New Mexico Medical Board
2055 S. Pacheco Street, Building 400
Santa Fe, NM 87505
505-476-7220
Fax: 505-476-7233

TO ALL APPLICANTS

Thank you for requesting an application for a license to practice medicine in New Mexico. We look forward to working with you to process your application. Starting in 2003 the Board is using a Statewide Application that has been approved by the NM Medical Society and the NM Hospitals & Health Systems Association. Regardless of what application method is used, we urge you to retain a copy of this application. More information about the Statewide Application can be found at www.nmhsc.com, then go into the Credentials Verification Services link. The application is accepted by all third party payers in NM, as well as a large number of other facilities found on the "users listing" link.

You may choose from several methods to obtain licensure in New Mexico. If you are getting ready to start practice in the State we suggest you apply through the NM Hospital Services Corporation Credentials Verification Organization (HSC). They will not only provide nearly all of the required documents, but they will also have the information available to process your application for privileges at most New Mexico hospitals and credentialing for all health plans in the State. It's "one stop" credentialing to help you start practice as soon as possible. Endorsed by the New Mexico Medical Society, this is generally the fastest choice.

The second method permits completion of the application packet by using the Federation of State Medical Boards (FSMB) Federation Credentials Verification Service (FCVS) to supply core documents. If you use FCVS the application requirements are on page 3 of this packet. FCVS requires a one-time submission of education and training documents directly to a depository maintained by FSMB. Once an applicant satisfies FCVS criteria, those documents that do not change over time need not be reproduced when you apply for a license in another jurisdiction (e.g., transcripts, postgraduate training records, exam scores). Again the idea is to expedite the application process and eliminate the duplication of education and training documents each time you seek licensure in another state. Not all jurisdictions accept FCVS documents, but most states do and some actually require its use. If you think that you may apply for licenses in several states over the coming years, FCVS may save you time and money by requiring only one set of source documents for your education and training. You may obtain additional information or an application by calling 1-888-ASKFCVS (275-3287) or checking their website at www.fsmb.org, then the link to the Credential Verification Service.

The third choice is the traditional application process requiring you to satisfy all of the requirements noted on page 5 of this packet. This method requires you to request that documentation verifying your education, post-graduate training, and examination history be sent directly to the board office from the source. If you choose this method you will need to follow essentially the same process next time you apply for a license in another state. In addition, when you begin practicing in New Mexico you will still need to go through HSC for credentialing purposes.

PLEASE READ THE DIRECTIONS CAREFULLY. Call or e-mail us as soon as possible with any questions.

A license to practice medicine in New Mexico is a privilege, not a right. The members of the New Mexico Medical Board, one or all of whom individually review your application and who may interview you as part of the application process, take their responsibilities very seriously. Please do not assume that licensure is a mere formality or that the granting of a license is automatic. We make every effort to complete the process as quickly as possible but occasionally we encounter unanticipated questions or difficulties that may cause delay or even denial.

PLEASE DO NOT: close your practice and move your family to New Mexico, enroll your children in school, begin construction of a new home, execute contracts with prospective practice partners, schedule patients, or begin practicing until you have interviewed with a board member (if applicable) and received a license.

Thank you for your application. We look forward to working with you.

ELIGIBILITY FOR LICENSURE IN NEW MEXICO

A complete copy of the rules may be downloaded from the website at www.nmmb.state.nm.us. Part 2 of the rules addresses licensure requirements in detail, and Part 3 addresses examinations approved by the Board.

I. BASIC REQUIREMENTS FOR ALL APPLICANTS:

- **Examination Requirements:**

Applicants for licensure must have attained a passing score of at least 75 on each required exam. An applicant may attempt to successfully complete any part of a board-approved examination **six times**, as long as the entire examination is successfully completed within **seven years** from the date the first step of the examination is passed. MD/PhD candidates must successfully complete the entire examination within ten years from the date the first step of the examination is passed.

- **Board Approved Examinations** (for more specific information see Part 3 of rules)**:**

1. All three "steps" of the United States Medical Licensing Examination (USMLE).
2. Two "components" of the Federation Licensing Examination (FLEX).
3. All three "parts" of the National Board of Medical Examiners examination (NBME).
4. Any of the above listed in (1), (2) or (3) in an approved "hybrid" combination, per Board rule 16.10.3.8 NMAC.
5. The Board will accept the results of State Board examinations if taken and passed **before December 1973** (one of the national licensing examinations is required after that date).
6. Medical Council of Canada Qualifying Examination (MCCQE).
7. International medical graduates must have passed the ECFMG exam plus one of the approved combinations listed in Board rule 16.10.3.8 NMAC.

