



Michigan Department of Licensing and Regulatory Affairs
Bureau of Health Care Services

Board of Medicine

PO Box 30670
Lansing, MI 48909
(517) 335-0918

www.michigan.gov/healthlicense

**MEDICAL DOCTOR
ENDORSEMENT APPLICATION PACKET**

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MEDICAL DOCTOR ENDORSEMENT INSTRUCTIONS

* Please read application instructions carefully and answer all questions completely.
Failure to do so may cause a delay in your application process.*

IF YOU HAVE BEEN LICENSED IN ANOTHER STATE AND HAVE BEEN ENGAGED IN THE PRACTICE OF MEDICINE FOR AT LEAST 10 YEARS, THE FOLLOWING MUST BE SUBMITTED:

1. You must complete and submit the application for licensure with the appropriate fee, as well as arrange for supporting documents to be sent to the Michigan Board of Medicine.
2. Applicants for a Michigan health professional license or registration are required to submit fingerprints and undergo a Criminal Background Check (CBC). Fingerprints must be taken using the Customer ID number and instructions provided in the Application Confirmation letter that will be sent when your license application and fee are processed. Do not have your fingerprints taken prior to receiving your Customer ID number.
3. Arrange for a verification and/or certification to be sent directly to the Michigan Board from any state or province where you currently hold or have ever held a permanent license or registration. **Copies of licenses are not acceptable.**

IF YOU HAVE BEEN LICENSED IN ANOTHER STATE AND HAVE PRACTICED MEDICINE FOR LESS THAN 10 YEARS AT THE TIME OF YOUR APPLICATION, THE FOLLOWING DOCUMENTS MUST BE SUBMITTED IN ADDITION TO THE ONES LISTED ABOVE:

1. You must complete and submit the application for licensure with the appropriate fee, as well as arrange for supporting documents to be sent to the Michigan Board of Medicine.
2. Applicants for a Michigan health professional license or registration are required to submit fingerprints and undergo a Criminal Background Check (CBC). **You should make contact with an approved agency 7-10 days after application submission.** Additional documentation is included in this packet offering detailed instructions on the CBC and fingerprinting process.
3. An official score report for the examination that you took to obtain licensure is submitted directly to the Board of Medicine from the examination agency. Score reports must be sent from either the Federation of State Medical Boards at (817) 868-4000, website: www.fsmb.org or the National Board of Medical Examiners (if tested May 1994 or earlier) at (215) 590-9700, website: www.nbme.org.
4. Certification of successful completion of two years postgraduate clinical training in an active, approved program in a Board approved hospital or institution. The Certification of Postgraduate Training form (attached) must be submitted directly to the Board from the Director of Medical Education where you completed your postgraduate training.
5. If you are a graduate of a foreign medical school, verification of your Educational Commission for Foreign Medical Graduates (ECFMG) certificate must be electronically submitted directly to the Michigan Board from ECFMG. Go to www.ecfm.org for information and instructions on how to apply for your ECFMG status report to be sent to the Board.
6. Arrange for a verification and/or certification to be sent directly to the Michigan Board from any state or province where you currently hold or have ever held a permanent license or registration. **Copies of licenses are not acceptable.**

MEDICAL DOCTOR ENDORSEMENT INSTRUCTIONS CONTINUED

Note: All active, postgraduate clinical training programs accredited by the Accreditation Council of Graduate Medical Education (ACGME), the College of Family Physicians of Canada, the Royal College of Physicians and Surgeons of Canada, or the National Joint Committee on Accreditation of Pre-registration Physician Training Programs of the Canadian Medical Association are approved by the board. All hospitals accredited by the Joint Commission on Accreditation of Hospitals (JCAH) are board approved.

FEDERATION CREDENTIALS VERIFICATION SERVICE

The Michigan Board of Medicine now accepts the Federation Credentials Verification Service (FCVS) to provide documentation for endorsement applications for applicants licensed less than 10 years in another state. The Federation of State Medical Boards (FSMB) makes this service available to applicants. The FCVS verifies a physician's basic credentials with primary sources. Those credentials include postgraduate training, examination history, ECFMG certification and board action history. FCVS does NOT provide licensure verification from other states. Verification information must be sent as specified in #4 above.

Please note that the use of the FCVS is strictly voluntary on the part of the applicant. The Michigan Board of Medicine reserves the right to request additional information from the applicant during the application review process.

If you are interested in receiving more information or have any questions regarding this service, please contact the FSMB at (888) 275-3287, website www.fsmb.org.

