

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](mailto:st-medicine@pa.gov)

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

**APPLICATION FOR A LICENSE TO PRACTICE MEDICINE  
 WITHOUT RESTRICTION FOR GRADUATES OF UNACCREDITED  
 MEDICAL SCHOOLS (SCHOOLS OUTSIDE THE U.S. AND CANADA)**

**APPLICANTS MUST COMPLETE THE FOLLOWING:**

1. Submit the \$85 fee, check or money order, made payable to the "Commonwealth of Pennsylvania." **FEES ARE NOT REFUNDABLE. Check or money order must be in U.S. funds.** Note: A processing fee of \$20 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.
2. Complete pages 1, 2 and 3 of the application. **Note: If you are a graduate of a school inside of the United States or Canada, you may NOT use this form.**
3. 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, naturalization, etc.).

**PLEASE NOTE:** If a pending application is older than one year from the date submitted and the applicant wishes to continue the application process, the Board shall require the applicant to submit a new application including the required fee. In order to complete the application process, many of the supporting documents associated with the application cannot be more than six months from the date of issuance.

**MEDICAL EDUCATION AND TRAINING**

1. Request verification of your ECFMG Certification directly from ECFMG. **Your certification must be current and valid. The name of the State Medical Board that the Status Report should be sent to is Pennsylvania State Board of Medicine—State Code: 039.**  
  
**PLEASE NOTE:** If you have current ECFMG certification and ECFMG verified your medical education at the time you received certification, you **DO NOT** need to provide the verification items outlined in #2 below. The verification of your medical education through ECFMG will satisfy this requirement. If ECFMG **DID NOT** verify your medical education at the time you received ECFMG certification, you **MUST** provide the Board with verification of your medical education as outlined and listed in # 2 below.
2. Complete Section 1 of the Verification of Medical Education and forward to your medical school for completion of Section 2. **The medical school must send the following documents directly to the Board in an official school envelope:**
  - a. **Verification of Medical Education**
  - b. **Certified copy of Diploma**
  - c. **Transcript** – If the official transcript does not provide detailed information regarding the courses attended from which the applicant's eligibility is determined, the Board retains the right to request a copy of the medical school curriculum.

**NOTE:** If you attended more than one medical school, documents must be received directly from ALL schools. All documents must be in ENGLISH or an official translation must be submitted to the Board from an official translation agency or professor of the language.

3.	<p>Complete Section 1 of the Verification of ACGME Approved Graduate Medical Training form and send to the U.S./Canadian hospital(s) where you completed the required PGY 1, PGY 2 and PGY 3 postgraduate training.</p> <p>Section 2 should be completed by the training hospital(s). For applicants still in PGY 3, the program director <b><u>may not sign and date the form more than thirty (30) days prior to the completion of the approved training.</u></b> Forms postmarked or signed prior to the thirty days will not be accepted. The hospital(s) must return the completed form directly to the Board in an official hospital envelope.</p>
----	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

### EXAMINATIONS

Submit proof of obtaining a passing score on one of the following examinations acceptable to the Board by contacting the appropriate agency and request scores be sent **directly** to the Board:

FLEX	<ul style="list-style-type: none"> <li>• If taken after December 1984 – A score of 75 on each component.</li> <li>• If taken between June, 1968 and December 1984 – A score of 75 weighted average in an individual attempt. Contact the Federation of State Medical Boards of the United States, Inc.</li> </ul>
LMCC	Qualifying Examination LMCC taken in English language (If taken in or after May 1970) - Contact the Medical Council of Canada. <b>The scores must verify the language in which the examination was taken.</b> If the examination was not taken in English, but is otherwise acceptable, and a passing score was secured, the Board will accept the examination results if the applicant has also secured a passing score on the Test of English as a Foreign Language (TOEFL).
STATE BOARD	Must have been taken prior to December 1973.
USMLE	Must have secured a passing score on Steps 1, 2 and 3. <b>If USMLE Step 2 was taken on or after June 14, 2004, both the clinical skills and clinical knowledge results will be required.</b>
NBME	Must have secured a passing score on Parts I, II & III.

### ALL OTHER REQUIREMENTS

1.	If you completed an approved Fifth Pathway Program, submit a notarized copy of the Fifth Pathway Certificate.
2.	The Bureau of Professional and Occupational Affairs (BPOA), in conjunction with the Department of Human Services (DHS), is providing notice to all health-related licensees and funeral directors that are considered "mandatory reporters" under section 6311 of the Child Protective Services Law (CPSL) (23 P.S. § 6311), as amended, that EFFECTIVE JANUARY 1, 2015, all persons applying for issuance of an initial license shall be required to complete 3 hours of DHS-approved training in child abuse recognition and reporting requirements as a condition of licensure. Please review the Board website for further information on approved CE providers. Once you have completed a course, the approved provider will electronically submit your name, date of attendance, etc., to the Board. <a href="#">Child Abuse Continuing Education Providers Information can be found here.</a>
3.	Contact the state board office(s) where you hold or have ever held a license, certificate, permit, registration or other authorization to practice a profession or occupation and request letters of good standing. The letter must include the following: license issue and expiration date, license status (current or expired) and disciplinary standing. The letter(s) of good standing must be sent directly to the Board.
4.	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. <u>You should make a copy for your records.</u>
5.	Attach a current Curriculum Vitae listing <b>ALL</b> periods of employment or unemployment (i.e., child rearing, research, etc.) from graduation from medical school to present. The list must be in chronological order, include the month and year, and indicate the state/territory in which the employment occurred.

6.	<p>Applicants may also use the FCVS credentials verification service through the Federation of State Medical Boards to verify their ECFMG certification, medical education, post graduate training and examination scores. <b>The Board will accept FCVS if primary source verification is provided. However, you will need to meet <u>all Pennsylvania licensure requirements</u>.</b> Additional documents are required by the Board that are <b>NOT</b> included in the FCVS report but are listed in items #1-4 in the “All Other Requirements” section of the application instructions. It is the applicant’s responsibility to ensure that these additional documents are provided to the Board as outlined in the application instructions.</p>
----	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

### IMPORTANT INFORMATION

1.	<p><b>PLEASE ALLOW AT LEAST 30-60 DAYS FOR PROCESSING.</b></p>
2.	<p><b>PLEASE FOLLOW ALL DIRECTIONS. ANY DISCREPANCIES WILL CAUSE A DELAY IN THE ISSUANCE OF A LICENSE.</b></p>
3.	<p><b>IF THIS APPLICATION IS NOT COMPLETED WITHIN SIX MONTHS, <u>UPDATES OF CERTAIN SECTIONS AND/OR SUPPORTING DOCUMENTS WILL BE REQUIRED.</u></b></p>
4.	<p><b>IT IS YOUR RESPONSIBILITY TO MAINTAIN A COPY OF THIS APPLICATION AND ALL DOCUMENTS SUBMITTED TO THE BOARD OR RECEIVED FROM THE BOARD.</b></p>
5.	<p><b>YOU MAY NOT PRACTICE IN THE COMMONWEALTH OF PENNSYLVANIA UNTIL THE PENNSYLVANIA STATE BOARD OF MEDICINE HAS ISSUED A LICENSE.</b></p>
6.	<p><b>YOU MAY NOT PRACTICE IN THE COMMONWEALTH OF PENNSYLVANIA UNTIL YOU HAVE PURCHASED MEDICAL PROFESSIONAL LIABILITY COVERAGE.</b></p>
7.	<p><b>ALL LICENSES WILL EXPIRE DECEMBER 31<sup>ST</sup> OF AN EVEN-NUMBERED YEAR. THE EXPIRATION DATE IS NOT DETERMINED BY THE ISSUE DATE.</b></p>
8.	<p><b>THE FEE SUBMITTED WITH THIS APPLICATION IS A PROCESSING FEE. AT RENEWAL TIME, YOU WILL BE ASSESSED THE FULL RENEWAL FEE.</b></p>

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](mailto:st-medicine@pa.gov)

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

**APPLICATION FOR A LICENSE TO PRACTICE MEDICINE  
 WITHOUT RESTRICTION FOR GRADUATES OF UNACCREDITED  
 MEDICAL SCHOOLS (SCHOOLS OUTSIDE THE U.S. AND CANADA)**

Submit the \$85 fee, check or money order, made payable to the "Commonwealth of Pennsylvania." **FEES ARE NOT REFUNDABLE.** Note: A processing fee of \$20 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.

