



**STATE OF MAINE
BOARD OF LICENSURE IN MEDICINE
137 STATE HOUSE STATION
AUGUSTA, ME 04333-0137
Phone: (207)287-3601
Fax: (207)287-6590
Web: www.maine.gov/md**

EDUCATIONAL CERTIFICATE APPLICATION

I Hereby apply for a temporary educational permit to practice medicine and surgery as a resident in a training program affiliated with _____ Hospital, in _____, MAINE

BEGINNING _____ ENDING _____

NAME: _____
Last First Middle

Home Address: _____ Work Address: _____
 Use this as my contact address Number and Street Use this as my contact address Number and Street

City State Zip/Postal Code City State Zip/Postal Code

Home Telephone: _____ Work Telephone: _____

Social Security Number: _____ - _____ - _____ Email address _____

Date Of Birth: _____ / _____ / _____ Place of Birth: _____
Month Day Year

Medical School: _____ GRADUATION DATE _____
NAME
City, State, Country

AFFIDAVIT OF APPLICANT

I, _____, being duly sworn, depose and say that I am the person described and identified in this application.

I have carefully read the questions in this application and have answered them completely, without reservations of any kind, and declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension or revocation of my license to practice medicine and surgery in the state of Maine, or other discipline as the Board may determine.

I hereby authorize all hospitals, medical institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present) and all governmental agencies and instrumentalities (local, state, federal, and foreign) to release to this licensing Board any information, files or records required by the Board for its evaluation of any professional and ethical qualifications for licensure in the state of Maine. I hereby release any and all entities from responsibility regarding the information they release to the Board of Licensure in Medicine.

I hereby authorize the Board of Licensure in Medicine to transmit any information contained in the application, or information that may otherwise become available to them, to any agency, organization, hospital, or individual, who, in the judgment of the Board, has a legitimate interest in such information.

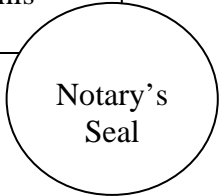
Signature of Applicant

Date

Signature of Notary
Notary Commission Expires:

Attach Current
Passport-Type
Photo
Here

(Photo must be no
larger than this
square.)



**1) APPLICANTS MUST SIGN THEIR FULL NAME IN THE PRESENCE OF A NOTARY PUBLIC.
2) NOTARY PUBLIC MUST COMPLETE THE AFFIDAVIT AND AFFIX A NOTARIAL SEAL
OVERLAPPING A PORTION OF THE PHOTOGRAPH BUT NOT COVERING ABOVE THE NECK.**

PROFESSIONAL TRAINING AND EXPERIENCE

List **in chronological order** all professional education and experience including college, medical school, internships and residencies. Be certain to report **COMPLETE ADDRESSES**. Failure to do so will delay the application process. You may photocopy this page, if necessary.

From Mo./Yr.	To Mo./Yr.	Name of Hospital, Institution, or Practice	Complete Address (Street, City, State, Zip)	Degree or Certificate and date or Nature of Experience

MEDICAL LICENSURE

List licenses currently held.

State	CERTIFICATE		Permanent or Temporary	License Received by		Currently in Force
	Year	No.		EXAMINATION	OTHER	

INSTRUCTIONS

1. This application, together with supporting documents and the fee of \$300.00 for a 3-year program must be filed with the Board of Licensure in Medicine at least thirty days prior to the start of training at the above-named hospital. If participation is less than three years, please contact your program.
2. Please type or print clearly in ink.
3. All applicants must provide a notarized copy of medical school diploma and a copy of a letter of offer of employment/appointment in a Maine postgraduate medical training program. Foreign medical graduates must also provide a notarized copy of their Standard ECFMG Certificate, or letter showing results on the VQE. All documents must be notarized with the statement: **"I certify that I have seen the original and this is a true copy of same."**
4. The fee is non-refundable.

PERSONAL DATA

Circle each appropriate response. Every "YES" response must be fully explained by written statement on a separate 8.5" x 11" sheet of white paper. Each such explanation must be referenced by question number, signed, dated, and enclosed with your application.