- **Fees:**

The application fee is payable in U.S. funds by cashier's check, money order, personal check, Master Card or Visa. Applications will not be processed until the application fee has been received. **All fees are non-refundable.**

- **License application fee:**
  - $350 if you are applying directly to the NMBME
  - $100 if you are using HSC (plus check to HSC for $320). Be aware that any add-on charges will be billed to applicant by HSC, including any verification or notary fees
  - $100 if you are using FCVS (plus additional fee to FCVS)
  - Public Service License application fee: $50 ***(valid only for applicants who are enrolled in a postgraduate training program).*** Full license fee will be charged prior to issuance of permanent license

II. REQUIREMENTS FOR LICENSURE BY EXAM

- **Education Requirements:** All applicants must have graduated from a New Mexico Board-approved medical college or school that has been approved by the Liaison Committee on Medical Education (LCME), or has been approved by Medical Board of California.

- **Postgraduate Training Requirements:** All applicants for a license must have satisfactorily completed twenty-four (24) months of postgraduate medical education in a program approved by the Board. The ACGME *Graduate Medical Education Directory* and the *Directory of Residency Programs of the Royal College of Physicians and Surgeons of Canada* are the official lists approved by the Board.

III. REQUIREMENTS FOR LICENSURE BY ENDORSEMENT

Applicants who meet the following requirements may apply for licensure by endorsement:

1. Hold an unrestricted license in another state and be free of disciplinary history, license restrictions, or pending investigations in all states where they hold a license;
2. Passed one of the examinations or combination exams listed above;
3. Graduated from an approved medical school or hold current ECFMG certification; and
4. Have three years of progressive postgraduate training in an accredited program **or** current certification from a medical specialty board recognized by ABMS.
5. Has been a licensed physician in the United States or Canada and has practiced medicine (not including postgraduate training) in the United States or Canada immediately preceding the application for at least three years.

IV. LICENSE REINSTATEMENT Please contact the Board office at 505-476-7220 for license reinstatement information.

INSTRUCTIONS FOR COMPLETING THE APPLICATION

OPTION ONE: USING HSC FOR SOURCE DOCUMENTS

Step 1: Complete the NM Statewide application in its entirety. **Please type or print legibly** in blue or black ink. **An incomplete application will delay processing.**

Step 2: **The following documentation and fees *must* be included with the application**:

a. Application fee of **$100 to New Mexico Medical Board** (or $50 if you are enrolled in a postgraduate training program and are applying for a Public Service License).
b. A check in the amount of **$320 made payable to NMHSC**. A copy of the application and your check will be forwarded to HSC from the Board. HSC will bill the applicant for any add-on costs required to obtain the source documents. These may include license verifications or notarized proof of education.
c. Completed the "Applicant's Oath" in it's entirety, including a **passport quality color photo of the applicant taken within the last six months. This form must be completed, signed and sealed in the presence of a Notary Public.**
d. If you are board certified, a copy of your specialty board certificate and re-certification, if applicable.
e. Applicants who are not US citizens must provide proof of compliance with immigration laws, e.g. copies of naturalization papers, passport, J-1 or H-1 visa.

Step 3: Attach your payment to the Board, and the check for HSC, to the front of the application. Your payment to the Board must be in U.S. funds, and may be in the form of personal check, money order, Visa, or MasterCard. Do not send cash. Mail your completed application to:

New Mexico Medical Board
2055 S. Pacheco St. Bldg. 400
Santa Fe, NM 87505

Step 4: **The following documentation must be requested by applicant and submitted directly from the appropriate source to the Board. WE WILL NOT ACCEPT THESE DOCUMENTS FROM THE APPLICANT.**

a. **Verification of Examination Scores.** The NMBME requires verification of exam scores directly from the source.
   - National Board scores can be obtained by calling 215-590-9592 or downloading the required request form at www.nbme.org.
   - USMLE, Flex and Spex scores may be obtained from the Federation of State Medical Boards by calling 817-868-4000, or downloading the required request form from www.fsmb.org. The EBAHR form and fee changed effective July 29, 2002, so please be sure you are using the correct form and attaching the correct fee. A web-based system for online EBAHR requests is available at the site noted above by simply clicking on "Transcript Requests" and following the instructions. This will expedite processing.
   - MCCQE scores can be requested by calling 613-521-6012.
   - State board exam scores and pass date should be requested with the Verification of Licensure form.

b. **Status report of ECFMG certification** for all international graduates. Please contact ECFMG at 215-386-5900 or www.ecfmg.org to request a Status Report of ECFMG Certification be sent directly to the New Mexico Medical Board. If applying through a Fifth Pathway, a copy of the ECFMG interim letter documenting the additional postgraduate training is required.

Step 5: **Personal Interview.** If you are required to schedule an appointment for a personal interview with the Board or the Board's designee, you will be notified after your application and all required documents have been received and are complete in every detail.

Step 6: **License.** Applicants whose applications are approved for licensure and who successfully complete an interview (if required) will be issued a license to practice in New Mexico.

