Government of the District of Columbia
Department of Health
Health Regulation and Licensing Administration

BOARD OF MEDICINE
RENEWAL APPLICATION FOR MEDICINE & OSTEOPATHY (MD & DO)

MEDICINE RENEWAL BEGINS ON OCTOBER 1, 2012. LICENSES EXPIRE DECEMBER 31, 2012

NEW REQUIREMENT: STATE & FBI CRIMINAL BACKGROUND CHECKS (CBC) ARE REQUIRED FOR LICENSURE RENEWAL.

For information on obtaining your CBC, please go to http://www.L1enrollment .com or call 1-877-783-4187 for scheduling.

GENERAL INSTRUCTIONS: Complete all sections of this application in its entirety. Renewal applications submitted after December 31, 2012 will be required to pay an $85.00 late fee. If you are unable to renew your license by December 31, 2012 or within the 60-day grace period (Jan – Feb 28, 2013), you will then be required to apply for reinstatement of your license.

If you are in violation with the Board you will not be permitted to renew until the matter is resolved. You should contact the processing center at 1-877-672-2174.

SECTION 1A. APPLICANT INFORMATION

Note: LEGAL NAME: ***(Do not use any initials unless they are a part of your name)***

_____ _____ _____ _____
FIRST NAME **MI** **LAST NAME** **(SUFFIX: Jr., Sr. etc.)**

___/___/___ _____ _____ _____ - _____ - _____
Date of Birth **Place of Birth : State/Providence/Territory** **Country if not USA** **Social Security Number**

TITLE: ☐ **MD** ☐ **DO** **LICENSE NUMBER**_____ **GENDER:** ☐ **MALE** ☐ **FEMALE**

ARE YOU APPLYING FOR A CONTROLLED SUBSTANCE REGISTRATION? ☐ **YES** ☐ **NO**

TO RENEW YOUR CONTROLLED SUBSTANCE REGISTRATION PLEASE CONTACT THE PHARMACEUTICAL CONTROL DIVISION. GO TO WWW.DOH.DC.GOV/BOP FOR MORE INFO

SECTION 2A. OTHER NAMES USED: (Please print clearly)

If your name has changed at any point since your last renewal cycle, you must provide a copy of a legal name change documents for EACH time that it has changed. Acceptable documents for individuals are marriage certificates, divorce decrees, or court orders.

_____ _____ _____ _____
FIRST NAME **MI** **LAST NAME** **(SUFFIX: Jr., Sr. etc.)**

_____ _____ _____ _____
FIRST NAME **MI** **LAST NAME** **(SUFFIX: Jr., Sr. etc.)**

SECTION 3A. PREFERRED MAILING ADDRESS

Note: A P.O. BOX MAY NOT BE USED FOR AN ADDRESS. PLEASE PROVIDE A STREET ADDRESS.

Indicate your preferred mailing address by placing an "X" in the appropriate box. This will be the address to which all future licensing documents will be mailed.

☐ **HOME ADDRESS** ☐ **PRIMARY PRACTICE/BUSINESS ADDRESS**

SECTION 3B. HOME ADDRESS

THIS INFORMATION WILL NOT BE MADE AVAILABLE TO THE PUBLIC.

HOME ADDRESS:_____
(Street Number and Street Name) (City) (State/Province/Territory) (Zip Code)

APARTMENT #_____ **HOME PHONE NUMBER: (**_____**)** _____ **-** _____ **HOME FAX: (**_____**)** _____ **-** _____

EMAIL ADDRESS: _____ **(REQUIRED)** **CELL PHONE: (**____**)**_____**-**_____

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SECTION 3C. PRIMARY PRACTICE/ BUSINESS ADDRESS:

THIS INFORMATION WILL BE MADE AVAILABLE TO THE PUBLIC.

