Instructions for Temporary License Application

A temporary license allows a physician to practice in approved hospital training programs as an intern, resident or fellow. This application should be submitted by the hospital.

Your Application Packet Consists of:

- These instructions;
- Postgraduate Reference Form;
- Verification of Licensure Form;
- Application;
- Verification of Hospital Affiliation Form;
- Original 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 http://pr.mo.gov/healingarts-rules-statutes.asp.

GENERAL INFORMATION

All temporary licenses expire on June 30. Please remember this date so you can allow time for your renewal to be processed if needed. If your license expires, you cannot practice until your renewal is granted.

In addition to the materials you are required to submit, the Board makes independent inquiries into your background. You should allow a minimum of 30 days for the processing of your application once the Board has received all documents. Additionally, the Board can request that you appear before them before your license is issued.

FEES

The fee for a temporary license is $30. Please make checks payable to the **Missouri Board of Healing Arts.** No application will be processed until the fee is received. The Board cannot accept credit or debit cards for payment.

ACTIVITIES STATEMENT

- Please provide all medical and nonmedical activities since graduation from your medical/doctorate program to the present date in CHRONOLOGICAL ORDER.
- All dates must be accounted for in the MM/YYYY format.
- Please include complete names and address for each activity listed.
- If unemployed or on vacation for more than one month, list your exact activities.

Note: if there are dates not accounted for, your application will be delayed.

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

- **Questions 1-5** - Include a separate statement/letter explaining the circumstances behind your "yes" answer and documentation supporting that statement, if applicable (i.e. a settlement agreement from another state disciplining your license, documents showing probation in your postgraduate program, etc.).
- **Question 6** - If you were a defendant in a civil suit, include a separate statement/letter explaining the circumstances behind your "yes" answer and also submit a certified copy of the court records or have your attorney send the documents to the Board. The Board needs to receive a copy of the complaint/petition, judgment, settlement, or disposition.
- **Question 7** - If you were arrested and/or charged with a crime, include a separate statement/letter explaining the circumstances behind your "yes" answer along with a copy of the charge (it may be called a petition, indictment, information, or complaint), the judgment, sentence, or dismissal order, certified by the court or from your attorney.
- **Question 8** -
  - If you were named in only one or two medical malpractice claims or cases, and the cases were resolved more than five years ago, you are only required to provide a statement. The statement should contain a summary of the incident leading to the suit, the date of the incident, the name of the patient, and how the case was resolved.
  - If any medical malpractice claim or case is still pending against you, please submit a certified copy of the complaint, certified by the court or directly from your attorney, and a statement containing a summary of the incident leading to the suit, the date of the incident, and the name of the patient.
  - If you have been involved in more than two claims or cases, or if any claims or cases have been resolved in the last five years, you are required to submit a certified copy of the complaint and the document showing the disposition of the case, certified by the court or directly from your attorney. You should also submit a statement containing a summary of the incident leading to the suit, the date of the incident, the name of the patient, and how the case was resolved. If a claim was paid without a formal case being filed, include in your statement the name of your insurance carrier and the date and amount of the settlement.
- **Questions 9-10** - Include a separate statement/letter explaining the circumstances behind your "yes" answer and documentation supporting that statement, if applicable.
- **Questions 11-15** – 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.
- **Questions 16** - Include a separate statement/letter explaining the circumstances behind your "yes" answer and documentation supporting that statement.

*******Certified court copies must have the original court seal or come directly from the court. Copies are only acceptable if they come directly from the attorney. Copies of documents sent by the applicant or credentialing office will not be accepted.

