ECONOMIC AFFAIRS IC
JUNE 11, 2012
EXHIBIT 17

Montana Board of Medical Examiners
P.O. Box 200513 (301 S. Park, 4th Floor - Delivery) Helena, Montana 59620-0513
(406) 841-2361 or (406) 841-2364 FAX (406) 841-2305
EMAIL: dlibsdmed@mt.gov **WEBSITE:** www.medicalboard.mt.gov

PHYSICIAN APPLICATION FOR LICENSURE

Please review the Instructions section carefully before you begin filling out any part of this application or its supporting forms. All forms are interactive and can be filled out on your computer prior to you printing and submitting these forms to the Board office or other entity.

TABLE OF CONTENTS:

Page 2 Instructions
Page 4 Application Form
Page 11 Form #1: Verification of Licensure
Page 12 Form #2: Certification of Medical Education
Page 15 Form #3: Postgraduate Training Verification
Page 17 Form #4: Fifth Pathway Verification
Page 18 Form #5: DEA Query
Page 19 Form #6: Character Reference Form
Page 20 Form #7: ECFMG Verification

MONTANA BOARD OF MEDICAL EXAMINERS

P. O. Box 200513 (301 S Park, 4 TH Floor - Delivery) Helena, Montana 59620-0513
(406) 841-2361 or (406) 841-2364 FAX (406) 841-2305
EMAIL: dlibsdmed@mt.gov **WEBSITE:** www.medicalboard.mt.gov

ILLEGIBLE AND INCOMPLETE APPLICATIONS WILL BE RETURNED.
(Please allow 30 days for processing from the date that the Board has a complete routine application).

Physicians are not permitted to practice medicine in Montana in any manner without an active Montana license.

LICENSING REQUIREMENTS:

- Must be a graduate of a medical school approved by the American Osteopathic Association (AOA) or the Council for Medical Education of the American Medical Association (AMA).
- U.S. graduates must have successfully completed an approved program in the United States or Canada (For Montana Family Residency Program, see Board Statute 37-3-305(4), MCA).
- Foreign graduates must complete at least 3 years post-graduate training in an approved program in the United States or Canada or been granted board certification by a specialty board which is approved by AMA or AOA.
- Foreign graduates must provide a certificate from the Educational Council for Foreign Medical Graduates (ECFMG, www.ecfmg.org) and from the Fifth Pathway Program, if applicable.
- Must have passed a licensing exam, approved by the Board, with a score of at least 75% on all portions of the examination. Please refer to the Board statutes and rules (ARM 24.156.606) for specific information regarding examination information and limits on attempts.
- Must be of good moral character.

FEES: **$325.00** - Application Fee Make payable to Montana Board of Medical Examiners

APPLICATION PROCESSING PROCEDURES:

- When the application file is complete, it will be processed and considered by Board staff for licensure. The applicant may be notified if additional information is required or if required to appear before the Board for an interview. Once a routine application is complete, the application may take up to 30 days to process.
- You will be notified by mail when the application has been successfully processed and you have been licensed to practice medicine in Montana.
- Applicant will be notified in writing of any deficient or missing items from the application file.
- If the application is considered a non-routine application, there will be a delay in processing of the application. You may be requested to provide additional information or make a personal appearance before the Board during a regularly scheduled Board meeting and/or the application may require Board consideration. You will be notified in writing if you are required to appear before the Board. Non-routine applications may take up to 120 days to process. We will make best effort to process non-routine applications as quickly as possible.
- Keep the Board office informed at all times of any address changes, changes in license status and complaints or proposed disciplinary action. This is essential for timely processing of applications and subsequent licensure.

PLEASE BE SURE TO REVIEW THE MONTANA LAWS AND RULES FOR THE PRACTICE OF MEDICINE ON OUR WEBSITE: www.medicalboard.mt.gov

DOCUMENTS TO SUBMIT FOR AN APPLICATION TO BE COMPLETE:

The Board accepts documents from FCVS (Federation Credentials Verification Service).