BUSINESS NAME:_____

BUSINESS ADDRESS:_____
(Street Number and Street Name) (City) (State/Province/Territory) (Zip Code)

SUITE #_____

BUSINESS PHONE NUMBER: (_____) _____ - _____ **BUSINESS FAX: (_____) _____ - _____**

EMAIL ADDRESS: _____

SECTION 4A. LICENSE RENEWAL AND FEES

Please check the appropriate boxes to indicate other requests you would like to be processed with your license renewal and then total the fee column. This form will be returned if the fee is not included or if the fee is less than required. Make your check or money order payable to "DC Treasurer" CASH PAYMENTS ARE NOT ACCEPTED.

A. Renewal License Type:

☐ **MD/DO Renewal** **= $500.00**

☐ **Paid Inactive Status Request** **= $500.00**

B. ☐ **Cancel License (No Fee)** **$0.00** **= $_____**

C. ☐ **Late Fee** **$85.00** **= $_____**
(if postmarked after December 31, 2012)

D. ☐ **Duplicate License Request** **QTY: _____ x $34.00 = $_____**

TOTAL FEE DUE **= $_____**

L1 /Morpho Trust - Criminal Background Check (CBC) = $50 (prices vary)
http://www.L1enrollment .com

Make check or money order payable to DC TREASURER.

Mail to:

Department of Health Professional Licensing Administration
Board of Medicine – Renewals
899 North Capitol Street NE, 1st Floor
Washington, D.C. 20002

A Charge of $65.00 will be imposed for dishonored checks (Public Law 89-208)

SECTION 5A. PRACTICE INFORMATION

Please provide practice information

(1.A) Do you plan to practice in the District of Columbia? ☐ Yes ☐ No

(1.B) Are you engaged in? ☐ Academic ☐ Administrative ☐ Clinical ☐ Preventive ☐ Research
(check all that apply)

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(1.C) Please indicate the average number of hours spent per week on these activities:

☐Academic Educational Medicine	☐Administrative Medicine	☐Clinical/Patient Care	☐Preventive Medicine & Public Health	☐Research Medicine
○ 0 hours ○ <20 hours ○ >=20 hours	○ 0 hours ○ <20 hours ○ >=20 hours	○ 0 hours ○ <20 hours ○ >=20 hours	○ 0 hours ○ <20 hours ○ >=20 hours	○ 0 hours ○ <20 hours ○ >=20 hours
Are greater than 50% of these hours spent in DC?	Are greater than 50% of these hours spent in DC?	Are greater than 50% of these hours spent in DC?	Are greater than 50% of these hours spent in DC?	Are greater than 50% of these hours spent in DC?
☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No

