Michigan Department of Licensing and Regulatory Affairs
Bureau of Health Care Services
Board of Medicine
PO Box 30192
Lansing, MI 48909
(517) 335-0918
www.michigan.gov/healthlicense

MEDICAL DOCTOR
EXAMINATION APPLICATION PACKET

INCLUDED IN THIS PACKET:

Michigan Department of Licensing and Regulatory Affairs
Bureau of Health Care Services
Board of Medicine
PO Box 30670
Lansing, MI 4909
(517) 335-0918

MEDICAL DOCTOR EXAMINATION INSTRUCTIONS

Please read application instructions carefully and answer all questions completely.
Failure to do so may cause a delay in your application process.

APPLICANTS FOR LICENSURE BY EXAMINATION WHO ARE GRADUATES OF FOREIGN MEDICAL SCHOOLS MUST SUBMIT THE FOLLOWING:

1. You must complete and submit the application for licensure with the appropriate fee, as well as arrange for supporting documents to be sent to the Michigan Board of Medicine.

2. Applicants for a Michigan health professional license are required to submit fingerprints and undergo a Criminal Background Check (CBC). Fingerprints must be taken using the Customer ID number and instructions provided in the Application Confirmation letter that will be sent when your license application and fee are processed. Do not have your fingerprints taken prior to receiving your Customer ID number.

3. A completed Certification of Medical Education for Graduates of Foreign Medical Schools form (attached). This form must be completed and returned to the Board directly from the medical school you attended.

4. Certification of your examination scores submitted directly to the Board from the Federation of State Medical Boards. You may contact that agency at (817) 868-4000, website: www.fsmb.org.

5. Certification of successful completion of 2 years postgraduate clinical training in an active program approved by the Board. The Director of Medical Education where you completed your postgraduate training must submit the Certification or Postgraduate Training Form (attached) directly to the Board.

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 of Canada, the Royal College of Physicians and Surgeons of Canada, or the National Joint Committee on Accreditation of Preregistration Physician Training Programs of the Canadian Medical Association are approved by the Board.

6. Verification of your Educational Commission for the Foreign Medical Graduates (ECFMG) certificate must be electronically submitted directly to the Michigan Board from ECFMG. Go to www.ecfmg.org for information and instructions on how to arrange for your ECFMG status report to be sent to the Board.

APPLICANTS FOR LICENSURE BY EXAMINATION WHO ARE GRADUATES OF MEDICAL SCHOOLS LOCATED IN THE UNITED STATES, ITS TERRITORIES, THE DISTRICT OF COLUMBIA, OR THE DOMINION OF CANADA, MUST SUBMIT THE FOLLOWING:

1. A completed Certification of Medical Education Form (attached). The Dean or Registrar of the medical school you attended must submit this form directly to the Board.

NOTE: All medical schools accredited by the Liaison Committee on Medical Education (LCME) are approved by the Board.

2. Certification of your examination scores submitted directly to the board 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.
3. Certification of successful completion of 2 years postgraduate clinical training in an active program approved by the Board. The Director of Medical Education where you completed your postgraduate training must submit the Certification of Postgraduate Training Form (attached) directly to the Board.

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.

Section 17031 of PA 368 of 1978, as amended, states that the board may grant a full license to individuals who have held a Clinical Academic Limited License if the applicant has been engaged in the practice of medicine for not less than 10 years after completing the requirements for a degree in medicine located outside the United State or Canada.

1. The applicant must have completed not less than 3 years of postgraduate clinical training in an institution that has an affiliation with a medical school that is listed in a directory of medical schools published by the World Health Organization (WHO). The Certification of Postgraduate Training Form that is part of the packet must be submitted directly to the Board by the Director of Medical Education where you completed your postgraduate training.

2. Certification of your examination scores submitted directly to the Board from the Federation of State Medical Boards. You may contact that agency at (817) 868-4000, website: www.fsmb.org .

3. Certification of Medical Education form completed by your medical school must be forwarded directly to this office from the medical school (unless already on file with this office).

4. The Certification of Practice in an Academic Institution form (attached) must be submitted directly to the Board by the Director of Medical Education where you practiced under the Clinical Academic license. You must have practiced under a clinical academic license for at least 2 years immediately preceding the date of application for a full license and during that time have functioned at least 800 hours per year in the observation and treatment of patients.

