Montana Department of LABOR & INDUSTRY

Montana Board of Medical Examiners
PO Box 200513
301 S Park, 4th Floor
Helena, MT 59620-0513
Phone: 406-444-6880
Email: dlibsdhelp@mt.gov Website: www.medicalboard.mt.gov

Licensing Requirements and Application Checklist
Physician

License Requirements for Physician

Below are the minimum requirements you must meet in order to be licensed in the state of Montana.

1. Graduation from an approved medical school – [MCA 37-3-102, 37-3-305]
2. Completion of an approved residency – [MCA 37-3-102, 37-3-305, ARM 24.156.508, ARM 24.156.607]
3. Passage of USMLE or other approved medical licensure exam – [MCA 37-3-305, ARM 24.156.606, ARM 24.156.608]
4. Is of good moral character as determined by the board – [MCA 37-3-305]
5. Is able to communicate in the English language as determined by the board – [MCA 37-3-305]

Checklist of Required Documents to Submit for Application for Physician

The following documents and additional forms are required in addition to the basic application. None of these documents may be submitted directly by the applicant as part of the application. All must be sent to the board directly from either the primary source. The Board of Medical Examiners accepts Federation Credential Evaluation Service (FCVS) profiles and Uniform Applications submitted via the Federation of State Medical Boards. The Board also accepts state Physician license verifications submitted via VeriDoc.

- ☐ License verification. Board staff will verify all U.S. physician licenses via the physician data center. Applicants must request license verifications be sent directly to the Board in the following circumstances: licenses held that are not physician licenses, licenses held in Canada, any license that has ever been disciplined.
- ☐ Verifications from medical school and post-graduate medical educational programs. (Can be in FCVS)
- ☐ Verifications of medical licensure exam(s), including ECFMG if the applicant is a foreign medical graduate. (Can be in FCVS)
- ☐ If you answered yes to discipline questions, include a detailed explanation on the event(s) and documentation from the source (licensing board, federal agencies/programs, or civil/criminal court proceedings such as initiating/charging documents, final disposition/judgement documents, etc.)

Application Fee(s) for Physician

The following fee(s) must be submitted with your application. Online applicants can pay using a credit card or e-check. If you submit a paper application, include a check payable to the Board of Medical Examiners. Do not mail cash.

- ☐ $375 application fee

You can apply for a license online at https://ebiz.mt.gov/POL/ or download a paper application from the website. Online application is recommended.

Include a valid e-mail address with your application. E-mail is the department's primary form of communication.

If you have any questions about the application process or the licensing requirements please contact the Department of Labor and Industry Professional Licensing Bureau using the contact information at the top of this checklist.

MONTANA BOARD OF MEDICAL EXAMINERS

PO Box 200513 (301 S Park, 4th Floor - Delivery) Helena, Montana 59620-0513

PHONE (406) 444-6880 FAX (406) 841-2305

EMAIL: dlibsdmed@mt.gov **WEBSITE:** www.medicalboard.mt.gov

PHYSICIAN APPLICATION FOR LICENSURE

ILLEGIBLE AND INCOMPLETE APPLICATIONS WILL BE RETURNED.

Physicians are not permitted to practice medicine in Montana in any manner without an active Montana License.

LICENSING REQUIREMENTS:

- Must be a graduate of a medical school accredited by the American Osteopathic Association (AOA) or conforms to standards of the Liaison Committee on Medical Education (LCME).
- U.S. graduates must have successfully completed a post-graduate residency program accredited by the Accreditation Council for Graduate Medical Education (ACGME) or the AOA.
- Foreign graduates must complete at least 3 years post-graduate training or attain alternative certification or fellow status from a Board-approved organization, such as the American Board of Medical Specialties (ABMS) or the AOA. Please see ARM 24.156.607 for further information.
- Foreign graduates must provide a certificate from the Educational Council for Foreign Medical Graduates (www.ecfmg.org) and from the Fifth Pathway Program, if applicable.
- Must have passed a licensing exam approved by the Board. Please refer to the Board statutes and rules (ARM 24.156.606) for specific information regarding examination information and limits on attempts.
- Must be of good moral character.

