Instructions for completing the license application
for a New Jersey Medical License

Read the application and instructions before completing the application.
Each section of the application is explained in these instructions -follow them carefully. Completing the enclosed application and mailing it to the Board office does not constitute the completion of your application. You must request verifications and certifications from schools, employers, etc.(third parties) using forms enclosed in this packet and follow-up with the third parties to ensure materials are sent directly to the Board office. Do not substitute a different form/document for the one requested or those provided with the application. Your application cannot be reviewed and approved until all documentation regarding your education, post-graduate training and professional experience are received. **Request verification from all third parties immediately.** Get them expedited, if possible.

The application must be submitted with a **certified check or money order** in the amount of $325.00 (nonrefundable) and three photographs, which must be signed and dated. An endorsement fee and registration fee will be requested just prior to your license being issued. Your application reviewer will inform you regarding how much is owed when it is due.

Type or print neatly. All questions must be answered. For "Yes" or "No" questions, **circle** the correct answer. If you determine a question does not apply to you, please indicate that fact by writing "N/A" as your response. When space provided is insufficient, attach additional sheets of paper. Print your first name, middle initial and last name on each page of the application and on each attachment. Attachments are considered part of your application.

Due to confidentiality restrictions, **information about the status of your license application can only be discussed with you** unless you provide written authorization for it to be discussed with another interested party. This restriction includes your spouse and/or family members.

Please note -if you are using a independent credentialing service to assist with the submission of elements required for your application, you are still required to complete every section of the application and ensure all third-party forms are completed and returned directly to the Board. Applicants choosing to utilize the Federation Credentials Verification Service (FCVS) should refer to FAQs found under the Applicants heading on the home page of this web site to find which application elements will be met by the Board's receipt of an FCVS packet on your behalf.

When preparing your curriculum vitae, be complete and accurate. You must account for all periods of time beginning with your entry into medical school.

When the Board has received your application, fee and third-party documentation, your file will be reviewed. At that time, you will be notified of any additional information or clarification that may be required to complete your application. Should you have questions about the application, or process, please contact the Board by telephone at 609.826.7100, by fax at 609.984.3930 or by e-mail at mailto:bmeapp@dca.lps.state.nj.us.

Falsification or misrepresentation of any item or response on this application or any attachment hereto is sufficient basis for denying a license.

Section One -Demographics

1. Print your legal name. This is the name that will appear on your license certificate. If you have changed your name, submit a copy of the associated legal document with this application. Print your current first name, middle initial and last name on the **copy** of the legal document.

2. Print any other name which may appear on documents you submit, or others may submit as part of this application (i.e., maiden name, legal name change, etc.). If you have changed your name, submit a copy of the associated legal document with this application. Print your current first name, middle initial and last name on the copy of the legal document.

3. Print your current mailing address and contact information. Your mailing address cannot be a post office box unless you also enter your street address. Application reviewers will contact you via e-mail, and follow-up in writing to your mailing address. It is your responsibility to notify the Board immediately, in writing by mail or FAX, of changes to your mailing address. You may also provide an Address of Record and home/business addresses (attach to application). The Address of Record will be printed on your license certificate. If you do not provide an Address of Record before becoming licensed, your mailing address will be printed on your license certificate. Your name and address will be posted on the Online License Directory. As a matter of information, under New Jersey public disclosure law, any of your license addresses must be provided if requested under the Open Public Records Act.

4. Enter your date and place of birth. Federal law limits the issuance or renewal of professional licenses to U.S. citizens or qualified aliens. To comply with federal law you must provide evidence of citizenship status. ***If you were born in the United States***, submit a copy of your birth certificate or passport with this application. ***If you were born elsewhere***, submit a copy of your passport or a copy of an official document granting citizenship status. If you are not a U.S. citizen, submit a copy of the official immigration document authorizing you to work in the United States. Questions about your immigration status and whether it is a qualifying status under federal law should be directed to the U.S.C.I.S. at (800) 375-5283.

5. Pursuant to N.J.S.A. 2A:17-56.44e of the New Jersey Child Support Enforcement Law,

   N.J.S.A. 54:50-25 of the New Jersey Taxation law, and Section 1128E(b)(2)A of the Social Security Act, the Board is required to obtain your Social Security number. The Board is further obligated to provide your Social Security number to the Director of Taxation, the Probation Division or any other agency responsible for child support enforcement, upon request, and to the National Practitioner Data Bank and the H.I.P. Data Bank when reporting adverse actions.

   Pursuant to the Federal Privacy Act (5 U.S.C. Section 55a(note(b)), the Board is requesting your consent to use your Social Security number for the following purposes: 1) to verify identity; 2) to aid in the collection of financial obligations due and owing the Board or any other State agency; and 3) to aid in the disclosure to State or federal law enforcement and licensing officials and agencies of information obtained in investigations pertaining to licensure and disciplinary proceedings.

6. Circle Yes or No. If "Yes," enter the type of license/registration for which you applied, and the date you applied (month/year).

Section Two - Education

Pre-Medical Education
Answer the questions by circling yes or no.

Print the information requested for each college/university you attended. Enter the dates in the following format: From Month/Year - To Month/Year.

