

Michigan Department of Community Health
Board of Medicine
P.O. Box 30192
Lansing, Michigan 48909
(517) 335-0918

EDUCATIONAL LIMITED LICENSURE INSTRUCTIONS

Authority: P.A. 368 of 1978, as amended
This form is for information only.

NOTE: It is your responsibility to have all required documentation sent to the Board of Medicine. Questions regarding your application can be directed to the Michigan Board of Medicine at (517) 335-0918 three weeks after the date you sent the application. Please allow 4-6 weeks processing time. Applications submitted without the required licensing fee, applicant's signature and date will be returned.

EDUCATIONAL LIMITED LICENSE APPLICANTS WHO ARE GRADUATES OF A MEDICAL SCHOOL LOCATED IN THE UNITED STATES, ITS TERRITORIES, THE DISTRICT OF COLUMBIA, OR THE DOMINION OF CANADA, MUST SUBMIT THE FOLLOWING:

1. A completed application and a check or money order, drawn on a U.S. financial institution, in the amount of \$170.00, made payable to the **STATE OF MICHIGAN**. An application accompanied by the appropriate fee is valid for two years. If an applicant fails to complete the requirements for licensure within two years from the date of filing the application, the application is no longer valid. An Educational Limited license may be renewed 5 times, with no extensions available.
2. Certification of medical education submitted directly from the medical school to the Board on the proper form (attached).
3. Certification of appointment to a Michigan training hospital to be completed, on the proper form (attached) and submitted directly to the board by the hospital in which the training is to occur.
4. If you have ever held a permanent license in another state, official verification of your license must be received in this office directly from the other states(s). You may use the Verification form that is attached to this application. Most states charge a fee for providing license verification.

EDUCATIONAL LIMITED LICENSE APPLICANTS WHO ARE GRADUATES OF FOREIGN MEDICAL SCHOOLS MUST SUBMIT THE FOLLOWING:

1. A completed application and a check or money order, drawn on a U.S. financial institution, in the amount of \$170.00, made payable to the **STATE OF MICHIGAN**. An application accompanied by the appropriate fee is valid for two years. If an applicant fails to complete the requirements for licensure within two years from the date of filing the application, the application is no longer valid. An Educational Limited license may be renewed 5 times. No extensions are available.
2. Certification of medical education submitted directly from the medical school to the board on the proper form (attached).
3. Certification of appointment to a Michigan training hospital to be completed, on the proper form (attached) and submitted directly to the board by the hospital in which the training is to occur.
4. Certification of having passed examinations in the basic and clinical medical sciences conducted by the Educational Commission for Foreign Medical Graduates.
5. If you have ever held a permanent license in another state, official verification of your license must be received in this office directly from the other states(s). You may use the Verification form that is attached to this application. Most states charge a fee for providing license verification.

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

Board of Medicine

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APPLICATION FOR EDUCATIONAL LIMITED AND CONTROLLED SUBSTANCE LICENSES

Authority: Public Act 368 of 1978, as amended
If this form is not completed, a license will not be issued.

A controlled substance license is required for every person who prescribes, manufactures, distributes, or dispenses any controlled substance in Michigan as described in Article 7 of Public Act 368 of 1978, as amended. Information on obtaining a Federal controlled substance license may be obtained by contacting the Regional Branch, Drug Enforcement Administration, 431 Howard Street, Detroit, MI 48226 (Telephone 1-800-882-9539).

Board Use Only

License Number

C.S. License Number

Date of Licensure

Type or Print Only**I AM APPLYING FOR THE FOLLOWING:**

- Educational Limited and Controlled Substance Fee: 170.00
71-43-01-375705

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

First Name	Middle Name	Last Name
U.S. Social Security Number	Date of Birth	Previous MI License Number and Expiration Date, If applicable
Daytime Phone Number	All Previous Names and/or Birth Name Used (if applicable)	
Have you ever held a health professional license in Michigan? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Name of Training Hospital		
Street Address of Training Hospital		
City	State	ZIP Code

Check the appropriate answer to each of the following questions. NOTE: Attach a detailed explanation for any Yes answer you check.

1. Have you ever been convicted of a felony?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you ever been convicted of a misdemeanor punishable by imprisonment for a maximum term of 2 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you ever been convicted of a misdemeanor involving the illegal delivery, possession, or use of alcohol or a controlled substance (including motor vehicle violations)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you been treated for substance abuse in the past 2 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you had 3 or more malpractice settlements, awards, or judgments totaling \$200,000 or more in any consecutive 5 year period?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have you had one or more malpractice settlements, awards, or judgments totaling \$200,000 or more in any consecutive 5 year period?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Have you ever had a federal or state health professional license or registration revoked, suspended, or otherwise disciplined; been denied a license; or currently have disciplinary action pending against you?	<input type="checkbox"/> Yes <input type="checkbox"/> No

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

Board of Medicine

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CERTIFICATION OF APPOINTMENT TO A MICHIGAN TRAINING HOSPITAL

Authority: Public Act 368 of 1978, as amended
 If this form is not completed, a license will not be issued.

INSTRUCTIONS TO APPLICANT:

Complete Section I. Type or print your name exactly as it appears on your application. For Section II, send this form to be completed by the Program Director of the Michigan hospital where you have been appointed. This certification must be submitted to the Board of Medicine by the hospital.

SECTION I - APPLICANT INFORMATION

First Name	Middle Name	Last Name
Social Security Number		Date of Birth
Street Address		
City	State	ZIP Code
Daytime Telephone Number	All Previous Names and/or Birth Name Used (if applicable)	

Signature of Applicant	Date
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APPLICANT: UPON COMPLETION OF SECTION I, SEND THIS FORM TO THE PROGRAM DIRECTOR FOR COMPLETION OF SECTION II ON PAGE 2 OF THIS FORM.

Name

THIS SIDE TO BE COMPLETED BY THE PROGRAM DIRECTOR

INSTRUCTIONS FOR COMPLETING SECTION II:

Please complete the following information. Return this completed certification directly to the Michigan Board Medicine at the address shown on page 1 of this form.

SECTION II - CERTIFICATION OF RESIDENCY APPOINTMENT

Name of Training Hospital

Street Address of Training Hospital

City, State and ZIP Code

I certify that _____ has been duly

appointed to a training program in the clinical area of _____

beginning _____ and ending _____
Month/Day/Year Month/Day/Year

at _____
Name of Training Hospital

Is this program accredited by ACGME? YES NO

Is this hospital or institution accredited by JCAH? YES NO

Signature of Director of Medical Education

Date of Signature

(S E A L)

Print or Type Name of Director of Medical Education

If hospital has no seal, please indicate.

Board of Medicine

P.O. Box 30192

Lansing, MI 48909

(517) 335-0918

**CERTIFICATION OF MEDICAL EDUCATION FOR
GRADUATES OF FOREIGN MEDICAL SCHOOL GRADUATES**

Authority: Public Act 368 of 1978, as amended
If this form is not completed, a license will not be issued.

INSTRUCTIONS TO APPLICANT:

Complete Section I. Type or print your name exactly as it appears on your application. For completion of Section II, send this form to the Dean of the medical school you attended. This certification must be submitted directly to the Michigan Board of Medicine by the medical school.

SECTION I - APPLICANT INFORMATION

First Name	Middle Name	Last Name
Social Security Number	Date of Birth	
Street Address		
City	State	ZIP Code
Daytime Telephone Number	All Previous Names and/or Birth Name Used (if applicable)	
Date of Admission	Date of Graduation	

Signature of Applicant	Date
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APPLICANT: UPON COMPLETION OF SECTION I, SEND THIS FORM TO THE DEAN OF YOUR MEDICAL SCHOOL FOR COMPLETION OF SECTION II.