All Applicants

Certification of Medical Education

Postgraduate Training Verification

Recent DEA Query Form

DD214, Military Discharge Paper (if applicable)

Recent National Practitioner Databank (NPDB) self-query (letter unopened)http://www.npdb-hipdb.hrsa.gov/

Current Verification from all State Licensing Boards

Examination Scores

3 Character References

Passport size photograph

Foreign Graduates Must Also Supply

E.C.F.M.G. Certificate www.ecfmg.org

Fifth Pathway Verification, if applicable

- **Certificate of Medical Education**. Complete the top portion of form and send to each medical school. The bottom portion of the form must be completed by school officials and sent directly back to the Board office.
- **Postgraduate Training Verification.** Complete Section 1 of form and send it to each postgraduate training program. The Program Director or designated official will complete Section 2 and return the form directly to the Board office.
- **DEA Query Form**. Complete top of form and send to DEA at address indicated on form. The DEA will complete the form and mail to Board office. There is no fee required.
- **National Practitioner Data Bank (NPDB) self-query**. This form can be obtained by calling NPDB at 800-767-6732 or online at http://www.npdb-hipdb.hrsa.gov/ . This form must be mailed directly to the address indicated in the instructions. The results will come to you. Do not open the envelope, but forward the unopened envelope directly to the Board office.
- **Verification of Licensure.** Complete the top portion of this form and forward it to all states or provinces in which you hold or have ever held any health care license or certification. The verifying entity will forward all documents directly to the Board office. Many states participate in VeriDoc, an online medical license verification service at www.veridoc.org.
- **Exam Scores**: Forms can be obtained from the National Board of Medical Examiners at www.nbme.org, the Federation of State Medical Boards at www.fsmb.org for USMLE or FLEX scores, or National Board of Osteopathic Medical Examiners at (773)-714-0622 or www.nbome.org. Please use the appropriate from to request exam scores and send directly to the Board office. For all other exams, contact the testing entity for your scores.
- **Character Reference Form.** Complete the top portion of this form and send it to each of the character references listed on your application. Each individual will complete the form and mail it directly to the Board office.
- **Passport sized photograph:** attach where indicated on the application form.

Foreign graduates must also submit one of the following:

- **Request for Status Report of ECFMG Certification**. Submit the form to ECFMG with the required fee. The results will be mailed directly to the Board office.
- **Fifth Pathway Verification.** Complete Section 1 and send the form to the Program Director of your Fifth Pathway Program. The Director or designated official will complete the form and mail it directly to the Board office.

NOTE: ALL DOCUMENTS NOT IN ENGLISH MUST BE ACCOMPANIED BY CERTIFIED TRANSLATIONS

For information with regard to the processing of this application or other concerns, please contact the Board of Medical Examiners staff at (406) 841-2361 or (406) 841-2364, or by emailing us at dlibsdmed@mt.gov.

MONTANA BOARD OF MEDICAL EXAMINERS
P. O. Box 200513 (301 S Park, 4 TH Floor - Delivery)
Helena, Montana 59620-0513
(406) 841-2361 or (406) 841-2364 FAX (406) 841-2305
EMAIL: dlibsdmed@mt.gov **WEBSITE:** www.medicalboard.mt.gov

AFFIX PHOTO HERE PASSPORT SIZE

Application for Licensure as:

☐ **Medical Doctor** ☐ **Doctor of Osteopathy**

Allow 30 days from the date the Board has a Complete routine application for licensure.

1. FULL NAME: _____
   Last First Middle
2. OTHER NAMES KNOWN BY: _____
3. BUSINESS NAME: _____
4. BUSINESS ADDRESS: _____
   Street or PO Box # City and State Zip Country
5. HOME ADDRESS: _____
   Street or PO Box # City and State Zip Country

PREFERRED MAILING ADDRESS:
☐ Home ☐ Business EMAIL ADDRESS: _____

6. TELEPHONE: _____ HOME _____ FAX _____
   Business
7. SOCIAL SECURITY NUMBER: _____ FOREIGN ID NUMBER: _____
8. DATE OF BIRTH: _____ ☐ MALE ☐ FEMALE

   PLACE OF BIRTH: _____
9. LICENSE NAME: _____
   (State your name as it should appear on the license if granted.)
10. If you are a foreign medical graduate, have you satisfied the requirements of the Education Council for Foreign Medical Graduates (ECFMG)?

