Regular Mailing Address
STATE BOARD OF MEDICINE
P.O. BOX 2649
HARRISBURG, PA 17105-2649
717-783-1400/717-787-2381
Email: st-medicine@pa.gov

Courier Delivery Address
STATE BOARD OF MEDICINE
2601 NORTH THIRD STREET
HARRISBURG, PA 17110

REACTIVATION OR STATUS CHANGE APPLICATION – PHYSICIAN AND SURGEON

The following checklist item descriptions apply to the checklist items noted under each status option listed on Page 2.

1.	**Name Change Documentation:** If documents will be submitted to the Board under a name different from your present name, submit a copy of the legal document evidencing the name change (i.e., marriage license, divorce decree, etc.).
2.	**Curriculum Vitae:** Attach a current Curriculum Vitae listing **all** periods of employment or unemployment (i.e., child rearing, research, etc.) for at least the past 10 years. If your initial license in Pennsylvania was issued within the past 10 years, please provide activities from date of initial licensure to the present. The list must be in chronological order, including the month and year, and indicate the state/territory in which the employment occurred.
3.	**Data Bank Report:** Provide an official notification of information (Self Query) from the National Practitioner Data Bank. Please refer to the NPDB website for additional information. **When you receive the "Response to your Self Query," forward the entire report directly to the Board Office.** You should make a copy for your records.
4.	**Continuing Education:** Submit copies of your continuing medical education certificates/documentation. Continuing medical education requirements can be found at **www.dos.pa.gov/med.**
5.	**Child Abuse Recognition and Reporting Continuing Education**: All health-related licensees/certificate holders are considered "mandatory reporters" under section 6311 of the Child Protective Services Law (23 P.S. § 6311). Therefore, all persons applying for renewal of a license or certificate from any of the health-related boards (except the State Board of Veterinary Medicine) are required to complete, as a condition of biennial renewal, 2 hours of approved training on the topic of child abuse recognition and reporting. After you have completed the required course, the approved provider will electronically submit your name, date of attendance, etc. to the Bureau. For that reason, it is imperative that you register for the course using the information on file with the Board. A list of approved child abuse education providers can be found on the Department of State Website. **Please note that it may take 7-10 days for the provider to submit the records to the Board office.**
6.	**Opioid Continuing Education**: Section 9.1(a)(2) of ABC-MAP* requires that all prescribers or dispensers, as defined in Section 3 of ABC-MAP, complete at least two hours of continuing education in pain management, the identification of addiction or in the practices of prescribing or dispensing of opioids as a portion of the total continuing education required. The required continuing education is part of the total required and must be taken from a Board-approved continuing education provider. *The Achieving Better Care by Monitoring All Prescriptions Program Act (ABC-MAP) (Act 191 of 2014, as amended) is available on the Legislature's website at: http://www.legis.state.pa.us/cfdocs/Legis/LI/uconsCheck.cfm?txtType=HTM&yr=2014&sessInd=0&smthLwInd=0&act=191

IMPORTANT INFORMATION

1.	A reactivation/status change application for a Pennsylvania license/certification which has been inactive/expired/active-retired for four years or more will require a review by the full Board. Please note that the Board has the authority to place conditions on your return to practice in order to protect the health, safety and welfare of the public. The Board may require applicants who have not actively practiced for four or more years and are requesting reactivation of an expired/inactive/active-retired license/certification to successfully complete a clinical skills evaluation and/or retraining program. This may delay the reactivation of your license until an approved skills evaluation and/or retraining program has been successfully completed.
2.	**FEES ARE NOT REFUNDABLE. Check or money order must be in "US funds**." **Note**: A processing fee of $20.00 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment. Your cancelled check is your receipt of payment.
3.	**Licenses expire every even numbered year regardless of reinstatement date.**
4.	If this application is not completed **within six months**, updates of certain sections and/or supporting documents will be required.

5.	You are hereby reminded that in order to practice in Pennsylvania, **you must comply with the professional liability insurance requirements of your profession as required by law and/or regulation**.
6.	Effective Jan. 1, 2017, act 191 of 2014 requires all prescribers and dispensers to register for the Pennsylvania Prescription Drug Monitoring Program (PA PDMP). Prescribers are required to query the PA PDMP System for each patient the first time the patient is prescribed a controlled substance by the prescriber, when there is clinical concern that the patient may be abusing or diverting a controlled substance(s), and/or each time the patient is prescribed an opioid drug product or a benzodiazepine. To learn more and to register, please visit www.doh.pa.gov/pdmp.

