FOR OFFICE USE ONLY
Receipt #
ID #
Issue Date
License #

Rhode Island
Board of Medical Licensure and Discipline

Room 205
3 Capitol Hill
Providence, RI 02908-5097

Instructions and License Application for:

- ☐ Allopathic Medicine
- ☐ Osteopathic Medicine
- ☐ Academic Faculty (Limited Medical Registration)

Applicant – Print/Type Name (First/MI/Last)

☐ I am also applying for a RI Uniform Controlled Substance Registration (CSR) and I have attached the CSR application to this license application.

Phone: (401) 222-3855 **TTY/TDD: (800) 745-5555** **Fax: (401) 222-2158**

GENERAL INFORMATION

Components of the Application. The following materials and information should be enclosed within this application packet:

Instructions:

General Information …………………………………………………………… Instructions Pages 1-2
Instructions for Completing Board Application/Checklist ……………………….. Instructions Pages 3-5

Uniform Application for Physician Licensure:

Online Application ……………………………………………………………… Online Application

Addenda:

Addendum Instructions ………………………………………………………… Addendum Page 1
Addendum 1 – Additional Questions …………………………………………… Addendum Pages 2-4
ABMS Certification Codes …………………………………………………….... Addendum Pages 5-6
Addendum 2 – Hospital Privileges ……………………………………………… Addendum Page 7
Addendum 3 – Voluntary Race/Ethnicity Questions …………………………....... Addendum Page 8
Addendum 4 – Reciprocity Release Form (Licensure Verification)……...……….. Addendum Page 9
Addendum 5 – Reference Form ………………………………………………… Addendum Page 10
Addendum 6 – Mandatory Addendum to Licensure Application/ Verif. Of SSN… Addendum Page 11
Addendum 7 – Uniform Controlled Substances Act Registration (CSR) ……...…. Addendum Page 12
Addendum 8 – Academic Faculty, Limited Medical Registration Applicants… Addendum Page 13

Licensure Requirements.

U.S./Canadian Graduates:

- Graduated from a medical school accredited by the Liaison Committee for Medical Education (LCME).
- Satisfactorily completed two (2) years of internship or residency by the Accreditation Council for Graduate Medical Education, Accreditation Committee of the Federation of the Medical Licensing Authority of Canada or the Royal College of Physicians and Surgeons of Canada.
- Satisfactorily passed a licensure examination approved by the Board.
- Met any other requirement(s) set forth by regulation or established by the Board.

Foreign Graduates:

- Successfully completed a course of study from a medical school located outside the United States which is recognized by the World Health Organization.
- Obtained ECFMG certification.
- Have attained a score satisfactory to a medical school approved by the Liaison Committee on Medical Education on a qualifying examination acceptable to the State Board for Medicine.
- Have satisfactorily completed three (3) years of internship or residency in a training program accredited by the Accreditation Council for Graduate Medical Education.
- Have satisfactorily passed a license examination approved by the Board.
- Met any other requirement(s) set forth by regulation or established by the Board.

Academic Faculty – Limited Medical Registration. Academic Faculty – Limited Medical Registration Applicants **MUST**:

- Be recommended by the Medical School Dean.
- Be appointed to Senior Rank at the Medical School.
- Renew yearly and reapply every five (5) years.
- Practice ONLY in hospital and facilities affiliated with the Medical School.

Rules and Regulations. The rules and regulations governing the Practice of Medicine and Limited Medical Registration can be obtained at the following web site:

http://www2.sec.state.ri.us/dar/regdocs/released/pdf/BMLD/4905.pdf

Applicant Name: ____ Date: ____________

Rhode Island General Laws pertaining to the Practice of Medicine can be obtained at the following web sites:

Medical Licensure http://www.rilin.state.ri.us/statutes/title5/5-37/index.htm

Controlled Substance Act http://www.rilin.state.ri.us/statutes/title21/21-28/index.htm

Application Process Overview. The licensure process in the State of Rhode Island is conducted jointly by the Rhode Island Board of Medical Licensure and Discipline (Board) and the Federation of State Medicine Boards' Federation Credentials Verification Service (FCVS). All licensure applicants must complete and submit a Board application and a separate FCVS application.

FCVS Application Process. For applicants who have an active and unrestricted license in another state, the Board may elect to consider granting licensure pending receipt of FCVS, provided the applicant has submitted documentation of payment to FCVS and a written statement confirming completion of the FCVS application packet.

To have your "core" credentials verified, you must submit an FCVS application directly to the Federation's national office (Texas). This application must be obtained by contacting FCVS toll free at **1-888-ASK-FCVS** (1-888-275-3287), or it can be downloaded at the Federation's web site at: http://www.fsmb.org

This verification process is conducted separately and independently by the FCVS in accordance with established policies and procedures set forth by the Board. Because the verification process is the most time consuming task, it is recommended that you submit this application as soon as possible. You will deal directly with FCVS for all aspects of this verification. **Do not contact the Board about your FCVS application**.

The FCVS will verify your applicable credentials from the original, primary source in the following categories (some may not apply):

- Medical Education (Including Fifth Pathway)
- Post Graduate Training
- Examination History
- Board Action History
- ECFMG Certification
- Identity

When all information is received and reviewed for accuracy, FCVS will forward directly to the Board in a non-interpretive "Physician Information Profile" containing certified photocopies of your credentials. For more information about the FCVS process, or if you need assistance completing the FCVS application, call FCVS toll free at **1-888-ASK-FCVS** (1-888-275-3287).

Uniform Application for Physician Licensure (UA): The Board has incorporated the Uniform Application (UA) into its Medical Licensing Application. This form will make it easier for physicians to apply for licensure in states that utilize this form (UA). The Rhode Island Board of Medical Licensure and Discipline is one of the first boards to incorporate the UA into its state license application.

