

**Regular Mailing Address:**  
 State Board of Medicine  
 P.O. Box 2649  
 Harrisburg, PA 17105-2649  
 717-783-1400 OR 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  
[www.dos.pa.gov/med](http://www.dos.pa.gov/med)

## APPLICATION FOR VOLUNTARY SURRENDER OF LICENSE

*Please print or type.  
 Illegible applications will be returned.*

### FOR OFFICE USE ONLY

Legal Approval:  Yes  No Date: \_\_\_\_\_ File No: \_\_\_\_\_

Surrender As:  Disciplinary  Non-Disciplinary Reviewed By: \_\_\_\_\_

Comments:

FSMB Verification Completed Date: \_\_\_\_\_ Report Available:  Yes  No

Verified By: \_\_\_\_\_

### TO BE COMPLETED BY APPLICANT

Name: (Last, First, Middle) ▶

Address: ▶

*(This address will be on file with the PA State Board of Medicine and is public information.)*

Telephone Number: ▶

Phone:

Fax:

Date of Birth: ▶

Social Security Number: ▶

Pennsylvania Medical License Number: ▶

List ALL jurisdictions in which you hold or have ever held a license: ▶

Name of the medical school completed and the date you graduated: ▶

School:

Date:

Is your license in any other state or jurisdiction under pending investigation?

Yes  No If Yes, please attach written explanation.

Has your license in any other state or jurisdiction ever been disciplined?

Yes  No If Yes, please attach written explanation.

Have charges been filed against your license in any other state or jurisdiction?

Yes  No If Yes, please attach written explanation.

Have criminal charges been filed against you in any state or jurisdiction?

Yes  No If Yes, please attach written explanation.

Have you been convicted of a crime in any state or jurisdiction?

Yes  No If Yes, please attach written explanation.

Once this form is properly completed and approved, you will be notified of the date your license status will be changed to reflect this voluntary surrender status. Once surrendered, it may not be renewed, reissued, reinstated or restored. If you later decide to become licensed in the Commonwealth of Pennsylvania, you will be required to apply for a new license and will be subject to the requirements in effect at the time of application. This may include a written and/or oral examination.

**IF DISCIPLINARY ACTION HAS BEEN INITIATED, OR IF YOU ARE THE SUBJECT OF A DISCIPLINARY INVESTIGATION BY THE COMMONWEALTH OF PENNSYLVANIA OR ANOTHER LICENSING AUTHORITY, YOUR LICENSE WILL BE SURRENDERED AS “VOLUNTARY SURRENDER - DISCIPLINARY” AND WILL BE REPORTED AS SUCH TO THE NATIONAL PRACTITIONER DATA BANK/HEALTHCARE INTEGRITY AND PROTECTION DATA BANK**

**YOU ARE REQUIRED TO RETURN YOUR ORIGINAL WALL CERTIFICATE AND THE LAST ORIGINAL LICENSE ISSUED TO YOU BY THE BOARD.**

This request for a voluntary surrender of license **must be accompanied by your original wall certificate and the last original license issued to you by the Board.** If the wall certificate and/or last original license are no longer in your possession, provide below a brief explanation as to the reason the license is no longer in your possession.

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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. Section 4904 relating to unsworn falsification to authorities and may result in other sanctions or penalties. I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Pennsylvania State Board of Medicine any information, files or records requested by the Board.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Applicant