Medical Education

List every medical school in which you were ever enrolled EVEN IF NO CREDIT WAS GRANTED OR NO CREDIT WAS SOUGHT FOR THE STUDY. Enter your full name at the top of form BME-MEV and mail a copy of the form to every school you attended - not just the school from which you graduated. Direct the school(s) to return the form **with an official transcript** directly to the N.J.B.M.E. address on the form. Forms submitted by you will not be accepted - they must be mailed directly from the school to the N.J.B.M.E.

If submitting a copy of a foreign medical school diploma or transcript: A copy of the original diploma must be notarized. Transcripts and diplomas which are not in English must be translated by one of the approved translation agencies (Appendix A). If a translated copy is not received, the foreign language copy will be returned to you for translation.

Graduates of foreign medical schools must be certified by the Educational Commission for Foreign Medical Graduates (E.C.F.M.G.). Contact the E.C.F.M.G. (see Appendix A) and request that your certification be sent directly to the N.J.B.M.E.

Applicants educated in India, Pakistan or Bangladesh - submit an original and official Mark Sheet for each Bachelor of Science and/or Bachelor of Medicine (M.B.B.S.) Examination taken. Failed examinations must be included. Submit the certificate verifying completion of a year of compulsory rotating internship.

Clinical Clerkships - Circle **Yes or No** for each category.

Board Certifications - Complete by entering the required information for each certification you hold.

Endorsement Examinations - Enter the dates for each exam taken. Enter "N/A" for exams not taken. If your application is based on a licensing examination taken in another state **prior to December 31, 1972**, complete Section 1 and mail Form BME-VSL to the state medical board which administered the exam. Direct them to complete Sections 2, 3 and 4 and return it directly to the N.J.B.M.E. at the address on the form. This form is not to be used if you are applying on the basis of FLEX Endorsement, National Board Endorsement, U.S.M.L.E. Endorsement or N.B.O.M.E./ COMLEX Endorsement. State exams taken after December 31, 1972, will not be accepted for endorsement.

If you are applying on the basis of FLEX Endorsement, National Board Endorsement, U.S.M.L.E. Endorsement or N.B.O.M.E./COMLEX Endorsement, contact the appropriate organization (see Appendix A) and have your report sent directly to the N.J.B.M.E.

Postgraduate Training

List each training program (including Fifth Pathway Program, internship, residency and/or fellowship) in which you have participated and the information requested on the form for each program. Enter your full name at the top of Form BME-VPT and mail a copy of the form to each training program you list whether you received credit, no credit or partial credit. Direct the training program to mail the form directly to the N.J.B.M.E. at the address on the form.

Section Two -Education (continued)

Graduates of L.C.M.E./A.O.A. approved medical schools and graduates of foreign medical schools who graduated **prior to July 1, 1985**, must successfully complete at least one year of A.C.G.M.E. or A.O.A. approved postgraduate training.

Graduates of foreign medical schools who graduated **after July 1, 1985 and prior to July 1, 2003**, must successfully complete a minimum of three (3) years of A.C.G.M.E. or A.O.A. approved postgraduate training.

All applicants who graduated from medical school after **July 1, 2003**, must successfully complete a minimum of two (2) years of postgraduate training in an A.C.G.M.E. or A.O.A. accredited program and have a signed contract for a third year of training in an accredited program where at least two years of that training are in the same field or would, when considered together, be credited toward the criteria for certification by a single specialty board.

Section Three -Employment/Malpractice History/Other Licenses

Privileges/Affiliation/Employment/Appointments History
Print the required information for every private office, residency program, H.M.O., etc. where you were employed or with whom you were affiliated for the five-year period that immediately precedes the filing of this application. Enter your full name at the top of Form BME-PEA and mail a copy of the form to every entity you have listed in this section of your application.

Malpractice History

Answer all of the questions. Attach a written statement identifying every malpractice suit in which you have been listed as a defendant. Include the name of the plaintiff, date of the incident and status of each suit, i.e. open, dismissed, closed with payment. Provide your personal description of the clinical aspects of the case as it would be explained to a fellow professional and a copy of the Complaint or Bill of Particulars. If the malpractice suit has been closed, you must provide a copy of the Final Disposition including the amount of payment on your behalf. Failure to provide this information when submitting your application will delay your application review. **If a malpractice carrier has taken an action with reference to you or your policy, you must submit an explanation and documentation of the action from the carrier.**

Enter your full name at the top of Form BME-MI and forward a copy of the form to every malpractice insurance carrier which has provided coverage to you during the three-year period immediately preceding the submission of your license application. If your malpractice coverage is/was provided by a hospital, forward the form to the Risk Management office of the hospital. Direct the hospital and insurance carriers to mail the form directly to the N.J.B.M.E. -forms submitted by you will not be accepted.

Verification of State License
Print the required information for each license and/or permit ever held in another state. For each license or permit held, no matter the status, complete Section 1 of Form BME-VSL and mail the form to the state which granted it. Direct them to complete Section 2 and 4 and mail it directly to the N.J.B.M.E.

Note: All applicants meeting the Postgraduate Training criteria detailed in Section Two of these instructions, who have never held a plenary medical license in any other state or jurisdiction, are not required to submit forms BME-PEA, BME-MI and BME-VSL.

Section Four -Character, Ethics and Medical Conditions

Information regarding moral character and ethical professional responsibility

Answer all questions by circling either Yes or No. For all "Yes" answers, attach a full explanation and any pertinent documentation. Print your first name, middle initial and last name on each page of any attachment.

