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 EDUCATIONAL LIMITED
APPLICATION PACKET

INCLUDED IN THIS PACKET:

Michigan Department of Licensing and Regulatory Affairs
Bureau of Health Care Services
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Lansing, MI 48909
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MEDICAL EDUCATIONAL LIMITED LICENSURE INSTRUCTIONS

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

EDUCATIONAL LIMITED LICENSE APPLICANTS WHO ARE GRADUATES OF A MEDICAL SCHOOL LOCATED IN THE UNITED STATES, ITS TERRITORIES, THE DISTRICT OF COLUMBIA, OR THE DOMINION OF CANADA, 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 Board of Medicine.

2. Applicants for licensure in Michigan are required to undergo a Criminal Background Check (CBC) and provide evidence of fingerprint processing from an authorized agency. 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 Certification of medical education submitted directly from the medical school to the Board on the proper form.

4. Certification of appointment to a Michigan training hospital to be completed, on the proper form and submitted directly to the board by the hospital in which the training is to occur.

5. Arrange for a verification and/or certification of your license status to be sent directly to the Michigan Board from any state or province where you currently hold or have ever held a permanent license or registration. Copies of licenses are not acceptable.

PLEASE NOTE: An Educational Limited license may be renewed 5 times, with no extensions available.

MEDICAL EDUCATIONAL LIMITED
LICENSURE INSTRUCTIONS CONTINUED

EDUCATIONAL LIMITED LICENSE APPLICANTS 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 Board of Medicine.

2. Applicants for licensure in Michigan are required to undergo a Criminal Background Check (CBC) and provide evidence of fingerprint processing from an authorized agency. 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. Certification of medical education submitted directly from the medical school to the board on the proper form.

4. Certification of appointment to a Michigan training hospital to be completed, on the proper form and submitted directly to the board by the hospital in which the training is to occur.

5. Verification of your Educational Commission for Foreign Medical Graduates (ECFMG) certificate must be electronically submitted directly to the Michigan Board from ECFMG.
   Go to https://cvsonline2. ecfmg.org/lmgGenInfo.asp for information and instructions on how to apply for your ECFMG status report to be sent to the Board.

6. Arrange for a verification and/or certification of your license status to be sent directly to the Michigan Board from any state or province where you currently hold or have ever held a permanent license or registration. Copies of licenses are not acceptable.

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

APPLICATION FOR MEDICAL EDUCATIONAL LIMITED AND CONTROLLED SUBSTANCE LICENSES

I am applying for the following:

☐ **Medical Educational Limited and Controlled Substance Licenses Fee: $170.00 [71-4301-375705]**

Your check or money order drawn on a U.S. financial institution and made payable to the **STATE OF MICHIGAN** must accompany this application. 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?		☐ Yes ☐ 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 judgments in any consecutive 5 year period? ☐ Yes ☐ No

If yes, please explain

5. Have you had one or more malpractice settlements, awards, or judgments 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 ☐ No
If yes, list name(s):

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

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 From	To	Degree

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 From	To	Program Title

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

☐ Yes
☐ No

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 APPOINTMENT TO A MICHIGAN TRAINING HOSPITAL

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

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 Medical Director or Superintendent of the Michigan training hospital for completion of Section II. **This certification must be submitted directly to the Michigan Board of Medicine by the Director or Superintendent of the training program.**

Full Name:

THIS SECTION TO BE COMPLETED BY THE PROGRAM DIRECTOR

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 RESIDENCY APPOINTMENT

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

I certify that _____ has been duly appointed to the training program in
(Applicant's Full Name)

the clinical area of _____

beginning _____and ending _____
(Month/Day/Year) (Month/Day/Year)

at _____.
(Name of Training Hospital)

Is the program accredited by ACGME? ☐ Yes ☐ No

_____ _____
Signature of Director Medical Education Date of Signature

_____ (Seal)
Print or Type Name of Director of Medical Education

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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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 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.

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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 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 in the 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 of the clerkship.

Please print out the Application (pages 5-8), Certification of Appointment to a Michigan Training Hospital (pages 9-10), 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 11-12, if applicable) and the Certification of Medical Education for Graduates of Foreign Medical School Graduates (pages 13-14, 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

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.

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 a 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