FEES: **$375.00** Application Fee Payable to Montana Board of Medical Examiners

APPLICATION PROCESSING PROCEDURES:

- When the application file is complete, it will be processed and considered by Board staff for licensure. The applicant may be notified if additional information is required or if required to appear before the Board for an interview. Once a routine application is complete, the application may take up to 30 days to process.
- You will be notified by mail when the application has been successfully processed and you have been licensed to practice medicine in Montana.
- Applicant will be notified in writing of any deficient or missing items from the application file.
- If the application is considered a non-routine application, there will be a delay in processing of the application. You may be requested to provide additional information or make a personal appearance before the Board during a regularly scheduled Board meeting and/or the application may require Board consideration. You will be notified in writing if you are required to appear before the Board.
- **For an application requiring review by the full Board, all materials must be received by the Board office no later than 30 working days prior to the Board's next scheduled meeting. Applications completed after that deadline will not be put on the Board's agenda.** The Board meets six times per year Please visit www.medicalboard.mt.gov for exact meeting dates.
- Keep the Board office informed at all times of any address changes, changes in license status and complaints or proposed disciplinary action. This is essential for timely processing of applications and subsequent licensure.
- REVIEW THE MONTANA LAWS AND RULES FOR THE PRACTICE OF MEDICINE ON OUR WEBSITE: www.medicalboard.mt.gov

DOCUMENTS TO SUBMIT FOR AN APPLICATION TO BE COMPLETE:

The Board accepts documents from FCVS (Federation Credentials Verification Service).

All Applicants	**Foreign Graduates Must Also Supply**
Certification of Medical Education	E.C.F.M.G. Certificate
Postgraduate Training Verification	www.ecfmg.org Fifth Pathway
DD214, Military Discharge Paper (if applicable)	Verification, if applicable

National Practitioner Data Bank (NPDB) Report - NO SELF-QUERY REQUIRED. SEE EXPLANATION BELOW.
Current Verification from all State Licensing Boards
Examination Scores
Practice History and Specialty Information Form

Certificate of Medical Education. Complete the top portion of form and send to each medical school. The bottom portion of the form must be completed by school officials and sent directly back to the Board office. Submission of this certificate is not required if your U.S. accredited medical graduation was more than 10 years ago and you have had an active, full, and unrestricted license without discipline in another state since then.

Postgraduate Training Verification. Complete Section 1 of form and send it to each postgraduate training program. The Program Director or designated official will complete Section 2 and return the form directly to the Board office.

National Practitioner Data Bank (NPDB) Report. The NPDB is a national database of Board actions and other information about health care licensees across the United States. The Board requires this report for all applicants for physician licensure and will obtain it at the Board's expense during the application review process. The information contained in the NPDB report may require an applicant to submit further information to the Board before a licensing decision can be made.

Verification of Licensure. Complete the top portion of this form and forward it to any Canadian provinces in which you hold or have ever held any health care license or certification. The verifying entity will forward all documents directly to the Board office. Many states participate in VeriDoc, an online medical license verification service at www.veridoc.org.

Exam Scores: Forms can be obtained from the National Board of Medical Examiners at www.nbme.org, the Federation of State Medical Boards at www.fsmb.org for USMLE or FLEX scores, or National Board of Osteopathic Medical Examiners at (773)-714-0622 or www.nbome.org. Please use the appropriate from to request exam scores and send directly to the Board office. For all other exams, contact the testing entity for your scores.

Foreign graduates must also submit one of the following:

Request for Status Report of ECFMG Certification. Submit the form to ECFMG with the required fee. The results will be mailed directly to the Board office.

Fifth Pathway Verification. Complete Section 1 and send the form to the Program Director of your Fifth Pathway Program. The Director or designated official will complete the form and mail it directly to the Board office.

NOTE: ALL DOCUMENTS NOT IN ENGLISH MUST BE ACCOMPANIED BY CERTIFIED TRANSLATIONS

For information with regard to the processing of this application or other concerns, please contact the Board of Medical Examiners staff at (406) 444-6880, or by emailing us at dlibsdhelp@mt.gov

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Application for Physician Licensure with the following credential

◯ **Medical Doctor** ◯ **Doctor of Osteopathy**

Allow 30 days from the date the Board has a complete routine application for licensure.