You are advised that an application for licensure **WILL NOT BE CONSIDERED UNTIL ALL REQUIRED DOCUMENTATION IS SUBMITTED.**

Please Note:

- An application submitted with the appropriate fee is valid for two years from the date it is received. If an applicant fails to complete the requirements for licensure within the two year period following the date of application, the application will become invalid.

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FOR BOARD USE ONLY
License Number:
CS Number:
Issue Date:

APPLICATION FOR ENDORSEMENT

Please select the license you are applying for from the drop down list below:

<input type="checkbox"/>	Medical Doctor by Endorsement Fee: \$150.00 [71-4301-09]
<input type="checkbox"/>	MD by Endorsement & Controlled Substance Fee: \$150.00 [71-4301-09] & \$85.00 [71-5315-3757] Total Fee: \$235.00

Your check or money order drawn on a U.S. financial institution and made payable to the **STATE OF MICHIGAN** must accompany this application. DO NOT SEND CASH. Fees are deposited upon receipt and can only be refunded under refund rules promulgated by the Department.

1. Demographic Information

First Name:	Middle Name:	Last Name:
U.S. Social Security #:	Birth Date:	
Street Address:		Apt/Bldg #:
City:	State:	Zip Code:
Country:		
Phone Number:	Email Address:	
Have you ever held a health professional license in any profession in Michigan?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Was your health professional license issued after 2008?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Health Professional Permanent I.D./License Number:		Expiration Date:
Have you ever been known under any other name? If yes, list name(s):		<input type="checkbox"/> Yes <input type="checkbox"/> No
Will documents be received under any other name? If yes, list name(s):		<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever filed an application for this type of license in Michigan?		<input type="checkbox"/> Yes <input type="checkbox"/> No

Full Name:

2. Personal Data Questions

1. Have you ever been convicted of a felony?

Yes

No

If yes, please explain

2. Have you ever been convicted of a misdemeanor punishable by imprisonment for a maximum term of 2 years?

Yes

No

If yes, please explain

3. Have you ever been convicted of a misdemeanor involving the illegal delivery, possession, or use of alcohol or a controlled substance (including motor vehicle violations)?

Yes

No

If yes, please explain

4. Have you had 3 or more malpractice settlements, awards, or judgments in any consecutive 5 year period?

Yes

No

If yes, please explain

5. Have you had one or more malpractice settlements, awards, or judgments totaling \$200,000 in any consecutive 5 year period?

Yes

No

If yes, please explain

6. Have you ever been fined, denied, revoked, suspended, reprimanded, placed on probation, otherwise disciplined, or the subject of a final adverse action by a licensure, registration, disciplinary or certification board as a holder of or applicant for, a license or registration regulated by this state, another state or territory of the United States, the United States military, the federal government, or another country?

Yes

No

If yes, please explain

7. Have you ever been censured, or requested to withdraw from a health care facility's staff or had your health care staff privileges involuntarily modified?

Yes

No

If yes, please explain

8. Have you ever been treated for substance abuse in the past 2 years?

Yes

No

If yes, please explain

Note: If you answered "yes" to any of the questions in Section 2 (questions 1-8), you must provide a detailed explanation with copies of all available official and/or court documents related to your explanation along with your application. If you do not provide the explanation, your application will be deemed incomplete and processing will be delayed.

Full Name: _____

3. Professional Education

Name of Institution	Address of Institution	Graduation Date	Certificate/Diploma/Degree Granted

3. License(s) in Other State(s) and/or Province(s)

Do you hold or have you ever held a permanent health professional license, certification, or registration in any state or province? If yes, list each state or province, the license or registration number, the date issued and how the license was obtained (either examination or endorsement). **DO NOT LIST TEMPORARY/LIMITED LICENSES.** (Attach additional sheets if necessary.)

Yes
 No

State/Country	Permanent License/Registration Number	Date of Issue	Number of Years Licensed	Expiration Date	How Obtained (Exam or Endorsement)

4. CERTIFICATION

I understand that it is the policy of this agency to secure a criminal conviction history as part of the pre-licensure screening process. I authorize this agency to use the information provided in this application to obtain a criminal conviction history file search from the Central Records Division of the Michigan Department of State Police, law enforcement, or judicial record-keeping organization.

I further consent to the release of information to this agency regarding any disciplinary investigations conducted by a similar licensure, registration, or specialty certification board of this or any other state, of the United States military, of the federal government, or of another country.

The statements in this application are true and correct. I have not withheld information that might affect the decision to be made on this application. In signing this application, I am aware that a false statement or dishonest answer may be grounds for denial of my application or revocation of my license and that such misrepresentation is punishable by law.