INSTRUCTIONS FOR COMPLETING THE APPLICATION

OPTION TWO: USING FCVS FOR SOURCE DOCUMENTS

Step 1: Complete the NM Statewide application in its entirety. **Please type or print legibly** in blue or black ink. **An incomplete application will delay processing.**

Step 2: **The following documentation and fees *must* be included with the application:**

a. Application fee of **$100 made payable to New Mexico Medical Board** (or $50 if you are enrolled in a postgraduate training program and are applying for a Public Service License).
b. Completed the "Applicant's Oath" in it's entirety, **including a passport-quality color photo of the applicant taken within the last six months. This form must be completed, signed and sealed in the presence of a Notary Public.**
c. If you are board certified, a copy of your specialty board certificate and re-certification, if applicable.
d. Applicants who are not US citizens must provide proof of compliance with immigration laws, e.g. copies of naturalization papers, passport, J-1 or H-1 visa.

Step 3: Attach your payment to the Board to the front of the application. Your payment to the Board must be in U.S. funds, and may be in the form of personal check, money order, Visa, or MasterCard. Do not send cash. Mail your application, pages 1 through 12 to:

New Mexico Medical Board
2055 S. Pacheco St. Bldg. 400
Santa Fe, NM 87505

Step 4: Submit the FCVS Application. Obtain the Federation Credentials Verification Service (FCVS) application on-line at www.fsmb.org or by calling 1-888-275-3287. Submit the completed FCVS application directly to FCVS at the address shown on the application, along with appropriate fees. **Do not return the FCVS application to the Board**. Please refer any questions about the application to FCVS at 1-888-ASK-FCVS (1-888-275-3287).

Step 5: Upon receipt of your application the Board will send you the forms required to verify the following information. **These documents must be requested by applicant and submitted directly from the appropriate source to the Board.** Click here to download these forms.

a. **Verification of Work Experience**. You must have the chief of staff or administrator in each hospital or health facility where you have held privileges or been employed during the past five (5) years (not including internship, residency, or fellowship) verify your work experience.

b. **Professional Recommendations**. In addition to the documents identified above and in place of "letters of recommendation," the NMBME requires two Professional Recommendation forms sent directly to the Board from physicians, chiefs of staff, department chairs or equivalent with whom the applicant has worked and who have personal knowledge of the applicant's character and competence to practice medicine. The recommending physicians must have personally known the applicant and have had the opportunity to personally observe the applicant's ability and performance.

c. **Verification of Licensure**. You must have each state or territorial licensing authority, which has **ever** issued you a license to practice medicine (including temporary licenses and education/training permits, ***regardless*** of the status of the license), verify the standing of that license directly to the Board. Use the enclosed form entitled "Verification of Licensure." Complete the release on the top of the form and send one copy to each jurisdiction. These verifications must be received directly from the licensing authority.

Step 6: **Personal Interview.** If you are required to schedule an appointment for a personal interview with the Board or the Board's designee, you will be notified after your application and all required documents have been received and are complete in every detail.

Step 7: **License.** Applicants whose applications are approved and who successfully complete an interview (if required) will be issued a license to practice in New Mexico.

INSTRUCTIONS FOR COMPLETING THE APPLICATION

OPTION THREE: APPLYING DIRECTLY TO THE NM MEDICAL BOARD

Step 1: Complete the NM Statewide application in its entirety. **Please type or print legibly** in blue or black ink**. An incomplete application will delay processing.**

Step 2: **The following documentation and fees *must* be included with the application:**

a. Application fee of **$350 made payable to the New Mexico Medical Board** (or $50 if you are enrolled in a postgraduate training program and are applying for a Public Service License).
b. If you are board certified, a copy of your specialty board certificate and re-certification, if applicable.
c. Completed the "Applicant's Oath" including a **passport-quality color photo of the applicant taken within the last six months. This form must be completed, signed and sealed in the presence of a Notary Public.**
d. International medical graduates must submit a copy of their ECFMG certificate or fifth pathway certificate in addition to the information required above.
e. Applicants who are not US citizens must provide proof of compliance with immigration laws, e.g. copies of naturalization papers, passport, J-1 or H-1 visa.

Step 3: Attach your payment to the Board to the front of the application. Your payment to the Board must be in U.S. funds, and may be in the form of personal check, money order, Visa, or MasterCard. Do not send cash. Mail your completed application to:

New Mexico Medical Board
2055 S. Pacheco St. Bldg. 400
Santa Fe, NM 87505

Step 4: **The following documentation *must* be requested by the applicant and submitted directly from the source to the Board. WE WILL NOT ACCEPT THESE DOCUMENTS FROM THE APPLICANT.**

a. **Verification of Examination Scores.** The NMMB requires verification of exam scores directly from the source**.**
   - National Board scores may be obtained by calling 215-590-9592, or downloading the required request form at www.nbme.org.
   - USMLE, Flex and SPEX scores may be obtained from the Federation of State Medical Boards by calling 817-868-4000, or downloading the required request form from www.fsmb.org. The EBAHR form and fee changed effective July 29, 2002, so please be sure you are using the correct form and attaching the correct fee. A web-based system for online EBAHR requests is available at the site noted above by simply clicking on "Transcript Requests" and following the instructions. This will expedite processing.
   - MCCQE scores can be requested by calling 613-521-6012.
   - State board exam scores and pass date should be requested with the Verification of Licensure form.

b. If you are an international medical graduate (IMG):
   - Please contact ECFMG at 215-386-5900 or www.ecfmg.org to request a Status Report of ECFMG Certification be sent directly to the New Mexico Medical Board, or
   - Request certification of successful completion of the fifth pathway program, if applicable, directly from the school.
   - Both examination scores (USMLE, Flex, National Board) ***AND*** ECFMG Certification are required to be sent to the Board.
   - **Note**: documents in languages other than English must be translated and the translation certified as accurate. Documents without a certified translation will not be accepted.

