LARA/LMD-505 (05/11)

Michigan Department of Licensing and Regulatory Affairs
Board of Medicine
P.O. Box 30192
Lansing, Michigan 48909
(517) 335-0918
www.michigan.gov/healthlicense

MEDICAL CLINICAL ACADEMIC LIMITED LICENSURE INSTRUCTIONS

Authority: P.A. 368 of 1978, as amended
This form is for information only.

NOTE: It is your responsibility to have all required documentation sent to the Board of Medicine. Questions regarding your application can be directed to the Michigan Board of Medicine at (517) 335-0918 three weeks after the date you sent the application. Please allow 6-8 weeks processing time. Applications submitted without the required licensing fee, applicant's signature and date will be returned.

THE FOLLOWING MUST BE RECEIVED IN THE BOARD OFFICE:

1. A completed application and a check or money order, drawn on a U.S. financial institution(made payable to the **STATE OF MICHIGAN**, for the appropriate amount. An application accompanied by the appropriate fee is valid for two years. If an applicant fails to complete the requirements for licensure within two years from the date of filing the application, the application is no longer valid.

2. **Effective October 1, 2008**, all applicants for a health profession license or registration in Michigan are required to submit fingerprints and undergo a criminal background check. Please see the attached instructions. The Michigan Board is not able to accept fingerprints that have been obtained for any other purpose. Your license or registration will not be issued until this process is complete.

3. Certification of medical education submitted directly from the medical school to the board on the attached form.

4. The Certification of Appointment to a Michigan Academic Institution form (attached), certifying a teaching or research appointment to a Michigan academic institution as defined in Section 17001 of Public Act 368 of 1978, as amended, must be completed and submitted directly to the Board by the Director of Medical Education of the appointing institution.

5. Verification of licensure from any state where you hold or have ever held a permanent M.D. license. A form is enclosed for this purpose and may be copied as needed. As most states charge a fee for this service, you should contact each state board to determine if a fee is required prior to sending them the form for completion. The Verification of Licensure form must be sent to the Michigan Board directly from the state(s) where you are or have been licensed.

If you intend to apply for full licensure under Section 17031(1) of the Michigan Public Health Code, you will also need to submit:

5. Certification of all postgraduate training, completed on the enclosed form, and submitted directly to the board by the Director of Medical Education of the hospital(s) in which the training was completed.

GENERAL INFORMATION

1. NAME AND/OR ADDRESS CHANGES: If your name and/or address changes please notify the Board of Medicine in writing. To change a name or address, you can download the Data Change/Duplicate License Request Form from our website www.michigan.gov/healthlicense and fax it to (517) 373-2179 or mail the form to Bureau of Health Professions, PO Box 30670, Lansing, MI 48909. Telephone calls are NOT accepted for these changes.

2. REFUND POLICY: If you wish to withdraw your application, you may be eligible for a partial refund. You must notify the Board of Medicine in writing to request a refund.

3. **NOTE:** If you have ever been licensed in another state and you have a current disciplinary sanction on that license, (even if the license is inactive), you are **not** eligible for licensure in Michigan according to the Public Health Code, PA 368, as amended, Section 333.16174 (2). Sanctions include probation, limitation, suspension, revocation or fine. Upon resolution of the sanction and verification that the license is active with no disciplinary action in effect, you can proceed with the filing of an application for a Michigan license or registration.

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

RICK SNYDER
GOVERNOR

STEVEN H HILFINGER
DIRECTOR

CRIMINAL BACKGROUND CHECK
FINGERPRINT REQUEST FORM INSTRUCTIONS- (Michigan locations only)
AGENCY ID NUMBER IS 71734k

Applicants for a Michigan health professional license may have their fingerprints taken by either L-1 Identity Solutions or Cogent Systems. Whether you use L-1 Identity Solutions or Cogent Systems, the Agency ID Number for health professional licensing is 71734k. This ID number MUST be used in order to have your fingerprint report sent to the Bureau of Health Professions. Keep the receipt you receive once your fingerprints are taken.

You must bring the Livescan Fingerprint Request Form (attached) and a driver's license or other state or federal-issued picture identification to your fingerprint appointment. You will also be required to pay a separate fee to the fingerprinting agency when registering for or scheduling your appointment.

When your fingerprints are taken, a technician will perform a scan of your fingerprints and submit the data electronically to the Michigan State Police. If no criminal history is found, the Bureau of Health Professions will be notified. If criminal history information is found, the Michigan State Police will send the record directly to the Bureau of Health Professions for review.

Information about fees and scheduling your fingerprint appointment with L-1 Identity Solutions can be found at www.L1enrollment.com or by calling 1-866-226-2952.

