

Board of Medicine

P.O. Box 30192

Lansing, Michigan 48909

(517) 335-0918

www.michigan.gov/healthlicense**MEDICAL LICENSURE BY ENDORSEMENT 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.

IF YOU HAVE BEEN LICENSED IN ANOTHER STATE AND HAVE BEEN ENGAGED IN THE PRACTICE OF MEDICINE FOR AT LEAST 10 YEARS, THE FOLLOWING MUST BE SUBMITTED:

1. A completed application for medical license, and controlled substance license if desired, on the enclosed forms. Please be sure to check that you are applying for license by endorsement and controlled substance license, as applicable.
2. A check or money order, drawn on a U.S. financial institution (made payable to the **STATE OF MICHIGAN**) in the amount of \$150.00 for a medical license only or a total of \$235.00 if also applying for a controlled substance license. 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to complete the requirements for licensure within two years from the date of filing the application, the application is no longer valid.
3. **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.
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.

IF YOU HAVE BEEN LICENSED IN ANOTHER STATE AND HAVE PRACTICED MEDICINE FOR LESS THAN 10 YEARS AT THE TIME OF YOUR APPLICATION, THE FOLLOWING DOCUMENTS MUST BE SUBMITTED IN ADDITION TO THE ONES LISTED ABOVE:

1. An official score report for the examination that you took to obtain licensure, submitted directly to the Board of Medicine from the examination agency. Score reports must be sent from either the Federation of State Medical Boards at (817) 868-4000, website: www.fsmb.org or the National Board of Medical Examiners (if tested May 1994 or earlier) at (215) 590-9700, website: www.nbme.org.
2. Certification of successful completion of two years postgraduate clinical training in an active, approved program in a Board approved hospital or institution. The Certification of Postgraduate Training form (attached) must be submitted directly to the Board from the Director of Medical Education where you completed your postgraduate training.
3. If you are a graduate of a foreign medical school, 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.

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.

Note: All active, postgraduate clinical training programs accredited by the Accreditation Council of Graduate Medical Education (ACGME), the College of Family Physicians of Canada, the Royal College of Physicians and Surgeons of Canada, or the National Joint Committee on Accreditation of Pre-registration Physician Training Programs of the Canadian Medical Association are approved by the board. All hospitals accredited by the Joint Commission on Accreditation of Hospitals (JCAH) are board approved.

FEDERATION CREDENTIALS VERIFICATION SERVICE

The Michigan Board of Medicine now accepts the Federation Credentials Verification Service (FCVS) to provide documentation for endorsement applications for applicants licensed less than 10 years in another state. The Federation of State Medical Boards (FSMB) makes this service available to applicants. The FCVS verifies a physician's basic credentials with primary sources. Those credentials include postgraduate training, examination history, ECFMG certification and board action history. FCVS does NOT provide licensure verification from other states. Verification information must be sent as specified in #4 above.

Please note that the use of the FCVS is strictly voluntary on the part of the applicant. The Michigan Board of Medicine reserves the right to request additional information from the applicant during the application review process.

If you are interested in receiving more information or have any questions regarding this service, please contact the FSMB at (888) 275-3287, website www.fsmb.org.

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 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.
4. CONTINUING EDUCATION: This license has a continuing education requirement for renewal. Please check our website at www.michigan.gov/healthlicense for more information on the specific requirements.

PLEASE NOTE: You will not be required to complete any continuing education credits in order to renew your license for the first time because you will not have held the license for a full three-year period.

5. ORIGINAL LICENSES WILL EXPIRE ON JANUARY 31 OF THE FOLLOWING YEAR. SUBSEQUENT RENEWALS ARE FOR A THREE-YEAR PERIOD.



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 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.



RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
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**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: 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.

Board of Medicine

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

**APPLICATION FOR MEDICAL DOCTOR LICENSURE
 BY ENDORSEMENT**

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
Date of Licensure

Type or Print Only

I AM APPLYING FOR THE FOLLOWING:

- License by Endorsement Fee: \$150.00 71-4301-09
 (Must currently be licensed in another state)
- Controlled Substance Fee: \$85.00 43-01 71-5315-3757

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	Daytime Phone Number ()
Street Address		
City	State	ZIP Code
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 Permanent I.D. Number and Expiration Date	

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 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 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 or controlled substance license 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
8. Have you ever been denied the privilege of taking an examination by any state medical board?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Name			
9. Have you ever been censured, or requested to withdraw from a health care facility's staff or had your health care facility staff privilege involuntarily modified? <input type="checkbox"/> Yes <input type="checkbox"/> No			
10. Do you hold or have you ever held a permanent medical license in any state, U.S. Territory or Canadian province? If yes, list the State(s), U.S. Territory or Province in which you hold or have held a medicine license, the license or registration number, the date issued, and how the license was obtained. DO NOT LIST TEMPORARY LICENSES. You must have each licensing agency verify licensure directly to this board office. (Attach additional sheets, if necessary) <input type="checkbox"/> Yes <input type="checkbox"/> No			
State, U.S. Territory, Province	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 the 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	

Board of Medicine

P.O. Box 30192

Lansing, MI 48909

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www.michigan.gov/healthlicense

CERTIFICATION OF POSTGRADUATE TRAINING

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 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
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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

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 _____.	
Is this an active training program accredited by the ACGME, the College of Family Physicians of Canada, the Royal College of Physicians and Surgeons of Canada, or by the National Joint Committee on Accreditation of Preregistration Physician Training Programs of the Canadian Medical Association? <input type="checkbox"/> Yes <input type="checkbox"/> 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
NOTE: Certification of Postgraduate Training will not be accepted if signed and submitted more than 15 days prior to actual completion.	

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"/> Audiology <input type="checkbox"/> Chiropractic <input type="checkbox"/> Counseling <input type="checkbox"/> Dentistry <input type="checkbox"/> Marriage & Family Therapy	<input type="checkbox"/> Medicine <input type="checkbox"/> Nursing <input type="checkbox"/> Nursing Home Admin. <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Optometry <input type="checkbox"/> Osteopathy	<input type="checkbox"/> Pharmacy <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Physician's Assistants <input type="checkbox"/> Podiatry <input type="checkbox"/> Psychology <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