Board Application Process. In addition to the FCVS application and verification process, you must submit additional information directly to the Board. The Board will use this information, along with the FCVS Profile, to assess your qualifications for licensure. Please allow a minimum of 8 weeks for the entire licensure process to be completed. If you have malpractice or disciplinary history, it can take an additional 2 or 3 months for all pertinent documentation to be received.

The Board meets during the first week of each month. Only applications which are complete, including all outside verifications, will be forwarded to the Board for review and issuance of a license. You are responsible for notifying the Board office, in writing, if your address changes in the interim.

Please continue to review the remaining portions of this application packet for instructions and other materials necessary to complete the Board application. If you have any questions about this application process, or would like to check on the status of your Board application, please contact Lauren Lasso at (401) 222-7887 or by email at Lauren.Dixon-Lasso@health.ri.gov.

Applicant Name: ____ Date: __________

Instructions for Completing the Board Application

Read the following instructions and those throughout the online application carefully before completing the Board application. Failure to submit all required information and appropriate documentation may result in processing delays. All of the information provided is subject to change.

General Instructions.

1. Type your information or print in blue or black ball-point pen. Board staff will not make assumptions about illegible information. Be sure to print your name in the box provided on the cover page.
2. Provide a response to each section or questions; otherwise, mark "N/A" for Not Applicable.
3. We suggest that you make a copy of your completed application and addenda before submitting it to the Board.
4. **It is your responsibility to check on the status of your application**.

Completing Your Board Application.

1. **Fees**. Make a check or money order (in U.S. funds only) for the application fee of $570.00 (or $710.00 if you applying for your Controlled Substance Registration (CSR), payable to "Rhode Island General Treasurer" and staple it to the upper left-hand corner of the first (Top) page of the Application Instructions. These application fees are NON-REFUNDABLE. If you are applying for your CSR, you MUST submit the Board application at the SAME TIME as the CSR application.

   NOTE: These are Board Application Fees. The FCVS verification fee is an additional and separate fee paid directly to the FCVS.
2. **Complete the Online Application (Uniform Application, UA)**. Complete the online Uniform Application as instructed in each section. **Please make special note of the information and instructions appearing in light blue at the beginning of each section; as this information will instruct you on how to complete the section as well as any documentation that will need to be submitted to the Board. Please utilize the Checklist to ensure that you submit all required documentation.** You must respond to all components of the application as instructed.

   ****Please see below for specific instructions on completing certain sections of the online UA:**

   Malpractice & Liability Section: Report all medical malpractice court judgments, medical malpractice arbitration awards and settlements, within the past ten (10) years, in which payment was made to a complaining party.

   Special Notice about Malpractice Information: Pursuant to R.I.G.L.§ 5-37-9.2, the Rhode Island Board of Medical Licensure and Discipline must collect data regarding your malpractice history. You are required to report to the Board all actual settlement or jury verdict amounts in the past ten (10) years. The Board will not make actual settlement or verdict amount available to the public. I must report the fact that a payment was made and how it compared to other payments made in your specialty. For each incident you report, you must include documentation that verifies the date, place, reason and disposition of the matter.

   Licensure & Employment Section: Please be sure to list ALL state and Canadian provinces where you currently hold or have ever held any type of Medical/Osteopathic license. You will need to obtain licensure verification from each licensing Board by completing the top portion of the Reciprocity Release Form (Addendum 4, Forms and Affidavit Section) and sending it to each board or province. The Board will need to complete the form and return it directly to the Rhode Island Board.

   Forms & Affidavit Section: DO NOT COMPLETE THE LICENSURE VERIFICATION FORM. In lieu of this form, you will obtain licensure verification on the Reciprocity Release Form (Addendum 4, in the Addendum Section).
3. **State Addendums.** Complete the addenda as instructed. Print out the completed addenda and return to the Rhode Island Board. Please type or print all responses.

Applicant Name: ______________________ Date: __________

4. **National Practitioner Data Bank Report**. Submit a "self-query" of the National Practitioner Data Bank (NPDB). The application is a Practitioner Request for Information Disclosure, which can be obtained by calling the NPBD, or downloading it from the NPDB web site.

   Phone: 1-800-767-6732
   Web Site: http://www.npdb-hipdb.com

   You must mail this completed form directly to NPBD. **When you receive a response, send the Board the ORIGINAL, UNOPENED response**. The Board must have this response in order to complete your application so you are encouraged to make this request as soon as possible.

The application process is not considered complete until your Board application, applicable forms and FCVS Physician Information Profile are received in a manner satisfactory to the Board. Neither the Board nor FCVS will accelerate processing of one application at the expense of others for any reason. Once completed, your application will be reviewed and you will be contacted in writing. Be advised that you may be required to appear for an interview. Please allow 7-10 working days following the Board meeting for you wallet size license cared to be mailed to you. [Note: You may not practice medicine in Rhode Island until you have received a license number.]

Complete all application materials as instructed and arrange them in order as they appear in the application checklist (Instructions Page 5). Do not submit an application without all applicable information, documentation and fee.
Mail these components of the application to:

Rhode Island Department of Health
Board of Medical Licensure & Discipline
Room 205, Three Capitol Hill
Providence, RI 02908-5097

Applicant Name: ______________________________ Date: ____________

Application Checklist

Please review the following checklist to ensure you have satisfied all components of the application process. Some items may not apply.

