Montana Board of Medical Examiners
P.O. Box 200513 (301 S. Park, 4th Floor - Delivery) Helena, Montana 59620-0513
(406) 444-5773 FAX (406) 841-2305
EMAIL: dlibsdmed@mt.gov **WEBSITE:** www.medicalboard.mt.gov

APPLICATION FOR LICENSURE AS RESIDENT PHYSICIAN

ILLEGIBLE AND INCOMPLETE APPLICATIONS WILL BE RETURNED.

RESIDENT PHYSICIANS ARE SUBJECT TO BOARD RULES ON SCOPE OF PRACTICE. (ARM 24.156.507)

In 2015, the Montana Legislature passed SB 77 at the request of the Board of Medical Examiners. Effective July 1, 2015, the bill established a Resident Physician license—and requirements for that license—in MCA 37-3-307. Previously, that statute governed "temporary licenses."

The Resident license is valid for up to one year and may be renewed, at the Board's discretion, for additional 1-year periods as long as the resident is in good standing in an approved residency program.

Beginning in 2016, the renewal deadline will be June 30. The renewal fee is $100.

This application form reflects the changes brought by SB 77 that became effective July 1, 2015.

LICENSING REQUIREMENTS:

All applicants for a Resident license:

- Must submit an application and fee to the Board.
- Must be a current resident in good standing:
  1) In a Montana residency program and is seeing patients under the supervision of a physician who possesses a current, unrestricted license to practice medicine in Montana; or
  2) With an approved residency (one that is accredited by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association) and who, in the course of an approved rotation of the applicant's residency program, is seeing patients under the supervision of a physician who possesses a current, unrestricted license to practice medicine in Montana. a program.

APPLICATION FEE: $100.00

****Make payable to Montana Board of Medical Examiners****

DOCUMENTS:

The following documents must be submitted to the Board office in order to complete your license application. Please make 8 ½" x 11" copies of the following and submit with your application.

- **Letter of Verification from an Approved Residency Program**
- **Copy of all Current State Medical Licenses or Certificates (if applicable)**
- **Copy of DEA license (if applicable)**

APPLICATION PROCEDURES:

The letter of Verification from your Approved Residency Program must state that you are in good standing and that your current status or rotation is part of the training program.

Your application must include the name and address of the Montana-licensed Physician who will be responsible for your supervision. The Physician's license must be current and unrestricted.

The Board office must be 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.

PROCESSING PROCEDURES:

An application may take up to 30 days to process from the time it is received in the Board office.

Upon receipt of a completed application with all the supporting documentation, the application will be reviewed for compliance with the Board's statutes and rules.

The applicant will be notified in writing of any deficient or missing items from the application file.

For information with regard to the processing of this application and other concerns, please contact the Board of Medical Examiners staff at (406) 444-5773 or email us at dlibsdmed@mt.gov

PLEASE BE SURE REVIEW THE MONTANA LAWS AND RULES FOR THE PRACTICE OF MEDICINE ON OUR WEBSITE: **http://www.medicalboard.mt.gov**

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Application for Licensure as Resident Physician

FEE: $100. Valid for 1 year and may be renewed.

Allopathic ☐ **Osteopathic** ☐

1. FULL NAME: _____
   Last First Middle
2. OTHER NAMES KNOWN BY: _____
3. BUSINESS NAME (If Any):_____
4. BUSINESS ADDRESS: _____
   Street or PO Box # City and State Zip Country
5. HOME ADDRESS: _____
   Street or PO Box # Zip Country

   PREFERRED MAILING ADDRESS: Home ◯ Business ◯
6. TELEPHONE: _____ FAX_____
7. EMAIL: _____ DEA # (if applicable): _____
8. SOCIAL SECURITY NUMBER: _____FOREIGN ID NUMBER:_____
9. DATE OF BIRTH: _____
10. GENDER: Male ◯ Female ◯
11. If you are a foreign medical graduate, have you satisfied the requirements of the Education Council for Foreign Medical Graduates? ◯ Yes ◯ No
12. Have you ever previously applied for a license to practice in Montana? If yes, please provide date and results. ◯ Yes ◯ No
13. 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

14. List all professional licenses you hold or **ever** have held. Verification must be sent directly to Montana from each state/province/territory. Use additional paper if needed.

State	License #	Issue Date	Expiration Date	License Method	Requested State Verification
				Exam ◯ Endorse ◯ Other ◯	Yes ◯ No ◯
				Exam ◯ Endorse ◯ Other ◯	Yes ◯ No ◯
				Exam ◯ Endorse ◯ Other ◯	Yes ◯ No ◯

15. If you already have received a license, which exam did you take for initial licensure?

◯ National Boards ◯ FLEX ◯ USMLE ◯ LMCC

◯ State Exam (indicate state)_____

16. Have you ever withdrawn an application for licensure prior to the licensing agency's decision regarding your application? If yes, please attach a detailed explanation and provide supporting documentation from the source. ◯ Yes ◯ No

17. **PRIOR RESIDENCIES/INTERNSHIPS**
Please enter information about any programs you have attended previously.

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

18. **INFORMATION ABOUT THE RESIDENCY/ROTATION ASSOCIATED WITH THIS APPLICATION:**

NAME OF RESIDENCY PROGRAM:_____

IF A ROTATION ONLY, NAME OF ROTATION:_____

ADDRESS:_____

CITY, STATE, ZIP:_____

DATES OF RESIDENCY OR ROTATION: FROM:_____ TO:_____

19. **MONTANA SUPERVISING PHYSICIAN(S)**
Please enter the names and information about the Montana-licensed physician(s) who will supervise you during the duration of your Resident license.

PHYSICIAN NAME: LICENSE NUMBER:
PHYSICIAN ADDRESS:
PHYSICIAN TELEPHONE NUMBER: PHYSICIAN E-MAIL ADDRESS:

PHYSICIAN NAME: LICENSE NUMBER:
PHYSICIAN ADDRESS:
PHYSICIAN TELEPHONE NUMBER: PHYSICIAN E-MAIL ADDRESS:

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