Michigan Department of Licensing and Regulatory Affairs
Bureau of Health Care Services
Health Professions Licensing Division
Board of Medicine
PO Box 30192 | Lansing, MI 48909
(517) 335-0918
www.michigan.gov/healthlicense

FOR BOARD USE ONLY
License Number:
CS Number:
Issue Date:

APPLICATION FOR LICENSE BY EXAMINATION

Select the license type you are applying for from the list below:

☐ Medical Doctor License by Exam Fee: $150.00 [71-4301-01]
☐ Medical Doctor License by Exam Fee & Controlled Substance Fee: $150.00 [71-4301] & $85.00 [71-5315] Total Fee: $235.00

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.

1. Demographic Information

First Name:	Middle Name:	Last Name:
U.S. Social Security #:	Birth Date:	
Street Address:	Apt/Bldg#:	
City:	State:	Zip Code:
Country: United States		
Phone Number:	Email Address:	

Have you ever held a health professional license in any profession in Michigan? ☐ Yes ☐ No

Was your health professional license issued after 2008? ☐ Yes ☐ No

Health Professional Permanent I.D./License Number:

Expiration Date:

Have your ever been known under any other name? If yes, list name(s): ☐ Yes ☐ No

Will documents be received under any other name? If yes, list name(s): ☐ Yes ☐ No

Have your ever filed an application for this type of license in Michigan? ☐ Yes ☐ No

Full Name:

2. Personal Data Questions

1. Have you ever been convicted of a felony?

   If yes, please explain

   ☐ Yes
   ☐ No

2. Have you ever been convicted of a misdemeanor punishable by imprisonment for a maximum of 2 years?

   If yes, please explain

   ☐ Yes
   ☐ No

3. Have you ever been convicted of a misdemeanor involving the illegal delivery, possession, or use of alcohol or a controlled substance (including motor vehicle violations)?

   If yes, please explain

   ☐ Yes
   ☐ No

4. Have you had 3 or more malpractice settlements, awards, or judgments in any consecutive 5 year period?

   If yes, please explain

   ☐ Yes
   ☐ No

5. Have you had one or more malpractice settlements, awards, or judgments totaling $200,000 in any consecutive 5 year period?

   If yes, please explain

   ☐ Yes
   ☐ No

6. Have you ever been fined, denied, revoked, suspended, reprimanded, place on probation, otherwise disciplined, or the subject of a final adverse action by a licensure, registration, disciplinary or certification board as a holder of or applicant for, a license or registration regulated by this state, another state or territory of the United States, the United States military, the federal government, or another country?

   If yes, please explain

   ☐ Yes
   ☐ No

7. Have you ever been censured or requested to withdraw from a health care facility's staff or had your health care staff privileges involuntarily modified?

   If yes, please explain

   ☐ Yes
   ☐ No

8. Have you ever been treated for substance abuse in the past 2 years?

   If yes, please explain

   ☐ Yes
   ☐ No

Note: If you answered "yes" to any of the questions in Section 2 (questions 1-8), you must provide a detailed explanation with copies of all available official and/or court documents related to your explanation along with your application. If you do not provide the explanation, your application will be deemed incomplete and processing will be delayed.

Full Name:	
☐ Yes ☐ No Have you taken a National examination for another U.S. Jurisdiction?	Please list exam name and date taken (month & year).
☐ Yes ☐ No Have you taken a State Constructed examination for another U.S. Jurisdiction?	Please list state and date taken (month & year).

3. Professional Education

Name of Institution	Address of Institution	Graduation Date	Certificate/Diploma/Degree Granted

4. License(s) in Other State(s) and/or Province(s)

Do you hold or have you held a permanent license or registration in any state or Canadian province, for the type of license for which you are applying?

☐ Yes
☐ No

Please list each state or province, the license or registration number, the date issued, the number of year you held the license, and how the license was obtained (either examination or endorsement). **DO NOT LIST TEMPORARY LICENSES**. (Attach additional sheets, if necessary.)

State/Country	Permanent License/Registration Number	Date of Issue	Number of Years Licensed	Expiration Date	How Obtained (Exam or Endorsement)

5. 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, 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 State 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_____

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 maybe make your needs known to this agency.

Michigan Department of Licensing and Regulatory Affairs
Board of Medicine
PO Box 30192
Lansing, MI 48909
(517) 335-0918
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, certification will not be issued.

SECTION I-APPLICANT INFORMATION

Instructions: Complete Section I. Type or print your name as it appears on your application. Print this form and then 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.

