



APPLICANT'S NAME: \_\_\_\_\_

**Pre-medical School**

Facility: \_\_\_\_\_ Degree: \_\_\_\_\_ From \_\_\_\_/\_\_\_\_/\_\_\_\_ To \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Facility: \_\_\_\_\_ Degree: \_\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

**Medical School**

Facility: \_\_\_\_\_ Degree: \_\_\_\_\_ From \_\_\_\_/\_\_\_\_/\_\_\_\_ To \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Facility: \_\_\_\_\_ Degree: \_\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Date of medical school graduation: \_\_\_\_\_

**Note:** U.S. graduates must include a written explanation for the duration of medical education longer than four (4) years, and for any breaks in medical education. International graduates must provide a written explanation for the duration of medical education longer than six (6) years and any breaks in medical education.

**Postgraduate Education:**

List all postgraduate training from medical school to the present in chronological order. List the name and address of the facility, your position, e.g. PGY 1, 2, fellow, etc. and dates of affiliation. You must account for all periods of training or postgraduate work from the time you graduated from medical school.

Facility: \_\_\_\_\_ Position: \_\_\_\_\_ From \_\_\_\_/\_\_\_\_/\_\_\_\_ To \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Facility: \_\_\_\_\_ Position: \_\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Facility: \_\_\_\_\_ Position: \_\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

APPLICANT'S NAME: \_\_\_\_\_

**Hospital Affiliations and Employment**

List hospital appointments where you had active staff privileges in chronological order. Include the name and address of the facility, your position and dates of affiliation in postgraduate training, in chronological order. Also include periods of unemployment or employment outside of medicine. Attach a separate sheet of paper if necessary.

	<u>From</u>	<u>To</u>
Facility: _____	Position: _____	____/____/____
Street: _____	City: _____	State: _____
Facility: _____	Position: _____	____/____/____
Street: _____	City: _____	State: _____
Facility: _____	Position: _____	____/____/____
Street: _____	City: _____	State: _____
Facility: _____	Position: _____	____/____/____
Street: _____	City: _____	State: _____

1. List other states (abbreviations) where you are currently or have ever been licensed: \_\_\_\_ \_\_\_\_ \_\_\_\_
2. Are you certified by the American Board of Medical Specialties?  Yes  No
3. List Board Certification(s): \_\_\_\_\_
4. Have you attached an up-to-date copy of your curriculum vitae?  Yes  No
5. Reason for requesting a Massachusetts medical license: \_\_\_\_\_  
\_\_\_\_\_
6. Name of Facility: \_\_\_\_\_
7. Address: \_\_\_\_\_ City: \_\_\_\_\_
8. Anticipated starting date in Massachusetts: \_\_\_\_/\_\_\_\_/\_\_\_\_

Under the penalties of perjury, I declare that I have examined this temporary license application and all its accompanying instructions, forms and statements, and to the best of my knowledge and belief, the information contained herein is true, correct and complete. As an applicant for a temporary license to practice medicine, I understand that a criminal record check may be conducted for conviction and pending criminal case information from the Criminal History Systems Board only and that it will not necessarily disqualify me from licensure.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

The primary purpose of the NPI is to uniquely identify health care providers as “health care providers” in HIPAA standard transactions. The NPI will replace all other identifiers assigned to health care providers, such as those assigned by health plans, government programs and health care purchasers for purposes of conducting these business transactions. Under the final HIPAA NPI Rule, all individual and organization covered providers **were required to obtain an NPI by May 23, 2007.**

You must supply the Board of Registration in Medicine with your valid NPI. If you do not have an NPI number, you can apply for an NPI directly by using the NPPES web site at [www.NPPES.cms.hhs.gov](http://www.NPPES.cms.hhs.gov).

My current NPI is:

**Penalties for Falsifying Information on the National Provider Identifier Application**

18 U.S.C. 1001 authorizes criminal penalties against an individual who in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry. Individual offenders are subject to fines of up to \$250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to \$500,000. 18 U.S.C. 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.

**Please sign and date to confirm that all of the information on this form is true and accurate.**

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_