Information about fees and registering to have your fingerprints taken by Cogent Systems can be found at www.cogentid.com/index.htm. Click on Michigan and then select the Cogent MAPS (Michigan Applicant Processing Service) option. If you are using Cogent Systems, the MAPS option must be used for health professional licensing purposes. Cogent Systems can be reached by phone at 1-877-838-4903. E-mail inquiries about using Cogent Systems may be sent to mihelp@cogentsystems.com.

BUREAU OF HEALTH PROFESSIONS
611 W. OTTAWA ST. P.O. BOX 30670 LANSING, MICHIGAN 48909-8170
www.michigan.gov (517) 335-0918

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

RICK SNYDER
GOVERNOR

STEVEN H HILFINGER
DIRECTOR

CRIMINAL BACKGROUND CHECK
FINGERPRINT REQUEST FORM INSTRUCTIONS
(For applicants out of state or out of country)

1. Contact a local law enforcement , governmental, or private fingerprinting agency to see if they can perform an ink fingerprint on an FBI (FD-258) card or on another state's official fingerprint card. The ink fingerprint must be completed on card stock.

2. Submit the card with your fingerprints, the completed Livescan Fingerprint Request Form (attached) and a business check or money order for $62.75 made payable in U.S. Funds to L-1 Identity Solutions to the following address:

   L-1 Enrollment Services/LiveScan Processing Unit
   1650 Wabash Ave. Ste. D
   Springfield, IL 62704

3. Please include a daytime telephone number or e-mail address where you can be reached if there are any questions.

4. L-1 Identity Solutions will submit your fingerprints to the Michigan State Police for analysis.

5. If no criminal history information is found, the Bureau of Health Professions will be notified.

6. If criminal history information is found, the Michigan State Police will send the record directly to the Bureau of Health Professions for review.

7. Call L-1 Identity Solutions toll-free at 1-866-226-2952 (8 am - 5 pm EST) if you have any questions.

8. L-1 Identity Solutions is under contract with the Michigan State Police (MSP) to provide fingerprint services. For questions, call MSP at (517) 241-0606.

Michigan Department of Licensing and Regulatory Affairs
Bureau of Health Professions
P.O. Box 30670
Lansing, MI 48909
(517) 335-0918

LARA/300L (04/11)

LIVESCAN FINGERPRINT REQUEST FORM

Fingerprint Date:	TCN:

Type of I.D. Presented:	Type of Licensure/Registration:

Applicant Instructions: Take this completed form along with your picture I.D. to your scheduled appointment. Please print clearly.

First Name:	Middle Name:	Last Name:	
Street Address:			
City:	State:	ZIP Code:	
Daytime Telephone Number w/ Area Code:	State or Country of Birth:		
Date of Birth (MM/DD/YYYY):	Race:	Sex:	
Height:	Weight:	Eye Color:	Hair Color:

REQUESTING AGENCY INFORMATION

Agency I.D. Number: 71734k	Agency Name: Department of Licensing and Regulatory Affairs, Bureau of Health Professions
Reason Fingerprinted: LHP - Licensed Health Care Professional (MCL333.16174)	Cost:

Disclaimer: Any and all errors that result in dual fingerprinting (Duplicate transmission to MSP), multiple fingerprint codes, fingerprints processed with incorrect fingerprint codes/reasons, etc., are the responsibility of the **LIVESCAN AGENCY. **MSP** will charge for dual fingerprinting (transmission), etc.

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APPLICATION FOR CLINICAL ACADEMIC LIMITED LICENSE AND CONTROLLED SUBSTANCE LICENSES

Authority: Public Act 368 of 1978, as amended
If this form is not completed, a license will not be issued.

A controlled substance license is required for every person who prescribes, manufactures, distributes, or dispenses any controlled substance in Michigan as described in Article 7 of Public Act 368 of 1978, as amended. Information on obtaining a Federal controlled substance license may be obtained by contacting the Regional Branch, Drug Enforcement Administration, 431 Howard Street, Detroit, MI 48226 (Telephone 1-800-882-9539).

Board Use Only
License Number
C.S. License Number
Date of Licensure

Type or Print Only

I AM APPLYING FOR THE FOLLOWING:

❐ **Limited Clinical Academic and Controlled Substance Fee: 170.00**
71-43-01-375705

Your check or money order drawn on a U.S. financial institution and made payable to the **STATE OF MICHIGAN** must accompany this application. **DO NOT SEND CASH.** Fees are deposited upon receipt and can only be refunded under refund rules promulgated by the Department.