- YES NO 1. Have you EVER had ANY licensing authority (INCLUDING MAINE) deny your application for any type of license, or take any disciplinary action against the license issued to you in that jurisdiction, including but not limited to warning, reprimand, fine, suspension, revocation, restrictions in permitted practice, probation with or without monitoring?
- YES NO 2. Have you EVER been notified of the existence of allegations involving you, filed with or by ANY licensing authority (INCLUDING MAINE), which allegations remain open as of the date of this application?
- YES NO 3. Have you EVER left a medical licensing jurisdiction (INCLUDING MAINE) while a complaint or allegation was pending?
- YES NO 4. Have you EVER been denied registration or had your ability to prescribe or dispense controlled substances modified, restricted, suspended, revoked, or voluntarily suspended by
 - YES NO a) U. S. Drug Enforcement Administration (DEA)?
 - YES NO b) Any state/territory of U. S. INCLUDING MAINE?
- YES NO 5. Have you EVER received a sanction from Medicare or from any state Medicaid program?
- YES NO 6. Have you EVER suffered from any physical, psychiatric, or addictive disorder that would impair or require limitations on your functioning as a physician, or that resulted in the inability to practice medicine for more than 30 days?
- YES NO 7. Have you EVER been charged, summonsed, indicted, arrested, or convicted of any criminal offense (including motor vehicle offenses but not including minor traffic or parking violations)?
- YES NO 8. Have you EVER applied for hospital, HMO or other health care entity privileges which were denied?
- YES NO 9. Have you EVER had your hospital, HMO, or other health care entity privileges revoked, suspended, restricted, limited in any way, or withdrawn involuntarily?
- YES NO 10. Have you EVER voluntarily surrendered privileges or resigned from staff membership during peer review or investigation or to avoid peer review or investigation?
- YES NO 11. Have you EVER been deselected from a managed care organization physician panel?
- YES NO 12. Have you EVER been disciplined by a professional society or resigned while accusation was pending?
- YES NO 13. Have you EVER had a claim or suit alleging malpractice liability in which you are/were named as a defendant, including nuisance suits settled, adjudicated by a court in favor of the other party, or settled by your insurance company /representatives without your express consent? If 'Yes', a reporting form is enclosed at page 4. Photocopy as necessary.
- YES NO 14. Do you have any open malpractice claims? If 'Yes', a reporting form is enclosed at page 4. Photocopy as necessary.
- YES NO 15. Do you intend to practice medicine within the State of Maine without active medical staff privileges at a Maine hospital?

Claims:

Malpractice claim instructions:

Your insurance carrier or attorney must provide an independent detailed explanation of all malpractice claims. This information must be received directly from the insurance company or attorney. This information is in addition to your personal explanation.

Application form items regarding professional (malpractice) liability claims experience, are the questions most likely to generate follow-up letters from the Board staff and delay your licensure if not answered completely. Report all claims of which you have been noticed, as well as all claims from which you were dismissed as a defendant or for which your insurance company made a settlement of any kind with the plaintiff, or any claim for which a court found you liable in any degree. A reporting form is provided at page 6. Claims against a professional corporation are considered a claim against the individual licensee who provided the professional services in dispute. To be complete, your supplemental explanation must include, for each such claim reported, a full description using the **Professional (Malpractice) Liability Claims Experience Form** (page 6).

See the following fictitious example:

Identity of Case: Burns v. John B. Doe, MD, Samuel E. Smith, MD, Topeka Woman's Hospital, Inc. et al.;
Kansas Third Circuit Court, Topeka, Case #89-10203

Date/Place of Original Occurrence: June 4, 1990, Topeka Woman's Hospital

Malpractice Alleged by Claimant: Delayed diagnosis of ectopic pregnancy.

Summary of my Defense: I was a PGY II resident at the time. Dr. Samuel E. Smith, Chief of Obstetrics, Topeka Woman's Hospital was attending physician in this case. I was named in the claim because my name appears in the chart as the physician ordering ultrasonography on first hospital day.

Current Status of Case: Although a motion to dismiss me as a defendant is pending, my insurance company has offered a settlement on my behalf of \$15,000.00 on February 14, 1992. I have been told the plaintiff rejected this and the claim is still pending.

Name and Address of Insurance Company/Attorney Defending Case: Great Plains Physicians' Mutual Indemnity, Attn: Jim Brown, Claims Manager, 4321 Ketcham Blvd., Rock Springs, SD 79104. I am also represented by William B. Eagle, Eagle, Hare, P.A., 44 West River Drive, Suite 200, Topeka, KS 60301.

Maine Board of Licensure in Medicine

Professional (Malpractice) Liability Claims Experience

Duplicate For Multiple Claims.

My Name:

Identity of Case:

Date and Place of Original Occurrence:

Malpractice Alleged By Claimant:

Summary of My Defense:

Current Status of Case:

Name and Address of Insurance Company and/or Attorney Defending the Case:
