of the patient located in Missouri.(Section 334.010.3, RSMo)
2. T F Patient records remaining under the care, custody and control of a licensee need not to be maintained by the licensee or the licensee's designee for a minimum of seven (7) years from the date of when the last professional service was provided. (Section 334.097, RSMo)
3. T F Except as provided in Section 334.044 and 334.150, RSMo, practicing medicine in the state of Missouri without current registration is authorized as long as the physician holds an unencumbered license in another state. (Section 334.010, RSMo)
4. T F Conviction of a felony offense that is reasonably related to the qualifications, functions or duties of a physician and surgeon's profession in the state of Missouri or any other state does not constitute ground(s) for discipline. (Section 334.103.1, RSMo)
5. T F Prescribing, administering or dispensing controlled substances for a non-therapeutic purpose, or in a non-therapeutic manner, and failure to document such in the physician's medical records constitute violation(s) of Intractable Pain Treatment Act. (Sections 334.106 and 334.107, RSMo)
6. T F If a physician does not renew his/her Missouri license for two consecutive renewal periods, such license shall be deemed void. (Section 334.080, RSMo)
7. T F If a physician's license, permit or certificate is denied in another state, his/her Missouri license will not automatically be denied in the state of Missouri. (Section 334.103, RSMo)
8. T F A physician 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. (Section 334.100.2(4)(d), RSMo)
9. T F Section 334.100, RSMo provides the grounds for denial, suspension or revocation of a physician's license. (Section 334.100 RSMo)
10. T F As a condition of discipline, the Board may not require a physician to submit to care, counseling or treatment at the expense of the individual to be examined, or require the person to attend relevant continuing educational courses and pass an examination as the Board may direct. (Section 334.100.4, RSMo)
11. 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. (Section 334.100.2(4)(c), RSMo)
12. T F Each physician renewing his/her license is required to complete and report twenty five (25) hours of continuing medical education every three (3) years. (Rule 20 CSR 2150-2.125)
13. T F A physician cannot require, as condition of the physician-patient relationship, the patient only receive prescribed drugs, devices or other professional services directly from the physician's office or other entities under the physician's ownership or control. (Section 334.100.2(22), RSMo)
14. T F While a pharmacist can administer vaccines pursuant to a written protocol authorized by a Missouri licensed physician who is actively engaged in the practice of medicine, the authorizing physician is responsible for the oversight of, and accepts responsibility, for the vaccines administered by the pharmacist. (Rule 20 CSR 2150-5.025)
15. T F Physicians are not allowed to enter medication therapy written protocols with Missouri licensed pharmacists. (Rule 20 CSR 2150-5.028)
16. T F Prior to prescribing any drug, controlled substance, or other treatment through telemedicine, as defined in section 191.1145, RSMo, or the internet, a physician shall establish a valid physician-patient relationship as described in section 191.1146. (Section 334.108, RSMo)
17. T F With written collaborative practice agreements in place, a Missouri-licensed physician may serve as a supervising physician for assistant physicians, advanced practice registered nurses, and/or physician assistants. (Sections 334.037, 334.104, and 334.735, RSMo)
18. T F Failure to receive a renewal application form does not relieve any licensee of the duty to renew or register and pay the required fee, nor does such failure exempt the licensee from the penalties provided by Chapter 334 for failure to register. (Section 334.080, RSMo)
19. T F Physicians are required to notify the Board within fifteen (15) days of the occurrence of a name or address change. (Section 334.070 and Rule 20 CSR 2150-2.045)
20. T F Application fees are refundable by the Board upon a written request of the applicant or licensee. (Rule 20 CSR 2150-2.080(2))

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
TELEPHONE (573) 751-0098
TOLL FREE (866) 289-5753
FAX (573) 751-3166

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

POSTGRADUATE REFERENCE LETTER

APPLICANT LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX	SSN	DOB

The applicant 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 ACGME/AOA/Canadian Royal College of Physicians and Surgeons approved training program the applicant has been in or is currently enrolled. Please provide **all** of the information requested on this form and return it to the address above. This information will become part of the permanent records maintained in this office. Please note that the applicant cannot receive final consideration without your cooperation.

I hereby authorize the below-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 below-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.

APPLICANT SIGNATURE	DATE

PROGRAM DIRECTOR NAME	EMAIL ADDRESS	PHONE NUMBER

NAME OF TRAINING HOSPITAL	ADDRESS	CITY, STATE, ZIP

ACCREDITED BY
☐ ACGME ☐ AOA ☐ Royal College ☐ Other _____

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

Please check one of the following:

☐ The above named applicant satisfactorily completed _____ months of a _____ month program.