Legal First Name	Legal Middle Name	Legal Last Name
U.S. Social Security Number	Date of Birth	E-Mail Address
Daytime Phone Number	All Previous Names and/or Birth Name Used (if applicable)	

Have you ever held a health professional license in Michigan? ❐ Yes ❐ No	Michigan Health Professional Permanent I.D/License Number and Expiration Date:
Name of Appointing Academic Institution	
Street Address of Academic Institution	

City	State	ZIP Code

Check the appropriate answer to each of the following questions. NOTE: Submit a detailed explanation for any YES answer you check on a separate sheet with your application.

Question	Yes	No
1. Have you ever been convicted of a felony?	❐ Yes	❐ No
2. Have you ever been convicted of a misdemeanor punishable by imprisonment for a maximum term of 2 years?	❐ Yes	❐ No
3. Have you ever been convicted of a misdemeanor involving the illegal delivery, possession, or use of alcohol or a controlled substance (including motor vehicle violations)?	❐ Yes	❐ No
4. Have you been treated for substance abuse in the past 2 years?	❐ Yes	❐ No
5. Have you had 3 or more malpractice settlements, awards, or judgments totaling $200,000 or more in any consecutive 5 year period?	❐ Yes	❐ No
6. Have you had one or more malpractice settlements, awards, or judgments totaling $200,000 or more in any consecutive 5 year period?	❐ Yes	❐ No
7. Have you ever had a federal or state health professional license or registration revoked, suspended, or otherwise disciplined; been denied a license; or currently have disciplinary action pending against you?	❐ Yes	❐ No

The Department of Licensing and Regulatory Affairs will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

Name

8. Have you ever been censured, or requested to withdraw from a health care facility's staff or had your health care facility staff privileges involuntarily modified? ☐ Yes ☐ No

9. Do you hold or have you held a medical license in any state? If yes, list each state, the license or registration number, the date issued, and how the license was obtained DO NOT LIST TEMPORARY LICENSES. **You must have each state board verify licensure directly to this board office. (Attach additional sheets if necessary.)** ☐ Yes ☐ No

State	License Number	Date of Issue	How obtained (Endorsement or examination)

Provide a complete chronological record of your educational preparation.
Attach additional sheets **if necessary**.

Name and Address of Institution	Dates of Attendance From	To	Degree

Provide a description of your professional medical experience.
Attach additional sheets if necessary.

Name and Address of Employer	Dates of Practice From	To	Duties

CERTIFICATION

I understand that it is the policy of this agency to secure a criminal conviction history as part of their pre-licensure screening process. I authorize this agency to use the information provided in this application to obtain a criminal conviction history file search from the Central Records Division of the Michigan Department of State Police or other law enforcement or judicial record-keeping organization.

I further consent to the release of information to this agency regarding any disciplinary investigations conducted by a similar licensure, registration, or specialty certification board of this or any other state, of the United States military, of the federal government, or of another country.

The statements in this application are true and correct. I have not withheld information that might affect the decision to be made on this application. In signing this application, I am aware that a false statement or dishonest answer may be grounds for denial of my application or revocation of my license and that such misrepresentation is punishable by law.

Signature of Applicant	Date

Michigan Department of Licensing and Regulatory Affairs

Board of Medicine
P.O. Box 30192
Lansing, MI 48909
(517) 335-0918
www.michigan.gov/healthlicense

CERTIFICATION OF POSTGRADUATE TRAINING
(CLINICAL ACADEMIC LIMITED LICENSE)

Authority: Public Act 368 of 1978, as amended
If this form is not completed, a license will not be issued.

INSTRUCTIONS TO APPLICANT:

Complete Section I. Type or print your legal name exactly as it appears on your application. For completion of Section II, send this form to be completed by the Director of Medical Education where you completed your postgraduate training. This certification must be submitted directly to the Michigan Board of Medicine by the Director of Medical Education.

SECTION I - APPLICANT INFORMATION

First Name	Middle Name	Last Name
Social Security Number	Date of Birth	
Street Address		
City	State	ZIP Code
Daytime Telephone Number	All Previous Names and/or Birth Name Used (if applicable)	

Signature of Applicant	Date

APPLICANT: UPON COMPLETION OF SECTION I, SEND THIS FORM TO THE DIRECTOR OF MEDICAL EDUCATION FOR COMPLETION OF SECTION II.

The Department of Licensing and Regulatory Affairs will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

Name

TO BE COMPLETED BY THE DIRECTOR OF MEDICAL EDUCATION

INSTRUCTIONS FOR COMPLETING SECTION II:

Please complete the following information. Return this completed certification directly to the Michigan Board of Medicine at the address shown on Page 1 of this form.