Signature of Applicant _____ Date _____

The Department of Licensing and Regulatory Affairs will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

Board of Medicine

PO Box 30670

Lansing, MI 48909

(517) 335-0918

www.michigan.gov/healthlicense**CERTIFICATION OF POSTGRADUATE TRAINING**

Authority: Public Act 368 of 1978, as amended.

If this form is not completed, certification will not be issued.

SECTION I - APPLICANT INFORMATION

Instructions: Complete Section I. Type or print your name exactly as it appears on your application. Print this form and then for completion of Section II, send this form to the Director of Medical Education where you completed your postgraduate training. This certification must be submitted directly to the Michigan Board of Medicine by the Director of Medical Education.

SECTION I - APPLICANT INFORMATION

First Name:	Middle Name:	Last Name:
Street Address:		Apt/Bldg#:
City:	State:	Zip Code:
SSN:	Date of Birth:	
Email:	Phone Number:	
All Previous Names and/or Birth Name Used (if applicable):		

Signature _____ Date _____

Upon completion of Section I, print, sign, and date the form then send the form to the Director of Medical Education for completion of Section II.

This certification must be submitted directly to the Michigan Board of Medicine.

Full Name:

THIS SIDE TO BE COMPLETED BY THE DIRECTOR OF MEDICAL EDUCATION**SECTION II - CERTIFICATION OF POSTGRADUATE TRAINING**

Please complete the following information. Return this completed certification directly to LARA, Michigan Board of Medicine, PO BOX 30670, Lansing, MI 48909.

Name of Hospital

Street Address of Hospital

City

State

Zip Code

I certify that _____ a graduate of
(Applicant's Full Name)

the _____ medical school, has successfully completed postgraduate clinical training offered by the

hospital named above from _____ to _____,
(Month/Day/Year) (Month/Day/Year)

in the clinical area of _____.

Is this an active training program accredited by the ACGME, the College of Family Physicians of Canada,
The Royal College of Physicians and Surgeons of Canada, or by the National Joint Committee on Accreditation
of Preregistration Physician Training Programs of the Canadian Medical Association?

Yes

No

Signature of Director of Medical Education

Date of Signature

Print or Type Name of Director of Medical Education

(Seal)

If hospital has no seal, please indicate

NOTE: Certification of Postgraduate Training will not be accepted if signed and submitted more than 15 days prior to actual completion.

The Department of Licensing and Regulatory Affairs will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

Please print out the Application (Pages 5-7) and the Certification of Postgraduate Training form (Page 8-9, if applicable). Sign and date your application, and submit the application along with any supporting documentation and with your check or money order made payable to the "State of Michigan" to:

Michigan Department of Licensing and Regulatory Affairs
Bureau of Health Care Services
Board of Medicine
PO Box 30670
Lansing, MI 48909

APPLICATION CHECKLIST

Application Fee: Submit a check or money order drawn on a U.S. financial institution and made payable to the **STATE OF MICHIGAN**.

1. Demographic Information: Social Security Number: Please list only a United States Social Security number.

Name: List your full name: first, middle and last name. If your name changes after you apply, you must submit a name change to the Bureau of Health Care Services in writing along with legal documentation within 30 days.

Birth Date: Provide the month, day and year of your birth.

Address: List the address we should use to send any information about your license. Be sure to include the city, state, zip code, and country. This will be your permanent address with the Bureau of Health Care Services. If your address changes, you must notify us in writing within 30 days.

Phone: Enter a telephone number where you can be reached in case we have questions about your application.

E-mail: Enter your e-mail address. E-mail is a quick way our office can communicate with you about your application.

Other Name(s): Indicate whether you have been known by any other names.

2. Personal Data Questions: All applicants must answer the same personal data questions. If you answer "yes" to any questions in this section, you must submit a detailed explanation with your application. If you do not provide this information, your application will be deemed incomplete and processing will be delayed.

3. Professional Education: List your current or completed professional school. Indicate degree/certificate/diploma earned. List graduation and/or anticipated graduation date.

4. License in Other State(s) and/or Province(s): List all states/provinces where you have held a medical license or registration. Indicate method of licensure - examination or endorsement.

5. Certification: You must sign and date your application for it to be valid. By signing the application you are indicating that you have read and understood the certification section.

