

MONTANA BOARD OF MEDICAL EXAMINERS
P. O. Box 200513 (301 S PARK, 4TH FLOOR - Delivery)
Helena, Montana 59620-0513
(406) 444-5773 FAX (406) 841-2305

EMAIL: dlibsmed@mt.gov **WEBSITE:** www.medicalboard.mt.gov

Application for Registration as a Health Corps Physician

ILLEGIBLE AND INCOMPLETE APPLICATIONS WILL BE RETURNED.

(Please allow 30 days for processing from the date that the Board has a complete routine application)

**PHYSICIANS ARE NOT PERMITTED TO PRACTICE MEDICINE IN MONTANA IN ANY MANNER
WITHOUT AN ACTIVE MONTANA LICENSE**

APPLICATION REQUIREMENTS:

- ◆ Must hold an active physician license in Montana.
- ◆ Has actively practice medicine in the two years preceding the application date OR has passed the Special Purpose Examination (SPEX) within the past six months.
- ◆ Must be retired from the practice of medicine.

FEES: **\$25.00 - Application Fee** **Make payable to Montana Board of Medical Examiners**

DOCUMENTS TO SUBMIT FOR AN APPLICATION TO BE COMPLETE:

- ▶ **SPEX SCORES, if applicable to applicant.** Forms can be obtained from the Federation of State Medical Boards at www.fsmb.org Please use the appropriate form to request exam scores and send directly to the Board office, letter unopened.
- ▶ **APPLICATION FOR ACTIVE MEDICAL DOCTOR LICENSE**, if not currently licensed in Montana.

APPLICATION PROCESSING PROCEDURES:

- ▶ When the application file is complete, it will be processed and considered by Board staff for registration. The applicant may be notified if additional information is required or if required to appear before the Board for an interview. Once a routine application is complete, the application may take up to 30 days to process.
- ▶ You will be notified by mail when the application has been successfully processed and you have been accepted into the Health Corps.
- ▶ Applicant will be notified in writing of any deficient or missing items from the application file.
- ▶ If the application is considered a non-routine application, there will be a delay in processing of the application. You may be requested to provide additional information or make a personal appearance before the Board during a regularly scheduled Board meeting and/or the application may require Board consideration. We will make the best effort to process non-routine applications as quickly as possible.

For information with regard to the processing of this application or other concerns please contact the Board staff at (406) 444-5773 or email us at: dlibsmed@mt.gov

PLEASE BE SURE TO REVIEW THE MONTANA LAWS AND RULES FOR THE PRACTICE OF MEDICINE
ON OUR WEBSITE: www.medicalboard.mt.gov

MONTANA BOARD OF MEDICAL EXAMINERS
P. O. Box 200513 (301 S PARK, 4 TH FLOOR - Delivery)
Helena, Montana 59620-0513
(406) 444-5773 FAX (406) 841-2305
EMAIL: dlibsmed@mt.gov WEBSITE: www.medicalboard.mt.gov

Application for Registration as a Health Corps Physician

Allow 30 days from the date the Board has a Complete routine application for licensure.

1. FULL NAME: _____
Last First Middle

2. OTHER NAMES KNOWN BY: _____

3. BUSINESS NAME: _____

4. BUSINESS ADDRESS: _____
Street or PO Box # City and State Zip Country

5. HOME ADDRESS: _____
Street or PO Box # City and State Zip Country

PREFERRED MAILING ADDRESS:

HOME BUSINESS EMAIL ADDRESS: _____

6. TELEPHONE: _____ BUSINESS _____ HOME _____ FAX _____

7. SOCIAL SECURITY NUMBER: _____ FOREIGN ID NUMBER: _____

8. DATE OF BIRTH: _____ PLACE OF BIRTH: _____ MALE
 FEMALE

9. LICENSE NAME: _____
(State your name as it appears on the physician license.)

10. Specify the date you retired, or plan to retire, from practicing medicine: _____

11. Have you actively practiced medicine in the past two years? YES NO

If you answered "No", please provide your SPEX score or date you intend to take the exam:

Score: _____ Date exam taken or planned: _____

14. Have you ever had an application for a professional or occupational license refused or denied? If yes, please attach a detailed explanation and provide supporting documentation from the source. YES NO
15. Have you ever withdrawn an application for licensure prior to the licensing agency's decision regarding your application? If yes, please attach a detailed explanation and provide supporting documentation from the source. YES NO
16. Have you ever been denied the privilege of taking an examination required for any professional or occupational license? If yes, please attach a detailed explanation and provide supporting documentation from the source. YES NO
17. Have you ever withdrawn or been suspended, placed on probation, expelled or requested to resign from any postsecondary educational program? If yes, please attach a detailed explanation and provide supporting documentation from the source. YES NO
18. Have you ever requested temporary or permanent leave of absence, been placed on probation, restricted, suspended, revoked, allowed to resign, or otherwise acted against by any professional or occupational education program (i.e., residency, internship, apprenticeship, etc)? If yes, please attach a detailed explanation and provide supporting documentation from the source. YES NO
19. Has a licensing agency initiated or completed disciplinary action against any professional or occupational license you have held? If yes, please provide agency documents including the complaint, initiating documents, orders, final orders, stipulations and consent and/or settlement agreements directly from the source. YES NO
20. Have you ever voluntarily surrendered, cancelled, forfeited, failed to renew a professional or occupation license in anticipation of or during an investigation or disciplinary proceeding or action? If yes, please attach a detailed explanation and provide supporting documentation from the source. YES NO
21. Is there a pending complaint against you with a professional or occupational licensing agency? If yes, please attach a detailed explanation and provide supporting documentation from the source. YES NO
22. Have you ever been the subject of any sanction or action, denial, suspension, revocation, restriction or termination regarding hospital, facility or staff privileges; health maintenance organization participation, third party provider or Medicare /Medicaid participation; or any other privileges? If yes, please attach a detailed explanation and provide supporting documentation from the source. YES NO

23. Have you ever been censured, expelled, denied membership or asked to resign from a professional organization related to your profession or occupation? If yes, please attach a detailed explanation and provide documentation from the source. YES NO
24. Have you ever been the subject of any sanction or action, denial, suspension, revocation, restriction or termination regarding your ability to prescribe, dispense or administer drugs including controlled substances? If yes, please attach a detailed explanation and provide documentation from the source. YES NO
25. Do you have any initiated or completed action against you by any state, federal, tribal, or foreign licensing jurisdiction? (For example: Drug Enforcement Agency; Alcohol, Tobacco and Firearms; Homeland Security; Indian Health Service, etc) If yes, please attach a detailed explanation and provide documentation from the source. YES NO
26. Have any civil legal proceedings been filed against you by a (patient/client), (former patient/client) or employer/employee? If yes, attach a detailed explanation and documentation from the source including initiating document(s) and documentation of final disposition. YES NO
27. Have you ever been convicted of a misdemeanor or felony crime or do you have a pending criminal charge? "Convicted" for the purposes of this question includes a conviction under appeal, guilty plea, no contest plea, and/or forfeiture of bond. "A pending criminal charge" for the purpose of this question includes a deferred imposition of sentence and/or deferred prosecution. If you answer yes, you must submit a detailed explanation of the events AND the charging documents and final judgments or orders of dismissal. You must report but may omit documentation for: (1) misdemeanor traffic violations older than 10 years and that resulted in fines of less than \$200; and (2) convictions prior to your 18th birthday unless you were tried as an adult. YES NO
31. Have you ever been diagnosed with chemical dependency or another addiction, or have you participated in a chemical dependency or other addiction treatment program? If yes, please attach a detailed explanation and provide documentation regarding evaluations, diagnosis, treatment recommendations and monitoring from the source. YES NO
28. Have you been diagnosed within the past 5 years with a physical condition or mental health disorder involving potential health risk to the public? If yes please provide a detailed explanation. YES NO
29. Have you ever been court-martialled or discharged other than honorably from any branch of the armed service? If yes, attach a detailed explanation and documentation for the source. YES NO
30. Have you any physical or mental condition(s) which may have or has adversely affected your ability to practice this profession, including but not limited to a contagious or infectious disease involving risk to the public? YES NO
31. Have you used alcohol or any other mood-altering substance in a manner which may have or has adversely affected your ability to practice this profession? If yes, attach a detailed explanation. YES NO

DECLARATION

I authorize the release of information concerning my education, training, record, character, license history and competence to practice, by anyone who might possess such information, to the Montana Board of Medical Examiners.

I hereby declare under penalty of perjury the information included in my application to be true and complete to the best of my knowledge. In signing this application, I am aware that a false statement or evasive answer to any question may lead to denial of my application or subsequent revocation of licensure on ethical grounds. I have read and will abide by the current licensure statutes and rules of the State of Montana governing the profession. I will abide by the current laws and rules that govern my practice.

Signature of Applicant

Date