

PHYSICIAN'S PROFILE SHEET

PLEASE PRINT CLEARLY!

State Licenses Requested: _____

Specialty: _____

Full Name: _____

Maiden or Any
Former _____

Home PH: _____

Home FAX _____

Work Phone: _____

Work FAX _____

E-mail address _____

Home/Express Delivery Address: _____

Business/Office Address: _____

Social Security# _____

DOB _____ Birthplace _____

US Citizen? _____ Immigration Status _____

PLEASE LIST ALL ATTENDED!

MED School _____

Location _____

Dates Attended (From-To Mo/Yr) _____

Exact Grad Date _____

For International Graduates Only:

Please attach a Clinical Rotations/Clerkships List.

___ Y/N Do you have your *official* Med-Sch. transcripts?

___ Y/N Translated into English?

ALL UNDERGRADUATE Colleges Attended:

School(s)&Location Degree Dates

From-To

=====

High School _____

Grad Date _____

Military Experience: Branch, Dates of Service, Rank,

Discharge Status _____ Discharge Date _____

=====

POST GRADUATE TRAINING:

Facility Name& Intern/Res/Fellow? From/To
Location &Specialty 00/00-00/00

=====

EXAMS:

FLEX-NBME-USMLE-NBOME-LMCC-SBME

Exam Part/Step Date State Taken Score

ECFMG Exam Date _____ Cert# _____

Are you Board Certified? If yes, please list

board _____

Original state of Licensure _____

=====

Height _____ Weight _____

Eye Color _____ Hair Color _____

Attach List of FOUR Professional References.

Include names, title, address and phone numbers. (Some state boards require letters on your behalf from your listed references.)

Please attach copies of your diploma, training certificates, state licenses, board certificates, and CV. These will help expedite your license.

PRACTICE/EMPLOYMENT: _____

Physician's Name

NOTE: Please list your *practice/employment history* and respective *hospitals of affiliation*, where you have held ANY type of privileges. Your practice history must account for **all periods of time since graduation from medical school**. Include locum tenens assignments, unemployment, vacation, illness and recovery. State applications require all time be accounted for. If you have **ALL** time accounted for on your CV, you may skip this page.

Practice/Employment Status: *Hospital(s) of Affiliation & Location:* *Month/Year to Month/Year*

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

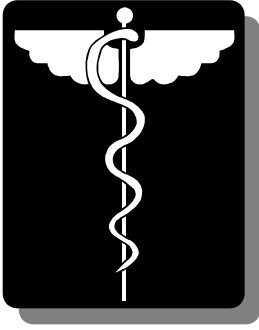
7. _____

8. _____

9. _____

10. _____

*Please attach continuation if needed.



US Medical Licensing

5631 Ballybunion Avenue Pace, Florida 32571
Phone: (850) 994-4646 Fax: (850) 994-3348
www.medicallicense.com

STATEMENT of ACCURACY

I attest that all information submitted to US Medical Licensing is true and correct to the best of my knowledge. No attempt has been made to omit, mislead, disguise or with hold any pertinent information required for licensure purposes. This also includes but is not limited to: malpractice suites, whether named, settled or pending; actions taken against my medical licensure or hospital privileges such as limitations, reprimand, suspension, or revocation; drug or alcohol addictions, impairment programs or psychiatric therapy, current or past; sanctions or assessments due to insurance reimbursements, alleged Medicare or Medicaid fraud; misdemeanor or criminal record and expungement; post graduate training, including clinical clerkships, problems or incidents; or any child support obligations.

I understand that incorrect and omitted information may result in additional research time and expenses by US Medical Licensing. I may be held responsible for any cost associated with this. Inaccurate information will inhibit the speed in which the application process is handled by the board of medicine. I agree that USML will hold no liability for this delay.

YES/NO (Any YES, please attach an explanation. State boards may require us to obtain further documentation)

_____ Any actions, loss, denial, probation, suspension restrictions, limitations, revocations of license?

_____ Have you ever been named in any malpractice suits, current/past?

_____ Any actions, loss, denial, probation, suspension, restrictions, limitations, revocations of staff privileges/employment or training?