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REACTIVATION OR STATUS CHANGE APPLICATION
PHYSICIAN AND SURGEON

YOU MUST COMPLETE AND RETURN PAGES 1, 2, 3, and 4 OF THE APPLICATION

(Please print or type)

NAME:	Last		First		Middle		
ADDRESS:	Street						
City			State		Zip		
DATE OF BIRTH:	Month	Day	Year	**SOCIAL SECURITY NUMBER:**			
EMAIL ADDRESS:							
PHONE NUMBER:							
LICENSE NUMBER:							
NAME OF UNIVERSITY OR SCHOOL:							
YEAR OF GRADUATION:							

Name Change

For a name change, indicate new name below and attach an 8 ½ x 11 photocopy of a legal document verifying the name change (i.e., marriage certificate, divorce decree, legal document indicating retaking of a maiden name, etc.).

New Name (Please Print):

_____

STATUS OPTIONS – SELECT ONE BELOW

ACTIVE STATUS – REQUESTING ACTIVE-RETIRED STATUS

☐ I am retired from practice but desire to keep my license active to treat immediate family members only. I understand that I am exempt from the medical professional liability insurance and continuing education requirements. (I understand that to reactivate my license, I will need to meet the continuing education requirements, obtain professional liability insurance, and meet any re-entry, clinical skills assessment as required by the Board.)

- Complete Sections A, B, and C.
- Return your "**Active**" wall and wallet licenses.
- Submit a $5 check or money order made payable to the "**Commonwealth of Pennsylvania**."

ACTIVE/RETIRED STATUS – REQUESTING ACTIVE STATUS

☐ I wish to reinstate my license to an active status. **I have completed the continuing education requirements and will hold medical professional liability insurance while practicing in Pennsylvania**.

- Complete Sections A, B and C.
- Submit a current Curriculum Vitae.
- Submit a National Practitioner Data Bank Report.
- Return your "Active-Retired" wall and wallet licenses.
- Submit copies of your continuing education certificates/documentation.
- Submit a $5 check or money order made payable to the "**Commonwealth of Pennsylvania**."

ACTIVE STATUS – REQUESTING INACTIVE STATUS

☐ I do not wish to practice as a physician and surgeon in the Commonwealth of Pennsylvania and wish to place my license on an inactive status. (I understand that to reactivate my license, I will need to meet the continuing education requirements, obtain professional liability insurance, and meet any re-entry, clinical skills assessment as required by the Board.)

- Complete Sections A, B and C.
- Return your "Active" wall and wallet licenses.
- No fee is required.

EXPIRED/INACTIVE STATUS – REQUESTING ACTIVE STATUS

☐ I wish to reinstate my license to an active status. I have completed the continuing education requirements and will hold professional liability insurance.

- Complete Sections A, B, C and D.
- Submit a current Curriculum Vitae.
- Submit a National Practitioner Data Bank Report.
- Submit copies of your continuing education certificates/documentation including opioid continuing education.
- Completion of the child abuse recognition and reporting continuing education will be uploaded to the Board by the Provider.
- Fee – The Board has waived the biennial renewal fee for the 2020 renewal. No fee will be required to reactivate.
- If practicing in Pennsylvania after the license expired, submit $5 per month, or part of a month, since the license expired.

EXPIRED/INACTIVE STATUS – REQUESTING ACTIVE-RETIRED STATUS

☐ I wish to reinstate my license to an active-retired status to treat immediate family members only. I understand that I am exempt from the medical professional liability insurance and continuing education requirements. (I understand that to reactivate my license, I will need to meet the continuing education requirements, obtain professional liability insurance, and meet any re-entry, clinical skills assessment as required by the Board.)

- Complete Sections A, B, C and D.
- Submit a current Curriculum Vitae.
- Submit copies of your opioid continuing education certificates/documentation.
- Completion of the child abuse recognition and reporting continuing education will be uploaded to the Board by the Provider.
- Fee – The Board has waived the biennial renewal fee for the 2020 renewal. No fee will be required to reactivate.
- If practicing in Pennsylvania after the license expired, submit $5 per month, or part of a month, since the license expired.

