

**Board of Medicine**

P.O. Box 30192

Lansing, Michigan 48909

(517) 335-0918

[www.michigan.gov/healthlicense](http://www.michigan.gov/healthlicense)**MEDICAL EDUCATIONAL 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.

**EDUCATIONAL LIMITED LICENSE APPLICANTS WHO ARE GRADUATES OF A MEDICAL SCHOOL LOCATED IN THE UNITED STATES, ITS TERRITORIES, THE DISTRICT OF COLUMBIA, OR THE DOMINION OF CANADA, MUST SUBMIT THE FOLLOWING:**

1. A completed application and a check or money order, drawn on a U.S. financial institution, in the amount of \$170.00, made payable to the **STATE OF MICHIGAN**. 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to complete the requirements for licensure within two years from the date of filing the application, the application is no longer valid. An Educational Limited license may be renewed 5 times, with no extensions available.
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.
2. Certification of medical education submitted directly from the medical school to the Board on the proper form (attached).
3. Certification of appointment to a Michigan training hospital to be completed, on the proper form (attached) and submitted directly to the board by the hospital in which the training is to occur.
4. 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.

**EDUCATIONAL LIMITED LICENSE APPLICANTS WHO ARE GRADUATES OF FOREIGN MEDICAL SCHOOLS MUST SUBMIT THE FOLLOWING:**

1. A completed application and a check or money order, drawn on a U.S. financial institution, in the amount of \$170.00, made payable to the **STATE OF MICHIGAN**. 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. An Educational Limited license may be renewed 5 times. No extensions are available.
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 proper form (attached).

4. Certification of appointment to a Michigan training hospital to be completed, on the proper form (attached) and submitted directly to the board by the hospital in which the training is to occur.
5. Verification of your Educational Commission for Foreign Medical Graduates (ECFMG) certificate must be electronically submitted directly to the Michigan Board from ECFMG. Go to <https://cvsonline2.ecfm.org/lmgGenInfo.asp> for information and instructions on how to apply for your ECFMG status report to be sent to the Board.
6. 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.

You are advised that an application for licensure **WILL NOT BE CONSIDERED UNTIL ALL REQUIRED DOCUMENTATION IS SUBMITTED.**

### **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](http://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.



RICK SNYDER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

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](http://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](http://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](mailto:mihelp@cogentsystems.com).



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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.

## LIVESCAN FINGERPRINT REQUEST FORM

Fingerprint Date:	TCN:
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Type of I.D. Presented:	Type of Licensure/Registration:
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**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: <b>71734k</b>	Agency Name: <b>Department of Licensing and Regulatory Affairs, Bureau of Health Professions</b>
Reason Fingerprinted: <b>LHP - Licensed Health Care Professional (MCL333.16174)</b>	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.

**Board of Medicine**

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**APPLICATION FOR EDUCATIONAL LIMITED 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).

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Board Use Only

License Number:
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C.S. License Number:
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Date of Licensure:
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**Type or Print Only**

**I AM APPLYING FOR THE FOLLOWING:**

- Educational Limited 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.

First Name	Middle Name	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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Michigan Health Professional I.D./License Number and Expiration Date, If applicable	
Name of Training Hospital		
Street Address of Training Hospital		
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.**

1. Have you ever been convicted of a felony?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you ever been convicted of a misdemeanor punishable by imprisonment for a maximum term of 2 years?	<input type="checkbox"/> Yes <input type="checkbox"/> 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)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you been treated for substance abuse in the past 2 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you had 3 or more malpractice settlements, awards, or judgments totaling \$200,000 or more in any consecutive 5 year period?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have you had one or more malpractice settlements, awards, or judgments totaling \$200,000 or more in any consecutive 5 year period?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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.



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**CERTIFICATION OF APPOINTMENT TO A MICHIGAN TRAINING HOSPITAL**

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 Program Director of the Michigan hospital where you have been appointed. This certification must be submitted to the Board of Medicine by the hospital.

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

<b>Name</b>
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**THIS SIDE TO BE COMPLETED BY THE PROGRAM DIRECTOR**

**INSTRUCTIONS FOR COMPLETING SECTION II:**

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

**SECTION II - CERTIFICATION OF RESIDENCY APPOINTMENT**

Name of Training Hospital
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Street Address of Training Hospital
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City, State and ZIP Code
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I certify that \_\_\_\_\_ has been duly  
(Applicant's Name)

appointed to a training program in the clinical area of \_\_\_\_\_

beginning \_\_\_\_\_ and ending \_\_\_\_\_  
(Month/Day/Year) (Month/Day/Year)

at \_\_\_\_\_  
(Name of Training Hospital)

Is this program accredited by ACGME?  Yes  No

\_\_\_\_\_  
Signature of Director of Medical Education

\_\_\_\_\_  
Date of Signature

\_\_\_\_\_  
Print or Type Name of Director of Medical Education

**(SEAL)**

If **hospital** has no seal, please indicate.

**Board of Medicine**

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Lansing, MI 48909

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[www.michigan.gov/healthlicense](http://www.michigan.gov/healthlicense)**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
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**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		<input type="checkbox"/> Yes <input type="checkbox"/> No
General Surgery		<input type="checkbox"/> Yes <input type="checkbox"/> No
Pediatrics		<input type="checkbox"/> Yes <input type="checkbox"/> No
Obstetrics and Gynecology		<input type="checkbox"/> Yes <input type="checkbox"/> No
Psychiatry		<input type="checkbox"/> Yes <input type="checkbox"/> No

Signature of Dean or Registrar

Date of Signature

Print or Type Name of Dean or Registrar

(SEAL)

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.

## Michigan Department of Licensing and Regulatory Affairs

**Board of Medicine**

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www.michigan.gov/healthlicense

**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
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**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
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**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	
<p>I certify that _____ attended the</p> <p style="text-align: center;">(Applicant's Name)</p> <p>medical school named above from _____ to _____,</p> <p style="text-align: center;">(Month/Day/Year) (Month/Day/Year)</p> <p>and was/will be granted the degree of _____ on</p> <p style="text-align: center;">_____</p> <p style="text-align: center;">(Month/Day/Year)</p>	
_____ Signature of Dean or Registrar	_____ Date of Signature
<b>(SEAL)</b>	
_____ Print or Type Name of Dean or Registrar	If school has no seal, please indicate

## 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.		
<input type="checkbox"/> Acupuncture	<input type="checkbox"/> Medicine	<input type="checkbox"/> Pharmacy
<input type="checkbox"/> Audiology	<input type="checkbox"/> Nursing	<input type="checkbox"/> Physical Therapy
<input type="checkbox"/> Chiropractic	<input type="checkbox"/> Nursing Home Admin.	<input type="checkbox"/> Physician's Assistants
<input type="checkbox"/> Counseling	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Podiatry
<input type="checkbox"/> Dentistry	<input type="checkbox"/> Optometry	<input type="checkbox"/> Psychology
<input type="checkbox"/> Marriage & Family Therapy	<input type="checkbox"/> Osteopathy	<input type="checkbox"/> Respiratory Therapy
<input type="checkbox"/> Sanitarian	<input type="checkbox"/> Social Work	<input type="checkbox"/> Veterinary Medicine
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:		
<input type="checkbox"/> Examination - Please indicate type of exam (National, Regional, State, etc.) _____		
<input type="checkbox"/> Endorsement - Please indicate name of state _____		
License Status	Has the applicant incurred any formal or informal actions in your State?	
<input type="checkbox"/> Current <input type="checkbox"/> Lapsed <input type="checkbox"/> Inactive	<input type="checkbox"/> No <input type="checkbox"/> 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?	
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> 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