_____ Any arrests or convictions, including misdemeanor or traffic related?

_____ Any alcohol, drug, rehab, mental treatment or ethical violations?

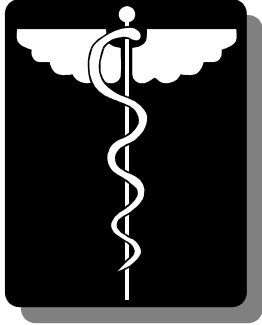
_____ Any hospitalization in the last five years?

Malpractice carrier, address and/or phone number _____

Malpractice attorney, address and/or phone number _____

Physician's Name
SIGNATURE

DATE



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SPECIFIC POWER OF ATTORNEY

I, _____, hereby authorize and direct US MEDICAL LICENSING and its agents, by my SPECIFIC POWER OF ATTORNEY, to execute its duties, required pursuant to my request for a license to practice my profession.

It is expressly understood that this SPECIFIC POWER OF ATTORNEY does not empower anyone other than US MEDICAL LICENSING employees to request, receive, and distribute information, concerning me, whether oral, in writing, documented or other, in order to execute the duties assigned to them by me.

I hereby release US MEDICAL LICENSING by my SPECIFIC POWER OF ATTORNEY, to act in my behalf, to execute its duties, pursuant to my request for a license to practice my profession.

Signed, this ____ day of _____, 20 ____ .

Physician's Name
SIGNATURE

This is to certify that the above SPECIFIC POWER OF ATTORNEY was signed

by _____, the ____ day of _____, 20 ____ .
PHYSICIAN'S NAME

SEAL

NOTARY PUBLIC

My Commission Expires: _____

RELEASE & WAIVER of RIGHTS

I, _____, hereby authorize the following entities and individuals to release all information in their possession concerning me, whether oral, in writing, documented or other, to US Medical Licensing and/or its agents acting on my behalf;

- A. All medical/osteopathic schools or undergraduate schools/universities which I have attended.
- B. All hospitals or health care facilities at which I have ever held staff privileges, whether full or limited, temporary or permanent; and all hospitals or health care facilities at which I have ever received training.
- C. All medical/osteopathic societies, specialty boards, and other medical/osteopathic organizations with which I have ever been associated.
- D. All agencies, from which, I have now or ever had obtained, Malpractice Insurance coverage.
- E. All attorneys who have ever participated in criminal or civil actions, in which I was named party, that would pertain to or directly effect my ability to obtain a State medical license, practice medicine and/or have clinical privileges.
- F. All state or country licensure boards, federal health agencies, and federal or state drug control agencies.

I hereby release the above-named entities and individuals from all liability for the release of information to the board and/or its agents.

I hereby agree to make this **RELEASE and WAIVER of RIGHTS** for the purpose of allowing **US Medical Licensing** and /or its agents, to execute its duties pursuant to my request for a license to practice my profession. I further authorize USML or any of its duly authorized agents to make any investigations that they deem necessary to secure information concerning me that is relevant to the requirements of licensure.

Physician's Name	DATE
SIGNATURE	

SS#: _____ DOB: _____

This is to certify that the above **RELEASE and WAIVER of RIGHTS** was signed

by _____, the _____ day of _____, 20__.

SEAL

NOTARY PUBLIC
 My commission expires:_____

US Medical Licensing & Credentialing

LICENSURE AGREEMENT:

CLIENT: _____
Physician's Name

DATE: _____

FOR THE STATE(s) OF _____

STATE LICENSE PROCESSING FEE

\$ 630 per state.

\$ 580 per state for three or more states.

[Expenses in addition to this fee include the state application fee, verification fees, and postage/delivery charges. All of these are fees you would otherwise pay if completing this process yourself. You may also be charged for expenses arising from missing information and/or history problems (i.e. malpractice or suspensions, etc.) You will be notified in advance before any charges are incurred.]

TOTAL

\$ _____ .00

US Medical Licensing will initiate this licensure process, upon receipt of this signed AGREEMENT, and Licensure Fee. I understand that expenses outlined above are in addition to the licensure assistance fee.

Please circle and/or complete one option

METHOD OF PAYMENT:

1. Personal check or money order

2. Credit Card :

() Visa

() MasterCard

() American Express

Acct. No. _____

Exp. Date: _____ / _____ / _____

CLIENT SIGNATURE

(Physician's Name)

DATE

*US Medical Licensing makes no representation of a physician's eligibility for a state license as state guidelines and requirements can change.