Step 5: The following documentation must be requested by the applicant and submitted directly from the appropriate source directly to the NM Medical Board. Click here to download these forms.

a. **Certification of Medical Education and Certified Transcripts**;

b. **Certification of Postgraduate Training**;

c. **Verification of Work Experience**. You must have the chief of staff or administrator in each hospital or health facility where you have held privileges or been employed during the past five (5) years (not including internship, residency, or fellowship) verify your work experience.

d. **Professional Recommendations.** In addition to the documents identified above and in place of "letters of recommendation," the NMBME requires two Professional Recommendation forms sent directly to the Board from physicians, chiefs of staff, department chairs or equivalent with whom the applicant has worked and who have personal knowledge of the applicant's character and competence to practice medicine. The recommending physicians must have personally known the applicant and have had the opportunity to personally observe the applicant's ability and performance.

e. **Verification of Licensure**. You must have each state or territorial licensing authority which has **ever** issued you a license to practice medicine (including temporary licenses and education/training permits, whether active or inactive) verify the standing of that license directly to the Board.

Step 6: **Personal Interview.** If you are required to schedule an appointment for a personal interview with the Board or the Board's designee, you will be notified after your application and all required documents have been received and are complete in every detail.

Step 7: **License.** Applicants whose applications are approved and who successfully complete an interview (if required) will be issued a license to practice in New Mexico.

INSTRUCTIONS FOR COMPLETING THE LICENSE APPLICATION FOR TELEMEDICINE LICENSE

Definition: The practice of medicine across state lines as defined in the Medical Practice act, Sections 61-6-6, K NMSA 1978. A telemedicine license is a limited license that allows a physician located outside New Mexico to practice medicine on patients located in New Mexico.

Requirements: Each applicant for a Telemedicine license must be of good moral character and hold a full and unrestricted license to practice medicine in another state or territory of the United States.

Instructions:

Step 1: Complete the NM Statewide application in its entirety. **Please type or print legibly** in blue or black ink. An incomplete application will delay processing.

Step 2: The following documentation and fee must be included with the application:

a. Application fee of **$180 made payable to the New Mexico Medical Board.**

b. Completed form entitled "Applicant's Oath" including a passport-quality color photo of the applicant taken within the last six months. **This form must be completed, dated, signed and sealed in the presence of a Notary Public.**

c. Copy of your Specialty Board Certificate and re-certification, if applicable.

Step 3: Attach your payment to the Board to the front of the application. Your payment to the Board must be in U.S. funds, and may be in the form of personal check, money order, Visa, or MasterCard. Do not send cash. Mail your application and fee to:

New Mexico Medical Board
2055 S. Pacheco St. Bldg. 400
Santa Fe, NM 87505

Step 4: The following documentation *must* be requested by the applicant and submitted directly from the source to the Board. WE WILL NOT ACCPET THESE DOCUMENTS FROM THE APPLICANT. CLICK HERE TO DOWNLOAD THESE FORMS.

a. **Verification of Licensure**: You must have each state or territorial licensing authority which **ever** issued you a license to practice medicine (including temporary licenses and education/training permit, **whether active or inactive**) verify the standing of that license to the Board. You need to contact each licensing authority to inquire if they charge a fee to verify the license and send them the fee, if applicable, with the request form.

Licensure Process: Upon receipt of a completed application, including all required documentation and fee, Board staff will request and review an AMA Physician Profile and Federation of State Medical Boards Board Action Databank Search. When the application is complete in every detail, it will be reviewed for quality assurance and then forwarded to the Board designee for review and possible approval for licensure. A personal interview is not required unless there is a discrepancy in the application that cannot be resolved.

Initial License Expiration: Telemedicine licenses expire on July 1 of every third year. Initial licenses are valid for a period of not more than three years or less than two years.