SECTION II - CERTIFICATION OF POSTGRADUATE TRAINING

Name of Hospital
Street Address of Hospital
City, State and ZIP Code
Identify all medical schools affiliated with the training hospital:

I certify that ______________________________ **a graduate of the**
(Applicant's Name)

______________________________ **medical school, has successfully completed postgraduate clinical training offered by the hospital named above from** ______________ **to** ______________,
Month/Day/Year Month/Day/Year

in the clinical area of ______________________________.

____
Signature of Director of Medical Education

____
Date of Signature

____
Print or Type Name of Director of Medical Education

(S E A L)

If hospital has no seal, please indicate

NOTE: Certification of postgraduate training will not be accepted if certified and submitted more than 15 days prior to actual completion.

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CERTIFICATION OF APPOINTMENT TO A MICHIGAN ACADEMIC INSTITUTION

Authority: Public Act 368 of 1978, as amended
If this form is not completed, a license will not be issued.

Please complete the following information. Return this completed certification directly to the Michigan Board of Medicine at the address shown above.

Name of Institution		
Street Address of Institution		
City	State	Zip Code

I certify that ______________________________ **has been duly**
(Applicant's Name)

appointed to this academic institution in the clinical area of ______________________________

____

beginning ______________________________ **and ending** ______________________________.
(Month/Day/Year) (Month/Day/Year)

The applicant is appointed to the following position:

☐ **Medical school faculty**

☐ **Research**

I further certify that the above-named academic institution meets all of the following requirements:

A. **Was the sole sponsor or a cosponsor, with either a medical school approved by the Michigan Board of Medicine or a hospital owned by the federal government and directly operated by the United States Department of Veterans' Affairs, of not less than four residency programs accredited by the Accreditation Council for Graduate Medical Education for not less than three years immediately preceding the date of my signature below.**

B. **Has spent not less than $2,000,000 for medical education during each of the three years immediately preceding the date of my signature below (As used in this statement, "medical education" means the education of physicians and candidates for degrees or licenses to become physicians, including physician staff, residents, interns and medical students).**

____
Signature of Director of Medical Education

____
Date of Signature

____
Print or Type Name of Director of Medical Education

(S E A L)

If school has no seal, please indicate

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CERTIFICATION OF MEDICAL EDUCATION FOR GRADUATES OF FOREIGN MEDICAL SCHOOL GRADUATES

Authority: Public Act 368 of 1978, as amended
If this form is not completed, a license will not be issued.

INSTRUCTIONS TO APPLICANT:

Complete Section I. Type or print your legal name exactly as it appears on your application. For completion of Section II, send this form to the Dean of the medical school you attended. This certification must be submitted directly to the Michigan Board of Medicine by the medical school.

SECTION I - APPLICANT INFORMATION

First Name	Middle Name	Last Name
Social Security Number	Date of Birth	
Street Address		
City	State	ZIP Code
Daytime Telephone Number	All Previous Names and/or Birth Name Used (if applicable)	
Date of Admission		Date of Graduation

Signature of Applicant	Date

APPLICANT: UPON COMPLETION OF SECTION I, SEND THIS FORM TO THE DEAN OF YOUR MEDICAL SCHOOL FOR COMPLETION OF SECTION II.

The Department of Licensing and Regulatory Affairs will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

Name

TO BE COMPLETED BY THE DEAN OR REGISTRAR OF THE MEDICAL SCHOOL

INSTRUCTIONS FOR COMPLETING SECTION II: Please complete the following information. Return this completed certification directly to the Michigan Board of Medicine at the address shown on Page 1 of this form.

SECTION II - CERTIFICATION OF MEDICAL EDUCATION

Name of Medical School

Street Address of Medical School

City, State and ZIP Code

I certify that ______________________________ attended the medical
Applicant's Full Name

school named above from ____________________ to ____________________, and was
Month/Day/Year Month/Day/Year

granted the degree of ______________________________ on ____________________.
Month/Day/Year

I also certify that the medical education program from which the applicant graduated was not less than 130 weeks and does not award credit for any courses taken by correspondence. I further certify that this medical education program included basic science courses in anatomy; physiology; biochemistry; microbiology; pathology; pharmacology and therapeutics; preventive medicine; and clinical sciences and clerkships in the completed at the hospitals or institutions listed below.

Clinical Sciences	Name and Address of Hospital	* Teaching Hospital
Internal Medicine		☐ Yes ☐ No
General Surgery		☐ Yes ☐ No
Pediatrics		☐ Yes ☐ No
Obstetrics and Gynecology		☐ Yes ☐ No
Psychiatry		☐ Yes ☐ No

______________________________ Signature of Dean or Registrar

______________________________ Date of Signature

______________________________ Print or Type Name of Dean or Registrar

(S E A L)

If school has no seal, please indicate

* Teaching hospital means that the hospital or institution offers a postgraduate clinical training program in the same content area of the clerkship.