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

Name

TO BE COMPLETED BY THE DEAN OR REGISTRAR OF THE MEDICAL SCHOOL

INSTRUCTIONS FOR COMPLETING SECTION II:

Please complete the following information. Return this completed certification directly to the Michigan Board of Medicine at the address shown on Page 1 of this form.

SECTION II - CERTIFICATION OF MEDICAL EDUCATION

Name of Medical School

Street Address of Medical School

City, State and ZIP Code

I certify that _____ attended the
 (Applicant's Name)
 medical school named above from _____ to _____
 Month/Day/Year Month/Day/Year
 and was granted the degree of _____ on

 Month/Day/Year

I also certify that the medical education program from which the applicant graduated was not less than 130 weeks and does not award credit for any courses taken by correspondence. I further certify that this medical education program included basic science courses in anatomy; physiology; biochemistry; microbiology; pathology; pharmacology and therapeutics; preventive medicine; and clinical sciences and clerkships in the completed at the hospitals or institutions listed below.

Clinical Sciences	Name and Address of Hospital	Teaching Hospital
Internal Medicine		<input type="checkbox"/> Yes <input type="checkbox"/> No
General Surgery		<input type="checkbox"/> Yes <input type="checkbox"/> No
Pediatrics		<input type="checkbox"/> Yes <input type="checkbox"/> No
Obstetrics and Gynecology		<input type="checkbox"/> Yes <input type="checkbox"/> No
Psychiatry		<input type="checkbox"/> Yes <input type="checkbox"/> No

Signature of Dean or Registrar

Date of Signature

Print or Type Name of Dean or Registrar

(S E A L)

If school has no seal, please indicate

* Teaching hospital means that the hospital or institution offers a postgraduate clinical training program in the same content area of the clerkship.

Michigan Department of Community Health
Bureau of Health Professions
P.O. Box 30670
Lansing, MI 48909

VERIFICATION OF LICENSURE OR REGISTRATION IN ANOTHER STATE

Authority: Public Act 368 of 1978, as amended.

PART I: To be completed by the applicant and forwarded to the appropriate State Licensing Board for completion.

Check the profession for which you are requesting verification.		
<input type="checkbox"/> Chiropractic <input type="checkbox"/> Counseling <input type="checkbox"/> Dentistry <input type="checkbox"/> Marriage & Family Therapy <input type="checkbox"/> Medicine	<input type="checkbox"/> Nursing <input type="checkbox"/> Nursing Home Adm. <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Optometry <input type="checkbox"/> Osteopathy	<input type="checkbox"/> Pharmacy <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Physician's Assistants <input type="checkbox"/> Podiatry <input type="checkbox"/> Psychology
<input type="checkbox"/> Sanitarians <input type="checkbox"/> Social Work <input type="checkbox"/> Veterinary		
First Name	Middle Name	Last Name
Previous Names Used	Date of Birth	U. S. Social Security Number
State Board	License Number	Date of Issue

The applicant listed above has applied for licensure in Michigan and has indicated licensure in your State. Please complete Part II of this form and return it to the appropriate Michigan Board at the address shown above.

PART II: To be completed by the State Licensing Board.

Basis for Issuance of License:		Type of License:
<input type="checkbox"/> Examination - Please indicate type of exam (National, Regional, State, etc.)	<input type="checkbox"/> Endorsement - Please indicate name of state	
License Status	Original Issue Date	Expiration Date
<input type="checkbox"/> Current <input type="checkbox"/> Lapsed <input type="checkbox"/> Inactive		
Has the applicant incurred any formal or informal actions in your State?		
<input type="checkbox"/> No <input type="checkbox"/> Yes - If Yes, Please attach certified copies of any actions.		
Are formal or informal actions pending?	Has the applicant's license ever been limited, denied, surrendered, reprimanded, suspended or revoked?	
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	

CERTIFICATION

I hereby verify, to the best of my knowledge, the information above is true to the records of this Board.

Signature

Date

Type or Print Name

(S E A L)

Title

Full Name of Licensing Board