UTAH DEPARTMENT OF COMMERCE
Division of Occupational and Professional Licensing

☐ Physician Educator: Type One
☐ Physician Educator: Type Two

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:** _____

.

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 question 4 you must submit a complete narrative of the circumstances and a 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*.

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

TYPE ONE LICENSURE PATHWAY

In addition to submitting a current copy of your curriculum vitae, you must submit documentation for meeting the following requirements:

1. It is required that you have practiced as an attending physician for at least 10 years. *Submit official verification from your employer(s) documenting the dates of employment and position(s) held.*
2. It is required that you meet at least three of the following qualifications. Please select all those that apply. *You must provide the supporting documentation listed for each selection.*
   - ☐ Published original results of clinical research, within 10 years before the day on which this application is submitted, in a medical journal listed in the Index Medicus or an equivalent scholarly publication. *Submit a copy of the publication, with a verifiable, certified English translation if needed.*
   - ☐ Held an appointment at a medical school approved by the LCME or at any medical school listed in the World Health Organization directory at the level of associate or full professor or its equivalent for at least 5 years. *Submit a letter of verification from the employing medical school which includes dates of employment and position held.*
   - ☐ Developed a treatment modality, surgical technique or other verified original contribution to the field of medicine within 10 years before the day on which this application is submitted AND have the original contribution attested to by the dean of an LCME accredited school of medicine in Utah. *Submit a letter of verification from the dean of a Utah school of medicine attesting to the contribution.*
   - ☐ Actively practiced medicine cumulatively for 10 years. *Submit official verification of licensure covering the 10 years of practice documented on the required CV.*
   - ☐ Board certified in good standing of a board of the American Board of Medical Specialties or equivalent specialty board. *Submit a copy of your most current board certification.*

TYPE TWO LICENSURE PATHWAY

In addition to submitting a current copy of your curriculum vitae, you must submit documentation for meeting the following requirements:

1. It is required that you have delivered clinical care to patients cumulatively for five years after graduation from medical school. *Submit official verification of licensure covering the 5 years of practice documented on the required CV.*
2. It is required that you meet one of the following qualifications. Please select one. *You must provide the supporting documentation listed for your selection.*
   - ☐ Will be completing a clinical fellowship *while* employed as a full-time member of a Utah medical school's academic faculty. *Submit a letter of verification from the fellowship program.*
   - ☐ Completed a medical residency accredited by the Royal College of Physicians and Surgeons of Canada, the United Kingdom, Australia or New Zealand, or a comparable accreditation organization as determined by the Division in collaboration with the board. *Submit official verification from your medical residency program.*

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 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".
- ☐ Official verification of licensure in good standing in a foreign country, the United States or its territories.
- ☐ Current copy of your curriculum vitae.
- ☐ Letter of invitation from the Dean of an LCME accredited medical school in Utah that indicates:
  - You are to serve as a full-time member of the medical school's academic faculty; and
  - You have a unique expertise in a specific field and are qualified by knowledge, skill, and ability to practice.
- ☐ Letter of invitation from the Head of the Department to which you are being appointed that:
  - States you will be under the direction of the head of the department and will be permitted to practice medicine only as a necessary part of the applicant's duties; and
  - Provides detailed evidence of your qualifications and competences, including the nature and location of your proposed responsibilities, reasons for any limitations of practice responsibilities, and the degree of supervision, if any, under which you will function.
- ☐ 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.
- ☐ All supporting documentation for the license pathway you have selected on page 4 of this application.

OPTIONAL CONTROLLED SUBSTANCE LICENSE

If your practice in the state of Utah will include administering, possessing, 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 on page 3 of this application.

  ***NOTE:** In addition to the Utah Controlled Substance License, you must hold a valid Federal Drug Enforcement Administration (DEA) registration.

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