Question a. asks about any arrests, charges or offenses you may have committed. **Carefully review the following definitions and instructions before answering the question.**

Definitions for the purpose of this question:

"Arrest" includes any detaining, holding or taking into custody by any police or other law enforcement authorities to answer for the alleged performance of any "offense."

"Charge" includes any indictment, complaint, information, summons, or other notice of the alleged commission of any "offense."

"Offense" includes all felonies, crimes, high misdemeanors, misdemeanors, disorderly persons offenses, petty disorderly offenses, driving while intoxicated/impaired motor vehicle offenses, violations of probation or any other court order, and local ordinance violations.

Instructions for the purpose of question a. Answer "Yes" and provide all information to the best of your ability EVEN IF:

1. You did not commit the offense charged;
2. The charges were dismissed or subsequently downgraded to a lesser charge;
3. You completed a Pretrial Intervention (P.T.I.) or equivalent diversionary program;
4. You were not convicted;
5. You did not serve any time in prison or jail; or
6. The charges or offenses happened a long time ago.

Answer "No" IF:

1. You have never been arrested or charged with any crime or offense; or
2. The records relating to a charge, an arrest or conviction have been expunged by the court or a government agency.

Questions h. through k. -Under N.J.S.A. 2A:17-56-44d, an answer of "Yes" to any of questions h.(a), h.(b), i., j., k. will result in a denial of licensure. Furthermore, any false certification of these questions may subject you to a penalty, including, but not limited to, immediate revocation or suspension of licensure.

Medical Conditions/Chemical Substances

Answer all questions by circling "Yes," "No" or "Not Applicable" (N/A), unless you are asserting your Fifth Amendment Privilege against self-incrimination. If you are asserting your Fifth Amendment Privilege, write that in the space under the first paragraph on the page.

If you are answering the questions, attach a detailed explanation for answers of "Yes," and include your printed first name, middle initial and last name on each page of the attachment.

Section Four -Character, Ethics and Medical Conditions (continued)

For the purposes of these questions, the following phrases or words have the following meanings:

"Ability to practice medicine" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments; and

2. The ability to communicate those judgments and medical information to patients and other health care providers with or without the use of aids or devices, such as voice amplifiers; and

3. The physical capability to perform medical tasks with or without the use of aids or devices such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, H.I.V. disease, tuberculosis, drug addiction and alcoholism.

"Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of the application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or within the past two years.

"Illegal use of controlled substances" means the use of controlled dangerous substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled dangerous substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

Documents to be completed and/or returned with your application:

1. **Certification and Authorization Form for a Criminal History Background Check -** The New Jersey Division of Consumer Affairs is required to conduct criminal history record background checks of all health care professionals prior to the issuance of an initial license to practice a health care profession (N.J.S.A. 45:1-28 et seq.). In order for the Division to conduct a criminal history record background check, you must complete the enclosed Certification and Authorization form and return the form with your license application. Upon receipt, the Board will mail you the information you will need to undergo the criminal history background check. The Board will forward to you information you will need to schedule an appointment to have your fingerprints electronically recorded if you work/reside in New Jersey, or live in a community near the State's borders (go to www.njconsumeraffairs.gov/chbc/ZipCodeList.pdf on the Web for a complete list of the ZIP codes of these nearby communities). The recording of your fingerprints is necessary to conduct the criminal history background check. If you do not live in a community near the State's borders, you will be sent information on your option for having your fingerprints recorded.

2. **Waiver and Certification -** Print your first name, middle initial and last name at the top of the form. Read, complete and sign the form in the presence of a Notary Public. Applications must be submitted to the N.J.B.M.E. within 30 days of notarization. The Board considers all information submitted to be the responsibility of the applicant. Please ensure that all of the information being submitted is accurate and complete.

3. **Curriculum Vitae -** Submit a copy of your curriculum vitae with your application. List all activities chronologically, with the month and year dates for the beginning and ending of each period of your medical education, postgraduate training, professional experiences and activities. The list must begin with the first medical school in which you were enrolled and continue through to the present date with no gaps. Label all periods of unemployment as such, and identify your activities during any period of unemployment. Provide addresses for all employers.

4. **Photographs -** Submit three passport-size professional photographs with your application. The photographs must not be more than six months old and must be signed and dated.

5. **Form BME-MEV -** Enter your full name at the top of this form and mail a copy to each school you attended whether credit was earned or not. The school must return the form directly to the N.J.B.M.E. with an official transcript. Keep track of the forms you mail, and follow-up with the school(s) to ensure the form is completed and mailed in a timely fashion.

6. **Form BME-VPT -** Enter your full name at the top of this form and mail a copy to each training program in which you participated whether credit was earned or not. The facility must return the form directly to the N.J.B.M.E. Keep track of the forms you mail and follow-up with the facility(ies) to ensure the form is completed and mailed in a timely fashion.

7. **Form BME-PEA -** Enter your full name at the top of this form and mail a copy to each facility at which you worked or with whom you are or have been affiliated. The facility must return the form directly to the N.J.B.M.E. Keep track of the forms you mail, and follow-up with the facility(ies) to ensure the form is completed and mailed in a timely fashion.