(2) Please indicate if you do or will practice in: ☐ Maryland ☐ Virginia

SECTION 5B. SPECIALTIES

- ☐ **AC Academic Medicine**
- ☐ **ADM Administrative Medicine**
- ☐ **AI Allergy & Immunology**
- ☐ **AN Anesthesiology**
- ☐ **DE Dermatology**
- ☐ **EM Emergency Medicine**
- ☐ **FM Family Medicine**
- ☐ **GE Geriatrics**
- ☐ **IM Internal Medicine (General)**
- ☐ **IM Internal Medicine (Specialized):**
  - ○ **IN/CA Cardiology**
  - ○ **IN/CC Critical Care**
  - ○ **IN/EN Endocrinology**
  - ○ **IN/GI Gastroenterology**
  - ○ **IN/HEM Hematology**
  - ○ **IN/ID Infectious Disease**
  - ○ **IN/NEP Nephrology**
  - ○ **IN/NEU Neurology**
  - ○ **IN/ONC Oncology**
  - ○ **IN/PC Palliative Care**
  - ○ **IN/PCC Pulmonary Critical Care**
  - ○ **IN/PUD Pulmonary Disease**
  - ○ **IN/RH Rheumatology**
- ☐ **MG Medicine Genetics**
- ☐ **NU Nuclear Medicine**
- ☐ **OC Occupational Health**
- ☐ **OB Obstetrics & Gynecology**
- ☐ **OP Ophthalmology**
- ☐ **OMT Osteopathic Manipulative Treatment**
- ☐ **ENT Otolaryngology**
- ☐ **PA Pathology**
- ☐ **PED Pediatrics (General)**
- ☐ **PED Pediatrics (Specialized)**
  - ○ **PED/AD Adolescent Medicine**
  - ○ **PED/CA Cardiology**
  - ○ **PED/CC Critical Care**
  - ○ **PED/EN Endocrinology**
  - ○ **PED/GI Gastroenterology**
  - ○ **PED/HEM Hematology**
  - ○ **PED/ID Infectious Disease**
  - ○ **PED/NEO Neonatology**
  - ○ **PED/NEP Nephrology**
  - ○ **PED/NEU Neurology**
  - ○ **PED/ONC Oncology**
  - ○ **PED/PC Palliative Care**
  - ○ **PED/PCC Pulmonary Critical Care**
  - ○ **PED/PUD Pulmonary Disease**
  - ○ **PED/RH Rheumatology**
- ☐ **PMR Physical Medicine & Rehabilitation**
- ☐ **PR Preventive Medicine/Public Health**
- ☐ **PSY Psychiatry**
- ☐ **RA Radiology**
- ☐ **REM Research Medicine**
- ☐ **SU/GE Surgery (General)**
- ☐ **Surgery(Specialized)**
  - ○ **SU/BT Burn/Trauma**
  - ○ **SU/CS Cardiac Surgery**
  - ○ **SU/CO Colon & Rectal Surgery**
  - ○ **SU/NE Neurological Surgery**
  - ○ **SU/OR Orthopedic Surgery**
  - ○ **SU/PL Plastic Surgery**
  - ○ **SU/TH Thoracic Surgery**
  - ○ **SU/TP Transplant**
  - ○ **SU/UR Urology**
  - ○ **SU/VA Vascular**
- ☐ **Other:____________**

SECTION 5C. BOARD CERTIFICATION(S)

Are you board certified in any specialty? ☐ *Yes* ☐ *No* ***(If yes please list in the provided space below)***

Please list certifying organization(s)

________________________ ________________________ ________________________

________________________ ________________________ ________________________

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SECTION 6A. CONTINUING MEDICAL EDUCATION (CME)

Please answer questions 1-3 by placing an X in the appropriate boxes. Please note, continuing medical education credits should have been completed between 2011- 2012.

1. **I have completed the required 50 CME's since January 1, 2011.** Yes☐ No☐

2. **If no, I am exempt from the CME requirement because I have one of the following approved exemptions:**
   [supporting documentation is required with any exemption with and asterisks (*)]

   ☐ **Disability;***

   ☐ **Deployed in Armed Services;***

   ☐ **Serving in Congress***

   ☐ **I am exempt because this is my first renewal after initial licensure**

   ☐ **I am exempt because I was enrolled in a training program for my profession over the past two years (2011-2012).**

3. ☐ **Other (None of the above exemptions apply).**

Please Note: Beginning in 2014, three (3) of your CME course hours must be completed in HIV/AIDS Education.

SECTION 6B. REQUIRED SCREENING QUESTIONS

Please answer questions 1 through 14 by placing an X in the appropriate boxes. If you answer "YES" to any question, you must provide full information and complete details **on a separate sheet of paper, attaching copies of all relevant documents such as final court orders or panel review decisions.**

