Regular Mailing Address STATE BOARD OF MEDICINE P.O. BOX 2649 HARRISBURG, PA 17105-2649	**Email:** st-medicine@pa.gov

APPLICATION FOR A TEMPORARY LICENSE FOR PHYSICIANS NOT LICENSED IN PENNSYLVANIA

- **This application is to be used only by Physicians seeking temporary licensure in the Commonwealth of Pennsylvania to aid in the Commonwealth's emergency declaration related to COVID-19.**
- **To Qualify for a Temporary License, You Must Hold an Active License in Good Standing in Another State.**
- **If you previously held a Pennsylvania license and are seeking to reactivate the license due to the emergency DO NOT SUBMIT this application. submit the application for Emergency Reactivation or Status Change.**

REQUIRED DOCUMENTS

1.	Complete Pages 1 and 2 of the application.
2.	Include a copy of your active license verification from the website of your home licensure state.
3.	Scan and email the application to St-Medicine@pa.gov. The subject line of the email should be listed as Emergency Temporary Licensure.
4.	Upon completion of your application, a temporary license will be issued with an expiration date of **December 31, 2020.** This temporary license is non-renewable. If you wish to practice after the declared state of emergency, you will need to obtain full licensure by meeting all standard licensing requirements. You can determine if you meet the Board's requirements by reviewing the Board's Rules and Regulations posted on our website at www.dos.pa.gov/med. You can also review the applications instructions at www.pals.pa.gov. Click on Application Checklist.

APPLICANT INFORMATION
(Please Print or Type)

NAME:	Last		First		Middle		
ADDRESS:	Street						
City			State		ZIP		
DATE OF BIRTH:	Month	Day	Year	**SOCIAL SECURITY NUMBER:**			
EMAIL ADDRESS:							
NAME OF MEDICAL SCHOOL ATTENDED:							
DATE OF GRADUATION:	Month		Day		Year		
CURRENT STATE LICENSE BEING USED TO APPLY FOR A TEMPORARY LICENSE IN PA:							

NAME AND ADDRESS OF PENNSYLVANIA PRACTICE LOCATION

NAME OF ORGANIZATION:			
ADDRESS:	Street		
City:		State	ZIP

LEGAL QUESTIONS

You must answer the following questions. If you answer "YES" to #2 through #12, 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 in 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	Do you currently have any criminal charges pending and unresolved in any state or jurisdiction?		
6	Have you ever had practice privileges denied, revoked, suspended, or restricted by a hospital or any health care facility?		
7	Have you had your DEA registration denied, revoked or restricted?		
8	Have you had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority?		
9	Have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?		
10	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?		
11	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 <u>filing date</u> and <u>the date you were served</u>. Submit a statement which includes complete details of the complaints that have been filed against you.** ****If you previously reported the complaint to the Board provide the docket number** _____		

SIGNED STATEMENT

NOTICE: Disclosing your Social Security Number on this application is mandatory in order for the State Boards to comply with the requirements of the Federal Social Security Act pertaining to Child Support Enforcement, as implemented in the Commonwealth of Pennsylvania at 23 Pa. C.S. § 4304.1(a). At the request of the Department of Human Services, the licensing boards must provide to the Department of Human Services information prescribed by the Department of Human Services about the licensee, including the social security number. In addition, Social Security Numbers are required in order for the Board to comply with the reporting requirements of the U.S. Department of Health and Human Services, National Practitioner Data Bank.

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.

_____ _____

Signature of Applicant Date

_____

Printed Name of Applicant