**TO BE COMPLETED BY APPLICANT  
 (Please print or type)**

<b>NAME:</b>	Last		First		Middle	
<b>ADDRESS:</b>	Street					
City			State		ZIP	
<b>DATE OF BIRTH:</b>	Month	Day	Year	<b>SOCIAL SECURITY NUMBER:</b>		
<b>EMAIL ADDRESS:</b>						
<b>PHONE NUMBER:</b>						
If your medical/licensure records are listed under another name or names, please list below: <hr/>						
<b>APPLYING USING FCVS (FEDERATION CREDENTIAL VERIFICATION SERVICE):</b>				<input type="checkbox"/> YES	<input type="checkbox"/> NO	
<b>HAVE YOU PREVIOUSLY HELD A PA MEDICAL TRAINING LICENSE?:</b>			<input type="checkbox"/> YES LICENSE NO. _____		<input type="checkbox"/> NO	

APPLICATION FOR UNRESTRICTED LICENSE - INTERNATIONAL													
<b>NAME OF APPLICANT:</b>	Last				First				Middle				
NAME & ADDRESS OF MEDICAL SCHOOL													
<b>1. NAME OF MEDICAL SCHOOL:</b>													
<b>ADDRESS OF SCHOOL:</b>													
<b>DATE OF ATTENDANCE:</b>	<b>FROM</b>	Month	Day	Year	<b>TO</b>	Month	Day	Year					
<b>2. NAME OF MEDICAL SCHOOL:</b>													
<b>ADDRESS OF SCHOOL:</b>													
<b>DATE OF ATTENDANCE:</b>	<b>FROM</b>	Month	Day	Year	<b>TO</b>	Month	Day	Year	<b>DATE OF GRADUATION</b>	Month	Day	Year	:
EXAMINATION INFORMATION													
<b>CHECK LICENSING EXAMINATION(S) PASSED:</b>	<input type="checkbox"/> <b>FLEX</b>		<b>STATE WHERE TAKEN</b> _____				<b>DATE TAKEN</b> <b>COMPONENT 1:</b> _____ <b>COMPONENT 2:</b> _____						
	<input type="checkbox"/> <b>NATIONAL BOARD</b>		<b>PART I:</b>			<b>PART II:</b>			<b>PART III:</b>				
	<input type="checkbox"/> <b>USMLE</b>		<b>STEP 1:</b>			<b>STEP 2:</b>			<b>STEP 3:</b>				
	<input type="checkbox"/> <b>LMCC – CANADIAN</b>												
	<input type="checkbox"/> <b>STATE BOARD</b>		<b>INDICATE STATE WHERE TAKEN:</b> _____										
ACGME POST GRADUATE TRAINING													
<b>PGY1 HOSPITAL:</b>					<u>FROM:</u> (MM/DD/YYYY)				<u>TO:</u> (MM/DD/YYYY)				
<b>PGY2 HOSPITAL:</b>					<u>FROM:</u> (MM/DD/YYYY)				<u>TO:</u> (MM/DD/YYYY)				
<b>PGY3 HOSPITAL:</b>					<u>FROM:</u> (MM/DD/YYYY)				<u>TO:</u> (MM/DD/YYYY)				

**IF YOU NEED TO LIST ADDITIONAL POST GRADUATE TRAINING, PLEASE MAKE COPIES OF THIS FORM.**

## 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 certified 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 a profession or occupation in any state or jurisdiction? <b>If you answered yes, provide the profession and state or jurisdiction.</b> <b>LIST:</b> _____		
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 been convicted (found guilty, pled guilty or pled nolo contendere), received probation without verdict or accelerated rehabilitative disposition (ARD), as to any criminal charges, felony or misdemeanor, including any drug law violations? Note: You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.		
6	Do you currently have any criminal charges pending and unresolved in any state or jurisdiction?		
7	Have you ever had practice privileges denied, revoked, suspended, or restricted by a hospital or any health care facility?		
8	Have you had your DEA registration denied, revoked or restricted?		
9	Have you had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority?		
10	Have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?		
11	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?		
12	Have you been the subject of a civil malpractice lawsuit? <b>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.</b> <b>**If you previously reported the complaint to the Board provide the docket number</b> _____		

## 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. Section 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

# VERIFICATION OF ACGME APPROVED GRADUATE MEDICAL TRAINING (Graduates of Unaccredited Medical Schools)

## SECTION 1 – TO BE COMPLETED BY APPLICANT

<b>NAME:</b>	Last	First	Middle
1.	If training began before July 1, 1987, one year of approved training at a first (PGY 1) or second (PGY 2) year level must be verified. If the training began on or after July 1, 1987, three (3) years of approved training are required, one at first (PGY 1) year level, one at second (PGY 2) year level and one at third (PGY3) year level.		
2.	Training at a first (PGY 1) year must be ACGME approved entry level (training which requires no previous training). Training at a second (PGY 2) year and third (PGY3) year must be ACGME approved and can be any specialty.		
3.	If training was completed at more than one hospital, duplicate this form and submit to each hospital.		