    Certificate Number: _____ Issue Date (MM/DD/YY) _____ Valid Through (MM/DD/YY) _____
11. Do you intend to practice in the State of Montana? If yes, attach a brief explanation. ☐ YES ☐ NO
12. Have you ever previously applied for a license to practice in Montana? If yes, give date, and results. ☐ YES ☐ NO
13. Have you ever been denied licensure or the opportunity to take this profession's licensing examination in any state or country? If yes, attach a detailed explanation. ☐ YES ☐ NO

14. List all professional licenses you hold or **ever** have held. Verification must be sent directly to Montana from each state/province/territory. Use additional paper if needed.

Type	State	License #	Issue Date	Expiration Date	Status	License Method	Requested State Verification
						☐ Exam ☐ Endorse ☐ Other _____	☐ Yes ☐ No
						☐ Exam ☐ Endorse ☐ Other _____	☐ Yes ☐ No
						☐ Exam ☐ Endorse ☐ Other _____	☐ Yes ☐ No

15. Have you ever had an application for a professional or occupational license refused or denied? If yes, please attach a detailed explanation and provide supporting documentation from the source. ☐ YES ☐ NO

16. Have you ever withdrawn an application for licensure prior to the licensing agency's decision regarding your application? If yes, please attach a detailed explanation and provide supporting documentation from the source. ☐ YES ☐ NO

17. Have you ever been denied the privilege of taking an examination required for any professional or occupational license? If yes, please attach a detailed explanation and provide supporting documentation from the source. ☐ YES ☐ NO

18. Have you ever withdrawn or been suspended, placed on probation, expelled or requested to resign from any postsecondary educational program? If yes, please attach a detailed explanation and provide supporting documentation from the source. ☐ YES ☐ NO

19. Have you ever requested temporary or permanent leave of absence, been placed on probation, restricted, suspended, revoked, allowed to resign, or otherwise acted against by any professional or occupational education program (i.e., residency, internship, apprenticeship, etc)? If yes, please attach a detailed explanation and provide supporting documentation from the source. ☐ YES ☐ NO

20. Has a licensing agency initiated or completed disciplinary action against any professional or occupational license you have held? If yes, please provide agency documents including the complaint, initiating documents, orders, final orders, stipulations and consent and/or settlement agreements directly from the source. ☐ YES ☐ NO

21. Have you ever voluntarily surrendered, cancelled, forfeited, failed to renew a professional or occupation license in anticipation of or during an investigation or disciplinary proceeding or action? If yes, please attach a detailed explanation and provide supporting documentation from the source. ☐ YES ☐ NO

22. Has a complaint ever been made against you with a professional or occupational licensing agency? If yes, please attach a detailed explanation and provide supporting documentation from the source. ☐ YES ☐ NO

23. Have you ever been the subject of any sanction or action, denial, suspension, revocation, restriction or termination regarding hospital, facility or staff privileges; health maintenance organization participation, third party provider or Medicare /Medicaid participation; or any other privileges? If yes, please attach a detailed explanation and provide supporting documentation from the source. ☐ YES ☐ NO

24. Have you ever been censured, expelled, denied membership or asked to resign from a professional organization related to your profession or occupation? If yes, please attach a detailed explanation and provide documentation from the source. ☐ YES ☐ NO

25. Have you ever been the subject of any sanction or action, denial, suspension, revocation, restriction or termination regarding your ability to prescribe, dispense or administer drugs including controlled substances? If yes, please attach a detailed explanation and provide documentation from the source. ☐ YES ☐ NO

26. Do you have any initiated or completed action against you by any state, federal, tribal, or foreign licensing jurisdiction? (For example: Drug Enforcement Agency; Alcohol, Tobacco and Firearms; Homeland Security; Indian Health Service, etc) If yes, please attach a detailed explanation and provide documentation from the source. ☐ YES ☐ NO

27. Have any civil legal proceedings been filed against you by a (patient/client), (former patient/client) or employer/employee? If yes, attach a detailed explanation and documentation from the source including initiating document(s) and documentation of final disposition. This includes malpractice claims, settlements, and judgements. This does not include filings with the Montana Legal Panel. ☐ YES ☐ NO

