

TO: Applicant for Fellowship Training Limited License
FROM: C. William Schmidt, Executive Director
RE: Application for Kentucky Medical Licensure

Attached is the application for a Fellowship Training Limited License to enable you to enter an approved Fellowship training program in Commonwealth of Kentucky. This training license is given for a one-year period. In accordance with KRS 311.571(5) the requirements for this license include the following:

- Has been accepted for a fellowship approved by the administration of any of Kentucky's medical schools and conducted under the auspices of that medical school

OR

- Has graduated from a medical school located outside the United States or Canada that has been approved by the Board, and:
 1. Has been certified by the appropriate licensing authority in his or her home country in the subject specialty of the fellowship; and
 2. Is able to demonstrate that he or she is a physician of good character and is in good standing in the country where he normally practices medicine.

The Kentucky Board of Medical Licensure meets quarterly to review applications for medical licensure. Your application along with the \$75.00 non-refundable licensure fee, and all supporting documentation must be received by the designated deadlines in order to be reviewed at the next regularly scheduled Board meeting.

Should you have any questions regarding the above, please contact your Licensure Coordinator.

- Files with last name beginning A – K
Rachel Noyes, Licensure Coordinator
Email: rachel.noyes@ky.gov
Phone: 502/429-7150, ext. 222
- Files with last name beginning L – Z
Christina Ford, Licensure Coordinator
Email: christina.ford@ky.gov
Phone 502/429-7150, ext. 223

Fellowship Training Application Instructions

Please type or print clearly. Please make sure all necessary forms are completely translated. All questions must be answered. Incomplete applications will be returned. The following are additional requirements that **MUST** be received with your application and \$75.00 fee made payable to Kentucky Board of Medical Licensure.

- **Licensure Verification Form** – Submit this form directly to the licensing Board where you are licensed in the United States or Canada. If you have multiple licenses you must have ALL licenses ever held verified. (US and Canadian graduates only)
- **Medical School Verification** – Submit this form to your Medical school for verification. Your medical school will verify and mail directly back to the Board.
- **Specialty Board Certification** – If you are an IMG you must submit a notarized copy of your specialty board certification.
- **Release and Waiver of Rights** - Must be signed and notarized.
- **Photograph** – Submit a recent (no more than six months old) passport photograph. Must be signed and dated.
- **Acceptance Letter From Your Program Director** – Submit a letter from your Program Director acknowledging acceptance into the training program and exact dates of training whether or not the fellowship is ACGME accredited.
- **HIV/AIDS Education Requirement** – Effective July 1, 1991, all applicants for medical licensure must comply with the two (2) hour HIV/AIDS Education requirement mandated by the Kentucky General Assembly. Following is the Web address to obtain course information: <http://chfs.ky.gov/dph/epi/HIVAIDS/ProfessionalEducation.htm>
- **\$75.00 Non-Refundable Licensure Fee** – Must be submitted with your application. Applications will not be processed without the licensure fee.

Application Deadlines and Board Meeting Dates

In order for your application to be presented to the Board, **your application must be completed in its entirety and must be on file in the Board office by the deadline dates listed below.** The fact that you have mailed the application form and fee does not constitute a completed application. Your application is complete when the Board staff has reviewed all parts of the application, including the FCVS Profile. You should allow a minimum of six to eight weeks for attachments to reach this office and be incorporated into your file.

Deadline Dates For Regular Applicants

February 19, 2010

May 28, 2010

August 27, 2010

November 19, 2010

Board Meeting Dates

March 18, 2010

June 24, 2010

September 23, 2010

December 16, 2010

If you are notified by the KBML that your application will be presented to the Board as a **“Special Application”**, your deadline will be different from the above dates. Please refer to the dates below: February 5th, May 14th, August 13th, and November 5th.

Fellowship Training Application

1. Name in Full _____
(First) (Middle) (Last) (Degree)
2. Address _____
City, State, Zip code _____
3. Social Security Number _____ Phone Number _____
4. Place of Birth _____ Date of Birth _____
5. What fellowship program have you been accepted to in Kentucky? *(Required Information)*

6. Specify level of training _____ Specialty _____
7. List name, location and dates of attendance of every college and medical school you have attended:

Name	Location	Dates (From – To)	Degree
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
7. List all internship and residency programs you have completed since medical school graduation. **Please list in chronological order.**

Name	Location	Dates (From – To)	Completed Yes/No
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
8. List all countries, states and Canadian provinces where you **currently hold or have ever held** any type of medical license:

Location	Type	License #	Date of Issuance	Current Yes/No
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
9. List all employment history (or non-employment history, i.e. vacations, seeking employment, etc.) between training dates. Do not leave any time gaps:

Employer Name	Position	Dates of Employment (From – To)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
10. IMG's only: Are you board certified in the country which you are currently practicing or in training? _____
If so, please specify what specialty: _____
11. Indicate your ECFMG number, if applicable: _____
12. Indicate which licensing examination(s) you have taken, if applicable. Include **all attempts and failures.**

Type (FLEX,NBME,USMLE,etc)	Location	Score	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

[Category I]

Please answer all questions on this application. Category I will help the Board determine if you meet the essential eligibility requirements for licensure by virtue of your background, education, training and experience. If you are qualified to practice under Category I, Category II will be reviewed to help the Board determine if you are qualified to practice safely and competently, with or without reasonable modification. If you answer "Yes" to any of the questions, you must attach a complete written explanation of the event(s) or condition(s), including dates, names, addresses, circumstances, and results along with your returned application.

NOTE: Intentional false answers or misrepresentation in applying for or procuring a license, registration or reactivation in Kentucky are grounds for disciplinary action, including denial or revocation of license, and are reported to the National Practitioner Data Bank and/or appropriate national professional credentialing organization.

1. Have you ever been dismissed from, resigned while under investigation or failed to complete an academic year at a medical school or a postgraduate training program?
 Yes No
2. Have you ever been denied a license or denied the privilege of taking a licensure examination by any State, Federal, or International licensure jurisdiction?
 Yes No
3. Have you ever had any license, certificate, registration or other privilege to practice as a health care professional denied, revoked, suspended, probated or restricted by a State, Federal, or International authority, or have you ever surrendered such credential to avoid or in connection with disciplinary investigation/action by such jurisdiction?
 Yes No
4. Has any hospital, hospital medical staff or any other health care facility ever revoked, suspended, restricted, limited, reprimanded, placed on probation or otherwise disciplined your staff privileges?
 Yes No
5. Have you ever resigned your privileges or failed to renew privileges at a licensed hospital or from the medical staff of the hospital, while under investigation or while you were subject to disciplinary proceedings by the hospital?
 Yes No
6. Have you ever been removed, suspended, expelled or disciplined by any professional medical association or society?
 Yes No
7. Has the Drug Enforcement Administration or any other state or International drug licensure/enforcement authority ever denied, revoked, suspended, restricted, limited, or otherwise disciplined a controlled substance registration certificate issued to you?
 Yes No
8. Have you ever voluntarily or involuntarily surrendered a medical or osteopathic license, or controlled substance registration certificate issued to you?
 Yes No
9. Have you ever been or are you currently under investigation by any State, Federal or International licensure authority or any drug licensure/enforcement authority?
 Yes No
10. Are any legal proceedings regarding licensure presently pending against you by any State, Federal or International licensure authority or any drug licensure/enforcement authority?
 Yes No
11. Have you ever been convicted of a felony or misdemeanor by any State, Federal or International court? Are any criminal charges presently pending against you in any of those courts?
 Yes No
12. To your knowledge, are you the subject of an investigation for a criminal act?
 Yes No
13. Have you ever had to pay a judgement in a malpractice action or other civil action against your medical practice or are any malpractice or other civil actions against your medical practice presently pending in any court?
 Yes No

Applicant Name _____ Date _____

*****Affidavit of Applicant*****

I hereby state that the information contained in this application is true, accurate, and complete to the best of my knowledge and belief. I understand that under Kentucky law the submission of any false, fraudulent or forged statement, document or other matter in connection with this application is grounds for criminal prosecution and the denial of licensure. I authorize the Board or its agents to obtain from other sources any information necessary for determining my qualifications for licensure. I also authorize them to furnish any information they may now or in the future have concerning my qualifications and fitness to practice medicine/osteopathy to any person, institution, association, school, hospital or government entity.

(Signature of Applicant) (Date)

(Printed Name of Applicant)

Subscribed and sworn to before me by _____ this _____ day of _____
(month, year)

(Signature of Notary)

My commission expires _____

Seal of Notary

Applicant Photograph

Securely tape or glue
in this square a
current front-view 2”
x 2” passport color
photo of yourself.

Applicant Name _____ Date _____

[Category II]

The answers to these questions are exempt from public disclosure under KRS 61.878(1)(a) and (l) and KRS 311.619 and shall be subject to inspection only upon order of a court of competent jurisdiction, except that no court shall authorize the inspection by any party of any materials pertaining to civil litigation beyond that which is provided by the Kentucky Rules of Civil Procedure governing pretrial discovery. The answers to these questions may be considered by the Board and may be disclosed in any contested case proceeding, including a Show Cause proceeding, or appeal of a licensing decision based upon them.

“Illegal drug use” means the use of an illegally obtained controlled substance or dangerous drug; the term “illegal drug use” also means the use of a legally obtained controlled substance or dangerous drug which is not taken in accordance with the direction of the licensed health care professional who prescribed the controlled substance or dangerous drug.

