UTAH DEPARTMENT OF COMMERCE
Division of Occupational and Professional Licensing

Osteopathic Physician and Surgeon

APPLICANT INFORMATION

Full Legal Name: _____
First *Middle* *Last*

All Previous Legal Names: _____

Other DOPL Licenses Held: _____

SSN: _____ **Date of Birth:** _____ **Gender:** ☐ Male ☐ Female

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

_____
City *State* *ZIP Code*

Phone: _____ **Email:** _____

Please Select ONE:

- ☐ I am a United States citizen OR a non-citizen of the United States who is lawfully present.
- ☐ I am a foreign national not physically present in the United States.
- ☐ None of the above, please explain: _____

Driver License or State ID Card _____
State of Issue *License Number* *Expiration Date*

NOTE: If you do not hold a US Driver License or a US State ID, you must present a legible copy of your current and valid government issued document(s) showing evidence of lawful presence in the United States.

AFFIDAVIT AND RELEASE

1. I certify that I am qualified in all respects for the license for which I am applying in this application.
2. I certify that to the best of my knowledge, the information contained in the application and all supporting document(s) are true and correct, discloses all material facts regarding the applicant, and that I will update or correct the application as necessary, prior to any action on my application.
3. I authorize all persons, organizations, governmental agencies, or any others not specifically listed, which are set forth directly or by reference in this application, to release to the Division of Occupational and Professional Licensing, State of Utah, any files, records, or information of any type reasonably required for the Division to properly evaluate my qualifications for licensure/certification/registration by the State of Utah.
4. I understand that it is the continuing responsibility of applicants and licensees to read, understand, and apply the requirements contained in all statutes and rules pertaining to the occupation or profession for which I am applying, and that failure to do so may result in civil, administrative, or criminal sanctions.
5. I certify that I do not currently pose a direct threat to myself, to my clients, or to the public health, safety or welfare because of any circumstance or condition.
6. I understand that I am responsible to update the Division of any changes relating to my license/certification/registration.

Signature of Applicant: _____ Date: _____

QUALIFYING QUESTIONNAIRE

Do not leave any question blank.

DOPL may request additional documentation if the information submitted is insufficient.

1.	☐ Yes ☐ No	Have you EVER had a license, certificate, permit, or registration to practice a regulated profession denied, conditioned, curtailed, limited, restricted, suspended, revoked, reprimanded, resigned, or surrendered while under investigation, or otherwise **disciplined in any way**?
2.	☐ Yes ☐ No	Do you CURRENTLY have **any criminal action active or pending**?
3.	☐ Yes ☐ No	WITHIN THE PAST 10 YEARS, have you pled **guilty** to, **no contest** to, entered into a **plea in abeyance,** or been **convicted** of **a misdemeanor** in any jurisdiction?
4.	☐ Yes ☐ No	Have you EVER pled **guilty** to, **no contest** to, entered into a **plea in abeyance**, or been **convicted** of a **felony** in any jurisdiction?

If you answered "Yes" to any of the above questions, enclose with this application complete information with respect to all circumstances and the final result, if such has been reached. If you answered "Yes" to questions 2, 3, or 4 you must submit the following for EACH and EVERY incident:

- personal account of the incident
- police report(s)
- court record(s)
- probation/parole officer report(s)

If you are unable to obtain any of the records required above, you must submit documentation on official letterhead from the police department and/or court indicating that the information is no longer available.

NOTE:

- **DISCLOSE** charges that were later held in abeyance, diverted, reduced, or dismissed.
- **DISCLOSE** motor vehicle offenses such as driving while impaired or intoxicated. But you do not need to disclose minor traffic offenses such as parking or speeding violations.
- You do **not need to disclose** juvenile offenses, unless you were tried as an adult.
- **DISCLOSE** if you are restricted from possession, purchase, transfer, or ownership of a firearm or ammunition (even if your restriction is based on a non-reportable juvenile conviction).
- You do **not need to disclose** legally expunged or sealed criminal history incidents.

For more information, see DOPL's criminal history FAQs.

PROFESSIONAL LICENSES

List all other licenses, registrations or certification issued by any state which you now hold or have ever held in any profession. *(Use additional sheets if necessary.)*

Profession: _____ **License Number:** _____

Issuing State: _____ **License Status:** _____ **Issue Date:** _____

Profession: _____ **License Number:** _____

Issuing State: _____ **License Status:** _____ **Issue Date:** _____

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MEDICAL QUALIFYING QUESTIONNAIRE

Read thoroughly, and answer each question. Do not leave any question blank.

A "yes" answer does not necessarily mean you will not be granted a license; however, DOPL may request additional documentation if the information submitted is insufficient.

1. Have your rights, privileges, and/or participation ever been denied, conditioned, curtailed, limited, restricted, suspended or revoked in any way by:

☐ Yes ☐ No a hospital or health care facility

☐ Yes ☐ No Medicaid, Medicare or any other state or federal health care payment reimbursement program

☐ Yes ☐ No the Federal Drug Enforcement Administration or any state drug enforcement agency

☐ Yes ☐ No malpractice insurance coverage

☐ Yes ☐ No other entity: _____

2. Have you ever been permitted to resign or surrender any rights, privileges and/or participation while under investigation or while action was pending against you from:

☐ Yes ☐ No a hospital or health care facility

☐ Yes ☐ No Medicaid, Medicare or any other state or federal health care payment reimbursement program

☐ Yes ☐ No the Federal Drug Enforcement Administration or any state drug enforcement agency

☐ Yes ☐ No malpractice insurance coverage

☐ Yes ☐ No other entity: _____

3. Is any action pending against you now by:

☐ Yes ☐ No a hospital or health care facility

☐ Yes ☐ No Medicaid, Medicare or any other state or federal health care payment reimbursement program

☐ Yes ☐ No the Federal Drug Enforcement Administration or any state drug enforcement agency

☐ Yes ☐ No malpractice insurance coverage

☐ Yes ☐ No other entity: _____

4. ☐ Yes ☐ No Have you been named as a defendant in a malpractice suit?