28. Do you have any criminal charges pending or have you ever pled guilty, forfeited bond, or been convicted of a crime (whether or not sentence was suspended or deferred), or have you pled no contest or had prosecution deferred whether or not an appeal is pending? If yes, attach a detailed explanation and documentation from the source. You must report but may omit documentation for: (1) misdemeanor traffic violations resulting in fines of less than $100; and (2) charges or convictions prior to your 18th birthday unless you were tried as an adult. ☐ YES ☐ NO

29. Have you ever been diagnosed with chemical dependency or another addiction, or have you participated in a chemical dependency or other addiction treatment program? If yes, please attach a detailed explanation and provide documentation regarding evaluations, diagnosis, treatment recommendations and monitoring from the source. ☐ YES ☐ NO

30. Have you ever been diagnosed with a physical condition or mental health disorder involving potential health risk to the public? If yes, please provide a detailed explanation. ☐ YES ☐ NO

31. Have you ever served in any branch of the armed forces? If yes, attach a DD214, Military Discharge paper, if you have been discharged. ☐ YES ☐ NO

32. Have you ever been court-martialled or discharged other than honorably from any branch of the armed service? If yes, attach a detailed explanation and documentation for the source. ☐ YES ☐ NO

33. Have you any physical or mental condition(s) which may have or has adversely affected your ability to practice this profession, including but not limited to a contagious or infectious disease involving risk to the public? If yes, attach a detailed explanation. ☐ YES ☐ NO

34. Have you used alcohol or any other mood-altering substance in a manner which may have or has adversely affected your ability to practice this profession? If yes, attach a detailed explanation. ☐ YES ☐ NO

35. **Undergraduate Education:** List all pre-medical schools you have attended, even those from which you did not graduate, in chronological order. Attach additional sheets if needed. Note that you do NOT need to submit transcripts or verification forms from these schools.

Name of University or College	City and State/Province/Territory	Dates Attended (MM/YYYY)	Degree Earned

36. **Medical School:** List all medical schools you have attended, even those from which you did not graduate, in chronological order. Attach additional sheets if needed. You must complete the "Medical Education Verification" form and send it to all medical schools you have attended. You must include a copy of your diploma to which the medical school must attach their seal prior to forwarding it to this Board. The medical schools must forward all documentation directly to this Board.

Name of Medical School	City and State/Province/Territory	Dates Attended (MM/YYYY)	Degree Earned

37. Postgraduate Training: List all postgraduate programs you have attended, even those you did not complete. This includes internship programs, residency programs and fellowships. Attach additional sheets if needed. You must complete the "Postgraduate Training Verification" form and send it to all postgraduate training programs you have attended. You must submit a copy of your certificate of program completion to this Board. The postgraduate program must forward all documentation directly to this Board.

Name of Program	City and State/ Province/Territory	PGY	Department/ Specialty	Dates Attended (MM/YYYY)	Certificate Received?
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

38. **Fifth Pathway:** If you attended a Fifth Pathway program, you must complete the "Fifth Pathway Verification Form" and send it to your medical school and to the institution where you completed your rotations. You must include a copy of your diploma. The medical school or institution must forward all documentation directly to this Board

Name and Address of the Affiliated Medical School That Awarded the Fifth Pathway Certificate	Attendance Dates From (MM/YYYY)	To (MM/YYYY)	Date Degree/ Certificate Issued	Degree Received

Name and Address of the Hospital or Clinic Which You Performed the Required Rotations	Attendance Dates From (MM/YYYY)	To (MM/YYYY)	Certificate Date (MM/DD/YYYY)

39. Which exam did you take for initial licensure?

☐ National Boards ☐ FLEX ☐ USMLE ☐ LMCC

☐ State Exam (indicate state) _____

Most recent test Date _____ ☐ Pass ☐ Fail

Number of attempts _____

40. Have you ever been certified by a Specialty Board?

Certifying Agency	Specialty	Date Awarded, Re-Certified

Have you ever been denied specialty certification or failed to pass a specialty certification examination or portion thereof? ☐ YES ☐ NO

By whom? _____

Reason for denial? _____ Number of times failed _____

41. **Practice History:** List **ALL** activities after medical school (other than those already set forth above) in chronological order, up to and including the present, indicating **Month and Year** for each activity. **Account for all periods of time longer than 1 month**. Specify nature of activity; for example, private practice, hospital practice, vacation, school, private employment, etc. For any non-working time, you must state exactly what your activities were, such as "vacation" or "seeking employment" as well as your permanent address during that time. If you are listing a medical practice, indicate the nature of the practice and the percentage of working time spent in clinical and administrative duties. If you worked for a physician staffing group or did locum tenens, you must list all facilities where you worked and include complete dates and addresses. **DO NOT SUBSTITUTE ANY OTHER RESUME FORMAT FOR THIS SECTION.** Use additional paper if necessary.