DOCUMENTS THAT NEED TO BE SUBMITTED

- **Pre-Medical Transcripts –** Official transcripts with school seal affixed, from any pre-professional (undergraduate) program you attended.
- **Medical Transcripts** – Official transcripts with school seal affixed, from any medical or osteopathic school you attended.
- **Medical Diploma** - A copy of your medical diploma (not larger than 8 ½" x11").
- **Verification of Licensure** – You must submit a verification of licensure from each state you have had any professional license in. This means any medical, dental, nurse, physician assistant, etc. license. This verification must be submitted directly from the licensing agency and may be either on the enclosed form or on the agency's letterhead. We recommend calling each state board to check for fees and procedures before sending verification forms.
- **Postgraduate Reference Letter** –The director of each 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.
- **National Practitioner's Data Bank Self-Query** – Contact the National Practitioner's Data Bank (NPDB) at 1-800-767-6732 or http://www.npdb.hrsa.gov/index.jsp and tell them you need a self query. 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.
- **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.
- **Name Change** – If you have had a name change for any reason, submit the document evidencing the name change (Marriage Certificate, Divorce Decree, Adoption Order, Court Order). If the name change is due to naturalization, you must bring the document to the office as it is illegal to copy the Naturalization Certificate.
- **Photograph** – A photograph no larger than 3 ½" x 5" must be attached to the application in the space provided. Please do not staple.

HOW TO CHECK THE STATUS OF YOUR APPLICATION

When your application is received and processed, the person(s) listed as your hospital contact(s) will be notified via email of how to check the status of your application online.

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 C on the application (Names of coordinators with whom the Board is authorized to discuss your file).

NOTICE

All persons receiving a license from, or renewing a license with the Division of Professional Registration, are required to have paid all state income taxes, and also are required to have filed all necessary state income tax returns for the preceding three years. If you have failed to pay your taxes or have failed to file your 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.

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.
- If you are sending original documents and need them to be returned, please fill out the "Original Documents Form."
- Foreign notaries are acceptable if they have the "Apostile" stamp or were notarized at a US Embassy.
- Provide proof of licensure in the country you graduated from unless you are in a Fifth Pathway program.
- Complete a "Request for Status Report of ECFMG Certification" on the ECFMG website at ecfmg.org. ECFMG must send this document to our office. Fifth Pathway applicants must submit a copy of the Interim Letter. Canadian graduates are not required to submit an ECFMG Certificate.
- Fifth Pathway Applicants – The training institute where the Fifth Pathway Program was completed must furnish a Post-Graduate Reference Letter directly to this office.
- Transcripts and other documents must be translated into English by:
  - A government official in the United States;
  - An official translation service in the US;
  - A professor of a language department in a US college or university; or
  - An official of an American Embassy.
- The translator should:
  - Translate on official letterhead;
  - Certify that the document is a true translation to the best of their knowledge and that they are fluent in both English and the language from which the document is translated;
  - Sign the translation and have their signature notarized; and
  - Print their name and title under the signature.

If you have questions after reading these instructions, you may call the Board office at 573-751-0098 or toll free at 866-289-5753 or email at licensure@pr.mo.gov.

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

APPLICATION FOR TEMPORARY LICENSURE INTERNATIONALLY EDUCATED PHYSICIAN

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

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

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

Pursuant to Section 324.010, RSMo:

I certify that in the last three (3) years:

1. I was a resident of Missouri; ☐ Yes ☐ No
2. I did have Missouri income; and ☐ Yes ☐ No
3. I was subject to any type of Missouri income tax ☐ Yes ☐ No

OR

4. I have filed and paid all applicable Missouri income tax ☐ Yes ☐ No

All questions must be completed. 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 income@dor.mo.gov.

B. IDENTIFYING INFORMATION

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

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

STREET ADDRESS	CITY	STATE	ZIP

CONTACT PHONE NUMBER	BUSINESS TELEPHONE NUMBER

EMAIL ADDRESS

DATE OF BIRTH	PLACE OF BIRTH	SSN

C. TRAINING PROGRAM

Print the name and address of the training hospital and the beginning date of the training program. If the training has already begun, it will be necessary for the hospital to submit a letter to our office explaining your activities during the unlicensed period.