First Name:	Middle Name:	Last Name:
Street Address:	Apt/Bldg#:	
City:	State:	Zip Code:
SSN:	Date of Birth:	
Email:	Phone Number:	
All Previous Names and/or Birth Name Used (if applicable):		
Date of Admission:	Date of Graduation:	

Signature_____ Date_____

Upon completion of Section I, print, sign, and date the form then send the form to the Dean of your medical school for completion of Section II. **This certification must be submitted directly to the Michigan Board of Medicine.**

Full Name:

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

Please complete the following information. Return this completed certification directly to Department of Licensing and Regulatory Affairs, Board of Medicine, PO Box 30192, Lansing MI 48909.

SECTION II-CERTIFICATION OF MEDICAL EDUCATION

Name of Medical School:		
Street Address of Medical School:		
City:	State:	Zip Code:

I certify that _____ attended the medical school named above
(Applicant's Full Name)

From _____ to _____ and was/will be granted
(Month/Day/Year) (Month/Day/Year)

the degree of _____on _____ .
(Month/Day/Year)

_____ _____
Signature of Dean or Registrar Date of Signature

_____
Print or Type Name of Dean or Registrar

Seal
If hospital has no seal, please indicate

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

CERTIFICATION OF MEDICAL EDUCATION FOR GRADUATES OF FOREIGN MEDICAL SCHOOLS

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

SECTION 1-APPLICANT INFORMATION

Instructions: Complete Section I. Type or print your name exactly as it appears on your application. Print this form and then 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.

First Name:	Middle Name:	Last Name:
Street Address:	Apt/Bldg#:	
City:	State:	Zip Code:
SSN:	Date of Birth:	
Email:	Phone Number:	
All Previous Names and/or Birth Name Used (if applicable):		
Date of Admission:	Date of Graduation:	

Signature_____ Date_____

Upon completion of Section I, print, sign and date the form then send the form to the Dean of your medical school for completion of Section II. This certification must be submitted directly to the Michigan Board of Medicine.

Full Name:

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

Please complete the following information. Return this completed certification directly to the Department of Licensing and Regulatory Affairs, Board of Medicine, PO Box 30192, Lansing MI 48909.

SECTION II-CERTIFICATION OF MEDICAL EDUCATION

Name of Medical School:		
Street Address of Medical School:		
City:	State:	Zip Code:

I certify that _____attended the medical school named above
(Applicant's Full Name)

from _____ to _____and was/will be granted
(Month/Day/Year) (Month/Day/Year)

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 clerkships completed at the hospitals or institutions listed below.

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

_____ _____

Signature of Dean or Registrar Date of Signature

_____

Print or Type Name of Dean or Registrar

(Seal)

If hospital has no seal, please indicate

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

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

CERTIFICATE OF POSTGRADUATE TRAINING

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

Section I-APPLICANT INFORMATION

Instructions: Complete Section I. Type or print your name exactly as it appears on your application. Print this form and then 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.

First Name:	Middle Name:	Last Name:
Street Address:	Apt/Bldg#:	
City:	State:	Zip Code:
SSN:	Date of Birth:	
Phone Number:	Email:	
All Previous Names and/or Birth Name Used (if applicable):		

Signature_____ Date_____

Upon completion of Section I, print, sign and date the form then send the form to the Director of Medical Education for completion of Section II. **This certification must be submitted directly to the Michigan Board of Medicine.**

Full Name:

THIS SECTION 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 Department of Licensing and Regulatory Affairs, Michigan Board of Medicine, PO Box 30192, Lansing MI 48909.

SECTION II-CERTIFICATION OF POST GRADUATE TRAINING

Name of Training Hospital:		
Street Address of Hospital:		
City:	State:	Zip:

I certify that _____a graduate of the
(Applicant's Full 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 ACGME, the College of Family Physicians of Canada, the Royal College of Physicians and Surgeons of Canada, or by the National Joint Committee on Preregistration Physician Programs of the Canadian Medical Association? ☐ Yes ☐ No

_____ **_____**
Signature of Director 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 certified and submitted more than 15 days prior to actual completion.

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

CERTIFICATION OF PRACTICE IN AN ACADEMIC INSTITUTION

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

DO NOT COMPLETE THIS FORM UNLESS YOU HAVE HELD A CLINICAL ACADEMIC LICENSE

SECTION I-APPLICANT INFORMATION

Instructions: Complete Section I. Type or print your name exactly as it appears on your application. Print this form and then for completion of Section II, send this form to be completed by the Director of Medical Education office where you practiced under a clinical academic limited license.