1. FULL NAME: _____
   Last First Middle
2. OTHER NAMES KNOWN BY: _____
3. BUSINESS NAME: _____
4. BUSINESS ADDRESS: _____
   Street or PO Box # City and State Zip Country
5. HOME ADDRESS: _____
   Street or PO Box # City and State Zip Country
6. PREFERRED MAILING ADDRESS: ◯ Home ◯ Business
6. TELEPHONE: _____ FAX: _____
7. EMAIL: _____
8. SOCIAL SECURITY NUMBER: _____ FOREIGN ID NUMBER: _____
9. DATE OF BIRTH: _____
11. SEX: ◯ MALE ◯ FEMALE

12. Do you intend to practice in the State of Montana? If yes, attach a brief explanation. ◯ Yes ◯ No
13. Have you ever previously applied for a license to practice in Montana? ◯ Yes ◯ No
14. Have you ever been denied licensure or the opportunity to take this profession's licensing examination in any state or country? If yes, attach a detailed explanation. ◯ Yes ◯ No

PERSONAL HISTORY QUESTIONS
IMPORTANT INSTRUCTIONS AND NOTICE

- Please read the following questions carefully. Giving an incomplete or false answer is unprofessional conduct and may result in denial of your application or revocation of your license. See, 37-1-105, MCA.
- You have a continuing duty to update the information you provide in your application and supplemental responses, including while your application is pending and after you are granted a license.
- Upon submittal of your application form, for every "yes" answer provided, you will receive a request for specific information or documents associated with the question. Your application is not complete until staff receive all information requested.

PERSONAL HISTORY QUESTIONS

15. Have you ever had any license, certificate, registration, or other privilege to serve as a volunteer or practice a profession denied, revoked, suspended, or restricted by a public or private local, state, federal, tribal, religious, or foreign authority? ◯ Yes ◯ No

16. Have you ever surrendered a credential like those listed in number 15, in connection with or to avoid action by a public or private local, state, federal, tribal, religious, or foreign authority? ◯ Yes ◯ No

17. Have you ever resigned to avoid discipline, been suspended, or been terminated from a volunteer or employment position? ◯ Yes ◯ No

18. Have you ever been required to participate in a behavioral modification or assistance program in lieu of suspension or termination from a volunteer or employment position? ◯ Yes ◯ No

19. Have you ever withdrawn an application for any professional license? ◯ Yes ◯ No

20. As of the date of this application, are you aware of any pending complaint, investigation, or disciplinary action related to any professional license you hold? ◯ Yes ◯ No

21. Are you under a current order that remains unsatisfied (e.g., fines unpaid, probation not concluded, conditions unmet?) ◯ Yes ◯ No

Note on Questions 22 and 23: Applicants who disclose medical, physiological, mental, or psychological conditions or chemical substance use in Question 8 or 9 may qualify for participation in the Montana Professional Assistance Program. Please visit the board website for more information about this program. "Chemical substances" include alcohol, drugs, or medications, whether taken legally or illegally.

22. Do you have any medical, physiological, mental, or psychological condition which in any way currently (within the last 6 months) impairs or limits your ability to practice your profession or occupation with reasonable skill and safety? ◯ Yes ◯ No

23. Do you currently (within the last 6 months) use one or more chemical substances in any way which impairs or limits your ability to practice your profession or occupation with reasonable skill and safety? ◯ Yes ◯ No

21. Are you under a current order that remains unsatisfied (e.g., fines unpaid, probation not concluded, conditions unmet?) ◯ Yes ◯ No

Note on Questions 22 and 23: Applicants who disclose medical, physiological, mental, or psychological conditions or chemical substance use in Question 8 or 9 may qualify for participation in the Medical Assistance Program. Please visit the board website for more information about this program. "Chemical substances" include alcohol, drugs, or medications, whether taken legally or illegally.

22. Do you have any medical, physiological, mental, or psychological condition which in any way currently (within the last 6 months) impairs or limits your ability to practice your profession or occupation with reasonable skill and safety? ◯ Yes ◯ No

23. Do you currently (within the last 6 months) use one or more chemical substances in any way which impairs or limits your ability to practice your profession or occupation with reasonable skill and safety? ◯ Yes ◯ No

The following information is provided for Question 24 below:

A criminal conviction may not automatically bar you from receiving a license. For more information about how a criminal conviction may impact your application, consult the board or program website.