1.	Have you ever been arrested, convicted, pled guilty to, or pled no contest to the violation of any federal, state or other statute or ordinance constituting a felony or misdemeanor (including driving under the influence or while impaired, but excluding minor traffic violations)?	Yes ☐ No ☐
2.	Since your last renewal, have you been licensed in any healthcare field (other than your current profession) in any state or jurisdiction? If yes, please list profession(s) & jurisdiction(s). **HEALTH PROFESSION(S)** _____ **JURISDICTION(S)** _____	Yes ☐ No ☐
3.	Since your last renewal, have you been a defendant or respondent to a claim for damages or a malpractice action? ***[If yes, please complete enclosed malpractice explanation form for each claim and submit with your application]***	Yes ☐ No ☐
4.	Since your last renewal, have you voluntarily surrendered a license or registration certificate (or allowed it to lapse) after formal charges had been brought against you or while you were under investigation?	Yes ☐ No ☐
5.	Since your last renewal, have you surrendered your clinical privileges (voluntary or involuntary) or had your clinical privileges denied, revoked, or suspended at any hospital or health care facility?	Yes ☐ No ☐
6.	Since your last renewal, have you been terminated or resigned (voluntary or involuntary) from a clinical or professional training program for any reason?	Yes ☐ No ☐
7.	Since your last renewal, has any licensing authority, health facility, or peer review board taken adverse action against your license or privileges, or informed you of any pending charge(s) or investigation(s) against you?	Yes ☐ No ☐
8.	Since your last renewal, are you presently or have you ever been under a corrective action plan imposed by an employer, medical facility or educational program?	Yes ☐ No ☐
9.	Do you have a medical condition or have you become aware of any medical condition that currently impairs or limits your ability to practice medicine safely or that could affect your performance or impact your ability to practice your profession?	Yes ☐ No ☐
10.	Are you currently being treated, or within the past five (5) years have you been treated, for a physical or mental condition that, but for the treatment, could impair your ability to practice your profession?	Yes ☐ No ☐

11.	Have you ever engaged in the excessive use of alcohol, controlled substances or prescription drugs or have you received treatment or therapy for abuse of alcohol or drugs?	Yes ☐ No ☐
12.	Within the last ten (10) years, have you voluntarily resigned, asked to resign, been terminated, or disciplined by any employer due to practice or moral turpitude issues?	Yes ☐ No ☐
13.	Have you ever withdrawn a license application or have you been denied a license or denied the privilege of taking a license examination by any professional licensing board or agency?	Yes ☐ No ☐
14.	Have you ever had a professional liability policy cancelled or not renewed?	Yes ☐ No ☐

SECTION 7A. CLEAN HANDS & AFFIRMATION – Applicants MUST answer all of the following questions.

Clean Hands Before Receiving a License or Permit Act of 1996 Certification Form Requirement

Please read the information below carefully before responding to this yes or no question, as **any false information provided requires that the Department of Health proceed immediately to revoke your License or Permit** for which you are now applying, and fine you one thousand dollars ($1,000.00), pursuant to D.C. Official Code § 47-2864 (2001).

IF YOU ANSWER "YES" TO THIS QUESTION, PLEASE SUBMIT PROOF OF THE ARRANGEMENTS YOU HAVE MADE TO PAY THE OUTSTANDING DEBT. IF YOU DO NOT HAVE AN APPROVED PAYMENT SCHEDULE TO PAY THE AMOUNT YOU OWE OR IF NO APPEAL IS PENDING, THE LAW REQUIRES THAT YOUR RENEWAL LICENSE APPLICATION BE DENIED.

As of this date, do you owe more than one hundred dollars ($100.00) to the District of Columbia Government as a result of any of the following:

- Fines, penalties, or interest assessed pursuant to ***D.C. Official Code Title 8, Chapter 8*** (Litter Control Administrative Act of 1985);
- Fines or interest assessed pursuant to ***D.C. Official Code Title 8, Chapter 9*** (Illegal Dumping Enforcement Act of 1994);
- Fines, penalties, or interest assessed pursuant to ***D.C. Official Code Title 2, Chapter 18*** (Civil Infractions Act of 1985);
- Past due taxes;
- Past due District of Columbia Water and Sewer Authority service fees; or
- Fines or penalties assessed pursuant to ***D.C. Official Code Title 50, Chapter 23*** (Traffic Adjudication)

Yes ☐ **No** ☐

The information presented above is in compliance with the requirement to submit with your application for licensure or permit under the *Clean Hands Before Receiving a License or Permit Act of 1996*, effective May 11, 1996 (***D.C. Law 11-118, D.C. Code §47-2861 et seq***.).

SECTION 7B. AFFIRMATION

I hereby affirm under the penalties of perjury that all of the information provided in this application, including all exhibits supporting this application is true and complete to the best of my personal knowledge.

_____ _____ _____

LICENSEE SIGNATURE ***PRINT NAME*** ***DATE***