THE NEW MEXICO MEDICAL SOCIETY

NMH&HSA New Mexico Hospitals & Health Systems Association

The New Mexico Statewide Application for Physician/Practitioner Appointment©

New Mexico Medical Board

Date of Application: _____

Demographics

Name			
	Last	First	Middle

Other Names Used	

Please check all that apply:

Physician (MD)	**Physician Assistant (PA)**	**Documents Obtained By**
Initial NM License ____	Initial NM License ____	FCVS ____
Telemedicine ____	Reinstatement ____	HSC ____
Public Service ____		NMMB ____
NM License Reinstatement ____		

Will you be applying by endorsement (See Page 1 of Instructions)? Yes ____ No ____

Are you requesting to be credentialed as a PCP if Family Practice, Internal Medicine, or Pediatrics?				**Yes____ No____**	
Gender M F	**Citizenship**			**Place of Birth**	
Immigration Status				**Certification #**	
***Social Security Number**				**Date of Birth**	
***NM Tax ID#**				Pending ☐	
***Fed. Tax ID#**				Pending ☐	
Practice Name					
Practice Limited to: (Clinical Specialty)					
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Answering Service		Effective Date			
Foreign Languages (spoken fluently by practitioner)					
Foreign Languages (spoken fluently at Practice)					
***E-Mail Address** (confidential)					
***Current Mailing Address** (if different from above -confidential unless no practice address indicated)					
*Street					
*City		*State		*Zip Code	
Telephone Number		Facsimile			
Answering Service		Effective Date			
*CLIA Number (if applicable)		Approval Level		Expiration Date	
*Office Manager or Contact Person					

* Information Confidential

Billing Address (if different from above)	Street				
City		State		Zip Code	
Telephone Number		Facsimile			
Answering Service		Effective Date			
Billing Manager or Contact Person					
***Home Address**	*Telephone Number				
*Street					
*City		*State		*Zip Code	

Practice Associates	**Call Coverage** (if different)

Other Practice Locations					
Practice Name					
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Answering Service		Effective Date			
Practice Name					
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Answering Service		Effective Date			

Education (Please attach a separate sheet, if necessary.)

Undergraduate Education					
College or University					
City		State/Country		Zip Code:	
Dates Attended	**From:** **To:**	Degree		Graduation Date	
Graduate Education					
College or University					
City		State/Country		Zip Code:	
Dates Attended	**From:** **To:**	Degree		Graduation Date	
Post-Graduate Education					
College or University					
City		State/Country		Zip Code:	
Dates Attended	**From:** **To:**	Degree		Graduation Date	
Professional / Medical Education					
College or University					
City		State/Country		Zip Code:	
Dates Attended	**From:** **To:**	Degree		Graduation Date	
Other Professional Education					
College or University					
City		State/Country		Zip Code:	
Dates Attended	**From:** **To:**	Degree		Graduation Date	

Internship	☐ Not Applicable				
Institution Name					
City		State/Country		Zip Code:	
Dates Attended	**From:**	**To:**	Type		
Residency/Fellowship	☐ Not Applicable				
(1) Institution Name					
City		State/County		Zip Code	
Dates Attended	**From:**	**To:**	Type		
(2) Institution Name					
City		State/Country		Zip Code:	
Dates Attended	**From:**	**To:**	Type		
(3) Institution Name					
City		State/Country		Zip Code:	
Dates Attended	**From:**	**To:**	Type		

Work History

Please list all previous practice experience for the previous 15 years, including military or government service, listing the most recent first. If military service, state type of discharge and rank achieved **and attach copy of discharge or separation documents**. Attach separate page, if necessary. Please provide written explanation for any gaps in work history of 6 months or more.

Location		From		To	
Street		Phone Number			
City		State		Zip Code	
Type of Practice		Contact Person			
Type of Discharge		Rank Achieved			
Location		From		To	
Street		Phone Number			
City		State		Zip Code	
Type of Practice		Contact Person			
Type of Discharge		Rank Achieved			
Location		From		To	
Street		Phone Number			
City		State		Zip Code	
Type of Practice		Contact Person			
Type of Discharge		Rank Achieved			
Location		From		To	
Street		Phone Number			
City		State		Zip Code	
Type of Practice		Contact Person			
Type of Discharge		Rank Achieved			

Hospital and Healthcare Affiliations (other than postgraduate training) ☐ N/A

Please list hospital staff membership and/or healthcare organization affiliations in the past fifteen (15) years. If an institution is no longer in existence, please provide an alternative source of verification. Use separate page, if necessary. **Providers who do NOT have admitting privileges, please explain your procedures or the arrangements you make in instances when patients require admission to a hospital. If you are applying with a health plan, should arrangements include admitting coverage by another provider, a signed letter from the covering provider, including their primary admitting facility, is to be included with this application.**

(1) Current Primary Admitting Facility (Hospital Name)					
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Appointment Dates	**From:**	**To:**			
Type of Appointment					
Privileges Assigned					

(2) Facility Name					
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Appointment Dates	**From:**	**To:**			
Type of Appointment					
Privileges Assigned					
(3) Facility Name					
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Appointment Dates	**From:**	**To:**			
Type of Appointment					
Privileges Assigned					
(4) Facility Name					
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Appointment Dates	**From:**	**To:**			
Type of Appointment					
Privileges Assigned					
(5) Facility Name					
Street					
City		State		ZIP Code	
Telephone Number		Facsimile			
Appointment Dates	**From:**	**To:**			
Type of Appointment					
Privileges Assigned					
(6) Facility Name					
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Appointment Dates	**From:**	**To:**			
Type of Appointment					
Privileges Assigned					

Professional References Please list three professional peers familiar with your professional performance in the past 5 years, (not including current or impending partners or associates in practice).