TOP THINGS APPLICANTS SHOULD KNOW

1. **NOTE:** If you have ever been licensed in another state and you have a current disciplinary sanction on that license (even if the license is inactive), you are not eligible for licensure in Michigan according to the Public Health Code, PA 368, as amended, Section 333.16174 (2). Sanctions include probation, limitation, suspension, revocation, or fine. Upon resolution of the sanction and verification that the license is active with no disciplinary action in effect, you can proceed with the filing of an application for a Michigan license or registration.
2. Read the entire application before submitting it and DO NOT send the checklist to the Board of Medicine office.
3. Applications and mail are processed as quickly as possible in date-received order.
4. Please allow time to process your application before you call or email our office to check on the status. Applications may take up to 2 weeks to reach our office. Applications with fees are first processed through our central mailroom then through our payment processing office.
5. Mail, including mail sent overnight, is first received by our central mailroom prior to reaching the Board.
6. Supporting documentation will not be accepted if faxed into our office.
7. **REFUND POLICY:** If you wish to withdraw your application, you must notify the Board of Medicine in writing to request a partial refund.
8. If your name and/or address changes please notify the Board of Medicine in writing within 30 days. To change a name or address, you can download the Data Change/Duplicate License Request Form from our website at www.michigan.gov/healthlicense and fax it to (517) 335-2044 ATTN: Applications Section or mail the form to: Licensing and Regulatory Affairs, Bureau of Health Care Services, Board of Medicine, Applications Sections, PO Box 30670, Lansing, MI 48909. Telephone calls are NOT accepted for these changes. After your license is issued, you can change your address online at www.michigan.gov/elicense.

GLOSSARY/DEFINITION OF TERMS

CONTACT HOUR/CREDIT	A continuing education credit or contact hour is equivalent to 50-60 minutes of program participation in a board-approved program.
ENDORSEMENT	Application made by an individual who holds an active license in another state with licensure requirements substantially equivalent to Michigan requirements.
EXAMINATION	Application made by an individual who must take and pass an examination in order to become licensed in Michigan.
LAPSED LICENSE	A lapsed license is a license that is no longer active. A license becomes inactive when it is not renewed upon the expiration date printed on the license.
RECIPROCITY	Process by which an individual could possibly become licensed in Michigan through a reciprocity agreement with another state board. Michigan does not have a reciprocity agreement with any other state.
REINSTATEMENT	The process in which a disciplinary, suspended or revoked license has not lapsed is reactivated by the Board.
RELICENSURE	The application process in which a licensee must apply to reactivate a lapsed or lapsed suspended license.
RENEWAL	Process to maintain active licensure status at the end of each renewal cycle.

FREQUENTLY ASKED QUESTIONS

Q. How long will it take to process my application?

Applications and mail are processed as quickly as possible in date-received order. Applications with fees are first processed through our central mailroom then through our payment processing office.

Q. What do I do if I forgot to include my payment with my application?

Please submit the fee along with a copy of your application and a letter indicating that you failed to submit the required payment with your previous application. Mail to: Licensing and Regulatory Affairs, Bureau of Health Care Services, Board of Medicine, PO Box 30670, Lansing, MI 48909.

Q. How do I check on the status of my application?

Within approximately three weeks of mailing your application to our office, you should receive an Application Confirmation letter containing your customer number. You may use your customer number to check the status of your application at www.michigan.gov/appstatus.

Q. If I have been convicted of a felony or misdemeanor will it stop me from being licensed?

We ask that you submit your application, fee and information regarding the occurrence. The Board will review your file and make a decision at that time. Please keep in mind that we do take into consideration the type of conviction, the age that you were when the incident occurred and the time that has elapsed since the conviction.

Q. Do I have to earn continuing education for this first license?

Since the initial license is valid for a partial licensure cycle you will not be required to earn continuing education. However, after the first renewal, Michigan physicians are required to earn 150 hours of board-approved continuing education credit over each three-year cycle of licensure. The Michigan Board of Medicine does not receive attendance reports or track your education for you. You should maintain copies of your continuing education certificates for at least a five year period in case you are audited by the Michigan Board Medicine.

Q. How long is my license valid?

The initial license is good for a partial licensure cycle and will expire on the upcoming January 31 renewal date. Each subsequent license will cover a full three-year cycle.

WEBSITES AND LINKS

WEBSITES:

Michigan Department of Licensing and Regulatory Affairs	www.michigan.gov/lara
Bureau of Health Care Services	www.michigan.gov/bhcs
Health Professions Licensing Division	www.michigan.gov/healthlicense
Michigan Board of Medicine Rules	www.michigan.gov/healthlicense
Michigan Public Health Code	www.michigan.gov/healthlicense
Application Status	www.michigan.gov/appstatus
Verify a Health Professional License	www.michigan.gov/verifylicense
Renewal Website	www.michigan.gov/elicense

LINKS:

Identogo	www.identogo.com
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