8. **Form BME-MI -** Enter your full name at the top of this form and mail a copy to each medical malpractice insurance carrier from whom you have obtained medical malpractice insurance, and/or to the Office of Risk Management for each hospital with whom you have been affiliated or employed. The malpractice insurance carrier and/or the hospital must return the form directly to the N.J.B.M.E. Keep track of the forms you mail, and follow-up to ensure the form is completed and mailed in a timely fashion.

Documents to be completed and/or returned with your application (continued)

9. **Form BME-VSL -**Make copies of the form and complete the top section for each state where you have taken a written examination, or have held a license to practice medicine whether the license is in active, inactive or some other status. The state must complete the appropriate sections of the form and return it directly to the N.J.B.M.E. Keep track of the forms you mail, and follow-up to ensure the form is completed and mailed in a timely fashion.

10. **Examination and Board Action History Report (E.B.A.H.R.) -**Contact the Federation of State Medical Boards (see Appendix A) and request that your E.B.A.H.R. be sent directly to the N.J.B.M.E.

11. **American Medical Association/American Osteopathic Association Physician Profile** Contact the appropriate organization (see Appendix A) and have your Profile sent directly to the N.J.B.M.E.

12. **Name Change -**If your name as it appears on your medical school diploma is not the same as it appears on documentation submitted, include a **copy** of the legal document effecting this change. Print your current first name, middle initial and last name on the copy of the document.

To request scores/transcripts and/or reports/profiles from any of the organizations listed below, to complete your application, refer to Appendix A for contact information.

National Board Of Medical Examiners (N.B.M.E.) National Board of Osteopathic Medical Examiners (N.B.O.M.E.) -COMLEX/N.B.O.M.E. Federation of State Medical Boards (F.S.M.B.) - U.S.M.L.E., SPEX and FLEX examination scores and E.B.A.H.R. Educational Commission for Foreign Medical Graduates (E.C.F.M.G.) American Medical Association (A.M.A.) American Osteopathic Association (A.O.A.)

Use these addresses when sending documents to the N.J.B.M.E.

Mailing Address: via U.S. Postal Service -

New Jersey Board of Medical Examiners
140 East Front Street -3rd Floor
P.O. Box 183
Trenton, NJ 08625

via other mail delivery service

New Jersey Board of Medical Examiners
140 East Front Street -3rd Floor
Trenton, NJ 08608

Application for Licensure by the State Board of Medical Examiners of New Jersey

This entire application must be typed or legibly printed.

Section One - DEMOGRAPHICS

1. Name _____
   First Middle Initial (M.I.) Last

2. List any other name which may appear on documents submitted as part of this application (See Instructions).

   _____

3. Contact Information E-mail address _____@_____

   Mailing address (This may not be a post office box.)

   _____
   Street City State/Country ZIP/Postal Code

   (_____)_____ (_____)_____
   Area Code Telephone Number Area Code Cell Phone Number

   (_____)_____ (_____)_____
   Area Code Work Telephone Number Area Code FAX Number

4. Date of Birth _____ /_____ /_____ Place of Birth _____
   Month Day Year City State Country

5. Social Security Number _____ _____ _____

   I _____ consent _____ do not consent to the use of my Social Security number for any of the additional purposes set forth in the Instructions. I understand that my consent is voluntary and that if I do not consent, no adverse action or inference will be taken or drawn.

6. Have you previously applied for a New Jersey medical license or residency training permit? Yes No
   If "Yes," specify and indicate the date submitted:

   _____ _____
   Type Month/Year Type Month/Year

Print Name_____
First M.I. Last

Section Two - Education

Pre-Medical Education

Did you take, pass and receive credit for a minimum of 60 (sixty) post-secondary, college level or equivalent credits prior to commencing medical school OR can you demonstrate that you have obtained the substantial equivalent? Yes No

Did you pass at least one college-level course in each of the subject areas listed below?

Biology	Yes	No
Chemistry	Yes	No
Physics	Yes	No

List the name and location of every college or university attended where pre-professional, post-secondary instruction was received:

Name	City/State/Country	Dates of Attendance (From - To)
_____	_____	___ / ___ - ___ / ___
_____	_____	___ / ___ - ___ / ___
_____	_____	___ / ___ - ___ / ___

Medical Education

	Month	Year		Month	Year	Name of Medical School(s)
1st year	_____	_____	to	_____	_____	_____
2nd year	_____	_____	to	_____	_____	_____
3rd year	_____	_____	to	_____	_____	_____
4th year	_____	_____	to	_____	_____	_____
5th year	_____	_____	to	_____	_____	_____
6th year	_____	_____	to	_____	_____	_____

Name of institution conferring degree:_____

Date degree was awarded: _____

Type (circle one): Medical Doctor or Doctor of Osteopathy

Print Name_____
First M.I. Last

Section Two - Education (continued)

Clinical Clerkships

During your medical school training, did you complete clinical clerkships of at least four (4) weeks duration in the following core rotations or specialties?

Medicine	Yes	No	OB/GYN	Yes	No
Pediatrics	Yes	No	Psychiatry	Yes	No
Surgery	Yes	No			

Board Certifications

List any certifying board(s) below:

Certification	Date Awarded/Expiration Date	Board
	/	
	/	
	/	

Endorsement Examinations

National Board Examination: Part 1 Date ___ / ___ Part 2 Date ___ / ___ Part 3 Date ___ / ___
Month Year Month Year Month Year

U.S.M.L.E.: Step 1 Date ___ / ___ Step 2 Date ___ / ___ Step 3 Date ___ / ___
Month Year Month Year Month Year

FLEX: Component 1/FLEX Date ___ / ___ Component 2/FLEX Date ___ / ___
Month Year Month Year

FLEX prior to 12/1994 Weighted Average _____

Sister State: State: _____ Date _____

N.B.O.M.E./COMLEX: Part 1 Level 1 _____ Part 2 Level 2 _____ Part 3 Level 3 _____

Postgraduate Training

List below each training program (including Fifth Pathway Program, internship, residency and/or fellowship) in which you have participated.

	Dates (From - To)	Institution	Specialty	Credit/No Credit/ Partial Credit
PGY1	___ / ___ - ___ / ___ (Month Year Month Year)	_____	_____	_____
PGY2	___ / ___ - ___ / ___ (Month Year Month Year)	_____	_____	_____
PGY3	___ / ___ - ___ / ___ (Month Year Month Year)	_____	_____	_____
PGY4	___ / ___ - ___ / ___ (Month Year Month Year)	_____	_____	_____
Fellowship	___ / ___ - ___ / ___ (Month Year Month Year)	_____	_____	_____
Other	___ / ___ - ___ / ___ (Month Year Month Year)	_____	_____	_____

Print Name____
First M.I. Last

Section Three - Employment/Malpractice History/Other Licenses

Privileges/Affiliation/Employment/Appointments History

From	To	Employer/Facility	Address
____/______ Month Year	____/______ Month Year	Name: Position: Malpractice Carrier:	Street: City: State/ZIP code:
____/______ Month Year	____/______ Month Year	Name: Position: Malpractice Carrier:	Street: City: State/ZIP code:
____/______ Month Year	____/______ Month Year	Name: Position: Malpractice Carrier:	Street: City: State/ZIP code:
____/______ Month Year	____/______ Month Year	Name: Position: Malpractice Carrier:	Street: City: State/ZIP code:
____/______ Month Year	____/______ Month Year	Name: Position: Malpractice Carrier:	Street: City: State/ZIP code:
____/______ Month Year	____/______ Month Year	Name: Position: Malpractice Carrier:	Street: City: State/ZIP code:
____/______ Month Year	____/______ Month Year	Name: Position: Malpractice Carrier:	Street: City: State/ZIP code:

Print Name_____
First M.I. Last

Section Three - Employment/Malpractice History/Other Licenses (continued)

Malpractice History

Answer the following questions:

a. Have you been named as a defendant in a medical malpractice suit?	Yes	No
b. Have you been denied malpractice insurance coverage?	Yes	No
c. Have you been reassigned to a risk retention or high-risk group?	Yes	No
d. Has your carrier limited or reduced your coverage?	Yes	No
e. Has your carrier required you to have office monitoring?	Yes	No
f. Has any carrier limited their coverage of your practice?	Yes	No
g. Have you limited your practice in order to obtain or maintain malpractice coverage?	Yes	No

Identify every malpractice suit in which you have been listed as a defendant and the status of the suit, i.e. open, dismissed or closed with payment.

_____

_____

_____

_____

Verification of State License/Sister State Endorsement

List below all state(s)/countries in which you hold or have ever held a medical license or residency training permit, and the status of the license/permit:

State	Number	Circle One		Other
_____	_____	Active	Inactive	_____ Specify
_____	_____	Active	Inactive	_____ Specify
_____	_____	Active	Inactive	_____ Specify

Print Name_____
First M.I. Last

Section Four - Character, Ethics and Medical Conditions

Information regarding moral character and ethical professional responsibility

a. Have you ever been arrested for, formally accused of, charged with, indicted for or convicted of the commission of any crime or offense, whether state, federal, or in other countries, including offenses categorized as misdemeanors, high misdemeanors or felonies? (NOTE: If you have been arrested or had a conviction for which you have been informed the record has been expunged, please verify that the expungement has in fact been implemented prior to answering "No" to this question.) (A dismissal is not an expungement.) Yes No

b. Have you ever been denied a license to practice medicine or eligibility to sit for a licensing exam in this State or in any other state or jurisdiction, foreign or domestic? Yes No

c. Has any action been taken or is any action now pending against your professional license or have you been permitted to surrender or otherwise relinquish your license to avoid inquiry, investigation or action by any other licensing authority or regulatory agencies? Yes No

d. Have you ever been denied eligibility to participate in a graduate medical education program in this State or any other state or jurisdiction, foreign or domestic? Yes No

e. Have you ever been denied privileges or had your privileges to practice terminated or limited? Yes No

f. Have you ever been terminated from or have you ever been asked to resign from your hospital staff membership, internship, residency position or fellowship? Yes No

g. Have you ever been permitted to resign while you were under review or investigation by a health care facility or, in return for not conducting an investigation? Yes No

h. Do you currently have a child-support obligation? Yes No
If "Yes," you must answer (a) and (b) below:
(a) Are you in arrears in payment of said obligation? Yes No
(b) Does the arrearage match or exceed the total amount payable for the past six months? Yes No

i. Have you failed to provide any court-ordered health insurance coverage during the past six months? Yes No

j. Have you failed to respond to a subpoena relating to either a paternity or child-support-related arrest warrant? Yes No

k. Are you the subject of a child-support-related arrest warrant? Yes No

Print Name_____
First M.I. Last

Section Four - Character, Ethics and Medical Conditions (continued)

Medical Conditions/Chemical Substances

If you have a good-faith reason to believe that answering these questions may expose you to possible criminal prosecution, you may assert the Fifth Amendment privilege against self-incrimination. If you do so, your application will still be processed. However, you may later be directed by the Attorney General to answer these questions, provided that the Attorney General first grants you immunity afforded by statutory law pursuant to N.J.S.A. 45:1-20.

a. Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? Yes No

b. Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? (NOTE: If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition to determine whether an unrestricted license should be issued, whether conditions should be imposed or whether you are not eligible for licensure.) N/A Yes No

c. Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting or the manner in which you have chosen to practice? N/A Yes No

d. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism? Yes No

e. Are you currently engaged in the illegal use of controlled dangerous substances? Yes No

If "Yes," are you participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? Yes No

f. Does your use of chemical substance(s) in any way impair or limit your ability to practice medicine with reasonable skill and safety? N/A Yes No

If you answered "Yes" to any of the questions above, you must explain in detail on a separate sheet of paper the reason for your responses.

Print Name_____
First M.I. Last

Waiver

I hereby authorize all hospitals, institutions, organizations, my references, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the New Jersey State Board of Medical Examiners any information, files or records requested by the Board. I further authorize the New Jersey State Board of Medical Examiners to release to any organizations, individuals and groups listed above, any information which is material to my application, relating to clinical, residency or postgraduate programs as well as hospital privileges or staff appointments.

I am the person referred to in the preceding application for licensure to practice medicine and surgery in the State of New Jersey. I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice medicine and surgery in the State of New Jersey.

Certification

"I certify that the information entered on this form is true and complete to the best of my knowledge, and further acknowledge that if the above information is willfully false, I am subject to punishment and/or disciplinary sanction including license denial, suspension/revocation or the imposition of civil penalties as may be provided by law. I am also aware that as a condition of licensure I am required to notify the State Board of Medical Examiners, in writing, within 21 days, of any subsequent changes to the information reported on my application."

_____
Signature of Applicant

_____
Name of Notary Public (please print)

Affix Seal Here

_____
Signature of Notary Public

_____
Date Signed

This application, once complete, must be **signed in the presence of a notary** and forwarded to the Board within 30 days of the notarization.

Medical Education Verification Form

Applicant's name:_____

Medical school: _____

Medical school address: _____
Street City State/Country Zip/Postal Code

Telephone number: ( ) _____
Area Code

1. Did this physician attend the medical school noted above? Yes No
2. What were the applicant's dates of enrollment? _____ to _____
   Month /Year Month /Year
3. Did this physician graduate from this medical school? Yes No
   If "No," please explain below:

   _____

   _____

4. What was the date of graduation? _____
   Month /Year
5. Did this individual take a leave of absence during his/her attendance at this medical school? Yes No

   If "Yes," what was the reason for the leave of absence?

   _____

   _____

6. Was this individual on probation during his/her attendance at this medical school? Yes No
7. Was this individual ever disciplined or under investigation during his/her attendance at this school? Yes No
8. Were any negative reports filed by instructors regarding this individual? Yes No
9. Were any special requirements imposed on this individual that were not required of all other students at his/her level of education? Yes No

Please supply any additional comments or information that the Board should consider prior to determining this applicant's eligibility for licensure.

_____

_____

Print Name of Registrar: _____

Signature of Registrar: _____

Date: _____

Please return **with an official transcript** directly to:

N.J. State Board of Medical Examiners
P.O. Box 183
Trenton, New Jersey 08625-0183

Seal of Medical School

BME-MEV-08

Verification of Postgraduate Training

Applicant's name:_____

Hospital: _____

Hospital address:_____
Street City State/Country Zip/Postal Code

Hospital telephone number: ( ) _____
Area Code

1. In what type and level(s) of training did this physician participate at your facility? Check each level in which this physician participated. Provide starting and ending dates of training, type of training and whether credit was awarded.

	Dates (Month/Year)	Specialty	Credit None	Partial	Full
PGY 1					
PGY 2					
PGY 3					
PGY 4					
Fellowship					
Other					

2. Was the residency/fellowship accredited by A.C.G.M.E. or A.O.A.? Yes No

3. Was the physician placed on probation, suspended or in any way sanctioned/ disciplined or placed under investigation while at your facility? Yes No

4. Was the physician granted a leave of absence or break from his/her training? Yes No

5. Were any restrictions placed on this physician's activities that were not placed on all other residents/fellows at his/her level of training? Yes No

6. Were any formal patient or staff complaints filed against this physician? Yes No

7. Were any malpractice actions filed naming this physician as a defendant that involved his/her period of training at your facility? Yes No

If you answered "Yes" to any one of questions 3-7, please attach an explanation, and sign and date the attachment. Also, please attach any additional comments or information that the Board should consider prior to determining this applicant's eligibility for licensure.

_____
Printed Name of Program Director

_____
Signature of Program Director

_____
Date form completed

Hospital Seal

If the hospital does not have a seal, a letter attesting to this fact, on hospital stationery, must accompany this certificate.

Please return directly to: **N.J. State Board of Medical Examiners**
P.O. Box 183
Trenton, New Jersey 08625-0183

BME-VPT-08

Verification of Privileges/Affiliation/Employment/Appointment

_____
License Applicant's Name

_____
Hospital/Facility Name

_____
Street Address

_____
City State/Country ZIP/Postal Code

_____
(Area Code) Telephone Number

_____
Position held at your facility

return completed form to:
N.J. State Board of Medical Examiners
P.O. Box 183
Trenton, NJ 08625-0183

from ___ /___ /____ to ___ /___ /____

1. Was this physician placed on probation, suspended or in any way sanctioned/disciplined while at your facility?	Yes	No
2. Was this physician granted a leave of absence while employed at your facility?	Yes	No
3. Were any restrictions placed on this physician's activities or privileges that were not placed on others holding similar positions?	Yes	No
4. Was this physician subject to non-routine monitoring and/or non-routine quality assessment review?	Yes	No
5. Was this physician involuntarily removed from a call schedule?	Yes	No
6. Was this physician the subject of a negative review while at your facility?	Yes	No
7. Was this physician the subject of an investigation while at your facility?	Yes	No
8. Were any malpractice actions filed naming this physician during his/her period of employment at your facility?	Yes	No
9. Did this physician leave your facility in good standing?	Yes	No
10. Would you recommend this physician for privileges or consider rehiring this physician at your facility?	Yes	No

If you answered "Yes" to any one of questions 1-8, please attach an explanation. You may also attach additional comments or information that the N.J. State Board of Medical Examiners should consider prior to determining this applicant's eligibility for licensure. All attachments should be on your facility's letterhead.

_____
Printed Name and Title of Certifying Official

_____
Signature of Certifying Official

_____
Date form was completed

Hospital Seal

If the hospital does not have a seal, a letter attesting to this fact, on hospital stationery, must accompany this certificate.

BME-PEA-08

Malpractice Insurance Verification

_____ has applied for a medical license with the State
Insured's Name
of New Jersey. He/she held medical malpractice insurance issued by your company. Please complete this form, attach relevant supporting documentation concerning any medical malpractice cases in which this practitioner was named and the business card of the individual completing this form and return directly to: **N.J. State Board of Medical Examiners**
P.O. Box 183
Trenton, New Jersey 08625

_____
Malpractice Insurance Company Name

_____
Street Address City State ZIP code (Area Code) Phone

Dates of coverage: from: _____ /_____ /_____to: _____ /_____ /_____

Dates should include entire period the insured was covered, not just the dates of the current policy.

List the name(s) and status of each case in which the doctor has been involved. Attach supporting documents concerning the status of the case.

Plaintiff's Name	**Status**
_____	_____
_____	_____
_____	_____
_____	_____

1. Was this doctor ever denied malpractice coverage? Yes No
2. Was this doctor's practice ever curtailed or limited? Yes No
3. Was this doctor ever assessed a surcharge based upon specific claims history? Yes No
4. Was office monitoring or special hospital monitoring ever required for this doctor? Yes No
5. Was this doctor ever subjected to underwriting review based upon specific claims history or for any other cause? Yes No

_____
Print the name and title of the person completing this form.

_____
Signature

_____
Date form completed

BME-MI-08

Verification of State License/Examination

I, _____ , born _____/_____/_____
First Name Middle Initial Last Name Month Day Year

Social Security No._____-_____-_____ , hold/held medical license _____
Registration number

issued by_____. I am requesting that you complete this verification
State

form and mail it to the N.J. State Board of Medical Examiners (address below) as per my authorization. Thank you.

I hereby authorize the State of _____ to release all of the information in its files concerning my license/examination and any actions or pending actions against my license to the New Jersey State Board of Medical Examiners.

_____ _____
Signature Date

Section 2 - To be completed by the licensing/examination entity

The State of_____ certifies that_____ was issued license
Name of State Name of Physician

registration _____. Date Issued ___ /___ /___ Expiration Date ___ /___ /___
License Number Month Day Year Month Day Year

The status of this license is currently: (Circle one) Active Inactive Other (specify)_____

1. Is the license in good standing? Yes No
   If "No," please attach details and certified copies of any orders.

2. To your knowledge, has this physician ever been disciplined by your board or any other regulatory agency? Yes No
   If "Yes," please attach details and certified copies of any orders.

3. Is there presently or has there been in the past a disciplinary proceeding against this licensee? Yes No
   If "Yes," please attach details and certified copies of any orders.

4. Is there presently or has there been in the past an investigation conducted relative to this licensee? Yes No
   If "Yes," please attach details and certified copies of any orders.

Please attach additional comments or information that the Board should consider prior to determining this applicant's eligibility for licensure.

Section 3 - State Licensing Examination Verification

After a written examination administered by this board in the following subjects:

_____

_____and upon obtaining a general average of _____

percent, the above license was issued.

Section 4 - Certification

_____ _____
Printed name and title of Certifying Official Signature of Certifying Official

Board Seal

Date form completed _____ /_____/_____

Please return directly to: **N.J. State Board of Medical Examiners**
P.O. Box 183
Trenton, New Jersey 08625-0183

Official Use Only
☐ Dual License
License Type 1

Applicant's Number

License Type 2

Applicant's Number

New Jersey Office of the Attorney General
Division of Consumer Affairs
State Board of Medical Examiners
P.O. Box 183
Trenton, New Jersey 08625
(609) 826-7100

Official Use Only

☐ Resubmit

Board or Committee

Certification and Authorization Form For a Criminal History Background Check

Directions: Answer all of the questions on this form.

