



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

**LIMITED MEDICAL LICENSE FROM A CLINICAL ACADEMIC LICENSE
APPLICATION PACKET**

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LIMITED MEDICAL LICENSE FROM A CLINICAL ACADEMIC LICENSE LICENSURE INSTRUCTIONS

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

Section 16182(1) of the Michigan Public Health Code, states that the board may grant a limited license to individuals who have shown that they are able to practice medicine in a safe and competent manner. This application is only for individuals who have held a clinical academic license issued by the Michigan Board of Medicine and renewed that license five times. This license is intended for physicians who are seeking to continue practicing in a specialized area at a specific academic institution. If granted this license, the provisions of the clinical academic license will continue under the limited medical license. An individual who holds this limited license may practice only in the clinical academic position to which the individual is appointed. An applicant for this limited license must demonstrate the following:

- a. That the applicant has been engaged in the practice of medicine for at least ten years after completing the requirements for a degree in medicine obtained in an institution outside of the United States or Canada.
- b. That the applicant has completed not less than three years of postgraduate clinical training in an institution that is affiliated with the World Health Organization (WHO).
- c. That the applicant has safely and competently practiced medicine under a clinical academic limited license for one or more academic institutions located in this state and that the clinical academic license has been renewed the maximum of five times preceding the date of application for this limited license and that during that time the applicant functioned at least 800 hours per year in the observation and treatment of patients.

INSTRUCTIONS:

1. A completed application and a check or money order, drawn on a U.S. financial institution (made payable to the **STATE OF MICHIGAN**, for the appropriate amount. 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.
2. All applicants for a health profession license or registration in Michigan are required to submit fingerprints and undergo a criminal background check. Please see the attached instructions. The Michigan Board is not able to accept fingerprints that have been obtained for any other purpose. Your license or registration will not be issued until this process is complete.
3. Certification of medical education submitted directly from the medical school to the board on the attached form (unless already on file with this office).
4. Certification of successful completion of three years postgraduate clinical training. The Certification of Postgraduate Training form must be submitted directly to the Board by the Director of Medical Education where you completed your postgraduate training.
5. The Certification of Practice in an Academic Institution form must be submitted directly to the Board by the Director (s) of Medical Education where you practiced under the Clinical Academic license. You must have renewed your clinical academic license the maximum of five times to qualify for the limited license.

LIMITED MEDICAL LICENSE FROM A CLINICAL ACADEMIC LICENSE LICENSURE INSTRUCTIONS CONTINUED

6. The Certification of Appointment to a Michigan Academic Institution form (attached), certifying a teaching or research appointment to a Michigan academic institution, must be completed and submitted directly to the Board by the Director of Medical Education of the appointing institution.

Please Note:

- An application submitted with the appropriate fee is valid for two years from the date it is received. If an applicant fails to complete the requirements for licensure within the two year period following the date of application, the application will become invalid.

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For Board Use Only
License #:
CS License #:
Issue Date:

APPLICATION FOR LIMITED MEDICAL LICENSE AND CONTROLLED SUBSTANCE LICENSES

I am applying for the following:

--

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:								
Phone Number:					E-mail Address:			
Name of Appointing Hospital:								
Hospital Street Address:								
City:			State:			Zip Code:		
Have you ever held a health professional license in any profession in Michigan?								<input type="checkbox"/> Yes
								<input type="checkbox"/> No
Health Professional Permanent I.D./License Number:						Expiration Date:		

Full Name:

2. Personal Data Questions

1. Have you ever been convicted of a felony?

 Yes
 No

If yes, please explain

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

 Yes
 No

If yes, please explain

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)?

 Yes
 No

If yes, please explain

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

 Yes
 No

If yes, please explain

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

 Yes
 No

If yes, please explain

6. Have you ever been fined, denied, revoked, suspended, reprimanded, placed 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?

 Yes
 No

If yes, please explain

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?

 Yes
 No

If yes, please explain

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

 Yes
 No

If yes, please explain

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:

Have you ever been known under any other name?

Yes

If yes, list name(s):

No

Will documents be received in any other name?

Yes

If yes, list name(s):

No

3. Professional Education

**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	

4. Post-graduate Experience

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

Hospital Name and Location	Dates of Practice		Program Title
	From	To	

Full Name: _____

5. License(s) in Other State(s) or Province(s)

Do you hold or have you held a permanent osteopathic license or registration in any state or province? If yes, list each state or province, the license or registration number, the date issued and how the license was obtained (either endorsement or examination).

 Yes No

DO NOT LIST TEMPORARY/LIMITED LICENSES. (Attach additional sheets if necessary.)

