APPLICATION FOR LICENSE

Candidate Information

NAME: _____
LAST FIRST MIDDLE

ADDRESS: _____
STREET CITY STATE ZIP CODE

SOCIAL SECURITY NUMBER: _____ DATE OF BIRTH: _____
Month/Date/Year

		YES	NO
1.	Do you hold or have you ever held an unrestricted license, certification, or registration (active or inactive, current or expired) to practice osteopathic medicine and/or surgery in any other state or jurisdiction? If yes, list the jurisdiction (s) below.	❑	❑
2.	Have you ever withdrawn an application for a license, certificate or registration, had an application denied or refused, or agreed not to reapply in another state, territory or country?	❑	❑
3.	Has any disciplinary action been taken against your license, certification or registration in another state, territory or country?	❑	❑
4.	Have you been convicted, pleaded guilty or entered a plea of nolo contendere, or received probation without verdict, accelerated rehabilitative disposition (ARD) or received any other disposition (excluding acquittal or dismissal) of any criminal charges, felony or misdemeanor, including any DUI/DWI, drug law violations, or are there any criminal charges pending and unresolved against you in any state or jurisdiction?	❑	❑
5.	Have you been arrested for criminal homicide, aggravated assault, sexual offenses or drug offenses in any state, territory or country?	❑	❑
6.	Have you had practice privileges denied, revoked or restricted in a hospital or other health care facility, or have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?	❑	❑
7.	Have you had your DEA registration denied, revoked or restricted or have you had your provider privileges terminated by any medical assistance agency for cause?	❑	❑
8.	Are you, or have you ever been, addicted to the intemperate use of alcohol or to the habitual use of narcotics or other habit-forming drugs? Note: You may answer "NO" if you are currently a participant in or have successfully completed the requirements of the Pennsylvania Board's Professional Health Monitoring Program.)	❑	❑
9.	Since May 19, 2002, have any malpractice complaints been filed against you? If yes, the Board requires that you submit a copy of the entire Civil Complaint which must include the docket number, filing date, and the date you were served	❑	❑

If you have answered YES to any of the above questions, please give details on a separate 8-1/2 X 11 sheet of paper.

In order to practice in Pennsylvania, you must comply with malpractice insurance requirements.

VERIFICATION STATEMENT

Note that disclosing your social security number on this application is mandatory in order for the State Board of Osteopathic Medicine to comply with the requirements of the federal Social Security Act pertaining to child support enforcement, as implemented in the Commonwealth of Pennsylvania at 23 Pa. C.S. § 4304.1(a). In order to enforce domestic child support orders, the Commonwealth's licensing boards must provide to the Department of Public Welfare information prescribed by DPW about the licensee, including the social security number. Additionally, disclosing the number is mandatory in order for this board to comply with the reporting requirements of the federal National Practitioner Data Bank and Healthcare Integrity and Protection Data Bank. Reports to the NPDB and HIPDB must include the licensee's social security number.

I verify that the statements on this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 19 Pa. C.S. Section 4904 relating to unsworn falsification to authorities and may result in the suspension of revocation of my license or certificate.

_____ _____
Signature of applicant Date

_____
Printed/Typed Name of Applicant

APPLICANT MUST SUBMIT THIS FORM TO THE
STATE BOARD OF OSTEOPATHIC MEDICINE,
P.O. BOX 2649, HARRISBURG, PA 17105-2649

APPLICANT MUST SUBMIT THIS FORM TO THE STATE BOARD OF OSTEOPATHIC MEDICINE, P.O. BOX 2649, HARRISBURG, PA 17105-2649.

CERTIFICATE OF MORAL CHARACTER

TO BE COMPLETED BY A CURRENTTLY LICENSED OSTEOPATHIC PHYSICIAN OR SURGEEON ACQUAINTED WITH YOU FOR AT LEAST SIX MONTHS.

Applicant name: _____
LAST FIRST MIDDLE MAIDEN

I hereby certify that to the best of my knowledge, the applicant is of good moral character and she/he is not under the addicting influence of alcohol, a narcotic or other habit forming drug. I recommend the applicant for a license to practice osteopathic medicine and surgery in the Commonwealth of Pennsylvania. I have been personally acquainted with the applicant for _____ years and months. _____

SIGNATURE OF PROFESSIONAL | DATE | STATE WHERE LICENSED

PRINT OR TYPE NAME AS SIGNED | TYPE LICENSE HELD

ADDRESS | LICENSE NUMBER

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SIGNATURE OF PROFESSIONAL | DATE | STATE WHERE LICENSED

PRINT OR TYPE NAME AS SIGNED | TYPE LICENSE HELD

ADDRESS | LICENSE NUMBER

COMMONWEALTH OF PENNSYLVANIA
STATE BOARD OF OSTEOPATHIC MEDICINE

VERIFICATION OF AOA APPROVED INTERNSHIP

SUBMIT TO:
STATE BOARD OF OSTEOPATHIC MEDICINE
P.O. BOX 2649
HARRISBURG, PA 17105-2649
1-717-783-4858

OFFICE USE ONLY - DO NOT WRITE IN THIS SPACE

O S | | | | | | | L
LICENSE NUMBER

						E D U C	
NAME					CODE		INITIAL

Completion of one year of an AOA-approved internship is required.

SECTION 1 - TO BE COMPLETED BY APPLICANT. PLEASE PRINT OR TYPE.

NAME: _____
LAST FIRST MIDDLE

ADDRESS: _____
STREET

_____
CITY STATE ZIP CODE

NAME OF HOSPITAL: _____

LOCATION: _____

_____

SECTION 2 - TO BE COMPLETED BY DIRECTOR OF MEDICAL EDUCATION. UPON COMPLETION, HOSPITAL **MUST** RETURN THIS FORM IN OFFICIAL ENVELOPE DIRECTLY TO THE STATE BOARD OF OSTEOPATHIC MEDICINE AT THE ABOVE ADDRESS. **DO NOT** RETURN TO THE APPLICANT. **FORM CANNOT BE SUBMITTED PRIOR TO COMPLETION.**

This is to certify that _____ D.O. has completed an AOA approved internship at:

_____
NAME OF HOSPITAL

_____
STREET ADDRESS CITY STATE ZIP CODE

From _____ To _____
MONTH DAY YEAR MONTH DAY YEAR

(Seal of Hospital Mandatory)

_____ _____
SIGNATURE OF DIRECTOR OF MEDICAL EDUCATION DATE