☐ The above named applicant is on track to successfully complete _____ months of postgraduate training at this hospital on _____ (DATE) . I further certify that I will notify the Missouri Board of Healing Arts if there are any changes to the answers on this postgraduate reference letter, prior to the completion of the postgraduate training program.

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

1. During the time this applicant was in your training program has he/she ever been subject to any disciplinary or corrective action, such as imposition of consultation requirements, suspension, termination, probation or remediation plan? ☐ Yes ☐ No
2. At the time the applicant left your institution, were any actions instituted, in process or pending against him/her? ☐ Yes ☐ No
3. Do you have knowledge of any condition or impairment which in any way affects the applicant's ability to practice in a professional competent and safe manner, including but not limited to: (1) a mental, emotional, nervous or sexual disorder, (2) an alcohol or substance abuse disorder or (3) a physical disease or condition? ☐ Yes ☐ No

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

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

IF YOU DO NOT RECOMMEND THIS APPLICANT FOR LICENSURE OR RECOMMEND HIM/HER WITH RESERVATIONS, PLEASE EXPLAIN WHY. USE A SEPARATE SHEET IF NECESSARY.

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

SIGNATURE	DATE
▶	

ADMITTING PRIVILEGES ONLY

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

PHYSICIAN HOSPITAL AFFILIATION VERIFICATION

STATE BOARD OF REGISTRATION FOR THE HEALING ARTS
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APPLICANT LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX	DATE

HOSPITAL NAME

HOSPITAL ADDRESS	CITY, STATE ZIP

TERM STARTED	TERM COMPLETED

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.

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.

1. The above-named applicant is/has been affiliated with our hospital from _____ to _____.
2. Based on past performance, would you recommend this applicant for reappointment at this hospital? ☐ YES ☐ NO
3. During the stated period of time, were the practice privileges of this applicant 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 NAME OF ADMINISTRATOR/REPRESENTATIVE	TITLE	EMAIL ADDRESS

SIGNATURE OF ADMINISTRATOR/REPRESENTATIVE	TELEPHONE NUMBER	DATE
▶		

* VERIFICATION PURPOSES ONLY

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STATE OF MISSOURI
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MALPRACTICE CLAIM INFORMATION

APPLICANT LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX	DATE

If you answered yes to question 14 on the application in Section N, please answer the following questions for each claim. Copy this page as necessary.

PATIENT NAME	PLAINTIFF NAME (IF OTHER THAN PATIENT)

PATIENT'S DATE OF BIRTH	LAST 4 OF PATIENT'S SSN

YOUR INVOLVEMENT IN THE CASE (ATTENDING, CONSULTING, ETC.)	DATE OF OCCURRENCE (MONTH/DAY/YEAR)

STATUS OF THE ACTION (PENDING, DISMISSED, SETTLED, JUDGMENT, DROPPED)	MONEY PAID

DID THE PATIENT DIE?

☐ YES ☐ NO

IF THE CASE IS CLOSED, PLEASE INDICATE THE METHOD OF RESOLUTION.

☐ Dismissed with Payment - Date: _____

☐ Dismissed without Payment - Date: _____

☐ Settled, Payment Made - Date: _____

☐ Settled, No Payment Made - Date: _____

☐ Judgment in your Favor - Date: _____

☐ Judgment against you - Date: _____

☐ Other _____ Date: _____

EXPLAIN THE ALLEGATION AND **PROVIDE A NARRATIVE SUMMARY** REGARDING YOUR ROLE IN THE CARE PROVIDED.

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OFFICIAL DOCUMENTS

INSTRUCTIONS

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

1. NAME AS SHOWN ON APPLICATION		MIDDLE NAME	SUFFIX	DATE
LAST NAME	FIRST NAME			
2. NAME SHOWN ON DOCUMENTS IF DIFFERENT FROM APPLICATION		MIDDLE NAME	SUFFIX	
LAST NAME	FIRST NAME			
3. ADDRESS (STREET, CITY, STATE, ZIP) PLEASE NOTIFY BOARD OFFICE OF ANY ADDRESS CHANGE(S)				

4. LIST EACH OFFICIAL DOCUMENT ENCLOSED	NO. OF PAGES

STATE OFFICE USE ONLY

DATE RECEIVED	NUMBER OF ORIGINALS RECEIVED	DATE RETURNED	NUMBER OF ORIGINALS RETURNED

TRACKING NUMBER	RETURN ADDRESS IF NOT SAME AS LISTED ABOVE	INITIAL 1	INITIAL 2