

Michigan Department of Licensing and Regulatory Affairs

Board of Osteopathic Medicine and Surgery

P.O. Box 30670

Lansing, Michigan 48909

(517) 335-0918

www.michigan.gov/healthlicense

**EDUCATIONAL LIMITED LICENSURE INSTRUCTIONS
OSTEOPATHIC MEDICINE AND SURGERY**

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 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.

EDUCATIONAL LIMITED LICENSES

The Administrative Rules of the Michigan Board of Osteopathic Medicine and Surgery require an applicant for an Educational Limited license to be appointed to an AOA approved program **OR** have verification that they have completed an AOA approved internship.

INSTRUCTIONS FOR INTERNS –

1. Application and required fee. 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to complete the requirements for licensure within two years from the date of filing the application, the application is no longer valid.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 a maximum of 5 times, with no extensions available. An Educational Limited license is renewed each year on June 30.
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. Final, official transcripts, requested by you and sent directly to this office from your school, showing the degree earned and the date conferred. If final transcripts are not available, an official letter of good standing from your Dean or Program Director may be substituted. This letter cannot be written more than 90 days prior to your date of graduation. Final, official transcripts will be required before you can upgrade to a full license.
4. Certification of Appointment to Training Program form that is mailed directly to this office from the institution where you have been appointed to Board-approved post-graduate internship training.

INSTRUCTIONS FOR RESIDENTS –

1. Application and required fee. 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 held for a maximum of 5 years, with no extensions available. An Educational Limited license is renewed each year on June 30.
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. Final, official transcripts, requested by you and sent directly to this office from your school, showing the degree earned and the date conferred. If final transcripts are not available, an official letter of good standing from your Dean or Program Director may be substituted. This letter cannot be written more than 90 days prior to your date of graduation. Final, official transcripts will be required before you an upgrade to a full license.
4. Certification of Appointment to Training Program form that is mailed directly to this office from the institution where you have been appointed to Board-approved post-graduate residency training.
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 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 license 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.

GENERAL INFORMATION

1. **NAME CHANGES:** If your name 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 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.



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.



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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.

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 Lansing, Michigan 48909
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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 (313)-234-4300).

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Board Use Only
License Number
CS License Number
Date of Licensure

Type or Print Only

I AM APPLYING FOR THE FOLLOWING:	
<input type="checkbox"/> Educational Limited and Controlled Substance Fee: \$170.00 71 - 5101- 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. **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
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	
All Previous Names and/or Birth Name Used (if applicable)		
Name of Appointing Hospital	Hospital Street Address	
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 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 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 osteopathic 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 privilege 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.

Name

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		Degree
	From	To	

**Provide a description of your intern training experience.
Attach additional sheets if necessary**

Name and Address of Hospital	Dates of Practice		Program Title
	From	To	

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
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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

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; margin-left: 300px;">(Applicant's Name)</div> has completed one year of internship at the above named hospital beginning _____ <div style="text-align: right; margin-left: 250px;">(Month/Day/Year)</div> and ending _____. <div style="text-align: center; margin-left: 100px;">(Month/Day/Year)</div> <p>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.</p> <div style="margin-top: 20px;"> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border-top: 1px solid black; text-align: center; padding-top: 5px;">Signature of Medical Director or Superintendent</td> <td style="width: 50%; border-top: 1px solid black; text-align: center; padding-top: 5px;">Date of Signature</td> </tr> <tr> <td style="border-top: 1px solid black; text-align: center; padding-top: 5px;">Print or Type Name</td> <td style="border-top: 1px solid black; text-align: center; padding-top: 5px;">Date of Signature</td> </tr> <tr> <td style="border-top: 1px solid black; text-align: center; padding-top: 5px;">Title</td> <td style="border-top: 1px solid black; text-align: center; padding-top: 5px;">(S E A L)</td> </tr> </table> <p align="right" style="margin-top: 10px;">If hospital has no seal, please indicate</p> </div>			Signature of Medical Director or Superintendent	Date of Signature	Print or Type Name	Date of Signature	Title	(S E A L)
Signature of Medical Director or Superintendent	Date of Signature							
Print or Type Name	Date of Signature							
Title	(S E A L)							

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
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 Lansing, MI 48909
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CERTIFICATION OF APPOINTMENT TO A MICHIGAN TRAINING PROGRAM

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 Program Director or Superintendent of the Michigan training hospital where you have been appointed. This certification must be completed and submitted to the Board of Osteopathic Medicine and Surgery by the hospital.

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)	

Program (Internship or Residency)
Name of Hospital

Signature of Applicant	Date
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APPLICANT: UPON COMPLETION OF SECTION I, SEND THIS FORM TO THE PROGRAM DIRECTOR OR SUPERINTENDENT FOR COMPLETION OF SECTION II.

Name

THIS SIDE TO BE COMPLETED BY THE PROGRAM DIRECTOR/SUPERINTENDENT

INSTRUCTIONS FOR COMPLETING SECTION II:

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

SECTION II - CERTIFICATION OF APPOINTMENT

Name of Training Hospital		
Street Address of Training Hospital		
City	State	ZIP Code
Is this training program approved by the AOA? <input type="checkbox"/> Yes <input type="checkbox"/> No		
I certify that _____ has been duly <div style="text-align: center; margin-left: 100px;">(Applicant's Name)</div> appointed to the position of _____ in _____ <div style="display: flex; justify-content: space-around; margin-left: 100px;"> (Internship or Residency) (Program) </div> at the hospital named above beginning _____ and ending _____ <div style="display: flex; justify-content: space-around; margin-left: 100px;"> (Month/Day/Year) (Month/Day/Year) </div>		
_____ Signature of Director or Superintendent	_____ Date of Signature	
_____ Print or Type Name of Director or Superintendent	(SEAL) If school has no seal, please indicate.	
_____ Title		

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

(SEAL)

Title_____
Full Name of Licensing Board