(1) Name and Title					
Address					
City		State		Zip Code	
Telephone Number		Facsimile			
(2) Name and Title					
Address					
City		State		Zip Code	
Telephone Number		Facsimile			
(3) Name and Title					
Address					
City		State		Zip Code	
Telephone Number		Facsimile			

Licensure-Registration-Certification Information

ECFMG Number (if applicable)							
State Professional License/Certification Number							
State		Issue Date		Expiration Date		Pending ☐	
All Other State License Numbers (regardless of status - attach separate list if necessary.)							
State	**Number**	**Issue Year**	**Expiration Date**				
***Federal Drug Enforcement Admin. (DEA) Registration**						N/A ☐	
Number		Exp. Date				Pending ☐	
***State Controlled Substance Registration** (CSR)						N/A ☐	
Number		State		Exp. Date		Pending ☐	
***Medicare Unique Physician Identification Number (UPIN)**							
Pending ☐							
***State Medicaid Provider Number**							
Pending ☐							

Specialty Board Certifications ☐N/A

Are you Board Certified? ☐Yes ☐No **Note:** If you are not Board certified by a Board recognized by the American Board of Medical Specialties, the American Osteopathic Association, the National Commission on Certification of Physician Assistants, the American Nurses' Credentialing Center, or the National Certification Commission, or accepted for examination in your specialty, please give a brief explanation on an attached sheet.

Certified/Recertified by the:					
1.					
Date Certified		Date Last Recertified		Expiration Date	
2.					
Date Certified		Date Last Recertified		Expiration Date	
3.					
Date Certified		Date Last Recertified		Expiration Date	
Accepted for Examination by the:					
Until (expiration date)		If not accepted, have you made application?		Yes No	
Certified/Recertified by the Subspecialty Board of					
1.					
Date Certified		Date Last Recertified		Expiration Date	
2.					
Date Certified		Date Last Recertified		Expiration Date	
Accepted for Examination by the Subspecialty Board of					

Professional Liability Insurance (confidential information)

Do you have current liability insurance? ☐ Yes ☐ No

(Please list liability insurance carriers for the past 5 years.)

Current Carrier				Current ☐	Pending ☐
Address					
Dates Insured	From	To	Policy #		
			Coverage Limits		
Carrier					
Address					
Dates Insured	From	To	Policy #		
			Coverage Limits		

Professional Practice Questions Please answer the following Yes or No questions. If you answer YES to any question, please give details including name, address, and telephone number of significant parties on a separate sheet of paper.

1. Has your professional liability coverage ever been terminated by action of the insurance company?	Yes ☐	No ☐
2. Have you ever been denied professional liability insurance coverage?	Yes ☐	No ☐
3. Has your professional liability carrier ever excluded any specific procedures from your coverage?	Yes ☐	No ☐
4. Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any professional organization?	Yes ☐	No ☐
5. Have you ever been excluded from or sanctioned by Medicare and/or Medicaid?	Yes ☐	No ☐
6. Have you ever been charged with, arrested for, convicted of, or pled no contest to a misdemeanor or felony, or have you ever been named as a defendant in any criminal proceedings or subject to investigation by a governmental entity that could result in sanctions or licensure adverse actions?	Yes ☐	No ☐
7. Have you ever been named in any formal requests for corrective actions filed by any healthcare entity where you have had an appointment (a request which could result in either formal or informal proceedings).	Yes ☐	No ☐
8. Have your privileges at any healthcare entity ever been voluntarily or involuntarily suspended, restricted, diminished, revoked or not renewed, except for medical records?	Yes ☐	No ☐
9. Have you ever resigned from a healthcare entity to avoid modification, suspension, or termination of privileges?	Yes ☐	No ☐
10. Has your application for licensure or license to practice in any jurisdiction ever been investigated, voluntarily or involuntarily limited, suspended, revoked, denied or are any currently held licenses pending investigation or being challenged?	Yes ☐	No ☐
11. Have you ever been notified to appear before any licensing agency for a hearing or complaint of any nature?	Yes ☐	No ☐
12. Has your federal or state narcotics registration certificate in any jurisdiction ever been voluntarily or involuntarily limited (stipulations), suspended, revoked, restricted, or are there currently challenges to any of these items?	Yes ☐	No ☐
13. Have you ever been involved in a settlement, medical malpractice claim or suit, or have you ever received written notice of intent to file such a suit? If yes, please provide the following information for each claim or suit. Please type on a separate sheet of paper for each case. • Name, age, sex of patient/claimant. • Date(s) and type of treatment and/or surgery, which led to the allegations against you. • Nature of allegations in claims/suits. Specify whether a suit was ever filed. • Names of other practitioners and hospital, if any, involved in claims or suit. • Disposition or current status of claim or suit (be specific). • Name of insurance carrier defending you. • Name of defense attorney.	Yes ☐	No ☐
14. Do you know of any reason why you cannot perform the essential duties of the clinical privileges/functions for which you are requesting with or without a reasonable accommodation according to acceptable standards of professional performance and without posing a direct threat to patients?	Yes ☐	No ☐
15. Do you use illegal drugs or have you illegally used drugs in the past five years?	Yes ☐	No ☐

If you answer YES to any question, please give details including name, address, and telephone number of significant parties on a separate sheet of paper.

New Mexico Medical Board
2055 S. Pacheco St. Bldg. 400
Santa Fe, NM 87505
(505) 476-7220

Licensing Exam: (i.e State Board Exam, FLEX, LMCC, National Board or USMLE)

Exam Taken _____ Date Passed_____
Month/ Year

Exam Taken _____ Date Passed_____
Month/ Year

Exam Taken _____ Date Passed_____
Month/ Year

1 Have you been treated for mental illness during the past five (5) years? If yes, please have your treating physician provide the NM Medical Board with a letter regarding your diagnosis and treatment. ____Yes ____No

2 Have you had personal or legal problems with narcotics, alcohol or other dangerous drugs during the past five (5) years? (You may answer "no" if you are a voluntary participant in a board approved monitoring program) ____Yes ____No

3 Have you ever withdrawn from, or been suspended, dismissed, or expelled from, or have you ever been placed on probation or taken a leave of absence from a medical school or postgraduate training program? ____Yes ____No

If you answered "Yes" to any of the above, please provide a complete written explanation with this application.

APPLICANT'S OATH

You must complete this Oath in the presence of a Notary Public.

I, _____, hereby certify under oath that I am the person pictured below and named in this application for a license to practice as a Physician in the State of New Mexico; that all statements I have made herein are true; that I am the original and lawful possessor and person named in the various forms and credentials furnished to this Board with my application.

I acknowledge and state that I have read the Information and Instructions that accompanied this application and I have answered all questions truthfully. I understand that the fee I submitted is not refundable.

I hereby release, discharge, and exonerate the New Mexico Medical Board, and their agents or representatives, and any person furnishing information, from any and all liability of every nature and kind arising out of the furnishing or inspection of such documents, records, other information, or the investigation made by the New Mexico Medical Board. I authorize the New Mexico Medical Board to release information, material, documents, orders, or the like relating to me or to this application to any other agency of the State of New Mexico or the appropriate licensing agency of any other state or Territory of the United States or any agency of the United States government.

ATTACH RECENT PASSPORT-QUALITY PHOTOGRAPH THAT WILL FIT IN THIS SPACE

Notary seal must partially cover photograph

_____
Applicant Signature Date

(***must be signed and dated in the presence of the notary public***)

County of_____)
:
State of_____)

Subscribed and sworn to before me this _____ day of

_____, 20_____

_____
Notary Public Signature

Applicant's Attestation

I, _____, certify that the information I have provided and the statements I have made on this application are correct, true, and complete to the best of my knowledge. I will abide by the applicable bylaws, rules and regulations, and policies and procedures of the designated health care entity. I acknowledge that I have received and reviewed a copy of the bylaws if applicable of the designated health care entity. I further agree that, in the event there should arise an adverse ruling with respect to my status and/or clinical privileges, I will exhaust the administrative remedies afforded by the entity's bylaws before resorting to litigation.

_____ _____

Signature Date

Note: A cover letter should accompany this form identifying the requesting organization so that applicants can return the form to the appropriate organization.

All applicants have the right to be informed of their application status. Application status inquiries may be directed to either HSC or the appropriate health care organization.

(This attestation may be replaced by the healthcare organization's own attestation.)

This form may be downloaded from any of the following web-sites:

www.nmhsc.com
www.nmms.org
www.gamamed.org/gama

HSC

P.O. Box 92200
Albuquerque, NM 87199-2200
505-343-0070
Facsimile 505-346-0288
Office Hours M-F 800 a.m. - 500 p.m.
cvs@nmhsc.com
www.nmhsc.com

Hospital Services Corporation, a subsidiary of the New Mexico Hospitals and Health Systems Association, maintains this form, as well as a users' mailing list, to distribute any subsequent revisions. If you have any questions about this form or if you would like to be included on the users' list, please contact one of our credentials analysts at 1-800-577-2121 or 505- 343-0070, or by e-mail to cvs@nmhsc.com.

Applicants using HSC for source documents must complete this form.

CREDENTIALS VERIFICATION SERVICE
DESIGNATION AND AUTHORIZATION FOR RELEASE AND REDISCLOSURE OF INFORMATION ("Release")

Authority to Release: I have applied to participate as a provider for _____

_____

Print the names of all organizations to which you are applying.

and its authorized representatives (hereafter "Health Care Entity") which has designated the Hospital Services Corporation's Credentials Verification Service ("HSC/CVS") as their agent. I consent to complete disclosure by the recipient of this release to HSC/CVS of all relevant information pertaining to my professional qualifications, moral character, physical and mental health (hereinafter "qualifications"). I authorize the recipient to make available and/or disclose to HSC/CVS all such information in its files from any university, professional school, licensing authority, accreditation board, hospital, physician, dentist, professional society, insurance carrier, law enforcement agency, military service, or any other person or entity deemed necessary or appropriate in the investigation and processing of my application.