1. Do you currently, or have you had within the past 5 years, any physical, mental, or emotional condition which impaired, or might reasonably impair your ability to practice your health care profession safely and competently?
 Yes No
2. Within the past 5 years, have you been admitted to any hospital or other in-patient care facility for any physical, mental or emotional condition which impaired, or might reasonably be considered to impair, your ability to practice your health care profession safely and competently?
 Yes No
3. Do you currently have, or have you had within the past 5 years, a dependency on the use of alcohol or drugs, which impaired, or might reasonably impair, your ability to practice your health care profession safely and competently?
 Yes No
4. Within the past 5 years, have you engaged in the excessive use of alcohol or illegal drugs, or received any in-patient or outpatient or individual therapy/treatment or been hospitalized for alcoholism, or illegal use, or been arrested for a DUI (Driving Under The Influence)?
 Yes No
5. Within the past 5 years, have you been the subject of any chemical substance screening test which resulted in an indication of the presence in your body of any controlled substance, any dangerous drug, or alcohol level above .10% BAC (This does not include those drugs taken by you as a result of a legitimate health care diagnosis, and prescribed for you in good faith by another licensed health care professional)?
 Yes No

*****Affidavit of Applicant*****

I hereby state that the information contained in this application is true, accurate, and complete to the best of my knowledge and belief. I understand that under Kentucky law the submission of any false, fraudulent or forged statement, document or other matter in connection with this application is grounds for criminal prosecution and the denial of licensure. I authorize the Board or its agents to obtain from other sources any information necessary for determining my qualifications for licensure. I also authorize them to furnish any information they may now or in the future have concerning my qualifications and fitness to practice medicine/osteopathy to any person, institution, association, school, hospital or government entity.

(Signature of Applicant) (Date)

(Printed Name of Applicant)

Subscribed and sworn to before me by _____ this _____ day of _____
(month, year)

(Signature of Notary)

My commission expires _____

Seal of Notary

Applicant Name _____ Date _____

Release and Waiver of Rights Form

I, _____, hereby authorize the following individuals and entities to release all information (documented, oral or other) about me in their possession to the Kentucky Board of Medical Licensure (KBML) or its agents:

1. All medical/osteopathic schools which I have attended.
2. All hospitals or other health care facilities at which I have ever held staff privileges, whether full or limited, temporary or permanent; and all hospitals or other health care facilities at which I have ever received training.
3. All medical/osteopathic societies, specialty boards and other related organizations with which I have been associated.
4. All other state or Canadian licensure boards, federal health agencies, and federal and state drug control agencies.
5. All licensed physicians, nurses, or other health care professionals of any state or Canadian province.
6. All attorneys who have participated in civil or criminal actions in which I am named party.

I hereby release the above-named individuals and entities from all liability for the release of information to the Board (KBML) or its agents.

I further authorize the Board (KBML) or any of its duly authorized agents, to make any investigations that they deem necessary to secure information concerning me, which is relevant to the requirements of licensure. I further authorize them to release such information they may now or in the future have, concerning me to (i) any federal, state, county or local governmental entity, (ii) any hospital or other health care facility, or (iii) any other person upon a showing that the release of the information is vital to the health, safety and welfare of the general public.

I hereby make this release and waiver of rights for the purpose of allowing the Board (KBML) to carry out its duties pursuant to my request for licensure to practice medicine/osteopathy in the Commonwealth of Kentucky; and further, for the purpose of allowing the Board (KBML) to carry out its duties in regard to my continued licensure.

This release and waiver of rights has no expiration date and shall remain effective during my licensure in the Commonwealth of Kentucky.

(Signature of Applicant)

(Date)

(Printed Name of Applicant)

Subscribed and sworn to before me by _____ this _____ day of _____
(month, year)

(Signature of Notary)

My commission expires _____

Seal of Notary

**Kentucky Medical Board
Licensure Verification Form**
(Copy this form for multiple licenses)

The Kentucky Board of Medical Licensure requires that this form be completed by each state or Canadian province in which I hold or have ever held licenses, whether now current or not. Please complete the form and submit it directly to the state Board where the license is/was held. That Board will need to submit the verification to the KY Board at the address provided below.

TO BE COMPLETED BY APPLICANT:

Applicant Name: _____
Last First Middle Suffix

Date of Birth: _____

Social Security Number: _____

License Number: _____

(From State/Province you are sending this form to)

I hereby authorize the licensing agency of the State/Province of _____ to furnish the information to the Board indicated below.