- ☐ I have carefully read RIGL 5-37 and R5-37REG available at:

  http://www.rilin.state.ri.us/statutes/title5/5-37/index.htm
  http://sos.ri.gov/documents/archives/regdocs/released/pdf/DOH/5711.pdf

- ☐ I have completed the FCVS application, and submitted all required forms, documents, and fee directly to FCVS.
- ☐ I have a **check or money order** made payable (in U.S. funds only) to the "**Rhode Island General Treasurer**" in the amount of **$570.00 (or $710.00 with CSR Application)** and have attached it to the upper left-hand corner of the first (Cover/Top) page of the application instructions.
- ☐ I have read and understand the "Instructions for Completing the Board Application."
- ☐ I have read and understand the "Special Notice about Malpractice Information." (Instructions Page 3, Completing your Board Application, #2)
- ☐ I have completed the **Online Rhode Island Board Application (UA)** as instructed in each section and submitted it to the Board.
  - ☐ I have completed the **Affidavit and Authorization for Release of Information Form** (Forms & Affidavit Section of the Online UA). I have attached a color photograph of myself and the form has been notarized by a notary public.
  - ☐ I did NOT complete the Licensure Verification Form (Forms & Affidavit Section of the Online UA), but will complete Addendum 4 (Addendum Page 9) in lieu of this form.
- ☐ I have completed **Addendum 1** (Addendum 1, Pages 2-4) as instructed.
  - ☐ I have attached a copy(ies) of my ABMS Certificate(s).
  - ☐ I have attached complete details of all "Yes" responses to Question #10.
- ☐ I have completed **Addendum 2** "**Hospital Privileges**" (Addendum 2, Page 7) as instructed.
- ☐ I have completed **Addendum 3** "**Voluntary Race/Ethnicity Questions**" (Addendum 3, Page 8) as instructed. This information is voluntary and will NOT affect your application in any way.
- ☐ I have completed and mailed **Addendum 4** "**Reciprocity Release Form**" (Addendum 4, Page 9) as instructed.
- ☐ I have completed and mailed **four (4) Addendum 5** "**Reference Form**" (Addendum 5, Page 10) as instructed.
- ☐ I have completed **Addendum 6** "**Mandatory Addendum to Licensure Application, Verification of SSN**" (Addendum 6, Page 11) as instructed.
- ☐ I have completed **Addendum 7** "**Rhode Island Uniform Controlled Substances Act Registration (CSR)**" (Addendum 7, Page 12) as instructed.
- ☐ I have completed **Addendum 8 "Academic Faculty – Limited Medical Registration Applicants Only"** (Addendum 8, Page 13) as instructed.
- ☐ I have arranged my Board Application materials in the following order:
  1. Fee (Attached as instructed)
  2. Completed Top/Cover of Application Instructions
  3. Affidavit and Authorization for Release of Information Form
  4. Completed Addendum 1, followed by a copy(ies) of the ABMS Certificate(s), followed by details of any "Yes" response to Question #10.
  5. Completed Addendum 2 "Hospital Privileges"
  6. Completed Addendum 3 "Voluntary Race/Ethnicity Questions"
  7. Completed Addendum 4 "CSR Registration"
  8. Completed Addendum 6 "Mandatory Addendum to Licensure Application, Verification of SSN"

Applicant Name: ______________________________ Date: __________

Rhode Island Board of Medical Licensure and Discipline

Addendum Instructions

Addendum Instructions. Complete the addenda as instructed below. Return the completed addenda to the Rhode Island Board of Medical Licensure and Discipline.

☐ **Addendum 1:**

These questions must be completed by the applicant. Please complete each question as instructed. Include all requested information and documentation. Please either type or print your responses. If not applicable please respond with N/A. If you need additional space please attach a separate sheet.

☐ **Addendum 2:**

List the name and address of all hospitals where you have ever held privileges. You may duplicate this form if additional space is needed.

☐ **Addendum 3**:

The completion of this form is **voluntary** and will **NOT** affect your Application in any way.

☐ **Addendum 4:**

Obtain licensure verification from all states where you hold, or have ever held, a license to practice medicine. The applicant must complete the top portion of the Reciprocity Release Form and then mail to each licensing authority in which you are/were licensed. If you are licensed in Canada, send a copy to each province in which you are/were licensed. This form may be duplicated as necessary. This form will be completed in lieu of the "Licensure Verification Form" (Online Uniform Application, Affidavit and Forms Section).

☐ **Addendum 5:**

Obtain a total of four (4) references from fully licensed physicians attesting to your character and professional abilities. Make four (4) copies of this Reference Form and mail to each of the following:

- Chief of Staff in the hospital where you currently hold staff privileges or equivalent physician hospital administrator;
- Three (3) additional practicing physicians.

If you do not currently hold staff privileges or are within 5 years of completing GME training, mail this Reference Form to each of the following:

- Chairman of the department where you had your major training or Director of Residency or Fellowship Training Program
- Three (3) additional practicing physicians.

Letters or other forms submitted in lieu of the Reference Form will not be accepted. **The board must receive these forms directly from the reference source (with appropriate seal).**

☐ **Addendum 6:**

This form is mandatory and must be completed by the applicant.

☐ **Addendum 7:**

In order to dispense, prescribe, store, or order controlled substances, **you must obtain a Rhode Island Controlled Substance Registration (CSR) and a Drug Enforcement Administration (DEA) Registration.** If applying for a CSR you must complete this Registration form and submit it along with your license application. If you are NOT applying for a CSR, please write N/A across the form. After you obtain your Rhode Island CSR, you can apply for a federal DEA Number. An application for the federal DEA Number can be obtained by contacting the DEA: Phone Number (617) 557-2200; Web Site http://www.deadiversion.usdoj.gov/drugreg/reg_apps/.

☐ **Addendum 8:**

This form only needs to be completed if the applicant is applying for Academic Faculty – Limited Medical Registration. Complete the top portion of this form and forward to the Dean of the Medical School. Letters or other forms submitted in lieu of this form will not be accepted. **The board must receive this form(s) and attachments directly from the Medical School.**

Applicant Name: ______________________________ Date: ____________

Addendum 1

1. I am applying for a Rhode Island Licensure by:
   □ Endorsement
   To apply for licensure by endorsement you must currently hold, or have held, a full medical license in any state in the U.S.
   □ Examination
   If you do not currently hold, or have never held, a medical license in any state in the U.S. you must apply for licensure by examination.

