

STATE BOARD OF MEDICINE

REACTIVATION or STATUS CHANGE APPLICATION
PHYSICIAN AND SURGEON

Send to: STATE BOARD OF MEDICINE P.O. BOX 2649 HARRISBURG, PA 17105-2649 www.dos.pa.gov/med or STATE BOARD OF MEDICINE 2601 North Third Street Harrisburg, PA 17110	Full Name	Last	First	Middle
	Address			
	Address			
	Address	City	State	ZIP
	Email:			
	License No.		Telephone No.	
Name Change				
<p>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.).</p> <p>New Name (Please Print): _____</p>				

**LICENSES EXPIRE EVERY EVEN NUMBERED YEAR
REGARDLESS OF REINSTATEMENT DATE**

APPLICANTS MUST COMPLETE THE FOLLOWING:

1.	<p>Enclose a check or money order, in the amount of \$360.00, made payable to the "Commonwealth of Pennsylvania." If you have been practicing in Pennsylvania beyond the expiration date, include a late fee of \$5 per month or part of a month.</p> <p><u>FEES ARE NOT REFUNDABLE.</u> <u>Check or money order must be in "US funds."</u> 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.</p>
2.	Complete the legal questionnaire.
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, etc.).
4.	Complete the Verification of Practice / Non-Practice form.
5.	<u>AS APPLICABLE:</u> Attach a current Curriculum Vitae listing <u>all</u> 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. <u>The list must be in chronological order, including the month and year, and indicate the state/territory in which the employment occurred.</u>
6.	<u>AS APPLICABLE:</u> 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>
7.	<u>AS APPLICABLE:</u> Submit copies of your continuing medical education certificates/documentation. Continuing medical education requirements can be found at www.dos.pa.gov/med .
8.	<u>ALL HEALTH-RELATED LICENSEES:</u> Act 31 of 2014 requires that licensees complete at least 2 hours of Board-approved continuing education in child abuse recognition and reporting requirements. Details can be found at www.dos.pa.gov . For a list of Board-approved providers, choose the "Act 31 Mandated Child Abuse Reporter Training" link. <u>Verification of completion must be sent electronically directly from the course provider.</u> <u>Please note that it may take 7-10 days for the provider to submit the records to the Board office.</u>

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PLEASE NOTE: If this application is not completed within six months, updates of certain sections and/or supporting documents will be required.

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.**

PLEASE NOTE

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.

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 and B.
 - 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.
 - 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.
 - 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.**
 - 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 and B.
 - 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 and C.
 - 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.
 - 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.**
 - Submit copies of your continuing education certificates/documentation.
 - Act 31 of 2014 requires all licensees to complete 2 hours of Department of State approved continuing education in child abuse recognition and reporting requirements to reactivate a license.
 - Submit a \$360 check or money order made payable to the “Commonwealth of Pennsylvania.”
 - If practicing in Pennsylvania after the license expired, in addition to \$360, 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 and C.
 - 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.
 - Act 31 of 2014 requires all licensees to complete 2 hours of Department of State approved continuing education in child abuse recognition and reporting requirements to reactivate a license.
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SECTION A - LEGAL QUESTIONS

THE FOLLOWING LICENSE REACTIVATION QUESTIONS MUST BE ANSWERED. If you answer "YES" to #2 through #12, provide complete details on a separate sheet as well as copies of relevant documents. **Sign and date below.**

		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 or occupation 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 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.	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	Last	First	Middle
Social Security #	Date of Birth		
Name of University or School	Year of Graduation		Date
Signature (Mandatory)			Date

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