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

6. 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 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 _____

The Department of Licensing and Regulatory Affairs will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

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**CERTIFICATION OF POSTGRADUATE TRAINING
 (CLINICAL ACADEMIC LIMITED LICENSE)**

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 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 POSTGRADUATE TRAINING

Name of Training Hospital:

Street Address of Hospital:

City:

State:

Zip Code:

Identify all medical schools affiliated with the training hospital:

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 _____.

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.

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CERTIFICATION OF PRACTICE IN AN ACADEMIC INSTITUTION

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 exactly as it appears on your application. Print this form and then for completion of Section II, send this form to be completed by your chief academic 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):		

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 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 in
(Applicant's Full Name)

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 Veterans' 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

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**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 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:	
E-mail:		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, Michigan Board of Medicine, PO Box 30192, Lansing, MI 48909.

SECTION II - CERTIFICATION OF MEDICAL EDUCATION

Name of Medical School:

Street Address of Hospital:

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.

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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 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 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:	
E-mail:	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, Michigan Board of Medicine, PO Box 30192, Lansing, MI 48909.

SECTION II - CERTIFICATION OF MEDICAL EDUCATION

Name of Medical School:

Street Address of Hospital:

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 in the completed at the hospitals or institutions listed below.

Clinical Sciences	Name and Address of Hospital	*Teaching Hospital
Internal Medicine		<input type="checkbox"/> Yes <input type="checkbox"/> No
General Surgery		<input type="checkbox"/> Yes <input type="checkbox"/> No
Pediatrics		<input type="checkbox"/> Yes <input type="checkbox"/> No
Obstetrics and Gynecology		<input type="checkbox"/> Yes <input type="checkbox"/> No
Psychiatry		<input type="checkbox"/> Yes <input type="checkbox"/> No

Signature of Dean or Registrar

Date of Signature

Print or Type Name of Dean or Registrar

(Seal)

If 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 of the clerkship.

**CRIMINAL BACKGROUND CHECK
FINGERPRINT REQUEST FORM INSTRUCTIONS
(For Applicants in Michigan)**

1. Applicants for a Michigan health professional license must have their fingerprints taken under an Agency ID/ORI Number specific for the board for which they are applying. Fingerprints may be taken by either Identogo (formerly L-1 Enrollment) or another agency listed at www.michigan.gov/lsvendor. Whether you use Identogo or another agency, you must use an Agency ID Number for a Health Professional licensing board. These Agency ID numbers **MUST** be used in order to have the fingerprint report sent to the Health Professions Licensing Division. Receipts **should not** be mailed to the office, but kept for your own records.
2. Please complete the Livescan Fingerprint Request Form and check the box for the profession for which you have applied. Incorrectly selected professions/agency ID's may delay the criminal background check process.
3. You must bring the Livescan Fingerprint Request Form with 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 fingerprint agency when registering and/or scheduling your appointment.
4. When your fingerprints are taken, a technician will perform a scan of your fingerprints and submit the data electronically to the Michigan State Police.
5. If no criminal history is found, the Health Professions Licensing Division will be notified.
6. If criminal history information is found, the Michigan State Police will send the record directly to the Health Professions Licensing Division for review.
7. Information about fees and scheduling your fingerprint appointment with Identogo can be found at www.identogo.com or by calling 1-866-226-2952.
8. Identogo is under contract with the Michigan State Police to provide fingerprint services. For questions, call the Michigan State Police at (517) 241-0606.
9. Please do not contact the board office regarding your criminal background check, unless your fingerprints were taken **more** than 30 days ago.
10. **Please note:** Fingerprints taken for any other agency will not fulfill fingerprint requirements for a health professional license in Michigan.

**CRIMINAL BACKGROUND CHECK
FINGERPRINT REQUEST FORM INSTRUCTIONS
(For applicants out of state/out of country)**

1. Contact a local law enforcement, governmental, or private fingerprint agency to perform an ink fingerprint on an FBI (FD-258) card or on another state's or country's official fingerprint card. The ink fingerprint must be completed on card stock paper.
2. Submit the ink fingerprint card along with the completed Livescan Fingerprint Request Form and a business check or money order for \$62.75, made payable in U.S. Funds, to MorphoTrust USA to the following address:

MorphoTrust USA
Attn: Card Scan Processing Unit
3051 Hollis Drive Ste 310
Springfield IL 62704

3. Please include a daytime telephone number or e-mail address with your request where you can be reached if there are any questions.
4. Identogo will submit your fingerprints to the Michigan State Police for analysis.
5. If no criminal history information is found, the Health Professions Licensing Division will be notified.
6. If criminal history information is found, the Michigan State Police will send the record directly to the Health Professions Licensing Division for review.
7. Call Identogo toll-free at 1-866-226-2952 (8am - 5pm EST) if you have any questions.
8. Identogo is under contract with the Michigan State Police to provide fingerprint services. For questions, call the Michigan State Police at (517) 241-0606.
9. Applicants for a Michigan health professional license must have their fingerprints taken under the Agency ID/ORI Number specific for the board for which they are applying.
10. Please do not contact the board office regarding your criminal background check, unless your fingerprints were taken **more** than 30 days ago.
11. **Please note:** Fingerprints taken for any other agency will not fulfill fingerprint requirements for a health professional license in Michigan.