2. **Specialty of Practice**: Refer to the ABMS Certification Codes List (ABMS Codes Addendum Pages 5 and 6) when completing this section. You must provide a copy of your ABMS certificate(s). You may report "None", "Other", or "Unknown" if necessary.

______________________ Primary Specialty Code	Board Certified? ☐ Yes ☐ No If Yes, Year Certified/Recertified: __________
______________________ Secondary Specialty Code	Board Certified? ☐ Yes ☐ No If Yes, Year Certified/Recertified: __________
______________________ Secondary Specialty Code	Board Certified? ☐ Yes ☐ No If Yes, Year Certified/Recertified: __________
______________________ Secondary Specialty Code	Board Certified? ☐ Yes ☐ No If Yes, Year Certified/Recertified: __________

3. **Practice Information**: Specify where in this State do you intend to practice, and list type of practice using the codes below. (If additional space is needed, attach a separate sheet)

ACD = Academia
ADM = Administration
FTY = Faculty
FEL = Fellowship
GRP = Group
HSP = Hospital
HMO = HMO
OFC = Office
RES = Research
OTH = Other

Location #1: ______________________________
City: ______________________ Practice Type(See Code): ________
Location #2: ______________________________
City: ______________________ Practice Type(See Code): ________
Location #3: ______________________________
City: ______________________ Practice Type(See Code): ________

Identify any translational services that may be available at your primary practice location:

____

4. **Medical School Faculty Appointments**: Identify any appointments to medical school faculties and indicate as to whether you have had responsibility for graduate medical education within the most recent ten (10) years.

____
____
____
____

5. **Board Discipline**: List any disciplinary actions by licensing boards in other states. Please describe any prior or pending Board action or investigation. Please attach any relevant supplemental materials. If necessary, you may continue on a separate sheet. ☐ Check here if not applicable

Licensing Board (abbreviate) and Nature of Action (e.g. TX – Professional Misconduct):	Month/Year	Type of Discipline:
	/	
	/	
	/	
	/	
	/	

Applicant Name: ______________________________ Date: ____________

6. **Hospital Discipline**: Please explain any disciplinary actions and attach any relevant supplements materials. List any revocation of hospital privileges for reasons related to competence or quality of patient care that have been taken by the hospital's governing body or any other official of the hospital after procedural due process has been afforded. Also, report resignation from or the non-renewal of medical staff privileges or the restriction of privileges at a hospital during the course or threat of investigation. If necessary, you may continue on a separate sheet.
   ☐ Check here if not applicable

(1) Name of Hospital ______________________________

______/_____/________ ______________________________
Month Day Year Type of Action

(2) Name of Hospital ______________________________

______/_____/________ ______________________________
Month Day Year Type of Action

(3) Name of Hospital ______________________________

______/_____/________ ______________________________
Month Day Year Type of Action

7. **Criminal Convictions**: Respond to the questions below, then list any criminal conviction(s) in the space provided. If necessary, you may continue on a separate sheet.

   Have you ever been convicted of a violation, plead Nolo Contedere, or entered a plea bargain to any federal, state or local statute, or ordinance, or are any formal charges pending; including use of illicit substances or operating a motor vehicle while intoxicated (Please include any offenses which have been expunged from your record)?
   ☐ Yes ☐ No

   Abbreviation of State and Conviction*
   (e.g. CA – Illegal possession of a controlled substance) Month/Year

   ______________________________ ______/________
   ______________________________ ______/________
   ______________________________ ______/________

   *For purposes of this section, a person shall be deemed to be convicted of a crime if he/she please guilty or if he/she was found or adjudged guilty by a court of competent jurisdiction or has been convicted of a felony by the entry of Nolo Contendere in any state.

8. **Physician Honors and Peer-Reviewed Publications (Optional)**: List any information regarding professional or community service awards and/or information regarding publication in peer-reviewed medical literature within the last ten (10) years. Do **not** submit your curriculum vitae to satisfy the requirements of this section. If necessary, you may continue on a separate sheet.

   Awards, Honors:

   ____
   ____
   ____
   ____
   ____

   Publications:

   ____
   ____
   ____
   ____
   ____

Applicant Name: ______________________________ Date: ______________

9. **Professional and Community Memberships (Optional)**: List any professional and community memberships. Do **not** submit your curriculum vitae to satisfy the requirements of this section. If necessary, you may continue on a separate sheet.

____
____
____
____
____
____

10. **Questions**: Check either "Yes" or "No" for each question below. **Note: if you answer "Yes" to any question**, you are required to furnish complete details, including date, place, reason and disposition of the matter on a separate sheet.

    1. During any Professional/Medical Education, were you ever dismissed, suspended, restricted, put on probation, or otherwise acted against or did you take a leave of absence for medical reasons? ☐ Yes ☐ No
    2. During any Professional/Medical Education, were you ever requested to leave or did you leave, temporarily or permanently, prior to completion of training? ☐ Yes ☐ No
    3. During any Post Graduate Training, were you ever dismissed, suspended, restricted put on probation, or otherwise acted against or did you take a leave of absence for medical reasons? ☐ Yes ☐ No
    4. During any post graduate training, were you ever requested to leave or did you leave temporarily or permanently, prior to completion of training? (excluding maternity leave) ☐ Yes ☐ No
    5. Are there any charges or investigations pending, in any state, against you? ☐ Yes ☐ No
    6. Have your staff privileges at any hospital, nursing home, or other health care facility or health care provider or HMO ever been reduced, revoked, or suspended or have you voluntarily surrendered your clinical privileges from any such unit or facility while under investigation in any state? ☐ Yes ☐ No
    7. Have you ever had any disciplinary action(s) taken, or is any pending, against your License to practice medicine, DEA permit, State Controlled Substances Registration, Medicare Privileges, Medicaid Privileges, or are any complaints pending in any state? ☐ Yes ☐ No
    8. Have you ever had a membership in a professional society revoked, suspended, or limited in any manner or have you voluntarily withdrawn while under investigation? ☐ Yes ☐ No
    9. Have you ever failed to pass an examination for medical licensure (including National Boards, FLEX, USMLE)? If you have failed to pass any segment of the USMLE within three (3) attempts you do not meet the requirements for licensure. Please contact Lauren Lasso at (401) 222-7887 to discuss. ☐ Yes ☐ No