Section A – Legal Questions

You must answer the following questions. If you answer "YES" to #2 through #10, provide complete details on a separate sheet as well as copies of relevant documents.

		Yes	No
1	Do you hold or have you ever held a license, certificate, permit, registration or other authorization to practice any health-related profession in any state or jurisdiction? **If you answered yes, provide the profession and state or jurisdiction.** LIST: _____		
2	Have you withdrawn an application for a professional or occupational license, certificate, permit or registration, had an application denied or refused, or for disciplinary reasons agreed not to apply or reapply for a professional or occupational license, certificate, permit or registration in any state or jurisdiction?		
3	Have you had disciplinary action taken against a professional or occupational license, certificate, permit, registration or other authorization to practice a profession or occupation issued to you in any state or jurisdiction or have you agreed to voluntary surrender in lieu of discipline?		
4	Do you currently have any disciplinary charges pending against your professional or occupational license, certificate, permit or registration in any state or jurisdiction?		
5	Have you ever had practice privileges denied, revoked, suspended, or restricted by a hospital or any health care facility?		
6	Have you had your DEA registration denied, revoked or restricted?		
7	Have you had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority?		
8	Have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?		
9	Have you engaged in the intemperate or habitual use or abuse of alcohol or narcotics, hallucinogenics or other drugs or substances that may impair judgment or coordination?		
10	**Since May 19, 2002**, have you been the subject of a civil malpractice lawsuit? **If yes, please submit a copy of the entire Civil Complaint, which must include the filing date and the date you were served. Submit a statement which includes complete details of the complaints that have been filed against you.** **If you previously reported the complaint(s) to the Board provide the docket number(s)** _____		

Section B – Verification of Information

I verify that this application is in the original format as supplied by the Department of State and has not been altered or otherwise modified in any way. I am aware of the criminal penalties for tampering with public records or information under 18 Pa. C.S. § 4911. I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa C.S. § 4904 (relating to unsworn falsification to authorities) and may result in the suspension, revocation, or denial of my license, certificate, permit or registration.

Full Name (Please Print) _____

Signature of Licensee (Mandatory) _____ Date _____

Section C - Acknowledgement of Duty to Self-Report Disciplinary Conduct and Certain Criminal Activity (mandatory for all licensees; signature required)

I, _____, hereby acknowledge that in addition to any existing reporting requirement required by a specific board or commission, I am REQUIRED pursuant to Act 6 of 2018 to NOTIFY the Bureau of Professional and Occupational Affairs WITHIN 30 DAYS of the occurrence of any of the following: (1) A disciplinary action taken against me by a licensing board or agency in another jurisdiction; (2) A finding or verdict of guilt, an admission of guilt, a plea of nolo contendere, probation without verdict, a disposition in lieu of trial or an Accelerated Rehabilitative Disposition (ARD) of any felony or misdemeanor offense in a criminal proceeding. **I further acknowledge that failure to comply with these mandatory reporting requirements may subject me to disciplinary action by the Board.** I acknowledge my understanding that to self-report a disciplinary action or criminal matter as set forth above, I may log in to the Pennsylvania Licensing System (PALS) at www.pals.pa.gov and select "Mandatory Reporting by Licensee" under the heading "Your Licenses."

_____ _____

Licensee Signature Date

Section D – Verification of Practice/Non-Practice

VERIFICATION OF PRACTICE / NON-PRACTICE

***** Your reactivation cannot be processed unless this page is completed *****

	Last	First	Middle
Full Name			
License Number			

	Be sure that you are familiar with the definition of your profession from the licensing law which pertains to the license you are reactivating. THEN, answer the following questions.	Yes	No
1.	Have you engaged in or practiced in your profession in Pennsylvania since your license lapsed or since you placed it on inactive status?		
2.	Have you been employed by the federal government in the practice of your profession since your Pennsylvania license lapsed or since you placed it on inactive status?		

I verify that this application is in the original format as supplied by the Department of State and has not been altered or otherwise modified in any way. I am aware of the criminal penalties for tampering with public records or information under 18 Pa. C.S. § 4911. I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa C.S. § 4904 (relating to unsworn falsification to authorities) and may result in the suspension, revocation, or denial of my license, certificate, permit or registration.

_____

Printed Name of Licensee Last First Middle

_____

Signature of Licensee **Date**