This certification must be submitted directly to the Michigan Board of Medicine by the Director of Medical Education.

First Name:	Middle Name:	Last Name:
Street Address:	Apt/Bldg#:	
City:	State:	Zip Code:
SSN:	Date of Birth:	
Email:	Phone Number:	
All Previous Names and/or Birth Name Used (if applicable):		
Date of Admission:	Date of Graduation:	

Signature_____ Date_____

Upon completion of Section I, print, sign and date the form then send the form to the Dean of your medical school for completion of Section II. **This certification must be submitted directly to the Michigan Board of Medicine.**

Full Name:

THIS SECTION 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 Department of Licensing and Regulatory Affairs, Michigan Board of Medicine, PO Box 30192, Lansing MI 48909.

SECTION II-CERTIFICATION OF PRACTICE IN AN ACADEMIC INSTITUTION

Name of Institution:		
Street Address of Institution:		
City:	State:	Zip Code:

I certify that _____ has been duly appointed to this academic institution
(Applicant's Full Name)
in the clinical area of _____.

beginning _____ and ending _____.
(Month/Day/Year) (Month/Day/Year)
The applicant is appointed to the following position

☐ Medical school faculty

☐ Research

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

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

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

_____ _____
Signature of Director 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 certified and submitted more than 15 days prior to actual completion.

Please print out the Application (pages 5-7), Certification of Medical Education for Graduated of Medical Schools Located in the United States, its Territories, the District of Columbia, or the Dominion of Canada (pages 8-9, if applicable), Certification of Medical Education for Graduates of Foreign Medical School Graduates (pages 10-11, if applicable), Certification of Postgraduate Training (pages 12-13) and the Certification of Practice in an Academic Institution (pages 14-15, if applicable). Sign and date your application, and submit the application along with your check or money order made payable to the "State of Michigan" to:

Michigan Department of Licensing and Regulatory Affairs
Bureau of Health Care Services
Board of Medicine
PO Box 30192
Lansing, MI 48909

If applicable, sign and date the 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 then submit it to the Dean of medical school you attended to complete section II and send directly to our office.

If applicable, sign and date the Certification of Medical Education for Graduates of Foreign Medical Schools then submit it to the Dean of the medical school you attended to complete section II and send directly to our office.

Sign and date the Certification of Postgraduate Training then submit it to the Director of Medical Education where you completed your post-graduate training to complete section II and send directly to our office.

If applicable, sign and date the Certification of Practice in an Academic Institution then submit it to the Director of Medication Education to complete Section II and send directly to our office.

APPLICATION CHECKLIST

☐ **Application Fee**: Submit a check or money order drawn on a U.S. financial institution and made payable to the **STATE OF MICHIGAN.**

☐1. **Demographic Information:** Social Security Number: Please list only a United States Social Security number.

Name: List your full name: first, middle and last name. If your name changes after you apply, you must submit a name change to the Bureau of Health Care Services in writing along with legal documentation within 30 days.

Birth Date: Provide the month, day and year of your birth.

Address: List the address we should use to send any information about your license. Be sure to include the city, state, zip code, and country. This will be your permanent address with the Bureau of Health Care Services. If your address changes, you must notify in writing within 30 days.

Phone: Enter a telephone number where you can be reached in case we have questions about your application.

E-mail: Enter your e-mail address. E-mail is a quick way our office can communicate with you about your application.

Other name(s): Indicate whether you have been known by any other names.

☐2. **Personal Data Questions**: All applicants must answer the same personal data questions. If you answer "yes" to any questions in this section, you must submit a detailed explanation with your application. If you do not provide this information, your application will be deemed incomplete and processing will be delayed.

☐3. **Professional Education**: List your current or completed medicine school. Indicate degree/certificate/diploma earned. List graduation and/or anticipated graduation date.

☐4. **License in Other State(s) and/or Province(s)**: List all states/provinces where you have held a medical doctor license or registration. Indicate method of licensure-examination or endorsement.

☐5. **Certification**: You must sign and date your application for it to be valid. By signing the application you are indicated that you have read and understood the certification section.

TOP THINGS APPLICANTS SHOULD KNOW

1. 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 an application for a Michigan license or registration.