Applicant Name: ______________________________________ Date: ____________

ABMS Certification Codes

American Board	Code	General Certificate	Code	Subspecialty Certificates
Allergy & Immunology	**A & I**	Allergy and Immunology	**CLI** **DLI**	Clinical & Laboratory Immunology Diagnostic Laboratory Immunology
Anesthesiology	**Anes**	Anesthesiology	**CCM** **PM**	Critical Care Medicine Pain Management
Colon & Rectal Surgery	**CRS**	Colon & Rectal Surgery		
Dermatology	**D**	Dermatology	**CLDI** **DI** **DP**	Clinical & Laboratory Dermatological Immunology Dermatological Immunology Dermatopathology
Emergency Medicine	**EM**	Emergency Medicine	**MT** **PEM** **SM**	Medical Toxicology Pediatric Emergency Medicine Sports Medicine
Family Practice	**FP**	Family Practice	**Ger** **SM**	Geriatric Medicine Sports Medicine
Internal Medicine	**IM** **AI**	Internal Medicine Allergy & Immunology	**AM** **CE** **CCEP** **CCM** **CLI** **Cv** **DLI** **EDM** **En** **Ge** **Ger** **Hem** **IntvCd** **Inf** **Nep** **Onc** **Pul** **Rhu** **SM**	Adolescent Medicine Cardiac Electrophysiology Clinical Cardiac Electrophysiology Critical Care Medicine Clinical & Laboratory Immunology Cardiovascular Disease Diagnostic Laboratory Immunology Endocrinology, Diabetes & Metabolism Endocrinology Gastroenterology Geriatric Medicine Hematology Interventional Cardiology Infectious Disease Nephrology Medical Oncology Pulmonary Disease Rheumatology Sports Medicine
Medical Genetics	**MG CBCGn** **MG CBMG** **MG CcytG** **MG Cgen** **MG CMGn** **MG PhDMG**	Clinical Biochemical Genetics Clinical Biochemical/Molecular Genetics Clinical Cytogenetics Clinical Genetics (M.D.) Clinical Molecular Genetics Ph.D. Medical Genetics	**MGP**	Molecular Genetic Pathology
Neurological Surgery	**NS**	Neurological Surgery		
Nuclear Medicine	**NuM**	Nuclear Medicine		
Obstetrics & Gynecology	**ObG**	Obstetrics & Gynecology	**CCM** **GO** **MF** **RE**	Critical Care Medicine Gynecologic Oncology Maternal-Fetal Medicine Reproductive Endocrinology
Ophthalmology	**Oph**	Ophthalmology		
Orthopaedic Surgery	**OrS**	Orthopaedic Surgery	**HS**	Hand Surgery
Otolaryngology	**Oto**	Otolaryngology	**ON** **PO** **PSHN**	Otology/Neurology Pediatric Otolaryngology Plastic Surgery within the Head/Neck
Pathology	**Path AP/CP** **Path AP** **Path CP**	Anatomic & Clinical Pathology Anatomic Pathology Clinical Pathology	**BB** **BBTM** **ChemP** **CytoP** **DP** **Fpath** **Hem** **IP** **MMB** **MGP** **Npath** **PdP** **RIP**	Blood Banking Blood Banking Transfusion Medicine Chemical Pathology Cytopathology Dermatopathology Forensic Pathology Hematology Immunopathology Medical Microbiology Molecular Genetic Pathology Neuropathology Pediatric Pathology Radioisotopic Pathology

American Board	Code	General Certificate	Code	Subspecialty Certificates
Pediatrics	**Ped**	Pediatrics	**AI** **AM** **CCM** **Cd** **CLI** **DBP** **DLI** **En** **Ge** **HO** **Inf** **MT** **Ne** **NP** **ND** **PEM** **Pul** **Rhu** **SM**	Allergy & Immunology Adolescent Medicine Critical Care Medicine Pediatric Cardiology Clinical & Laboratory Immunology Development-Behavioral Pediatrics Diagnostic Laboratory Immunology Pediatric Endocrinology Pediatric Gastroenterology Pediatric Hematology-Oncology Pediatric Infectious Disease Medical Toxicology Pediatric Nephrology Neonatal-Perinatal Medicine Neurodevelopmental Disabilities Pediatric Emergency Medicine Pediatric Pulmonology Pediatric Rheumatology Pediatric Sports Medicine
Physical Medicine & Rehabilitation	PMR	Physical Medicine & Rehabilitation	**PM** **PedRM** **SCInj**	Pain Management Pediatric Rehabilitation Medicine Spinal Cord Injury Medicine
Plastic Surgery	**PIS**	Plastic Surgery	**HS**	Hand Surgery
Preventive Medicine	**PrM AeroM** **PrM GPM** **PrM OM** **PrM PH** **PrM PHGPM**	Aerospace Medicine General Preventive Medicine Occupational Medicine Public Health Public Health & General Preventive Medicine	**MT** **UM** **UHM**	Medical Toxicology Undersea Medicine Undersea & Hyperbolic Medicine
Psychiatry & Neurology	**ChiN** **N** **Psyc**	Neurology with Special Qualifications in Child Neurology Neurology Psychiatry	**AdP** **ChAP** **ChiP** **C/NPh** **FPsy** **GPsyc** **ND** **PM**	Addiction Psychiatry Child & Adolescent Psychiatry Child Psychiatry Clinical Neurophysiology Forensic Psychiatry Geriatric Psychiatry Neurodevelopmental Disabilities Pain Management
Radiology	**Rad DR** **Rad DRnt** **Rad DRSCNR** **Rad NM** **Rad R** **Rad Rnt** **Rad RO** **Rad RT** **Rad TO** **Rad TR**	Diagnostic Radiology Diagnostic Roentgenology Diagnostic Radiology with Special Competence in Nuclear Radiology Nuclear Medicine Radiology Roentgenology Radiation Oncology Radium Therapy Therapeutic Roentgenology Therapeutic Radiology	**NR** **NRad** **PR** **VIR**	Nuclear Radiology Neuroradiology Pediatric Radiology Vascular & Interventional Radiology
Radiological Physics	**Rad DRMNP** **Rad DRP** **Rad MNP** **Rad RP** **Rad RRP** **Rad TDRP** **Rad TRNP** **Rad TRP** **Rad XRP**	Diagnostic Radiology & Medical Nuclear Physics Diagnostic Radiological Physics Medical Nuclear Physics Radiological Physics Roentgen Ray Physics Therapeutic & Diagnostic Radiological Physics Therapeutic Radiology & medical Nuclear Physics X-Ray & Radium Physics		
Surgery	**S**	Surgery	**VascS** **HS** **PdS** **SCC**	Vascular Surgery Hand Surgery Pediatric Surgery Surgical Critical Care
Thoracic Surgery	**TS**	Thoracic Surgery		
Urology	**U**	Urology		