Signature of Applicant: _____ Date: _____

The verification of licensure needs to be mailed to:
**Kentucky Board of Medical Licensure
310 Whittington Pkwy, Ste 1B
Louisville, KY 40222**

TO BE COMPLETED BY STATE LICENSING BOARD OR CANADIAN PROVINCE:

Name of Licensee: _____
Last First Middle Suffix

License Type: _____ License #: _____

Issue Date: _____ Expiration Date: _____

Is this license current? Yes No

If No, please explain: _____

Have formal disciplinary proceedings been initiated against applicant's license by a disciplinary authority in your state?
 Yes No Cannot answer under state law

If Yes, please explain: _____

Has the applicant ever been warned, censured, placed on probation, formal consent, reprimand or in any other manner disciplined; or has the applicant's license ever been revoked, suspended, or in any other manner, limited by a licensing or disciplinary authority in your state?

Yes No Cannot answer under state

If Yes, please explain: _____

Board Authorized Signature: _____

Affix Board Seal Here

Title: _____

Date: _____

Please return this form to the Board listed at the top of this form.

Kentucky Board of Medical Licensure
Medical School Verification
(Copy this form for multiple schools)

Complete Section 1 of this form then send this form to your medical school along with a copy of your diploma. Request the Dean or designated official to complete Section 3 of this form and return this form, the sealed copy of your diploma (to be sealed by your medical school) and a copy of your official transcripts directly to this Board.

SECTION 1: APPLICANT INFORMATION

Applicant Full Name: _____
Last First Middle Suffix

Name if different when diploma awarded: _____

Social Security Number: _____ Date of Birth: _____
The applicant's social security number is to be used for purposes of identification and may not be used for any other reason.

Waiver for release of information: I authorize the Medical School below to provide any and all information pertaining to my medical education at your institution to the below listed Medical Board.

Applicant's Signature _____ Date _____

SECTION 2: INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL

Please complete Section 3 of this form, certify the enclosed copy of the above named applicant's diploma by placing your school seal on it, enclose an official copy of the transcripts of the above named physician and forward all of this information directly to this Board to the following address:

Kentucky Board of Medical Licensure
310 Whittington Pkwy, Ste 1B
Louisville, KY 40222

SECTION 3: MEDICAL SCHOOL VERIFICATION

Medical School Name: _____

School name if different when the above applicant attended: _____

Medical School Address: _____
Street City State ZIP Code

Hours of undergraduate education required for admission into your school: _____

Applicants Dates of Attendance: From _____ To _____ Graduation Date: _____ Degree: _____

Medical School Verification
(Copy this form for multiple schools)

Unusual Circumstances:

The following questions apply to unusual circumstances that occurred during any part of the individual's medical education. Please check the appropriate response and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation (attach additional pages as necessary).

1. Does this individual's official records reflect (an) interruption(s) or extension(s) in his/her medical education?

Response: Yes No

If YES, please select the reason(s) for, indicate the dates of the interruption(s) or extension(s) and check whether the interruption/extension was approved or unapproved.

	From Mo/Yr	To Mo/Yr	Approved	Unapproved
Personal/Family			<input type="checkbox"/>	<input type="checkbox"/>
Academic Remediation			<input type="checkbox"/>	<input type="checkbox"/>
Health			<input type="checkbox"/>	<input type="checkbox"/>
Financial			<input type="checkbox"/>	<input type="checkbox"/>
Participation in joint degree program (e.g., MD/PhD)			<input type="checkbox"/>	<input type="checkbox"/>
Participation in non-research special study (e.g., fellowship, international experience)			<input type="checkbox"/>	<input type="checkbox"/>
Participation in non-degree research			<input type="checkbox"/>	<input type="checkbox"/>
Other			<input type="checkbox"/>	<input type="checkbox"/>

Please Specify:

2. Does this individual's official records reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? Response: Yes No

If YES, please select the reason(s) for the probation, indicate the date(s) of placement on and removal from probation below and attach additional documentation to this report.

Academic Probation from _____ to _____

Probation for unprofessional conduct/behavioral from _____ to _____

Probation for other reason from _____ to _____

Please specify reason: _____

3. Does this individual's official records reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? Response: YES NO

If YES, please provide detailed documentation/information about the circumstances and outcome(s): _____

Medical School Verification

(Copy this form for multiple schools)

4. Does this individual's official records reflect that he/she was ever the subject of negative reports or an investigation by the medical school or parent university? Response: YES NO

If YES, please provide detailed documentation/information about the circumstances and outcome(s): _____

5. Does this individual's official records reflect that there were any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason? Response: YES NO

If YES, please provide detailed documentation/information about the nature of the limitations or special requirements.

I certify that to the best of my knowledge and belief the foregoing is a true, accurate and complete statement of the record of the individual named on this form.

Signature: _____

Print name: _____

Title: _____

Date: _____

Phone number: _____

Fax: _____

E-mail: _____

AFFIX INSTITUTIONAL SEAL HERE

(If no seal is available, this form must be notarized)