24. Have you ever been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or sentence deferred or suspended as an adult or "juvenile convicted as an adult" in any state, federal, tribal, or foreign jurisdiction? ◯ Yes ◯ No

25. Are you now subject to criminal prosecution or pending criminal charges? ◯ Yes ◯ No

26. Have you ever been disciplined, censured, expelled, denied membership or asked to resign from a professional society or organization? ◯ Yes ◯ No

27. Have you ever had a civil judgment entered against you in a lawsuit for incompetence, negligence, or malpractice in practicing any profession? ◯ Yes ◯ No

28. Have you ever been disqualified from working with children, elderly persons, mentally ill persons, or other vulnerable persons? ◯ Yes ◯ No

29. Have you ever been placed on probation, restricted, reprimanded, suspended, revoked, resigned in lieu of action against you, or had other action taken against you by any hospital, clinic, health care facility, group medical practice, health maintenance organization, or third-party insurance provider, including Medicare and Medicaid? ◯ Yes ◯ No

30. Are you currently on an exclusion list by the Office of Inspector General (OIG) for the U.S. Department of Health and Human Services prohibiting you from working in a facility receiving federal funding? ◯ Yes ◯ No

31. Has your authority to prescribe, dispense, or administer drugs, including controlled substances, ever been denied, restricted, suspended, or revoked? ◯ Yes ◯ No

32. Have you ever voluntarily surrendered or had your U.S. Drug Enforcement Administration registration placed on probation, restricted, suspended, or revoked? ◯ Yes ◯ No

33. Medical School: List all medical schools you have attended, even those from which you did not graduate, in chronological order. Attach additional sheets if needed. You must complete the "Medical Education Verification" form and send it to all medical schools you have attended. You must include a copy of your diploma to which the medical school must attach their seal prior to forwarding it to this Board. The medical schools must forward all documentation directly to this Board.

Name of Medical School	City and State/Province/Territory	Dates Attended (MM/YYYY)	Degree Earned
			◯ Yes ◯ No
			◯ Yes ◯ No

34. Postgraduate Training: List all postgraduate programs you have attended, even those you did not complete. This includes internship programs, residency programs and fellowships. Attach additional sheets if needed. You must complete the "Postgraduate Training Verification" form and send it to all postgraduate training programs you have attended. You must submit a copy of your certificate of program completion to this Board. The postgraduate program must forward all documentation directly to this Board.

Name of Program	City and State/ Province/Territory	PGY	Department Specialty	Dates Attended (MM/YYYY)	Certificate Received?
					◯ Yes ◯ No
					◯ Yes ◯ No
					◯ Yes ◯ No
					◯ Yes ◯ No

Fifth Pathway: If you attended a Fifth Pathway program, you must complete the "Fifth Pathway Verification Form" and send it to your medical school and to the institution where you completed your rotations. You must include a copy of your diploma. The medical school or institution must forward all documentation directly to this Board.

Name and Address of the Affiliated Medical School That Awarded the Fifth Pathway Certificate	Attendance Dates From (MM/YYYY)	To (MM/YYYY)	Date Degree/ Certificate Issued	Degree Received

Name and Address of the Hospital or Clinic Which You Performed the Required Rotations	Attendance Dates From (MM/YYYY)	To (MM/YYYY)	Certificate Date (MM/DD/YYYY)

36. Which exam did you take for initial licensure?

◯ National Boards ◯ FLEX ◯ USMLE ◯ LMCC ◯ COMLEX

State Exam (indicate state): _____

Most recent test date: _____ ◯ Pass ◯ Fail

Number of attempts: _____

Have you ever been certified by a Specialty Board?

Certifying Organization	Specialty	Date Awarded, Re-Certified

Have you ever been denied specialty certification or failed to pass a specialty certification examination or portion thereof? ◯ YES ◯ NO

If so, by whom? _____

Reason for denial? _____ Number of times failed _____

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PRACTICE HISTORY & SPECIALTY INFO

Practice History: List **ALL** activities after medical school (other than those already set forth above) in chronological order, up to and including the present. **Account for all periods of time longer than 1 month**. Specify nature of activity; for example, private practice, hospital practice, vacation, school, private employment, etc. For any non-working time, you must state exactly what your activities were, such as "vacation" or "seeking employment". If you are listing a medical practice, indicate the nature of the practice and the percentage of working time spent in clinical and administrative duties. If you worked for a physician staffing group or did locum tenens, list all facilities where you worked and include complete dates and addresses. **DO NOT SUBSTITUTE ANY OTHER RESUME FORMAT FOR THIS SECTION.** Use additional pages if necessary.