Addendum 2

Hospital Privileges: List the name and address of all hospitals where you have ever held any type of privileges (e.g. courtesy, admitting, etc.). If necessary, you may duplicate this form.

_____/_________ - _____/_________ ______________________________
Month Year Month Year Type of Privileges

____
Name of Hospital

______________________________ __________ __________
City State Zip/Postal Code

_____/_________ - _____/_________ ______________________________
Month Year Month Year Type of Privileges

____
Name of Hospital

______________________________ __________ __________
City State Zip/Postal Code

_____/_________ - _____/_________ ______________________________
Month Year Month Year Type of Privileges

____
Name of Hospital

______________________________ __________ __________
City State Zip/Postal Code

_____/_________ - _____/_________ ______________________________
Month Year Month Year Type of Privileges

____
Name of Hospital

______________________________ __________ __________
City State Zip/Postal Code

_____/_________ - _____/_________ ______________________________
Month Year Month Year Type of Privileges

____
Name of Hospital

______________________________ __________ __________
City State Zip/Postal Code

_____/_________ - _____/_________ ______________________________
Month Year Month Year Type of Privileges

____
Name of Hospital

______________________________ __________ __________
City State Zip/Postal Code

_____/_________ - _____/_________ ______________________________
Month Year Month Year Type of Privileges

____
Name of Hospital

______________________________ __________ __________
City State Zip/Postal Code

Applicant Name: ____ Date: ____________

Addendum 3

State of Rhode Island and Providence Plantations
Department of Health

This information is completely voluntary and will NOT affect your Application in any way.

VOLUNTARY RACE/ETHNICITY QUESTIONS*

Applicant Name: ____
Last First Middle

Note: This information is voluntary and refusal to provide it will not impact on the renewal of your license. It will be confidential and used only in accordance with Title VI of the Civil Rights Act of 1964.

1. **Ethnicity**: Are you Hispanic or Latino? **(Mark "No" if not Hispanic or Latino)**
   ☐ No, not Hispanic or Latino ☐ Yes, Hispanic or Latino
2. **Race**: What is your race? (Mark one or more)
   ☐ American Indian or Alaska Native ☐ Black or African American ☐ White
   ☐ Asian ☐ Native Hawaiian or other Pacific Islander

   For purposes of the above questions kindly use the "Federal Minimum Data Collection" explanations listed below:

1. **Ethnic Categories**:

   Hispanic or Latino – A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term, "Spanish Origin" can be used in addition to "Hispanic or Latino."

   Not Hispanic or Latino – A person who is not Hispanic or Latino.

2. **Racial Categories**:

   American Indian or Alaska Native – A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

   Asian – A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

   Black or African American – A person having origins in any of the Black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or African American."

   Native Hawaiian or other Pacific Islanders – A person having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands.

   White – A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

* This information is being collected in accordance with the Department of Health's policy for Maintaining, Collecting and Presenting Data on Race and Ethnicity. The mission of the Department is to protect and promote the health of the population and to prevent disease through life-style change, environmental change, and health services delivery. A copy of this policy is available upon request.

Applicant Name: ______________________________ Date: ____________

Addendum 4

Rhode Island Board of Medical Licensure and Discipline
Room 205, 3 Capitol Hill
Providence, RI 02908-5097
(401) 222-3855

Substitute forms are not acceptable. This form may be duplicated as needed.

Reciprocity Release Form

I am applying for a license to practice medicine in the State of Rhode Island. The Rhode Island Board of Medical Licensure and Discipline requires that the following form be completed by the jurisdiction in which I am now or was previously licensed. This constitutes your authority to release all information in your files, favorable or otherwise, directly to the Rhode Island Board of Medical Licensure and Discipline at the above address.

Print/Type Full Name	Signature	Date
Previous Names Used	Social Security Number	Date of Birth
License Number	Date Issued	

THIS SECTION TO BE COMPLETED BY THE MEDICAL BOARD

Basis for issuing license:

☐ NBME ☐ NBOME ☐ USMLE ☐ LMCC ☐ FLEX ______ State Sponsor ☐ State Exam ______(State)

If a combination of exams were taken, please list the specific combination:

License Status: ☐ Active ☐ Inactive ☐ Lapsed	**Original Date Issued**: _________________	**Expiration Date**: _________________

Questions:

1. Has this physician ever been investigated by your Board? ☐ Yes ☐ No
2. Has this physician incurred any disciplinary proceedings in your state, or is any action pending? ☐ Yes ☐ No
3. Has the applicant's license ever been denied, surrendered, reprimanded, suspended, revoked or placed on probation? ☐ Yes ☐ No
4. Are you aware of any information about this physician submitted to the National Practitioner Data Bank? ☐ Yes ☐ No
5. Do you know of any information that may discredit this person? ☐ Yes ☐ No

If you answer "Yes" to any of the above questions, please provide a written explanation below, and attach a copy of all supporting documentation (e.g. Board order, complaint, etc.).

