

**RETURNING
CAMP
PHYSICIANS
ONLY**

Fee: _____

**STATE OF MAINE
BOARD OF LICENSURE IN MEDICINE**
137 State House Station
Augusta, Maine 04333-0137
(207) 287-3602

**APPLICATION FOR LICENSE TO
PRACTICE MEDICINE AND SURGERY**

At Camp _____
Address: _____
_____, ME. _____
Camp Telephone (____) _____

Date From: _____
Date To: _____

Name _____
Last First Middle Social Security Number

Address _____

Birthplace _____
City State
Birthdate _____
Month Day Year

Daytime Telephone (____) _____ **Email Address** _____

Current Hospital Affiliation _____
Name Complete Address

Current State License _____
State License Number Status Expiration

AFFIDAVIT

I, _____, being duly sworn, depose and say that I am the person described and identified and that all statements made by me herein are true and correct.

Signature of Applicant Date

Subscribed and sworn to me this _____ day of _____, 20_____

Notary Public for _____
Signature of Notary

My commission expires: _____

PERSONAL DATA

Check off (X) 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 cross-referenced with the question number, and must be 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?
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?
3. Have you EVER left a medical licensing jurisdiction (INCLUDING MAINE) while a complaint or allegation was pending?
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, or surrendered to
- a) The U. S. Drug Enforcement Administration (US DEA)?
- b) Any state/territory of the U. S., INCLUDING MAINE?
5. Have you EVER received a sanction from Medicare or from any state Medicaid program?
6. The purpose of the following questions is to determine the current fitness of the applicant to practice medicine. The following inquiries concern medical, mental health, and addiction issues. This information is treated confidentially by the Board. The mere fact of treatment for medical, mental health or addiction(s) is not, in itself, a basis on which an applicant is ordinarily denied licensure when he/she has demonstrated personal responsibility and maturity in dealing with these issues. The Board encourages applicants who may benefit from such treatment to seek it. The Board may deny a license to applicants whose ability to function in the practice of medicine or whose behavior, judgment, and understanding is impaired by a medical, mental health or addictive condition.
- a. Since becoming a medical student, have you been diagnosed with or treated for a medical, mental health, or addictive condition which in any way currently limits or impairs your ability to practice medicine or to function as a physician?
- b. Within the last five (5) years have you been diagnosed with or treated for any medical, mental health, or addictive disorder that impaired your behavior, judgment, understanding, or ability to function in school, work or other important life activities?
- c. Are you now, or have you during the past five (5) years been dependent upon alcohol or habituating drugs or undergone treatment for such?
- d. If any of your answers to questions 6(a-c) is "Yes," are the limitations or impairments caused by your medical, mental health, or addictive condition reduced or improved because you receive ongoing professional treatment (with or without medication) or because you participate in a professional monitoring program?
- N/A

YES NO

- e. Within the last five (5) years have you ever raised the issue of consumption of drugs or alcohol or the issue of a medical, mental health or addictive disorder as a defense or in mitigation of, or as an explanation for your actions in the course of any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination action (educational, employer, government agency, professional organization, or licensing authority)?
- f. Are you currently engaged in the illegal use of drugs or misuse of any drugs?
- g. Have you ever been diagnosed with or treated for any type of sexual behavior disorder?
- 7. Have you EVER been charged, summonsed, indicted, arrested, or convicted of any criminal offense, including when those events have been deferred, set aside, dismissed, expunged or issued a stay of execution? Please include motor vehicle offenses but not minor traffic or parking violations.
- 8. Have you EVER applied for hospital, HMO or other health care entity privileges which were denied?
- 9. Have you EVER had your staff privileges or employment at any hospital, nursing home, HMO, or other health care entity terminated, revoked, reduced, restricted in any way, suspended, made subject to probation, limited in any way, or withdrawn involuntarily?
- 10. Have you EVER voluntarily surrendered privileges or resigned from staff membership during peer review or investigation or to avoid peer review or investigation?
- 11. Have you EVER been deselected from a managed care organization physician panel?
- 12. Have you EVER been disciplined by a professional society or resigned while accusation was pending?
- 13. Have you EVER been named as a party or a defendant, or as an employee of a party or a defendant, in a medical malpractice liability claim or lawsuit, 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?
- 14. Do you have any open malpractice claims?
- 15. Do you intend to practice medicine within the State of Maine without active medical staff privileges at a Maine hospital?

Board of Licensure in Medicine Camp License Renewal

APPLICATION INSTRUCTIONS

A temporary Camp License entitles the holder to care only for patients at the particular camp at which he/she is employed.

Before you complete this application, please review the following requirements for temporary license as camp physician in the state of Maine.

1. Please type or print clearly in ink.
2. Answer all questions completely and clearly.
3. Provide complete address of current hospital affiliation.
4. All Applicants must provide a notarized photocopy of a current, active, unrestricted medical license from another state/province.

Copy of current license must be notarized with this statement:

“I certify that I have seen the original and this is a true copy of same.”

5. This application, together with all supporting documents and the fee of \$100.00, must be filed with the Board of Licensure in Medicine **at least thirty days prior to the desired effective date of licensure.** THE FEE OF \$100 IS NON-RETURNABLE.
6. **Malpractice Claims:**

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 5.13 & 5.14, 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 11. 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 attached (Page 12). 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.

Physician Prescribing Information “Opt Out”

The 2007 Legislature established a state-sponsored “opt out” process for physicians, physician assistants and nurse practitioners to prevent access to practitioner specific prescribing data, through the Maine Health Data Organization. (P.L. 2007, Chapter 460) Prescribers seeking confidentiality protection with the Maine Health Data Organization to prohibit carriers, pharmacies, and prescription drug information intermediaries from licensing, using, selling, or exchanging for value prescription drug information for any marketing purpose that identifies those prescribers are required to complete an electronic form. The link to that “opt out” form is: <http://mhdo.maine.gov/imhdo/prescriberoptoutintro.aspx>

