

**Board of Osteopathic Medicine and Surgery**

P.O. Box 30670

Lansing, Michigan 48909

(517) 335-0918

[www.michigan.gov/healthlicense](http://www.michigan.gov/healthlicense)**OSTEOPATHIC MEDICINE AND SURGERY 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 Osteopathic Medicine and Surgery. Questions regarding your application can be directed to the Board of Osteopathic Medicine and Surgery 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.

**LICENSURE BY EXAMINATION –**

1. Completed application and required fee(s). 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to complete the requirements for licensure within two years from the date of filing the application, the application is no longer valid. A controlled substance license is required for every person who manufactures, distributes, prescribes, or dispenses any controlled substance in Michigan. A separate controlled substance license is required for each business location from which you manufacture, distribute, or dispense controlled substances. If you just prescribe controlled substances at more than one location, you only need one controlled substance license.
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. Passing scores on Parts 1, 2, and 3 of the National Board examination submitted directly to this office by the National Board of Osteopathic Medical Examiners.
4. Final, official transcripts, requested by you and sent directly to this office from your school, showing the degree earned and the date conferred.
5. Verification of the completion of one year of AOA approved post-graduate internship training that is forwarded directly to this office from the training hospital must be on the Certification of Internship form (attached). **If the internship you completed was in an allopathic facility, you must contact the AOA to request approval of the program. If approved, the AOA must submit a letter directly to this office verifying the program's approval. If the osteopathic internship you completed was prior to 1988, you must contact the AOA and request a letter from the AOA be submitted directly to this office verifying the program's approval.**
6. Verification of licensure from each state where you hold or have ever held a permanent D.O. 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.

## LICENSURE BY ENDORSEMENT -

1. Completed application and required fee(s). 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. A controlled substance license is required for every person who manufactures, distributes, prescribes, or dispenses any controlled substance in Michigan. A separate controlled substance license is required for each business location from which you manufacture, distribute, or dispense controlled substances. If you just prescribe controlled substances at more than one location, you only need one controlled substance license.
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. Applicants licensed in another state less than five years, must arrange for passing scores on Parts 1, 2 and 3 of the National Board examination to be sent directly to this office by the National Board of Osteopathic Medical Examiners.
4. Final, official transcripts, requested by you and sent directly to this office from your school, showing the degree earned and the date conferred.
5. Verification of the completion of one year of AOA approved post-graduate internship training that is forwarded directly to this office from the training hospital must be on the Certification of Internship form (attached). **If the internship you completed was in an allopathic facility, you must contact the AOA to request approval of the program. If approved, the AOA must submit a letter directly to this office verifying the program's approval. If the osteopathic internship you completed was prior to 1988, you must contact the AOA and request a letter from the AOA be submitted directly to this office verifying the program's approval.**
6. Verification of licensure from each state where you hold or have ever held a permanent D.O. 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.

The Michigan Board of Osteopathic Medicine and Surgery now accepts the Federation Credentials Verification Service (FCVS). 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 medical education, post-graduate training, examination history, and board action history.

Applicants for osteopathic medical licensure in Michigan may use the FCVS in lieu of separate verification of the above credentials from their primary source, as outlined above. **Please note, however, that the use of the FCVS is strictly voluntary on the part of the applicant and that the Michigan Board of Osteopathic Medicine and Surgery might still 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 (817) 868-5000.

## **GENERAL INFORMATION**

1. NAME AND/OR ADDRESS CHANGES: If your name and/or address changes please notify the Board of Osteopathic Medicine and Surgery 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 Osteopathic Medicine and Surgery 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](http://www.michigan.gov/healthlicense) for more information on the specific requirements.  
**PLEASE NOTE:** You are not required to complete any continuing education credits in order to renew your license for the first time because you will not have held your license for a full three-year period.
5. Information on obtaining a Federal controlled substance license may be obtained by contacting the Regional Branch, Drug Enforcement Administration, 431 Howard Street, Detroit, Michigan 48226 (800) 882-9539. The Michigan Board of Pharmacy is unable to answer questions about the federal licensing process.
6. ORIGINAL LICENSES ARE VALID FOR ONE YEAR OR LESS; 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](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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**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.

Michigan Department of Licensing and Regulatory Affairs  
**Board of Osteopathic Medicine and Surgery**

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**APPLICATION FOR LICENSURE**

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

Board Use Only

License Number

Controlled Substance License Number

Date of Licensure

**Type or Print Only**

**I AM APPLYING FOR THE FOLLOWING:**

- License by Examination Fee: 150.00 71-5101-01
- License by Endorsement Fee: \$150.00 71-5101-09  
 (Currently Licensed in Another State)
- Controlled Substance Fee: \$85.00 71-5315-3757

Your check or money order drawn on a US 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	Daytime Phone Number
Street Address		
City	State	ZIP Code
All Previous Names and/or Birth Name Used (if applicable)		E-mail Address
Have you ever held a health professional license in Michigan?		
<input type="checkbox"/> No <input type="checkbox"/> If Yes, Please provide Michigan Permanent I.D./License 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 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 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 censured, or requested to withdraw from a health care facility's staff or had your health care facility staff privileges involuntarily modified?	<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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Board of Osteopathic Medicine and Surgery**

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**CERTIFICATION OF INTERNSHIP**

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 name exactly as it appears on your application. For completion of Section II, send this form to the Medical Director or Superintendent of the training hospital where you served your internship. This certification must be submitted directly to the Michigan Board of Osteopathic Medicine and Surgery by the Director of the training program.

**SECTION I - APPLICANT INFORMATION**

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

Name of Hospital
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Signature of Applicant	Date
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**Applicant:** Upon completion of Section I, send this form to the Medical Director or Superintendent of the training hospital where you served your internship for completion of Section II.

Name

**THIS SIDE TO BE COMPLETED BY THE MEDICAL DIRECTOR OR SUPERINTENDENT****SECTION II - CERTIFICATION OF INTERNSHIP**

Please complete the following information. Return this completed certification directly to the Michigan Board of Osteopathic Medicine and Surgery at the address shown on the reverse side of this form.

Name of Hospital		
Street Address of Hospital		
City	State	Zip Code
Is this internship AOA approved?		
<input type="checkbox"/> Yes <input type="checkbox"/> No		
I certify that _____ <div style="text-align: right;">(Applicant's Name)</div> has completed one year of internship at the above named hospital beginning _____ <div style="text-align: right;">(Month/Day/Year)</div> and ending _____ <div style="text-align: center;">(Month/Day/Year)</div>		
I certify that this internship is one year in duration; of a rotating type, with rotations in the organized departments of Medicine, Surgery, Obstetrics and Gynecology; and that this Hospital is currently approved for the training of interns by the American Osteopathic Association. I further certify that the above named physician has served an apportioned time in each of the named rotations and has satisfactorily performed his/her duties.		
_____ Signature of Medical Director or Superintendent		
_____ Print or Type Name	_____ Date of Signature	
_____ Title	<b>( S E A L )</b>	
<b>If hospital has no seal, please indicate</b>		

**IMPORTANT: This certification may not be dated and submitted more than fifteen (15) days prior to the completion of a full year's internship.**

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.

## 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