____

____

____

____

Certification:

Signature ______________________ Date ______________

Type or Print Name

Title

Full Name and of Licensing Board including State

Please return directly to the Board at the above address. Thank you for your prompt cooperation.

Applicant Name: ____ Date: _____________

Addendum 5

Rhode Island Board of Medical Licensure and Discipline

Room 205, 3 Capitol Hill
Providence, RI 02908-5097
(401) 222-3855

Substitute forms are not acceptable. This form may be duplicated as needed.

Reference Form

I am applying for a license to practice medicine in the State of Rhode Island. The Rhode Island Board of Medical Licensure and Discipline requires this reference form be completed as part of my application process. This constitutes you authority to provide information about my character and professional abilities, favorable or otherwise, directly to the Rhode Island Board of Medical Licensure and Discipline at the above address.

Print/Type Full Name ______ Signature ______ Date ______

Previous Names Used ______ Social Security Number ______ Date of Birth ______

THIS SECTION TO BE COMPLETED BY THE INDIVIDUAL PROVIDING THE REFERENCE

Please Note: References must be typed or printed clearly. Illegible references may delay a candidate's application

EVALUATION

Based upon demonstrated performance and composite of evaluations by supervisors on file.

	Superior	Satisfactory	Unsatisfactory	No Information
Basic Clinical Knowledge				
Professional Judgement				
Clinical Competence				
Reliability/Sense of Responsibility				
Patient Management				
Ethical Conduct				
Physician-Patient Relationship				
Ability to Work with Other Hospital Staff				
Appearance				
Medical Recordkeeping				
Ability to Communicate Verbally				
Recommendation: **OVERALL RATING:**				

__ Recommended Highly without Reservation __ Recommended as Qualified and Competent __ Recommended with Reservation
__ No Comment __ Not Recommended

Additional Comments (Use reverse side if necessary):

You must affix your institution's office seal or have your signature notarized

Printed Name of Reference ______ Signature ______

Title ______ Date ______

Relationship to Applicant ______

Please return directly to the Board at the above address. Thank you for your prompt cooperation.

Please affix Department , Hospital or Notarial Seal Here.

Applicant Name: ______ Date: ______

Addendum 6

MANDATORY ADDENDUM TO LICENSURE APPLICATION
VERIFICATION OF SOCIAL SECURITY NUMBER
Tax Payer Status Affidavit / Identity Verification

Rhode Island Department of Health
3 Capitol Hill
Providence RI, 02908-5097

All persons applying or renewing any license, registration, permit or other authority (herein after called "licensee") to conduct a business or occupation in the state of Rhode Island are required to file all applicable tax returns and pay all taxes owed to the state prior to receiving a license as mandated by state law(RIGL 5-76) except as noted below.

In order to verify that the state is not owed taxes, licensees are required to provide their Social Security Number, or Federal Tax Identification Number (for businesses) as appropriate. These numbers will be transmitted to the Division of Taxation to verify tax status prior to the issuance of a license.

Licensee Declaration

□ I hereby declare, under penalty of perjury, that I have filed all required state tax returns and have paid all taxes owed.

□ I have entered a written installment agreement to pay delinquent taxes that is satisfactory to the tax administrator.

□ I am currently pursuing administrative review of taxes owed to the state.

□ I am in federal bankruptcy. (Case # ________________________________)

□ I am in state receivership. (Case # ________________________________)

□ I have been discharged from bankruptcy. (Case # ________________________________)

____
Type of Professional License for which you are applying.

____ ____________________
Full Name (Please Print or Type) Social Security Number

____ (_____)_______-___________
Signature Phone Number

____
Date

This form must be completed, signed and attached to your license application for processing.

Applicant Name: ____ Date: ____________

Addendum 7

Rhode Island Board of Medical Licensure & Discipline

Room 205, 3 Capitol Hill
Providence, RI 02908-5097
(401) 222-3855

IF Applying for CSR, this Application **MUST BE SUBMITTED ALONG WITH YOUR LICENSE APPLICATION**.
Substitute forms are not acceptable.

Rhode Island Uniform Controlled Substances Act Registration (CSR)

I am applying for a Rhode Island Uniform Controlled Substance Act Registration (CSR). **I understand that this application MUST be submitted along with my Board Application. I also understand that there is an additional $140.00 fee for this Registration and that the check or money order for $710.00 (Non-Refundable Board Application fee ($570.00) PLUS CSR Application fee ($140.00) must be made out to the "RI General Treasurer." Note: To be issued a RI Controlled Substance Registration you must have a Rhode Island Business Address.**

Print/Type Full Name ______________________ Business Name ______________________

Signature ______________________ Business Address ______________________

Date ______________________ Business Telephone ______________________ Business Fax

Complete this application for registration to prescribe controlled substances in the State of Rhode Island	The Rhode Island Uniform Controlled Substances Act can be accessed at the following web site: http://www.rilin.state.ri.us/Statutes/Title21/21-28/index.htm **Drug Schedule (Check all that apply)** ☐ Schedule II ☐ Schedule III ☐ Schedule IV ☐ Schedule V
A CSR is not required if there will be no controlled substances prescriptions prescribed in this state. The CSR is renewed at the same time that the professional license is renewed. Note: Read important information on the bottom of this application.	**A Copy of the DEA Registration must be provided to the Medical Board within 60 Days of its issuance by the DEA.** The DEA Registration must be issued to your Rhode Island Practice Address in order for it to be valid. If you are relocating form another state, you need to apply for a DEA Registration that is specific to Rhode Island. See the bottom of this form for information on how to contact the DEA. * All Applicants MUST answer the following: A. Has the applicant been convicted of, or entered a plea of nolo contedere to a violation of any state or federal law relating to manufacturing, distributing, possessing, prescribing, administering or dispensing of drugs presently defined as controlled substances under Chapter 21-28, General Laws of Rhode Island? ☐ Yes ☐ No B. Has the registration application or registration of the applicant, corporation, firm, partner, or officer of the applicant been surrendered, revoked, suspended or denied under any law of the United State or of any state relating to drugs presently defined as controlled substances under Chapter 21-28, General Laws of Rhode Island, or is such action pending? ☐ Yes ☐ No **If you answered "Yes" to question "A" or "B" attach an explanation to this form.**

Important Information

Issuance of a Rhode Island Controlled Substances Registration is contingent upon registration by the U.S. Drug Enforcement Administration. If denied a "DEA Registration", the Rhode Island Controlled Substances Registration becomes "VOID." Licensed drug facilities and licensed practitioners with prescriptive privileges cannot dispense, possess, store or ship controlled substances in or into the State of Rhode Island without a valid drug facility or professional license. Rhode Island Controlled Substances Registration (CSR), and a federal Drug Enforcement Administration (DEA) Registration. Practitioners may only prescribe, dispense, possess, and store controlled substances within their particular "scope of practice." "Controlled Substances" for purposes of this application, means a prescription drug in Schedules II through V, pursuant to the Rhode Island Uniform Controlled Substances Act, and 21 CFR 1300 of the Federal Code of Regulations. Schedule I drugs are used by researchers, and require the submission of a protocol.

Without a Rhode Island CSR and federal DEA Registration, licensed drug facilities, and practitioners with prescriptive privileges, may dispense or possess non-controlled prescription medications under its facility or professional license. A CSR will not be granted to an applicant whose BOARD licensure application is "pending" in this state.

A Rhode Island CSR must be obtained prior to applying for DEA Registration. Federal regulations require that applicants comply with individual state requirements prior to issuance of a DEA Registration. Once the CSR is issued, applicants must apply to the U.S. Drug Enforcement Administration for a federal registration using that agency's DEA Form 224 (New Application for Retail Pharmacy, Hospitals/Clinics, Practitioner, Teaching Institution, or Mid-Level Practitioner). Applicants may apply on-line for the DEA Registration at the following website: www.deadiversion.usdoj.gov./drugreg/reg_apps/index.html

*You can also receive an application, or check the status of a pending DEA Registration by contacting the Drug Enforcement Administration at the following location: Registration Unit, US Drug Enforcement Administration, JFK Federal Bldg., 15 new Sudbury Street, Boston, MA 02203-0131, Telephone (888) 272-5174.

NOTE:

- Schedules II, III, and IV of section 21-28-2.08 will become void unless dispensed within thirty (30) days of the original date of the prescription.
- Prescriptions in schedules III, IV, and V cannot be written for more than one hundred (100) dosage units and not more than one hundred(100) dosage units may be dispensed at one time. For purposes of this section, a dosage unit shall be defined as a single capsule, tablet, or suppository, or not more that one (1) teaspoon of an oral liquid.
- Prescriptions in schedule II may be written for up to a 30-day supply, with a maximum of two hundred and fifty (250) dosage units, as determined by the prescriber's directions for use of the medication.

Applicant Name: ______________________ Date: ____________

Addendum 8

Rhode Island Board of Medical Licensure & Discipline

Room 205, 3 Capitol Hill
Providence, RI 02908-5097
(401) 222-3855

Substitute forms are not acceptable. This form may be duplicated as needed.

Academic Faculty – Limited Medical Registration Applicants ONLY

I am applying for an Academic Faculty – Limited Medical Registration in the State of Rhode Island. The Rhode Island Board of Medical Licensure and Discipline requires these questions be answered as part o my application process. This constitutes your authority to provide information about my character and professional abilities, favorable or otherwise, directly to the Rhode Island Board of Medical Licensure and Discipline at the above address.

Print/Type Full Name	Signature	Date
Previous Names Used	Social Security Number	Date of Birth

THESE QUESTIONS ARE TO BE ANSWERED BY THE DEAN OF THE MEDICAL SCHOOL

Please Note: Information must be typed or printed clearly and submitted under separate cover.

Please provide information pertaining to the following:

1. Describe this candidate's exceptional qualifications that warrant consideration for licensure as an Academic Faculty – Limited Medical Registration.
2. Describe fully the candidate's primary clinical and non-clinical activities.
3. Please state the anticipated faculty rank of the candidate.
4. Please describe the Formal Search/Recruitment efforts that led to the selection of this candidate including the number of candidates interviewed and duration of search.
5. Please describe system academic supervision of candidate's clinical practice.

Applicant Name: ____ Date: _____________

Affidavit and Authorization for Release of Information: You must attach a recent (less than 6 months old) passport quality, color photograph of yourself to this form. Take the form to a notary public and sign the form in the presence of the notary public. The notarized form then must be sent directly to this Board.

Affidavit
And
Authorization For Release of Information

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my application and that all documents, forms or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the Application for Physician Licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge and exonerate the Board, its agents or representatives and any person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the Board.

I will immediately notify the board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice medicine being granted to me by the board.

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my license or permit to practice medicine.

____
Applicant's Signature (must be signed in the presence of a notary)

____
Applicant's Printed Last Name

____
Applicant's Printed First Name, Middle Initial, and Suffix (e.g., Jr.)

____
Date of Signature

Applicant Photograph

Securely tape or glue in this square a current front-view 2" x 2" passport-type color photograph of yourself.

NOTARY

Dated__________ Signed ______________________________

State of______________ County of ______________________

SUBSCRIBED AND SWORN TO before me this__________ day of, ______________ 20____.

My commission expires:______________________ (NOTARY PUBLIC SIGNATURE & SEAL)

Applicant Name: ______________________________ Date: ______________

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