HEALTHCARE LICENSING SERVICES
3 W. Garden St., Suite 700
Pensacola, FL 32502

Please complete each section of this packet thoroughly. Any omitted information can cause delays in processing your application. You may attach your curriculum vitae in place of completing the education, training, and employment portion of this packet. Attach any supporting documents you think may be useful (e.g. medical diploma, training certificates). Remember, you only have to provide this information once. It will be kept on file for any future licenses that you may need.

1. NAME: (Last) (First) (Middle)

Have you ever used any other name? ◯ Yes ◯ No

If yes, provide name

2. HOME ADDRESS:

(Number and Street) (City) (State) (Zip)

3. WORK ADDRESS:

(Number and Street) (City) (State) (Zip)

4. PREFERRED MAILING ADDRESS: ◯ Home ◯ Work

5. TELEPHONE: (Home) (Work) (Cellular)

6. EMAIL:

7. SOCIAL SECURITY NUMBER: U.S. Citizen? ◯ Yes ◯ No

Birth Date: Birth Place: (city/state/country)

8. PHYSICAL DATA:

Height Weight Gender

Eye Color Hair Color Race

Physical Marks

9. Have you ever been in the U.S. Military? ◯ Yes ◯ No

If yes, list branch of service, rank, and dates of service. Indicate if discharge was honorable.

Branch Rank Type of discharge

Start Date End Date

HEALTHCARE LICENSING SERVICES
3 W. Garden St., Suite 700
Pensacola, FL 32502

10. DEA NUMBER: _____ **ISSUING STATE:** _____

11. EDUCATION: List education in chronological order, **beginning with high school.** Also, please give your exact Medical school graduation date.

School/University	City/State	Course/Degree	Mo/Yr	Mo/Yr

12. Did you attend a fifth pathway program? _____

13. If yes, did you complete any clinical clerkship in a country other than where your medical school is located? _____

14. EXAMINATIONS: List all licensing examinations you have ever taken. These may include FLEX, USMLE, SPEX, NBME, NBOME, LMCC, SBME.

Exam/ Step	Date taken	State	# of attempts

15. ECFMG Certificate: Number _____ Issue Date _____

16. CERTIFICATION: Are you certified by any Specialty Board? _____

Name of Specialty Board	Specialty/Sub-Specialty	Date Cert./Re-cert.

Tel:(850) 444-9814 · Fax:(904) 339-9075 · Info@healthcarelicensing.com

HEALTHCARE LICENSING SERVICES
3 W. Garden St., Suite 700
Pensacola, FL 32502

17. LICENSES: Please list any and all professional licenses that you have ever held.

State----------Type of License--License #-------Issue Date-----Expire Date

18. POSTGRADUATE TRAINING: List in order of chronology from date of graduation from medical school, to present, all postgraduate training (Internship, Residency, Fellowship).

Facility Name _____ City/State _____

Program type/ Dept. _____ Start Date _____ End Date _____

Facility Name _____ City/State _____

Program type/ Dept. _____ Start Date _____ End Date _____

Facility Name _____ City/State _____

Program type/ Dept. _____ Start Date _____ End Date _____

Facility Name _____ City/State _____

Program type/ Dept. _____ Start Date _____ End Date _____

HEALTHCARE LICENSING SERVICES
3 W. Garden St., Suite 700
Pensacola, FL 32502

19. EMPLOYMENT/PRIVILEGES: List in order of chronology from date of completion of postgraduate training, to present, all employment (including staff affiliations) or non-employment activities. Be sure to include month and year.

Employer #1 City/State

Type of employment Start Date End Date

Employer #2 City/State

Type of employment Start Date End Date

Employer #3 City/State

Type of employment Start Date End Date

Employer #4 City/State

Type of employment Start Date End Date

Employer #5 City/State

Type of employment Start Date End Date

Employer #6 City/State

Type of employment Start Date End Date

Employer #7 City/State

Type of employment Start Date End Date

Employer #8 City/State

Type of employment Start Date End Date

20. MEDICAL SOCIETY/ASSOCIATION MEMBERSHIPS:

Society----------City/State----------Dates of affiliation

HEALTHCARE LICENSING SERVICES
3 W. Garden St., Suite 700
Pensacola, FL 32502

21. REFERENCES: Provide four PHYSICIAN references.

Name #1					Name #2						
Address					Address						
City		State		Zip Code		City		State		Zip Code	
Phone #		Email:			Phone #		Email:				
Name #3					Name #4						
Address					Address						
City		State		Zip Code		City		State		Zip Code	
Phone #		Email:			Phone #		Email:				

22. Adverse Actions:
Have you ever had any adverse actions taken by a medical school, hospital, licensing board, or have you ever been charged with, or found guilty of a violation of any national, federal, state, or local statute? If yes, please provide a brief narrative below.

23. Malpractice:
Have you ever been named in a malpractice suit? If yes, please provide a brief narrative for each suit. In addition, provide the name and phone number of all liability insurance carriers.

HEALTHCARE LICENSING SERVICES
3 W. Garden St., Suite 700
Pensacola, FL 32502

RELEASE & WAIVER OF RIGHTS

I hereby authorize the following entities and individuals to release all information in their possession concerning me, whether oral, in writing, documented or other, to HEALTHCARE LICENSING SERVICES and/or its agents acting on my behalf.

A. All schools or universities which I have attended.

B. All hospitals or healthcare facilities at which I have ever received training and all hospitals or healthcare facilities at which I have ever held staff privileges, whether full or limited, temporary or permanent.

C. All professional societies, specialty boards, and other all other organizations with which I have ever been associated.

D. All agencies from which I have now, or ever had obtained, Malpractice Insurance coverage.

E. All attorneys who have ever participated in criminal or civil actions, in which I was named party, that would pertain to or directly effect my ability to obtain a State medical license, practice my profession and/or have clinical privileges.

F. All state licensure boards, federal health agencies, and federal or state drug control agencies.

I hereby release the above-named entities and individuals from all liability for the release of information to the board and/or its agents.

I hereby agree to make this RELEASE & WAIVER OF RIGHTS for the purpose of allowing HEALTHCARE LICENSING SERVICES and/or its agents, to execute its duties pursuant to my request for a license to practice my profession. I further authorize HLS or any of its duly authorized agents to make any investigations that they deem necessary to secure information concerning me that is relevant to the requirements of licensure.

Print Name _____

Signature _____ Date _____

HEALTHCARE LICENSING SERVICES
3 W. Garden St., Suite 700
Pensacola, FL 32502

ACQUISITION AGREEMENT:

I hereby acknowledge that I have attained the services of **HEALTHCARE LICENSING SERVICES** (HLS) for assistance with licensure in the state(s) of

I understand that the fee for this service is $599 per state (*$499* for Resident Physician) and includes the cost of HLS administrating and processing my License Application(s) and related documents. It does not include the fees charged by the regulatory board, various agencies that charge for direct source documentation, or postage/delivery fees.

HEALTHCARE LICENSING SERVICES will initiate services upon receipt of this signed agreement and acquisition fee. By signing this agreement you acknowledge that you have read and understand the company policies outlined onour web site.

Total Payment Enclosed:

Method of Payment:

- ◯ I paid online via Google Checkout
- ◯ Check or Money Order
- ◯ Credit Card
  - ◯ Visa
  - ◯ Master Card
  - ◯ American Express
  - ◯ Discover

Card Holders Name

Card Number Expiration Date

Security Code (CCV)

Signature Today's Date

Type name in signature box if submitting form online

Print Form

Tel:(850) 444-9814 · Fax:(904) 339-9075 · Info@healthcarelicensing.com