5. ☐ Yes ☐ No Have you ever had office monitoring, practice curtailments, individual surcharge assessments based upon specific claims history, or other limitation, restrictions or conditions imposed by any malpractice carrier?

If you answered **"Yes"** to any of the above questions, enclose with this application complete information with respect to all circumstances and the final result, if such has been reached.

UTAH CONTROLLED SUBSTANCE AFFIDAVIT

If you are applying for a controlled substance license, you must read and sign the affidavit below.

1. I have reviewed and understand that I must abide by the additional laws and rules that govern the practice of my profession as it pertains to controlled substances.

2. I understand that there may be additional continuing education requirements for those who hold a controlled substance license.

3. I understand it is required that I hold a valid Federal Drug Enforcement Administration (DEA) registration.

Signature of Applicant: _____ Date: _____

Note: *In addition to signing this affidavit, you must complete the items listed on the OPTIONAL CONTROLLED SUBSTANCE LICENSE checklist at the end of this application.*

DESIGNATION OF CONTACT PERSON FOR ACCESS TO MEDICAL RECORDS

You must provide both a 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. All applicants must still list a second, unique contact.*

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

☐ Phone ☐ Mail ☐ In Person ☐ Other: _____

FCVS

I received notification from FSMB on _____ that my FCVS packet was complete. Initial: _____
MM/DD/YYYY

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 postgraduate training, you must have completed 12 months in an approved ACGME or AOA 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 or AOA approved program after receiving a degree of doctor of osteopathic medicine. I am successfully participating in the ACGME or AOA 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 Osteopathic Physician and Surgeon License

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

I certify that I meet all the qualifications for licensure outlined in U.C.A. 58-68-302 (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-renewable 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: _____

APPLICATION CHECKLIST AND INSTRUCTIONS

This checklist is for your convenience; you do not need to include it with your application.
NOTE: Incomplete applications will be denied.

As the applicant, you are responsible for submitting a complete application. We will not process your application until we receive all required items as explained on the checklist below. If your application packet is not complete within one month of filing, we will consider it abandoned and deny your application. Please do not submit your application until all items are available (e.g. FCVS released to Utah, verification for other states received).

ALL APPLICANTS

All applicants are required to submit the following items to complete the application:

- ☐ $200.00 non-refundable application processing fee, made payable to "DOPL".
- ☐ Supporting documentation for any "yes" answers provided on either the "Qualifying Questionnaire" or "Medical Qualifying Questionnaire".
- ☐ Request National Practitioner Data Bank report outlining all professional liability claims made against your license and any settlements paid by or on your behalf. *NPDB website: http://www.npdb.hrsa.gov*.
- ☐ Request an application packet from Federation Credentials Verification Service (FCVS). FCVS may be contacted via phone at 1-888-ASK-FCVS or via their website at www.fsmb.org/fcvs.html. You must have received an email from FSMB with notice that the FCVS packet has been released to Utah prior to submitting this application unless you are applying for a temporary license.

OPTIONAL CONTROLLED SUBSTANCE LICENSE

If your practice in the state of Utah will include administering, possession or prescribing of controlled substances, you must apply for a Utah Controlled Substance License by submitting the following:

- ☐ $100.00 non-refundable application processing fee, made payable to "DOPL".
- ☐ Complete the "Utah Controlled Substance Affidavit" found in this application.
  ***NOTE:** In addition to the Utah Controlled Substance License, you must hold a valid Federal Drug Enforcement Administration (DEA) registration.

LICENSURE BY ENDORSEMENT

If you are currently licensed in *good standing* as a physician and surgeon in any other state, a district or territory of the United States, or Canada; and have been actively engaged in the practice of medicine for not less than 6,000 hours in the last five years, you may apply for **Licensure by Endorsement**. *In addition* to the items required by all applicants, you must submit the following:

- ☐ Current and complete CV or resume outlining your professional practice for a minimum of 6,000 hours in the last five years.
- ☐ Official verification of license from one or more jurisdictions in which you are currently licensed. Verifications must cover the time period used to qualify for endorsement outlined above.

OPTIONAL TEMPORARY LICENSURE

If you qualify for licensure by endorsement, you *may* apply for temporary licensure during the time required to complete your application for licensure. In addition to requesting all the items listed for all applicants and licensure for endorsement prior to submitting this application, you must provide:

- ☐ $50.00 non-refundable Temporary Physician and Surgeon application fee.
- ☐ Additional $50.00 non-refundable Temporary Controlled Substance License application fee, if applicable.
- ☐ Complete the Temporary Licensure section in this application.
- ☐ Written statement from *one* of the following that includes your projected start date and proposed supervisors:
  - A healthcare facility stating that you will be practicing under the invitation of that facility.
  - Two individuals licensed and in good stating in Utah who are extending an invitation to you to practice at the same clinical location as those two physicians.

Submit the above items with your completed application to:

In person or via express delivery:
Division of Occupational and Professional Licensing
Heber M Wells Building, 1st Floor Lobby
160 E 300 S
Salt Lake City, UT 84111

US Postal Service:
Division of Occupational and Professional Licensing
PO BOX 146741
Salt Lake City, UT 84114-6741