Start (MM/ YYYY)	End (MM/ YYYY)	Type of Activity/ Position	Name and Address of Practice	Position/ Department	Percentage of Time Spent (total = 100%)		Reason For Leaving
					Clinical	Administrative	

42. **Professional and Character References.** Please type or print names and addresses of three references (must be MD or DO), who have known you or associated with you for a minimum of one year.

Name	
Address	
Telephone Number	

Name	
Address	
Telephone Number	

Name	
Address	
Telephone Number	

DECLARATION

I authorize the release of information concerning my education, training, record, character, license history and competence to practice, by anyone who might possess such information, to the Montana Board of Medical Examiners.

I hereby declare under penalty of perjury the information included in my application to be true and complete to the best of my knowledge. In signing this application, I am aware that a false statement or evasive answer to any question may lead to denial of my application or subsequent revocation of licensure on ethical grounds. I have read and will abide by the current licensure statutes and rules of the State of Montana governing the profession. I will abide by the current laws and rules that govern my practice.

Signature of Applicant

Date

Montana Board of Medical Examiners
P.O. Box 200513 (301 S. Park, 4th Floor - Delivery)
Helena, Montana 59620-0513
(406) 841-2361 or (406) 841-2364 FAX (406) 841-2305
EMAIL: dlibsdmed@mt.gov **WEBSITE:** www.medicalboard.mt.gov

VERIFICATION OF LICENSURE

Applicant Instructions: Complete Section 1 of this form and send this form to each state board in which you are now or have ever been licensed to practice as a physician. You may copy this form as many times as needed. Some boards require a fee for this service. Request the state board complete Section 2 of this form and return the form directly to this Board.

STATE BOARD: _____

Section 1: Applicant Information

I am applying for a license to practice medicine in the State of Montana and the Board of Medical Examiners requires this form to be completed by each state wherein I hold or have ever held a professional/occupational license. This is your authority to release any information in your files, favorable or otherwise, **DIRECTLY** to the **BOARD OF MEDICAL EXAMINERS, PO BOX 200513, HELENA, MT 59620-0513.** Your early response is appreciated.

_____ _____
(Signature) Name (Please Print)

Address _____ My License Number is _____

Section 2: To be completed by State Licensing Board or Canadian Province

Name of Licensee: _____
Last First Middle Suffix

License Type: _____ License #: _____ Issue Date: _____ Expiration Date _____

Is this license current? ☐ Yes ☐ No If no, please explain: _____

☐ Cannot answer under state law

1. Have formal disciplinary proceedings been initiated against the applicant's license by a disciplinary authority in your state? ☐ Yes ☐ No

   If yes, please explain and attach documentation: _____

2. Has the applicant ever been warned, censured, placed on probation, formal consent, reprimand or in any other manner disciplined; or has the applicant's license ever been revoked, suspended or, in any other manner, limited by a licensing or disciplinary authority in your state? ☐ Yes ☐ No
   If yes, please explain and attach documentation: _____ ☐ Cannot answer under state law

3. Has licensee ever been requested to appear before your Board? ☐ Yes ☐ No
   If yes, explain:

   _____

Other comments: _____

AFFIX BOARD SEAL HERE

Board Authorized Signature: _____

Printed Name: _____

Title: _____

Date: _____

Montana Board of Medical Examiners
P.O. Box 200513 (301 S. Park, 4th Floor - Delivery)
Helena, Montana 59620-0513
(406) 841-2361 or (406) 841-2364 FAX (406) 841-2305
EMAIL: dlibsdmed@mt.gov **WEBSITE:** www.medicalboard.mt.gov

CERTIFICATION OF MEDICAL EDUCATION

Applicant Instructions: Complete Section 1 of this form, then send this form to each medical school you attended. Request the Dean or designated official to complete Section 2 of this form and return the form directly to this Board.