I request and authorize the recipient to release the requested information and I expressly waive any claim of privilege or privacy with respect to the released information bearing on my admission to, retention or termination of medical staff appointment or clinical privileges. I release and discharge HSC/CVS, the Health Care Entity and the medical, dental, podiatry and ancillary staffs or panels, credentials committees, administrators, review and approval boards or committees, governing boards, whether or not designated by these titles, and their agents, servants or employees authorized by representatives and all other persons or entities supplying information to them from liability or claims of any kind or character in any way arising out of inquires concerning me or disclosures made in good faith in connection with my application for appointment to the Health Care Entity's Medical Staff or Provider Panel.

Authority to Redisclose: Unless I have denied authority by initialing here _____, I authorize the Health Care Entity, the Health Care Entity's Authorized Representatives, and HSC/CVS to redisclose information concerning my qualifications, or credentials and privileges to third parties who have a need to know the information (1) based upon New Mexico or federal laws or regulations, or (2) pursuant to any health care provider agreement to which I am or will be a party and in which I have an interest as an individual health care provider.

This Release does not authorize HSC/CVS to disclose information about my qualifications to any claimant. If a claimant requests information from HSC/CVS about me or if a subpoena duces tecum is served upon HSC/CVS seeking information about me, which is in HSC/CVS' possession, I understand I will be notified immediately. If I direct HSC/CVS to resist the subpoena, I hereby agree to indemnify and hold harmless HSC/CVS, its officers, directors, employees and agents for all attorney fees, costs, fines, and expenses incurred in resisting the subpoena at my request.

This authorization is limited to the acquisition and disclosure of information required by state or federal law, and information which is acquired or disclosed pursuant to activities protected by the New Mexico Review Organizational Immunity Act and the Health Care Quality Improvement Act of 1986. A photocopy of this Designation and Authorization for release and redisclosure of information shall be considered by the recipient to be a signed original, as long as it is transmitted to the recipient by HSC's Credentialing Verification Service and is received within five years of its date.

The certain definitions used in this Release and set forth on its reverse side are incorporated by reference. I understand that I may withdraw or modify this authorization at any time in writing by submitting a written request to the HSC/CVS. PHOTOCOPY BOTH PAGES OF THIS FORM.

_____

Applicant Signature

_____ _____

Printed Name Date

DEFINITIONS of terms used in this Designation and Authorization for Release and Redisclosure of information.

"Health Care Entity" is the Health Care Entity on the front of this form.

The "Health Care Entity's Authorized Representatives" include any management or quality assurance companies hired by the Health Care Entity or the HSC/CVS; the Health Care Entity's Board, staffs, committees, CEO, administrator medical director or other employees of the Health Care Entity whose performance of duties requires access to information about my qualifications; consultants whose contract with the Health Care Entity requires access to information about my qualifications; any independent credentialing services including the HSC/CVS; and the Health Care Entity's attorneys and insurers.

"Credentials and Privileges" means all information regarding my qualifications, my standing with the Health Care Entity, and my right to provide healthcare services at or through the Healthcare Entity. It also includes any limitations imposed upon my right to provide healthcare services and any final disciplinary action taken by the Health Care Entity with regard to my provision of healthcare services at or through the Healthcare Entity.

"Credentialing Verification Service" is the service operated by the Hospital Services Corporation. HSC/CVS may be required as a condition of certification by the National Committee for Quality Assurance (NCQA) to permit audits of HSC/CVS' system. The person providing this Release that these audits are conducted solely for the purpose of certifying the credentialing verification service, and all information utilized by the NCQA is treated as confidential.

"Claimant" means any person guardian, or personal representative who is asserting an administrative or legal claims against the person providing this release based in whole or in part upon allegations that the person providing this release has violated any state or federal law or regulation or has committed medical malpractice.

"Medical Staff or Provider Panel" is to be interpreted broadly to include any group of healthcare providers howsoever designated, who are authorized to provide healthcare services to patients, insureds, beneficiaries, members, or enrollees of a healthcare plan.

"Third Parties who have a need to know," include, but are not limited to governmental agencies and boards; organizations, associations, partnerships, corporations; other hospitals and clinics; managed care organizations, Independent Practice Associations ("IPAs"), Managed Service Organizations ("MSOs"), Physician Hospital Organizations ("PHOs"), Preferred Provider Organizations ("PPOs"), Health Maintenance Organizations ("HMOs"), medical foundations, insurance underwriters, employer or employee sponsored ERISA health plans, health care alliances, or others with whom I am negotiating a health care provider agreement, presently have a health care provider agreement or with whom the Health Care Entity identified on the front page of this authorization (or the Health Care Entity's Authorized Representatives) is negotiating a health care provider agreement or has health care provider agreement in which I have or will acquire an interest.

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REVISED APRIL, 1996