

<p style="text-align: center;"><u>Regular Mailing Address</u> STATE BOARD OF OSTEOPATHIC MEDICINE P.O. BOX 2649 HARRISBURG, PA 17105-2649 717-783-4858 Email: st-osteopathic@pa.gov</p>	<p style="text-align: center;"><u>Courier Delivery Address</u> STATE BOARD OF OSTEOPATHIC MEDICINE 2601 NORTH THIRD STREET HARRISBURG, PA 17110</p>
APPLICATION FOR AN OSTEOPATHIC UNRESTRICTED LICENSE	
<ul style="list-style-type: none"> • Applicants must have passed the <u>COMLEX Level 2-PE/Clinical Skills Examination</u> or have successfully completed an <u>Osteopathic Board Certification examination that included a practical OMT component</u> or have already successfully completed a <u>practical OMT examination as a requirement for another state license</u>. • Applicants who have not completed one of the OMT examinations listed above must take and pass the Osteopathic Manipulation Therapy Exam administered by Pearson VUE. Examination information is available at http://www.pearsonvue.com/pa/osteopathic-medicine. 	
APPLICANTS MUST COMPLETE THE FOLLOWING:	
1.	<p>Submit the \$45 fee, check or money order, made payable to the "Commonwealth of Pennsylvania." <u>FEES ARE NOT REFUNDABLE. Check or money order must be in U.S. funds.</u> 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.</p>
2.	<p>Complete pages 1 and 2 of the application.</p>
3.	<p>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.).</p>
<p><u>PLEASE NOTE:</u> 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.</p> <p>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.</p>	
MEDICAL EDUCATION AND TRAINING	
1.	<p>Complete Section 1 of the Verification of Medical Education and forward to your medical school for completion of Section 2. The school must return the completed verification <u>directly</u> to the Board.</p>
2.	<p>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. Child Abuse Continuing Education Providers Information can be found here.</p>
3.	<p>Complete Section 1 of the Verification of AOA approved internship form and forward it to the hospital where you completed your internship. This form cannot be submitted prior to the completion of the internship. The hospital must return the completed form <u>directly</u> to the Board.</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	Contact the Federation of State Medical Boards of the United States, Inc., at www.fsmb.org
NBOME/COMLEX	Contact the National Board of Osteopathic Medical Examiners, Inc., at www.nbome.org
STATE BOARD	Contact the state licensing board where the examination was taken.

USE OF FCVS

Applicants may also use the FCVS credentials verification service through the Federation of State Medical Boards to verify their medical education, AOA approved internship, and examination scores. **The Board will accept FCVS if primary source verification is provided. However, you will need to meet all Pennsylvania licensure requirements.** Additional documents are required by the Board that are **NOT** included in the FCVS report but are listed in items #1-3 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.

ALL OTHER REQUIREMENTS

1.	Contact the state board office(s) where you hold or have ever held a license, certificate, permit, registration or other authorization to practice any health-related 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.
2.	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>
3.	Attach a current Curriculum Vitae listing all 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.

APPLICANTS REQUESTING BOARD REVIEW OF AN AOA BOARD CERTIFICATION OR APPLICANTS REQUESTING BOARD REVIEW OF PASSING AN OMT EXAMINATION AS A REQUIREMENT FOR ANOTHER STATE LICENSE ARE REQUIRED TO:

	<p><u>Board Certification:</u></p> <p>1. Submit a copy of the AOA Board certificate with your application. Arrange for the certifying board to submit a letter confirming that you successfully completed the osteopathic board certification and that the specialty board certification examination administered to you included an OMT practical component. The letter must be sent <u>directly</u> to the Pennsylvania State Board of Osteopathic Medicine on official letterhead.</p>
	<p><u>Passing an OMT Examination as a requirement for another state license:</u></p> <p>2. Contact the state board office where you hold the unrestricted license to practice and request a letter certifying you successfully completed an Osteopathic Manipulative Treatment (OMT) practical examination as a requirement for licensure. The letter must be sent <u>directly</u> to the Pennsylvania State Board of Osteopathic Medicine on official letterhead.</p>

IMPORTANT INFORMATION

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

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TO BE COMPLETED BY APPLICANT

NAME:	Last	First	Middle
ADDRESS:	Street		
City	State		ZIP
DATE OF BIRTH:	Month	Day	Year
SOCIAL SECURITY NUMBER:			
EMAIL ADDRESS:			
PHONE NUMBER:			

If your medical/licensure records are listed under another name or names, please list below:

HAVE YOU PREVIOUSLY HELD A PA GRADUATE TRAINING LICENSE?

YES - LICENSE NO. _____

NO

NAME & ADDRESS OF MEDICAL SCHOOL

1. NAME OF MEDICAL SCHOOL:												
ADDRESS OF SCHOOL:												
DATE OF ATTENDANCE:	FROM	Month	Day	Year	TO	Month	Day	Year	DATE OF GRADUATION:	Month	Day	Year
2. NAME OF MEDICAL SCHOOL:												
ADDRESS OF SCHOOL:												
DATE OF ATTENDANCE:	FROM	Month	Day	Year	TO	Month	Day	Year	DATE OF GRADUATION:	Month	Day	Year

EXAMINATION INFORMATION

CHECK LICENSING EXAMINATION(S) PASSED:	<input type="checkbox"/> FLEX	<input type="checkbox"/> NBOME / COMLEX	
	<input type="checkbox"/> STATE BOARD	INDICATE STATE WHERE TAKEN: _____	

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 a 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 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

PENNSYLVANIA STATE BOARD OF OSTEOPATHIC MEDICINE

VERIFICATION OF MEDICAL EDUCATION

SECTION 1 – TO BE COMPLETED BY APPLICANT

NAME:	Last	First	Middle
NAME OF MEDICAL SCHOOL:			
LOCATION:			

Submit the verification of medical education form to your medical school and request the school return the completed form directly to the Board.

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

NAME OF MEDICAL SCHOOL:			
NAME OF MEDICAL STUDENT:	Last	First	Middle
DATE STUDENT BEGAN TO ATTEND THIS MEDICAL SCHOOL:	Month	Day	Year
DATE OF GRADUATION:	Month	Day	Year

I CERTIFY THAT ALL OF THE INFORMATION LISTED ABOVE IS CORRECT

SIGNATURE OF DEAN/REGISTRAR:			
DATE:	Month	Day	Year
(Seal of School)	<p>Upon completion, school must return this completed form directly to the PA State Board of Osteopathic Medicine.</p> <p><i>DO NOT RETURN THIS FORM TO THE APPLICANT</i></p>		

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PENNSYLVANIA STATE BOARD OF OSTEOPATHIC MEDICINE

VERIFICATION OF AOA APPROVED INTERNSHIP

SECTION 1 – TO BE COMPLETED BY APPLICANT

NAME:	Last	First	Middle

SECTION 2 – TO BE COMPLETED BY PROGRAM DIRECTOR WHERE THE INTERNSHIP OCCURRED

If internship was in Pennsylvania, information must coincide with data on graduate license. This form may NOT be submitted prior to completion of the internship.

HOSPITAL WHERE TRAINING WAS COMPLETED: _____

NAME OF SPONSORING INSTITUTION: _____

LOCATED IN:	CITY	STATE

INTERNSHIP COMPLETED:	FROM (MM/DD/YYYY)	TO (MM/DD/YYYY)

"I certify that the above named applicant successfully completed this AOA approved internship and that there was/is no disciplinary or administrative action outstanding against this applicant. If there has been disciplinary action regarding this applicant, I will 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: _____

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RETURN COMPLETED FORM DIRECTLY TO THE BOARD