NAME OF HOSPITAL	CITY	STATE
Univ. of Missouri-Kansas City, SOM	Kansas City	MO

DATE TRAINING WILL BEGIN	IF ALREADY AT THIS INSTITUTION, DATE TRAINING BEGAN (MONTH/YEAR)

	POSTGRADUATE YEAR
☐ Intern ☐ Resident ☐ Fellow ☐ Other	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8

I hereby authorize the State Board of Registration for the Healing Arts, its Director or designee, to release and/or discuss information contained in my application for temporary licensure in the State of Missouri to the following individuals. List the name of up to two hospital coordinators with whom we may discuss your file other than yourself. If no names are listed we will not speak to anyone about your file but you.

NAMES OF COORDINATORS WITH WHOM THE BOARD IS AUTHORIZED TO DISCUSS YOUR FILE

Rhonda Hughes

HOSPITAL CONTACT #1	DEPARTMENT
Rhonda Hughes	UMKC-SOM, GME
HOSPITAL CONTACT #1 EMAIL	**HOSPITAL CONTACT #1 TELEPHONE NUMBER**
HughesRS@umkc.edu	816/235-6627
HOSPITAL CONTACT #2	**DEPARTMENT**
Eve Medlock	UMKC-SOM, GME
HOSPITAL CONTACT #2 EMAIL	**HOSPITAL CONTACT #2 TELEPHONE NUMBER**
medlocke@umkc.edu	816/235-1742

D. PREMEDICAL EDUCATION

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

FROM		TO		NAME AND LOCATION OF SCHOOL	DEGREE AWARDED	DATE AWARDED
MONTH	YEAR	MONTH	YEAR			

E. MEDICAL/DOCTORATE EDUCATION

List the name of each school, city and state, dates of attendance, degree awarded and dates degree was awarded from all colleges attended. If it took longer than four-year period to complete medical school, provide complete details on separate statement.

FROM		TO		NAME AND LOCATION OF SCHOOL	DEGREE AWARDED	DATE AWARDED
MONTH	YEAR	MONTH	YEAR			

F. FIFTH PATHWAY EDUCATION

List name and location of hospital (city and states), dates attended and Program Director along with his/her address.

HOSPITAL		
ADDRESS		
PROGRAM DIRECTOR	TERM STARTED (MONTH/YEAR)	COMPLETED (MONTH/YEAR)

G. ECFMG CERTIFICATION

Indicate ECFMG Number and date of issuance.

ECFMG CERTIFICATE NUMBER	DATE ISSUED

H. POST GRADUATE EXPERIENCE

List training programs 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. ☐ Intern ☐ Resident ☐ Fellow ☐ Research ☐ Other	HOSPITAL	
ADDRESS		
DEPARTMENT/SPECIALTY	TERM STARTED (MONTH/YEAR)	TERM COMPLETED (MONTH/YEAR)
PROGRAM DIRECTOR		

2. ☐ Intern ☐ Resident ☐ Fellow ☐ Research ☐ Other	HOSPITAL	
ADDRESS		
DEPARTMENT/SPECIALTY	TERM STARTED (MONTH/YEAR)	TERM COMPLETED (MONTH/YEAR)
PROGRAM DIRECTOR		

POST GRADUATE EXPERIENCE (continued)

3. ☐ Intern ☐ Resident ☐ Fellow ☐ Research ☐ Other	HOSPITAL	
ADDRESS		
DEPARTMENT/SPECIALTY	TERM STARTED (MONTH/YEAR)	TERM COMPLETED (MONTH/YEAR)
PROGRAM DIRECTOR		

I. MEDICAL LICENSURE HISTORY

List all of the states and territories in which you currently hold or have ever held a license to practice medicine, including training licenses and previous Missouri licenses.

STATE	STATE

J. OTHER PROFESSIONAL LICENSES HISTORY

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

PROFESSION	STATE IN WHICH HELD

K. ACTIVITIES

Chronologically list all medical and nonmedical activities since graduation from your medical/doctorate program to the present date. Please account for all months.