Section 1: Applicant Information:

Last Name: _____ Suffix: _____

First Name: _____ Middle Name: _____

Name if different when diploma awarded: _____

Social Security Number: _____ Date of Birth: _____

The applicant's social security number is to be used for purposes of identification any may not be used for any other reason.

Waiver for release of information: I authorize the medical school below to provide any and all information pertaining to my medical education at your institution to the below listed Medical Board.

Applicant's Signature _____ Date: _____

Section 2: Medical School Verification

Instructions to the Dean or designated official of medical school: Please complete Section 2 of this form and forward directly to this Board at the following address:

Montana Board of Medical Examiners
PO Box 200513
Helena, MT 59620-0513

Medical School Name: _____

School name if different when the above applicant attended: _____

Medical School Address: _____
Street City State/Province Zip

Hours of undergraduate education required for admission into your school: _____

Applicant's Attendance Dates: From: _____ To: _____

Graduate Date: _____ Degree: _____
(Indicate N/A if not applicable)

Total weeks of education applicant attended at your school: _____

Certification of Medical Education, page 2 of 3

Applicant Name: _____ Date: _____

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the individual's medical education. Please check the appropriate response and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation. Attach additional pages as necessary.

1. Does this individual's official record reflect (an) interruption(s) or extension(s) in his/her medical education?
☐ Yes ☐ No If YES, please select the reason(s) for, indicate the dates of the interruption(s) or extension(s) and check whether the interruption/extension was approved or unapproved.

Reason	From (MM/YYYY)	TO (MM/YYYY)	Approved	Unapproved
Personal/Family			☐	☐
Academic Remediation			☐	☐
Health			☐	☐
Financial			☐	☐
Participation in joint degree program (e.g., MD/PhD)			☐	☐
Participation in non-research special study (e.g., fellowship, international experience)			☐	☐
Participation in non-degree research			☐	☐
Other (Please specify below)			☐	☐

_____

2. Does this individual's official record reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education?
☐ Yes ☐ No If YES, please select the reason(s) for the probation, indicate the date(s) of placement on and removal from probation and attach additional documentation to this report.

	Reason	From (MM/YYYY)	To (MM/YYYY)
☐	Academic Probation		
☐	Probation for unprofessional conduct/behavioral reasons		
☐	Probation for other reason		

Please specify reason: _____

Explanation: _____

3. Does this individual's official record reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university?
☐ Yes ☐ No If YES, please provide detailed documentation/information about the circumstances and outcome(s): _____

_____

Certification of Medical Education, page 3 of 3

Applicant Name: _____ Date: _____

4. Does this individual's official record reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical school or parent university?
☐ Yes ☐ No If YES, please provide detailed documentation/information about the circumstances and outcome(s): _____

_____

5. Does this individual's official record reflect that there were ever any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason?
☐ Yes ☐ No If YES, please provide detailed documentation/information about the circumstances and outcome(s): _____

_____

I certify that to the best of my knowledge and belief the foregoing is a true, accurate and complete statement of the record of the individual named on this form.

AFFIX INSTITUTIONAL SEAL HERE

(if no seal is available, this form must be notarized)

Signature: _____

Print Name: _____

Title: _____

Date: _____

Phone Number: _____

Fax Number: _____

E-mail: _____

Montana Board of Medical Examiners

P.O. Box 200513 (301 S. Park, 4th Floor - Delivery)
Helena, Montana 59620-0513
(406) 841-2361 or (406) 841-2364 FAX (406) 841-2305
EMAIL: dlibsdmed@mt.gov **WEBSITE:** www.medicalboard.mt.gov

POSTGRADUATE TRAINING VERIFICATION

Applicant Instructions: Complete Section 1 of this form, then send this form to each training program in which you participated (make as many copies of this form as you need). Request the Program Director or designated official to complete Section 2 of this form and return the form directly to this Board.

Section 1: Applicant Information

Last Name: _____ Suffix: _____

First Name: _____ Middle Name: _____

Name if different when diploma awarded: _____

Social Security Number: _____ Date of Birth: _____

The applicant's social security number is to be used for purposes of identification any may not be used for any other reason.

Waiver for release of information: I authorize the Postgraduate Training Program below to provide any and all information pertaining to my medical education at your institution to the below listed Medical Board.

Applicant's Signature _____ Date: _____

Section 2: Postgraduate Training Verification

Instructions to the Program Director or designated official of Postgraduate Training Program: Please complete Section 2 of this form and forward directly to this Board at the following address:

Montana Board of Medical Examiners
PO Box 200513
Helena, MT 59620-0513

Institution Name: _____

Institution Address: _____
Street City State/Province Zip

Affiliated Medical School Name: _____

Program Type/Specialty: _____ Postgraduate Year: _____

☐ Internship ☐ Residency ☐ Fellowship ☐ Research ☐ Chief Resident

Other: _____

From Date (MM/DD/YYYY) _____ To Date (MM/DD/YYYY) _____

Successfully Completed? ☐ Yes ☐ No ☐ In Progress (The definition of Successfully Completed is: In each year of training, did the applicant demonstrate sufficient academic and clinical ability to qualify for advancement without conditional or probationary status to the next year and next progressive level of responsibility in a designated specialty program?)

Postgraduate Training Verification, Page 2 of 2

Applicant Name: _____ Date: _____

Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ None of these

Unusual Circumstances:

Did this individual ever take a leave of absence or break from his/her training?	☐ Yes	☐ No
Was this individual ever placed on probation?	☐ Yes	☐ No
Was this individual ever disciplined or place under investigation?	☐ Yes	☐ No
Were any negative reports for behavioral reasons ever filed by instructors?	☐ Yes	☐ No
Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason?	☐ Yes	☐ No

Please explain any "Yes" responses from above (attach additional pages if necessary):

_____

_____

_____

I certify that to the best of my knowledge and belief the foregoing is a true, accurate and complete statement of the record of the individual named on this form.

AFFIX INSTITUTIONAL SEAL HERE.

(if no seal is available, this form must be notarized)

Signature: _____

Print Name: _____

Title: _____

Date: _____

Phone Number: _____

Fax Number: _____

E-mail: _____

Montana Board of Medical Examiners
P.O. Box 200513 (301 S. Park, 4th Floor - Delivery)
Helena, Montana 59620-0513
(406) 841-2361 or (406) 841-2364 FAX (406) 841-2305
EMAIL: dlibsdmed@mt.gov **WEBSITE:** www.medicalboard.mt.gov

FIFTH PATHWAY VERIFICATION

Applicant Instructions: Complete Section 1 of this form, then send this form to the director of your Fifth Pathway Program. Request the Program Director or designated official to complete Section 2 of this form and return the form directly to this Board.

Section 1: Applicant Information

Last Name: _____ Suffix: _____

First Name: _____ Middle Name: _____

Name if different when diploma awarded: _____

Social Security Number: _____ Date of Birth: _____

The applicant's social security number is to be used for purposes of identification any may not be used for any other reason.

Waiver for release of information: I authorize the Postgraduate Training Program below to provide any and all information pertaining to my medical education at your institution to the below listed Medical Board.
Applicant's Signature _____ Date: _____

Section 2: Medical School Verification

Instructions to the Program Director or designated official: Please complete Section 2 of this form and forward directly to this Board at the following address:

Montana Board of Medical Examiners
PO Box 200513
Helena, MT 59620-0513

Medical School Name: _____

School name if different when the above applicant attended: _____

Applicant's Attendance Dates: From: _____ To: _____ Program Completion Date: _____
(Indicate N/A if not applicable)

I certify that to the best of my knowledge and belief the foregoing is a true, accurate and complete statement of the record of the individual named on this form.