## SECTION 2 – TO BE COMPLETED BY PROGRAM DIRECTOR WHERE THE GRADUATE TRAINING OCCURRED

If training was completed in Pennsylvania, information must coincide with data on the graduate medical training license. For applicants still in the third year of training, this form may be completed and signed by the program director thirty (30) days prior to the completion of the approved training. Forms postmarked or signed prior to the thirty days will not be accepted.

<b>HOSPITAL WHERE TRAINING WAS COMPLETED:</b>											
<b>NAME OF SPONSORING INSTITUTION:</b>											
<b>LOCATED IN:</b>		CITY				STATE				<b>ACGME ACCREDITED</b>	
PGY LEVEL	FROM (MM/DD/YYYY)	TO (MM/DD/YYYY)	SPECIALTY			Yes	No				
PGY LEVEL	FROM (MM/DD/YYYY)	TO (MM/DD/YYYY)	SPECIALTY			Yes	No				
PGY LEVEL	FROM (MM/DD/YYYY)	TO (MM/DD/YYYY)	SPECIALTY			Yes	No				

"I certify that the above named applicant successfully completed/will successfully complete this graduate medical training and that there was/is no disciplinary action outstanding against this applicant. If this applicant does not complete this training, the Board will be notified." If there has been disciplinary OR administrative action regarding this applicant, please provide a separate statement outlining the details. If the hospital has no seal or stamp to affix to this document, I will have the form notarized to verify that it was completed by this hospital.

\_\_\_\_\_  
Signature of Program Director \_\_\_\_\_  
Date

(Seal)	_____ Notary Signature  Notary Commission Expiration Date: _____
--------	---------------------------------------------------------------------------

<b>Regular Mailing Address</b> STATE BOARD OF MEDICINE P.O. BOX 2649 HARRISBURG, PA 17105-2649 717-783-1400/717-787-2381	<b>Courier Delivery Address</b> STATE BOARD OF MEDICINE 2601 NORTH THIRD STREET HARRISBURG, PA 17110
--------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------

RETURN COMPLETED FORM DIRECTLY TO THE BOARD IN OFFICIAL HOSPITAL ENVELOPE

## PENNSYLVANIA STATE BOARD OF MEDICINE

**VERIFICATION OF MEDICAL EDUCATION  
(For Graduates of Unaccredited Medical Schools)**

## SECTION 1 – TO BE COMPLETED BY APPLICANT

<b>NAME:</b>	Last	First	Middle
--------------	------	-------	--------

<b>NAME OF MEDICAL SCHOOL:</b>	
--------------------------------	--

<b>LOCATION:</b>	
------------------	--

Submit the verification of medical education form to your medical school(s) and request the school(s) return the completed form, along with a certified copy of your diploma and transcripts, directly to the Board in an official school envelope.

## SECTION 2 – TO BE COMPLETED BY DEAN OR REGISTRAR OF MEDICAL SCHOOL

<b>NAME OF MEDICAL SCHOOL:</b>	
--------------------------------	--

<b>NAME OF MEDICAL STUDENT:</b>	Last	First	Middle
---------------------------------	------	-------	--------

<b>DATE STUDENT BEGAN TO ATTEND THIS MEDICAL SCHOOL:</b>	Month	Day	Year
----------------------------------------------------------	-------	-----	------

<b>TOTAL NUMBER OF ACADEMIC YEARS COMPLETED IN THIS MEDICAL SCHOOL:</b>	
-------------------------------------------------------------------------	--

<b>TOTAL NUMBER OF WEEKS OF ACADEMIC INSTRUCTION COMPLETED:</b>	
-----------------------------------------------------------------	--

<b>TOTAL NUMBER OF WEEKS OF CLINICAL INSTRUCTION COMPLETED:</b>	
-----------------------------------------------------------------	--

<b>DATE OF GRADUATION:</b>	Month	Day	Year
----------------------------	-------	-----	------

**I CERTIFY THAT ALL OF THE INFORMATION LISTED ABOVE IS CORRECT**

<b>SIGNATURE OF DEAN/REGISTRAR:</b>	
-------------------------------------	--

<b>DATE:</b>	Month	Day	Year
--------------	-------	-----	------

Upon completion, school must return this completed form and certified copies of the diploma and official transcript directly to the Pennsylvania State Board of Medicine in an official school envelope.

***DO NOT RETURN THIS FORM  
TO THE APPLICANT***

**Regular Mailing Address  
STATE BOARD OF MEDICINE  
P.O. BOX 2649  
HARRISBURG, PA 17105-2649  
717-783-1400/717-787-2381**

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