DATES		ACTIVITIES
BEGINNING MONTH/YEAR	ENDING MONTH/YEAR	
6/2011	6/2011	Vacation/Summer Break, CITY, STATE
7/2011	present	Internship/Residency, NAME OF HOSPITAL, ADDRESS, CITY, STATE

L. HOSPITAL AFFILIATION

List all hospital affiliations in which you had **admitting privileges for the last five (5) years**. Indicate name, address and dates of privileges, excluding all training programs.

HOSPITAL	CITY AND STATE	DATE OF PRIVILEGES	
		TERM STARTED	TERM COMPLETED
		(MONTH/YEAR)	(MONTH/YEAR)
		(MONTH/YEAR)	(MONTH/YEAR)
		(MONTH/YEAR)	(MONTH/YEAR)
		(MONTH/YEAR)	(MONTH/YEAR)
		(MONTH/YEAR)	(MONTH/YEAR)

M. EXAMINATION

HAVE YOU PREVIOUSLY TAKEN THE

FLEX ☐ Yes ☐ No USMLE ☐ Yes ☐ No NATIONAL BOARDS ☐ Yes ☐ No

LMCC ☐ Yes ☐ No STATE BOARDS ☐ Yes ☐ No

If Yes, indicate the number of times you have taken each portion of the examination in the space below:

PART 1/STEP 1/NB PART 1	PART 2/STEP 2/NB PART 2	PART 3/STEP 3/NB PART 3	COMPONENT I	COMPONENT 2

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.**

		YES	NO
1.	Have you ever had any right to practice (license) restricted or disciplined? This includes, but is not limited to actions such as revocation, suspension, probation, censure, admonishment, or reprimand by any state, territory, agency, or country. It also includes voluntary agreements for discipline.	☐	☐
2.	Have you ever surrendered your license or hospital privileges while under investigation or to avoid an investigation or disciplinary action? This does not include resigning voluntarily when no investigation is pending or not renewing a license or privileges because you don't practice in that state or hospital any more.	☐	☐
3.	Have you ever had a charge or complaint filed against you by the federal government, a federal agency, any state or country's licensing authority?	☐	☐
4.	Have you ever had your Drug Enforcement Agency (DEA) registration or state controlled substance registration denied, limited, restricted, placed on probation, censured or reprimanded? Or have you ever surrendered a DEA or other controlled substance registration during an investigation?	☐	☐
5.	Has any Federal or state agency, including Medicare or Medicaid, taken any disciplinary action against you, including excluding you from payments?	☐	☐
6.	Have you been sued in civil court for something related to your practice of medicine other than malpractice?	☐	☐
7.	Have you been arrested, charged, indicted, found guilty or pled guilty or entered an Alford, no contest or nolo contendere plea to any federal or state crime? This includes any cases where you pled guilty but entered drug court, a diversionary program, or received a suspended imposition of sentence.	☐	☐
8.	Have you ever been sued for malpractice or negligence associated with your medical practice or has anyone, including a hospital or insurance company, paid a malpractice or negligence claim on your behalf?	☐	☐
9.	Have you ever been denied a professional license or denied the opportunity to take a professional licensure exam?	☐	☐
10.	Have you ever withdrawn an application for a professional license?	☐	☐
11.	Are you currently addicted to or dependent on narcotics, drugs, or alcohol?	☐	☐
12.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism, or paraphilia as defined by the DSM-IV-TR?	☐	☐
13.	Have you been hospitalized for any mental health disorder?	☐	☐
14.	Have you ever been or are you currently being treated for a mental health disorder, which impaired your judgment or affected your ability to practice medicine? This does not include mild depression or adjustment disorder which was limited in duration.	☐	☐
15.	Are you currently experiencing any medical condition or any disorder that limits or impairs your judgment or that affects your ability to practice medicine in a safe and competent manner?	☐	☐
16.	Are you now or have you ever been required by any federal or state law to register as a sex offender?	☐	☐

O. 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 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).

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 ▶

P. 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		

PHOTO

Q. RECOMMENDATION OF MORAL, ETHICAL AND PROFESSIONAL CONDUCT

To be completed by the Chief Executive Officer, Superintendent, Chief of Staff, Program Director or Director of Medical Education in the hospital where applicant desires employment.