LIVESCAN FINGERPRINT REQUEST FORM

Applicant Instructions: Please complete the top section of this form, print it and take it along with your picture ID to your scheduled appointment or if you are an out of state/out of country applicant please mail it along with your fingerprints.

First Name:		Middle Name:		Last Name:	
Street Address:				Apt/Bldg. #:	
City:		State:		Zip Code:	
Phone Number:			Country:		
Date of Birth (MM/DD/YYYY):			Race:		Sex:
Height:	Weight:	Eye Color:		Hair Color:	
License/Registration you are applying for:					

THE FOLLOWING SECTION IS TO BE COMPLETED BY THE FINGERPRINT AGENCY

Fingerprint Date:	TCN:
-------------------	------

Type of ID Presented:

REQUESTING AGENCY INFORMATION

Agency Name Agency ID Number: MI DEPT OF LARA - Medicine Agency ID #90897K
Reason Fingerprinted: LHP - Licensed Health Care Professional (MCL333.16174)

Please print out the Application (pages 5-8), Certification of Postgraduate Training (Clinical Academic Limited License) (pages 9-10, if applicable), Certification of Appointment to a Michigan Academic Institution (page 11, if applicable), Certification of Practice in an Academic Institution (page 12-13, if applicable), 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 14-15, if applicable), Certification of Medical Education for Graduates of Foreign Medical School Graduates (pages 16-17, if applicable) and the LiveScan Fingerprint Request Form (page 20). 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

Sign and date the Certification of Practice in an Academic Institution then submit it to the Director of Medical Education to complete Section II and send directly to our office.

Sign and date the Certification of Postgraduate Training (Clinical Academic Limited License) then submit it to the Director of Medical Education to complete Section II and send directly to our office.

Sign and date the Certification of Appointment to a Michigan Training Hospital Form then submit it to the Program Director to complete Section II and send directly to our office.

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 the medical school you attended to complete section II and send directly to our office.

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.

Schedule your fingerprints to be taken 7-10 business days after you have mailed your application to our office.

APPLICATION CHECKLIST

All information should be typed or printed clearly. It is your responsibility to submit the required forms to our office.

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 us in writing within 30 days.

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

Email: 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 on the space provided on 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 medical school(s). Include the name and address of your medical school, the graduation date and degree earned.

4. Post-graduate Experience Education: List your internship/residency training experience. Include the name and address of the hospital, dates of practice and the title of the program.

5. License in Other State(s) and/or Province(s): List all states/provinces where you have held an medical license or registration. Indicate the license/registration number, date of issue, and the method of licensure - examination or endorsement. Please do not list temporary or educational licenses.

6. Certification: You must sign and date your application for it to be valid. By signing the application you are indicating 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 a Michigan license or registration.
2. Read the entire application before submitting it and DO NOT send the checklist to the Board 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. Transcripts, Certifications of Medical Education Forms, or Certifications of Appointment to a Michigan Training Hospital Forms will not be accepted if faxed into our office.
7. A controlled substance license that is issued with an educational limited license becomes NULL AND VOID when the educational limited license expires. You MUST reapply for a new controlled substance license when you upgrade to a full medical license.
8. REFUND POLICY: If you wish to withdraw your application, you must notify the Board of Medicine in writing to request a partial refund.
9. 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 ATTN: Application Section to (517) 335-2044 or mail the form to: Licensing and Regulatory Affairs, Bureau of Health Care Services, Board of Medicine, PO Box 30192, 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.
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 has taken and passed an examination.
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 that has not lapsed is reactivated by the Michigan Board of Medicine.
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.

FREQUENTLY ASKED QUESTIONS

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 Michigan Board of Medicine 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 for?

Educational limited licenses are valid for a one-year period until it must be renewed.

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

www.michigan.gov/healthlicense

Michigan Public Health Code

www.michigan.gov/healthlicense

Application Status

www.michigan.gov/appstatus

Renewal Website

www.michigan.gov/elicense

LINKS:

Identogo

www.identogo.com