Start (MM/ YYYY)	End (MM/ YYYY)	Type of Activity/ Position	Name and Address of Practice	Position/ Department	Percentage of Time Spent (total = 100%)		Reason For Leaving
					Clinical	Administrative	

AFFIDAVIT

I authorize the release of information concerning my education, training, record, character, license history and competence to practice, by anyone who might possess such information, to the Montana Board of Medical Examiners.

I hereby declare under penalty of perjury the information included in my application to be true and complete to the best of my knowledge. In signing this application, I am aware that a false statement or evasive answer to any question may lead to denial of my application or subsequent revocation of licensure on ethical grounds. I have read and will abide by the current licensure statutes and rules of the State of Montana governing the profession. I will abide by the current laws and rules that govern my practice.

Signature of Applicant:_____ Date: _____

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301 South Park Avenue, 4th Floor
PO Box 200513
Helena, Montana 59602-0513

(406) 444-5773 FAX (406) 841-2305

AUTHORIZATION FOR RELEASE OF INFORMATION AND RELEASE FROM LIABILITY

I, _____, am an applicant for licensure as a physician.

I authorize the Montana State Board of Medical Examiners (Board) to release information, verbally and in writing, to_____that includes, but is not limited to, application status, the particulars of missing application information or fees, disciplinary action, and any and all other information provided to the Board as part of my application.

I further expressly release the Board, the Department of Labor and Industry, and the State of Montana from liability for further unauthorized dissemination of this information by the above-named individual or entity.

A photocopy or electronic version of this signed release shall be considered as valid as the original. This authorization shall remain in force for as long as my application is pending, after a license is issued to me, and until revoked by me, in writing and received the Board.

_____

Signature of Applicant Date

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VERIFICATION OF LICENSURE
(ONLY NEEDED FOR LICENSES THAT HAVE BEEN DISCIPLINED AND ALL CANADIAN LICENSES)

Applicant Instructions: Complete Section 1 and send this form to each state board which has disciplined your license. You may copy this form as many times as needed. Some boards require a fee for this service. Request the state board complete Section 2 of this form and return the form directly to this Board.

STATE BOARD: _____

Section 1: Applicant Information

I am applying for a license to practice medicine in the State of Montana and the Board of Medical Examiners requires this form to be completed by each state wherein I hold or have ever held a professional/occupational license. This is your authority to release any information in your files, favorable or otherwise, **DIRECTLY** to the **BOARD OF MEDICAL EXAMINERS, PO BOX 200513, HELENA, MT 59620-0513.** Your early response is appreciated.

_____ _____
(Signature) Name (Please Print)
Address_____ My License Number is _____

Section 2: To be completed by State Licensing Board or Canadian Province

Name of Licensee: _____
Last First Middle Suffix

License Type:_____ License #:_____ Issue Date:_____ Expiration Date _____

Is this license current?
◯ **Yes** ◯ **No**

If no, please explain _____
☐ Cannot answer under state law

1. Have formal disciplinary proceedings been initiated against the applicant's license by a disciplinary authority in your state? ◯ **Yes** ◯ **No**

   If yes, please explain and attach documentation:

2. Has the applicant ever been warned, censured, placed on probation, formal consent, reprimand or in any other manner disciplined; or has the applicant's license ever been revoked, suspended or, in any other manner, limited by a licensing or disciplinary authority in your state? If yes, please explain and attach documentation: ◯ **Yes** ◯ **No**

3. Has licensee ever been requested to appear before your Board? If yes, explain: ◯ **Yes** ◯ **No**

_____

AFFIX BOARD SEAL HERE

Board Authorized Signature_____

Printed Name_____

Title_____ Date_____

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CERTIFICATION OF MEDICAL EDUCATION

Applicant Instructions: If certification is required, complete Section 1 of this form, then send this form to each medical school you attended. Request the Dean or designated official to complete Section 2 of this form and return the form directly to this Board.