2. Read the entire application before submitting it and DO NOT send the checklist to the Board of Medicine office.

3. Applications and mail are processed as quickly as possible in date-received order.

4. Please allow time to process your application before you call or email our office to check on the status. Applications may take up to 2 weeks to reach our office. Applications with fees are first processed through our central mailroom then through our payment processing office.

5. Mail, including mail sent overnight, is first received by our central mailroom prior to reaching the Board.

6. Supporting documentation will not be accepted if faxed into our office.

7. REFUND POLICY: If you wish to withdraw your application, you must notify the Board of Medicine in writing to request a partial refund.

8. If your name and/or address changes please notify the Board of Medicine in writing within 30 days. To change a name or address, you can download the Data Change/Duplicate License Request Form from our website at www.michigan.gov/healthlicense and fax it to (517) 335-2044 ATTN: Applications Section or mail the form to: Licensing and Regulatory Affairs, Bureau of Health Care Services, Board of Medicine, Applications Section, PO Box 30670, Lansing, MI 48909. Telephone calls are NOT accepted for these changes. After your license is issued, you can change your address online at www.michigan.gov/elicense.

GLOSSARY/DEFINITION OF TERMS

CONTACT HOUR/CREDIT	A continuing education credit or contact hour is equivalent to 50-60 minutes of program participation in a board-approved program.
CONTINUING EDUCATION	A medical doctor is required to earn 150 hours of board-approved continuing education to renew the license.
ENDORSEMENT	Application made by an individual who holds an active license in another state with licensure requirements substantially equivalent to Michigan requirements.
EXAMINATION	Application made by an individual who must take and pass an examination in order to become licensed in Michigan.
LAPSED LICENSE	A lapsed license is a license that is no longer active. A license becomes inactive when it is not renewed upon the expiration date printed on the license.
RECIPROCITY	Process by which an individual could possibly become licensed in Michigan through a reciprocity agreement with another state board. Michigan does not have a reciprocity agreement with any other state.
REINSTATEMENT	The process in which a disciplinary, suspended or revoked license has not lapsed is reactivated by the Board.
RELICENSURE	The application process in which a licensee must apply to reactivate a lapsed or lapsed suspended license.
RENEWAL	Process to maintain active licensure status at the end of each renewal cycle.

Q. How long will it take to process my application?

Applications and mail are processed as quickly as possible in date-received order. Applications with fees are first processed through our central mailroom then through our payment processing office.

Q. What do I do if I forgot to include my payment with my application?

Please submit the fee along with a copy of your application and a letter indicating that you failed to submit the required payment with your previous application. Mail to: Licensing and Regulatory Affairs, Bureau of Health Care Services, Board of Medicine, PO Box 30192, Lansing, MI 48909.

Q. How do I check on the status of my application?

Within approximately three weeks of mailing your application to our office, you should receive an Application Confirmation letter containing your customer number. You may use your customer number to check the status of your application at www.michigan.gov/appstatus.

Q. If I have been convicted of a felony or misdemeanor will it stop me from being licensed?

We ask that you submit your application, fee and information regarding the occurrence. The Board will review your file and make a decision at that time. Please keep in mind that we do take into consideration the type of conviction, the age that you were when the incident occurred and the time that has elapsed since the conviction.

Q. How long is my license valid?

The initial license is good a partial licensure cycle and will expire on the upcoming January 31 renewal date. Each subsequent license will cover a full two-year cycle.

Q. Do I have to earn continuing education for this first license?

Since the initial license is valid for a partial licensure cycle you will not be required to earn continuing education. However, after the first renewal, Michigan medical doctors are required to earn 150 hours of board-approved continuing education credit over each three-year cycle of licensure. The Michigan Board of Medicine does not receive attendance reports or track your education for you. You should maintain copies of your continuing education certificates for at least a five year period in case you are audited by the Michigan Board of Medicine.

WEBSITES AND LINKS

WEBSITES:

Michigan Department of Licensing and Regulatory Affairs	www.michigan.gov/lara
Bureau of Health Care Services	www.michigan.gov/bhcs
Health Professions Licensing Division	www.michigan.gov/healthlicense
Michigan Board of Medicine Rules	www.michigan.gov/healthlicense
Michigan Public Health Code	www.michigan.gov/healthlicense
Application Status	www.michigan.gov/appstatus
Verify a Health Professional License	www.michigan.gov/verifylicense
Renewal Website	www.michigan.gov/elicense

LINKS:

Identogo	www.identogo.com