1. Name ☐ Mr. ☐ Mrs. ☐ Ms. _____ (_____)
   Last First Middle Maiden Name
2. Address _____
   Street or P.O. Box City State ZIP code
3. Date of birth __ __ /__ __ /__ __ Sex: ☐ Male ☐ Female
   Month Day Year
4. Social Security number _____/_____ / _____
5. Have you completed the fingerprinting process for any **Board or Committee of the New Jersey Division of Consumer Affairs** since November 2003? ☐ Yes ☐ No
   If "No," you will receive a separate mailing from the Board or Committee regarding the criminal history record background check process. No payment is necessary as of now.
   If "Yes," please provide the following information and follow the instructions outlined below:

   _____ _____
   Board or committee requiring the fingerprinting Month and year you were fingerprinted

   If you were fingerprinted after November 2003 as part of the criminal history background process for licensure or certification by any other **Board or Committee of the New Jersey Division of Consumer Affairs** (a background check conducted for the Department of Education, another state agency or another state does not apply) you will not be required to be fingerprinted a second time. However, the Division must perform a criminal history background check each time you apply for licensure or certification. **The fee for this service is $20.25.** Payment should be made in the form of a check or money order payable to the State of New Jersey and should accompany your application packet.
6. Have you ever been arrested and/or convicted of a crime or offense? (Minor traffic offenses such as a parking or speeding violations need not be listed.) ☐ Yes ☐ No

   Every such conviction on record must be disclosed. A true copy of every police report, judgment of conviction, sentencing order and termination of probation order, if applicable, **must** be submitted with this form. Any documents (including employer or supervisor letters of reference, if applicable) which present clear and convincing evidence of rehabilitation **must** be submitted with this form. **Failure to follow these instructions may result in the denial of an initial application.**

   Note: Copies of judgments, sentencing and termination of probation orders may be obtained from the clerk of the county where those orders, disposing of the conviction, were issued and filed.

   Your continuing responsibility to disclose convictions of crimes or offenses: You **must** notify the Board or Committee within five (5) business days if you are convicted of any crimes or offenses after this form has been completed.

Continuation on the reverse side ➡

Certification

I, _____, in making this application to the Board or Committee for certification or licensure, certify that I am the applicant and that all of the information provided in connection with this application is true to the best of my knowledge and belief. I understand that any omissions, inaccuracies or failure to make full disclosures may be deemed sufficient to deny certification or licensure or to withhold renewal of or suspend or revoke a certificate or license issued by the Board or Committee.

I voluntarily consent to a thorough investigation of my present and past employment and other activities for the purpose of verifying my qualifications for certification or licensure. I further authorize all institutions, employers, agencies and all governmental agencies and instrumentalities (local, state, federal or foreign) to release any information, files or records requested by the Board or Committee.

I certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

_____ _____

Signature of applicant Date

APPROVED TRANSLATION AGENCIES

Action Translation Bureau LLC
17 Tilden Drive East Hanover, NJ 07936
(973) 386-9774
(973) 464-4445

Action Interpreting LLC
Director, Nicole Steranka
184 Columbia Turnpike Suite 4-297
Florham Park, NJ 07932
(973) 887-3580

Ambassador Translating Inc.
Box 1529
Morristown, NJ 07960
(973) 292-2737
email@ambassadornj.com

Allen Translation Service
Box 1529
Morristown, NJ 07960
(973) 292-2737
allentranslation.com

Inlingua School of Language/Translation Svs.
95 Summit Avenue Summit, NJ 07901
(908) 522-0622
www.inlinguametrony.com

Inlingua School of Language/Translation Svs.
171 E. Ridgewood Ave Ridgewood, NJ 07450
(201) 444-9500
www.inlinguametrony.com

Translation Company of New York, Inc.
8 South Maple Avenue Marlton, NJ 08053
(856) 983-4733
tcny2000.com
(e-mail) tcny2000@cs.com

Translation Company of America
211 East 43rd St. Rm. 505
New York, New York 10017
(212) 563-7054
www.thelanguagelab.com

Continental Translation Service, Inc.
110 W. 40th St. Rm. 606
New York, NY 10018
(212) 867-3646
continentaltranslation.com

Lawyers & Merchants Translation Bureau
11 Broadway Suite 466
New York, NewYork 10040-1303
(212) 344-2930
rws.com

Berlitz School of Languages
31D Hulfish Street
Princeton, NJ 08542
(609) 497-6571

Columbia University
70-74 Morningside Dr
New York, New York 10027
(212) 854-4888
cutta@columbia.edu

The Language Center, Inc
25 Kennedy Blvd Ste 400
East Brunswick, NJ 08816
(732) 613-4554

Endorsement Agencies

Federation of State Medical Boards
www.fsmb.org

Examination and Board Action History Report
(E.B.A.H.R.)
(817) 868-4041

Educational Commission for Foreign Medical
(E.C.F.M.G.) http://www.ecfmg.org

Controlled Dangerous Substance Registration
(State of N.J.) http://www.njconsumeraffairs.gov/drug/

National Board of Medical Examiners
(N.B.M.E.) www.nbme.org

American Medical Association (A.M.A.)
http://www.ama-assn.org

American Osteopathic Association
http://www.osteopathic.org

National Board of Osteopathic Examiners
(N.B.O.M.E.) http://www.nbome.org