

**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 TEMPORARY LICENSE

**\*To Qualify for a Temporary License, You Must Hold an Active Medical License in Another Jurisdiction.**  
**If you hold an Osteopathic License, please use the application under the Osteopathic Board.**

### **CHECK THE CIRCUMSTANCE UNDER WHICH YOU ARE SEEKING A TEMPORARY LICENSE:**

- Teaching and demonstrating advanced medical and surgical techniques. Applicant must be sponsored by a medical training facility licensed or authorized to do business in this Commonwealth.
- Participating in a medical or surgical procedure necessary for the well being of a specified patient or patients. Applicant must be sponsored by a health care facility licensed or authorized to do business in this Commonwealth and must work in collaboration with a medical doctor holding a license without restriction in this Commonwealth.
- Practicing medicine and surgery in a camp or resort for no more than three months. Adequate arrangements must be made for back-up medical care if the physician is unable to continue to serve as a medical doctor for the camp or resort.
- Attending to the medical and surgical needs of a person or persons visiting the Commonwealth for a brief period of time.
- Serving as a short-term replacement of a doctor of medicine employed by the Federal Government in a National Health Service Corps Clinic, pursuant to the Project U.S.A. arrangements.
- Other:

### REQUIRED DOCUMENTS

1.	Submit a \$45.00 fee, check or money order, made payable to the "Commonwealth of Pennsylvania." <b>FEES ARE NOT REFUNDABLE.</b> 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.
2.	Arrange for the hospital, health care facility, employer or camp to complete page 3 of the application. <b>This form must contain an original signature.</b>
3.	Arrange for the collaborating or back-up physician to complete and submit page 4 of the application indicating in detail the acceptance of specific responsibilities. <b>This form must contain an original signature.</b>
4.	Submit a letter from an insurance company which verifies malpractice insurance coverage at this facility during the dates of practice in Pennsylvania. This letter must include the policy number. If self-insured, provide a statement to this effect.
5.	Contact the State Board where you are currently practicing and request a letter of good standing to be sent directly to the Board. This letter of good standing must be sent directly to the Pennsylvania Board.
6.	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.
7.	Provide an official notification of information (Self Query) from the National Practitioner Data Bank 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.
8.	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>

**IMPORTANT INFORMATION**

**Please allow 60 days for processing of this application.**

**You may not practice in the Commonwealth of Pennsylvania until the Pennsylvania State Board of Medicine has issued you a license.**

**Failure to provide sufficient information and supporting documents may result in a processing delay or the return of your application.**

**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.**

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**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 HEALTH CARE FACILITY, CAMP OR ORGANIZATION**

**NAME OF ORGANIZATION:**

**ADDRESS:** Street

City: State ZIP

**NAME AND ADDRESS OF BACK-UP PHYSICIAN, SUPERVISOR OR AGENCY HEAD**

**NAME:** Last First Middle

**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 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

## HOSPITAL, HEALTH CARE FACILITY, EMPLOYER OR CAMP VERIFICATION FORM

### PENNSYLVANIA HEALTH CARE FACILITY, CAMP OR ORGANIZATION

<b>NAME OF ORGANIZATION:</b>			
<b>ADDRESS:</b>	Street		
City:		State	ZIP
<b>NAME OF APPLICANT:</b>	Last	First	Middle
<b>DATES OF SERVICE FOR THE APPLICANT:</b>	<u>From:</u> Month/Day/Year		<u>To:</u> Month/Day/Year
<p><b>LIST IN DETAIL THE ANTICIPATED PRACTICE OF THE APPLICANT. THIS MUST INCLUDE THE TYPE OF PRACTICE AND FREQUENCY OF PRACTICE.</b></p>			
<b>PRINTED NAME:</b>			
<b>TITLE:</b>			
<b>SIGNATURE:</b>			
<b>DATE:</b>	Month	Day	Year

## COLLABORATING/BACK-UP PHYSICIAN FORM

<b>COLLABORATING/BACK-UP PHYSICIAN'S NAME:</b>	Last	First	Middle
<b>LICENSE NUMBER OF COLLABORATING/BACK-UP PHYSICIAN:</b>			
<b>NAME OF TEMPORARY LICENSE APPLICANT:</b>	Last	First	Middle
<b>DATES YOU WILL SERVE AS THE COLLABORATING/BACK-UP PHYSICIAN:</b>	<u>From:</u> Month/Day/Year		<u>To:</u> Month/Day/Year
<b>PENNSYLVANIA HEALTH CARE FACILITY, CAMP OR ORGANIZATION</b>			
<b>NAME OF ORGANIZATION:</b>			
<b>ADDRESS:</b>	Street		
City	State		ZIP
<p><b>I AGREE TO SERVE AS THE COLLABORATING/BACK-UP PHYSICIAN FOR THE ABOVE NAMED APPLICANT IN THE PERFORMANCE OF THE FOLLOWING LISTED DUTIES:</b></p>			
<b>SIGNATURE OF COLLABORATING/BACK-UP PHYSICIAN:</b>			
<b>DATE:</b>	Month:	Day:	Year: