Regular Mailing Address **STATE BOARD OF OSTEOPATHIC MEDICINE** **P.O. BOX 2649** **HARRISBURG, PA 17105-2649**	**Email:** st-osteopathic@pa.gov

APPLICATION FOR AN OSTEOPATHIC SHORT-TERM LICENSE FOR PHYSICIANS NOT LICENSED IN PENNSYLVANIA

- **This application is to be used only by osteopathic physicians and surgeons seeking short-term licensure in the Commonwealth of Pennsylvania to aid in the Commonwealth's emergency declaration related to COVID-19.**
- **This application should not be completed if you are only requesting to perform telemedicine services. This application is to be utilized if you will be physically practicing in Pennsylvania. If you wish to perform telemedicine services, please follow the guidance listed at: https://www.dos.pa.gov/Documents/2020-03-18-Telemedicine-Summary.pdf.**
- **To qualify for a short-term license, you must hold an active osteopathic physician and surgeon license in good standing in another state or Canadian jurisdiction.**
- **If you previously held a Pennsylvania license and are seeking to reactivate the license due to the emergency declaration, do not submit this application. Please complete and submit the reactivation application found online at: https://www.dos.pa.gov/ProfessionalLicensing/BoardsCommissions/OsteopathicMedicine/Pages/Reactivation-and-Status-Change-Applications.aspx**

REQUIRED DOCUMENTS

1.	Complete pages 1 and 2 of the application.
2.	Include a copy of a verification of licensure from the website of your home licensure state.
3.	Scan and email the application to st-osteopathic@pa.gov. The subject line of the email should be listed as "Emergency Short-Term License"
4.	Upon completion of your application, a short-term license will be issued with an expiration date of **October 31, 2020.** This short-term license is non-renewable. If you wish to practice after the declared state of emergency, you will need to obtain full licensure by meeting all standard licensing requirements. You can determine if you meet the Board's requirements by reviewing the Board's Rules and Regulations posted on our website at www.dos.pa.gov/ost. You can also review the application instructions at www.pals.pa.gov by clicking on "Application Checklist"

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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 LICENSE BEING USED TO APPLY FOR A PENNSYLVANIA SHORT-TERM LICENSE:							

NAME AND ADDRESS OF PENNSYLVANIA PRACTICE LOCATION

NAME OF ORGANIZATION:			
ADDRESS:	Street		
City:	State	Zip	

LEGAL QUESTIONS

You must answer the following questions. If you answer "YES" to #2 through #10, 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 in any health-related profession 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 ever had practice privileges denied, revoked, suspended, or restricted by a hospital or any health care facility?		
6.	Have you had your DEA registration denied, revoked or restricted?		
7.	Have you had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority?		
8.	Have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?		
9.	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?		
10.	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.

I certify that I will comply with the malpractice insurance requirements of the Health Care Services Malpractice Act (40 P. S. § §1301.101—1301.1006) and regulations thereunder.

_____ _____
Signature of Applicant Date

_____
Printed Name of Applicant

ACKNOWLEDGEMENT OF DUTY TO SELF-REPORT DISCIPLINARY CONDUCT AND CERTAIN CRIMINAL ACTIVITY (MANDATORY – SIGNATURE REQUIRED)

I, _____, hereby acknowledge that in addition to any existing reporting requirement required by a specific board or commission, I am REQUIRED pursuant to Act 6 of 2018 to NOTIFY the Bureau of Professional and Occupational Affairs WITHIN 30 DAYS of the occurrence of any of the following: (1) A disciplinary action taken against me by a licensing board or agency in another jurisdiction; (2) A finding or verdict of guilt, an admission of guilt, a plea of nolo contendere, probation without verdict, a disposition in lieu of trial or an Accelerated Rehabilitative Disposition (ARD) of any felony or misdemeanor offense in a criminal proceeding. I further acknowledge that failure to comply with these mandatory reporting requirements may subject me to disciplinary action by the Board. I acknowledge my understanding that to self-report a disciplinary action or criminal matter as set forth above, I may log in to the Pennsylvania Licensing System (PALS) at www.pals.pa.gov and select “Mandatory Reporting by Licensee” under the heading “Your Licenses.”

_____ _____
Signature of Applicant Date