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CERTIFICATION OF MEDICAL EDUCATION FOR GRADUATES OF MEDICAL SCHOOLS LOCATED IN THE UNITED STATES, ITS TERRITORIES, THE DISTRICT OF COLUMBIA, OR THE DOMINION OF CANADA

Authority: Public Act 368 of 1978, as amended
If this form is not completed, a license will not be issued.

INSTRUCTIONS TO APPLICANT:

Complete Section I. Type or print your legal name exactly as it appears on your application. For Section II, send this form to be completed by the Dean of the medical school you attended. This certification must be submitted directly to the Michigan Board of Medicine by the medical school.

SECTION I - APPLICANT INFORMATION

First Name	Middle Name	Last Name
Social Security Number	Date of Birth	Daytime Telephone Number
Street Address		
City	State	ZIP Code
All Previous Names and/or Birth Name Used (if applicable)		
Date of Admission		Date of Graduation

Signature of Applicant	Date

APPLICANT: UPON COMPLETION OF SECTION I, SEND THIS FORM TO THE DEAN OF YOUR MEDICAL SCHOOL FOR COMPLETION OF SECTION II.

The Department of Licensing and Regulatory Affairs will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

Name

TO BE COMPLETED BY THE DEAN OR REGISTRAR OF THE MEDICAL SCHOOL

INSTRUCTIONS FOR COMPLETING SECTION II:

Please complete the following information. Return this completed certification directly to the Michigan Board of Medicine at the address shown on Page 1 of this form.

SECTION II - CERTIFICATION OF MEDICAL EDUCATION

Name of Medical School
Street Address of Medical School
City, State and ZIP Code

I certify that ______________________________ **attended the**
(Applicant's Name)

medical school named above from ________________ **to** ________________ ,
(Month/Day/Year) (Month/Day/Year)

and was/will be granted the degree of ______________________________ **on**

____________________ .
(Month/Day/Year)

______________________________ ____________________
Signature of Dean or Registrar Date of Signature

(S E A L)

____
Print or Type Name of Dean or Registrar

If school has no seal, please indicate

LARA/HLD-001 (04/11)

Michigan Department of Licensing and Regulatory Affairs

Bureau of Health Professions

P.O. Box 30670

Lansing, MI 48909

www.michigan.gov/healthlicense

VERIFICATION OF LICENSURE OR REGISTRATION IN ANOTHER STATE

Authority: Public Act 368 of 1978, as amended.

PART I: To be completed by the applicant and forwarded to the appropriate State Licensing Board for completion.

Check the profession for which you are requesting verification.

☐ Acupuncture	☐ Medicine	☐ Pharmacy	☐ Sanitarian
☐ Audiology	☐ Nursing	☐ Physical Therapy	☐ Social Work
☐ Chiropractic	☐ Nursing Home Admin.	☐ Physician's Assistants	☐ Veterinary Medicine
☐ Counseling	☐ Occupational Therapy	☐ Podiatry	
☐ Dentistry	☐ Optometry	☐ Psychology	
☐ Marriage & Family Therapy	☐ Osteopathy	☐ Respiratory Therapy	

First Name	Middle Name	Last Name
Previous Names Used	Date of Birth	U. S. Social Security Number
State Board	License Number	Date of Issue

The applicant listed above has applied for licensure in Michigan and has indicated licensure in your State.
Please complete Part II of this form and return it to the appropriate Michigan Board at the address shown above.

PART II: To be completed by the State Licensing Board.

Type of License:	Original Issue Date	Expiration Date

Basis for Issuance of License:

☐ Examination - Please indicate type of exam (National, Regional, State, etc.) ______________________________

☐ Endorsement - Please indicate name of state ______________________________

License Status	Has the applicant incurred any formal or informal actions in your State?
☐ Current ☐ Lapsed ☐ Inactive	☐ No ☐ Yes - If Yes, Please attach certified copies of any actions.

Are formal or informal actions pending?	Has the applicant's license ever been limited, denied, surrendered, reprimanded, suspended or revoked?
☐ No ☐ Yes	☐ No ☐ Yes

CERTIFICATION

I hereby verify, to the best of my knowledge, the information above is true to the records of this Board.

____
Signature

____
Date

____
Type or Print Name

(S E A L)

____
Title

____
Full Name of Licensing Board

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital sta
disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make
your needs known to this agency.