DESIGNATION OF CONTACT PERSON FOR ACCESS TO MEDICAL RECORDS

Please list the primary and alternate contact person for access to medical records. *This information is considered public information.*

Primary Contact: _____ Telephone: _____

Address: _____
Street Address (including Apt/Unit/Ste #) and/or PO Box *City* *State* *Zip*

Alternate Contact: _____ Telephone: _____

Address: _____
Street Address (including Apt/Unit/Ste #) and/or PO Box *City* *State* *Zip*

***Note**: If a hospital, clinic or other facility is the owner of your patient's medical records, the facility's records department may be listed as the primary contact, but you must still list a second contact.*

Please identify the method of notifying patients of location of records: (check all that apply):

☐ Phone ☐ Mail ☐ In Person ☐ Other: _____

AFFIDAVIT OF UTAH RESIDENCY (OPTIONAL)

This section is only required for applicants who are requesting licensure prior to completing 24 months of progressive resident training.

If you have not completed 24 months of post graduate training, you must have completed 12 months in an approved ACGME program and be currently enrolled in a progressive resident training program in Utah. Please list the program you are participating in:

Name of Hospital: _____ Date Began: _____

I certify that I have successfully completed 12 months of resident training in an ACGME approved program after receiving a degree of doctor of medicine. I am successfully participating in the ACGME progressive residency program listed above, and have no disciplinary action. I agree to surrender my license to DOPL without any proceedings under the Administrative Procedures Act and DOPL will automatically revoke my license as a physician and surgeon if I fail to continue in good standing in the program identified.

Signature of Applicant: _____ Date: _____

TEMPORARY LICENSE (OPTIONAL)

If you are applying for licensure by endorsement, you may also request an *optional* temporary license. To qualify, you must complete this section and submit all the items found on the checklist at the end of this application.

Employing Facility: _____ Expected Start Date: _____

Address: _____
Street Address (including Apt/Unit/Ste #) and/or PO Box *City* *State* *Zip*

Please check one:

☐ I am applying for a Temporary Physician and Surgeon License
☐ I am applying for a Temporary Physician and Surgeon and a Temporary Controlled Substance License.

I certify that I meet all the qualifications for licensure outlined in U.C.A. 58-67-302 (2) and (3). I understand that I may not practice in Utah until I have been granted a temporary license. I also understand that a temporary license is non-renewalable and it is my responsibility to ensure that all required documents to complete my full licensure process are submitted in a timely manner.

Signature of Applicant: _____ Date: _____