Signature: _____

Print Name: _____

AFFIX INSTITUTIONAL SEAL HERE

Title: _____

Date: _____

(if no seal is available, this form must be notarized)

Phone Number: _____

Fax Number: _____

E-mail: _____

Montana Board of Medical Examiners
P.O. Box 200513 (301 S. Park, 4th Floor - Delivery)
Helena, Montana 59620-0513
(406) 841-2361 or (406) 841-2364 FAX (406) 841-2305
EMAIL: dlibsdmed@mt.gov **WEBSITE:** www.medicalboard.mt.gov

DEA QUERY FORM

Applicant Instructions: Please complete the identifying information below and submit to:

DEA SALT LAKE CITY DO
DIVERSION GROUP
ATTN: WENDY A. COREY, RPS
348 E S TEMPLE
SALT LAKE CITY, UT 84111-1202

If you do not have a DEA Registration Number, please note that below. You will still need to submit this form to the DEA office.

Date: _____

To Whom It May Concern:

I am applying for a license to practice medicine in the State of Montana. Please indicate on the side portion of this form if there is any derogatory information on file against me. I hereby specifically authorize the release of any and all information concerning me, and agree to hold the DEA harmless from any liability for the disclosure of such information. Please send this form directly to the Montana Board of Medical Examiners. Thank you for your assistance.

DEA Use Only:

Name: _____

Date of Birth: _____

Social Security Number: _____

DEA Registration Number: _____

Address where DEA Number is registered:

_____

_____

_____

_____
Legal Signature of Applicant

_____
Printed Name of Applicant

MONTANA BOARD OF MEDICAL EXAMINERS
P. O. Box 200513 (301 S PARK, 4 TH FLOOR - Delivery)
Helena, Montana 59620-0513
(406) 841-2361 or (406) 841-2364 FAX (406) 841-2305
EMAIL: dlibsdmed@mt.gov **WEBSITE:** www.medicalboard.mt.gov

CHARACTER REFERENCE FORM

Applicant Instructions: Complete the upper portion of this form and mail to each of the character references you have listed in your application.

_____ _____
Legal Signature of Applicant Date

(Please Type or Print)
Name of Applicant: _____

Address: _____

This verification sent to: _____

Character Reference Instructions: Please answer the following questions concerning the applicant's moral and professional character. This document is your authorization to release any and all information and opinions you have, favorable or otherwise, directly to the Montana Board of Medical Examiners.
Your response will be kept confidential.

Name of reference: _____ Daytime phone: _____

Address: _____

Title/profession/position: _____

How long have you known the applicant? _____ (Yr/Mo) In what capacity? _____

1. To your knowledge, does the applicant have any habits or practices that would adversely affect his/her professional activities? If your answer is "yes", please explain:

2. Do you consider this applicant worthy of approval to practice as a physician in Montana?

3. Please comment on the applicant's professional character, morals and ethics (attach additional sheet as needed):

_____ _____
Signature of Reference Date

The Applicant and the Board thank you for your assistance.

ECFMG® | Request for Status Report of ECFMG Certification Form 282A-SB

Reports will be sent directly to the STATE MEDICAL BOARD.

To confirm ECFMG certification status for an international medical graduate, please complete and return this form to:

ECFMG *Certification Verification Service*
PO Box 48083
Newark, NJ 07101-4883

Please type or print.
Requests with incomplete or inaccurate information will not be processed.

USMLE®/ECFMG Identification Number: 0 - ☐☐☐-☐☐☐-☐

Physician's Name: _____
First Middle Last Name/Surname/Family Name

Date of Birth: _____ / _____ / _____
Day **Month** Year

Name of State Medical Board that Status Report should be sent to:

_____

State Board Contact: _____ _____
(if applicable) Name Title

Telephone Number (with Area Code) _____ - _____

☐ **Payment Form 900 is enclosed.**

Checks should be made payable to ECFMG in U.S. dollars. Status Reports will be mailed directly to the State Medical Board indicated above. Requests without payment attached will not be processed.

Note: Requesting organizations must normally secure and retain the physician's signed authorization to obtain certification information. Organizations may not resell the ECFMG certification information or make it available to any party beyond this request as authorized by the physician. The information may only be used to confirm ECFMG Certification for the purpose for which the physician provided authorization.

Physicians who are ECFMG certified have passed the requisite examinations and have had their medical education credentials verified by ECFMG. ECFMG Certification is a prerequisite for entry into ACGME-accredited residency or fellowship programs in the United States; is required for licensure to practice medicine in the United States; and is one of the eligibility requirements to take USMLE Step 3.

This form is available on the ECFMG web site at www.ecfmg.org

Montana Medical Board Form #7