Section 1: Applicant Information:

Last Name:_____ **First Name:** _____

Name if different when diploma awarded: _____

Social Security Number:_____ **Date of Birth:** _____

The applicant's social security number is to be used for purposes of identification any may not be used for any other reason.

Waiver for release of information: I authorize the medical school below to provide any and all information pertaining to my medical education at your institution to the below listed Medical Board.

Applicant's Signature_____ Date:_____

Section 2: Medical School Verification

Instructions to the Dean or designated official of medical school: Please complete Section 2 of this form and forward directly to this Board at the following address:

Montana Board of Medical Examiners
PO Box 200513
Helena, MT 59620-0513

Medical School Name:_____

School name if different when the above applicant attended:_____

Medical School Address:_____
Street City State/Province Zip

Hours of undergraduate education required for admission into your school:_____

Applicant's Attendance Dates: From:_____ To:_____

Graduate Date:_____ Degree:_____
(Indicate N/A if not applicable)

Total weeks of education applicant attended at your school:_____

Applicant Name: _____ Date: _____

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the individual's medical education. Please check the appropriate response and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation. Attach additional pages as necessary.

1. Does this individual's official record reflect (an) interruption(s) or extension(s) in his/her medical education?
   If YES, please select the reason(s) for, indicate the dates of the interruption(s) or extension(s) and check whether the interruption/extension was approved or unapproved.

REASON	From (MM/YYYY)	To (MM/YYYY)	Approved	Unapproved
Personal/Family			◯	◯
Academic Remediation			◯	◯
Health			◯	◯
Financial			◯	◯
Participation in joint degree program (e.g., MD/PhD)			◯	◯
Participation in non-research special study (e.g., fellowship, international experience)			◯	◯
Participation in non-degree research			◯	◯
Other (Please specify below)			◯	◯

2. Does this individual's official record reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education?
   If YES, please select the reason(s) for the probation, indicate the date(s) of placement on and removal from probation and attach additional documentation to this report. ◯ Yes ◯ No

Reason	From (MM/YYYY)	To (MM/YYYY)
☐ Academic Probation		
☐ Probation for unprofessional conduct/behavioral reasons		
☐ Probation for other reason		

Please specify reason: _____

Explanation: _____

Certification of Medical Education, page 3 of 3

3. Does this individual's official record reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? If YES, please provide detailed documentation/information about the circumstances and outcome(s):_____

4. Does this individual's official record reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical school or parent university? If YES, please provide detailed documentation/information about the circumstances and outcome(s):_____

5. Does this individual's official record reflect that there were ever any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason?
If YES, please provide detailed documentation/information about the circumstances and outcome(s): _____

I certify that to the best of my knowledge and belief the foregoing is a true, accurate and complete statement of the record of the individual named on this form.

AFFIX INSTITUTIONAL SEAL HERE

(If no seal is available, this form must be notarized.)

Signature: _____

Print Name: _____

Title: _____

Date: _____

Phone Number: _____

Fax Number: _____

E-mail: _____

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POSTGRADUATE TRAINING VERIFICATION

Applicant Instructions: If verification is required, complete Section 1 of this form, then send this form to each training program in which you participated (make as many copies of this form as you need). Request the Program Director or designated official to complete Section 2 of this form and return the form directly to this Board.

Section 1: Applicant Information:

Last Name:_____ **First Name:** _____

Name if different when diploma awarded: _____

Social Security Number:_____ **Date of Birth:** _____

The applicant's social security number is to be used for purposes of identification and may not be used for any other reason.

Waiver for release of information: I authorize the medical school below to provide any and all information pertaining to my medical education at your institution to the below listed Medical Board.

Applicant's Signature_____ Date:_____

Section 2: Postgraduate Training Verification

Instructions to the Program Director or designated official of Postgraduate Training Program: Please complete Section 2 of this form and forward directly to this Board at the following address:

Montana Board of Medical Examiners
PO Box 200513
Helena, MT 59620-0513

Institution Name:_____

Institution Address:_____

Affiliated Medical School Name:_____

Program Type/Specialty:_____ Postgraduate Year:_____

Internship ☐ Residency ☐ Fellowship ☐ Research ☐ Chief Resident ☐

Other: _____

From Date (MM/DD/YYYY)_____ To Date (MM/DD/YYYY)_____

Did the applicant complete the postgraduate training program? ◯ Yes ◯ No

Postgraduate Training Verification, Page 2 of 2

Applicant Name:_____ Date:_____

Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ None of these

Did this individual ever take a leave of absence or break from his/her training?	◯ Yes ◯ No
Was this individual ever placed on probation?	◯ Yes ◯ No
Was this individual ever disciplined or placed under investigation?	◯ Yes ◯ No
Were any negative reports for behavioral reasons ever filed by instructors?	◯ Yes ◯ No
Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason?	◯ Yes ◯ No

Please explain any "Yes" responses from above (attach additional pages if necessary):

_____

I certify that to the best of my knowledge and belief the foregoing is a true, accurate and complete statement of the record of the individual named on this form.

AFFIX INSTITUTIONAL SEAL HERE

(If no seal is available, this form must be notarized.)

Signature: _____

Print Name: _____

Title: _____

Date: _____

Phone: _____

Fax: _____

E-mail: _____

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FIFTH PATHWAY VERIFICATION

Applicant Instructions: Complete Section 1 of this form, then send this form to the director of your Fifth Pathway Program. Request the Program Director or designated official to complete Section 2 of this form and return the form directly to this Board.

Section 1: Applicant Information

Last Name:_____ **First Name:** _____

Name if different when diploma awarded: _____

Social Security Number:_____ **Date of Birth:** _____

The applicant's social security number is to be used for purposes of identification and may not be used for any other reason.

Waiver for release of information: I authorize the Postgraduate Training Program below to provide any and all information pertaining to my medical education at your institution to the below listed Medical Board.
Applicant's Signature_____ Date: _____

Section 2: Medical School Verification

Instructions to the Program Director or designated official: Please complete Section 2 of this form and forward directly to this Board at the following address:

Montana Board of Medical Examiners
PO Box 200513
Helena, MT 59620-0513

Medical School Name:_____

School name if different when the above applicant attended:_____

Applicant's Attendance Dates: From:_____ To:_____ Program Completion Date:_____
(Indicate N/A if not applicable)

I certify that to the best of my knowledge and belief the foregoing is a true, accurate and complete statement of the record of the individual named on this form.

Signature:_____

Print Name:_____

Title: _____

Phone Number: _____

E-mail:_____

Date:_____

AFFIX INSTITUTIONAL SEAL HERE

(If no seal is available, this form must be notarized.)

Request for Status Report of ECFMG Certification
Form 282A-SB

Reports will be sent directly to the STATE MEDICAL BOARD.

To confirm ECFMG certification status for an international medical graduate, please complete and return this form to:

ECFMG Certification Verification Service
3624 Market Street, 4th Floor
Philadelphia, PA 19104-2685 USA

Please type or print.
Requests with incomplete or inaccurate information will not be processed.

USMLE®/ECFMG Identification Number: ☐- ☐☐☐- ☐☐☐- ☐

Physician's Name: _____
First Middle Last Name/Surname/Family Name

Date of Birth: _____ / _____ / _____
Day Month Year

Name of State Medical Board that Status Report should be sent to:

Montana Board of Medical Examiners, PO BOX 200513, Helena, Montana, 59620-0513

State Board Contact: (if applicable) Samuel Hunthausen (Name) Executive Officer (Title)

Telephone Number (with Area Code) 406 - 841-2360

☐ **Payment Form 900 is enclosed.**

Checks should be made payable to ECFMG in U.S. dollars. Status Reports will be mailed directly to the State Medical Board indicated above. Requests without payment attached will not be processed.

Note: Requesting organizations must normally secure and retain the physician's signed authorization to obtain certification information. Organizations may not resell the ECFMG certification information or make it available to any party beyond this request as authorized by the physician. The information may only be used to confirm ECFMG Certification for the purpose for which the physician provided authorization.

Physicians who are ECFMG certified have passed the requisite examinations and have had their medical education credentials verified by ECFMG. ECFMG Certification is an ACGME requirement for entry into ACGME-accredited residency or fellowship programs in the United States; is required for licensure to practice medicine in the United States; and is one of the eligibility requirements to take USMLE Step 3.