By completing and signing this section, I recommend this applicant for temporary licensure and agree to supervise him/her in accordance with the Board's Rule 20 CSR 2150-2.060(7).

PRINT NAME	TITLE	
Eve Robb Medlock	Director of Graduate Medical Education	
SIGNATURE	DATE	TELEPHONE NUMBER
		816/235-1742

TEMPORARY LICENSURE DEPT.
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

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 AMA or AOA approved training program the applicant has been in or is currently enrolled.

Please provide **all** of the information requested on this 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 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 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.

APPLICANT SIGNATURE

PROGRAM DIRECTOR

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

THE PHYSICIAN SATISFACTORILY COMPLETED _____ MONTHS OF TRAINING HERE. (PLEASE FILL IN BLANK)

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 PROVIDE COMPLETE 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, 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

▶

THIS FORM MAY BE SENT ELECTRONICALLY TO THE HOSPITAL,
BUT THE ORIGINAL COMPLETED FORM MUST BE MAILED DIRECTLY TO THE BOARD OFFICE

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

TEMPORARY LICENSURE VERIFICATION

AUTHORIZATION AND REQUEST PLEASE TYPE OR PRINT FORM IN **BLACK** INK.

APPLICANT NAME (PLEASE PRINT)	STATE, TERRITORY OR INTERNATIONAL COUNTRY OF:

I, THE ABOVE NAMED APPLICANT, HEREBY AUTHORIZE AND REQUEST THE STATE BOARD NAMED ABOVE HAVING CONTROL OF ANY DOCUMENTS, RECORDS AND OTHER INFORMATION PERTAINING TO ME, TO FURNISH TO THE MISSOURI STATE BOARD OF 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	DATE

VERIFICATION - TO BE COMPLETED BY STATE LICENSING BOARD OFFICIALS

LICENSE NUMBER	ISSUE DATE	EXPIRATION DATE	LICENSE METHOD
			☐ STATE BOARD EXAM ☐ FLEX EXAM ☐ RECIPROCITY ☐ NATIONAL BOARD ENDORSEMENT ☐ OTHER (SPECIFY) ☐ USMLE ☐ LMCC

HAS DISCIPLINARY ACTION BEEN TAKEN AGAINST THE LICENSE? ☐ YES ☐ NO
IF YES, PLEASE PROVIDE COMPLETE DETAILS AND SEND COPIES OF ALL PERTINENT DOCUMENTATION.

▶ _____

_____

_____

HAVE ANY COMPLAINTS OR CHARGES BEEN FILED, FORMAL OR INFORMAL, PENDING OR CLOSED? ☐ YES ☐ NO
IF YES, PLEASE PROVIDE COMPLETE DETAILS AND SEND COPIES OF ALL PERTINENT DOCUMENTATION.

▶ _____

_____

_____

_____

STATE SEAL	STATE BOARD
	DATE
	STATE BOARD ADMINISTRATOR

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

TEMPORARY HOSPITAL AFFILIATION VERIFICATION

NAME OF APPLICANT (PLEASE PRINT FULL NAME)	DATE

HOSPITAL NAME

HOSPITAL ADDRESS (STREET, CITY, STATE & ZIP CODE)

DATE 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 be notarized or have the hospital seal affixed.

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 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

SIGNATURE OF HOSPITAL ADMINISTRATOR/REPRESENTATIVE	TELEPHONE NUMBER
▶	

* VERIFICATION PURPOSES ONLY

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

ORIGINAL DOCUMENTS

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 form 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	NOTARIZED COPIES ENCLOSED (✓) NO	NO. OF PAGES

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

COPIES MUST ACCOMPANY ALL ORIGINALS.

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		