

<i>Official Use Only</i>
Number: _____
Date Approved/Denied: _____
Approved/Denied By: _____

### 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/ State ID 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 authorization to work 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

**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. <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had a license, certificate, permit, or registration to practice a regulated profession denied, conditioned, curtailed, limited, restricted, suspended, revoked, reprimanded, or disciplined in any way?
2. <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever been permitted to resign or surrender your license, certificate, permit, or registration to practice in a regulated profession while under investigation or while action was pending against you by any professional licensing agency or criminal or administrative jurisdiction?
3. <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you currently under investigation or is any disciplinary action pending against you now by any <i>local, state or federal licensing, enforcement or regulatory agency</i> ?
4. <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever been declared by any court to be incompetent by reason of mental defect or disease and not restored?
5. <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had a documented case in which you were involved as the abuser in any incident of verbal, physical, mental, or sexual abuse?
6. <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you been terminated, suspended, reprimanded, sanctioned, or asked to leave voluntarily from a position because of drug or alcohol use or abuse within the past five (5) years?
7. <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you currently using or have you recently ( <i>within 90 days</i> ) used any drugs ( <i>including recreational drugs</i> ) without a valid prescription, the possession or distribution of which is unlawful under applicable state or federal laws?
8. <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever unlawfully used any drugs for which you have not successfully completed, or are not now participating in a supervised drug rehabilitation program, or for which you have not otherwise been successfully rehabilitated?
9. <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you currently have any criminal action pending?*
10. <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you pled guilty to, no contest to, entered into a plea in abeyance or been convicted of a misdemeanor in any jurisdiction within the past ten (10) years? *
11. <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever pled guilty to, no contest to, or been convicted of a felony in any jurisdiction?*
12. <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever been incarcerated for any reason in any correctional facility ( <i>domestic or foreign</i> ) in any jurisdiction or on probation/parole in any jurisdiction?*

**\*NOTE: Charges that were later dismissed and motor vehicle offenses such as driving while impaired or intoxicated must be disclosed; however, minor traffic offenses such as parking or speeding violations need not be listed.**

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 9,10,11 or 12 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.

## 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 (OPTIONAL)

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

- 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.
- I understand that I may need a written delegation of services agreement or a written consultation and referral plan for prescribing controlled substances as outlined in statute.
- I understand that there may be additional continuing education requirements for those who hold a controlled substance license.
- I understand it is required that I hold a valid Federal Drug Enforcement Administration (DEA) registration.

Signature of Applicant: \_\_\_\_\_ Date \_\_\_\_\_

I received notification from FSMB on \_\_\_\_\_ that my FCVS packet was complete. Initial: \_\_\_\_\_  
Date \_\_\_\_\_

## 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 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 requested).

### 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 of the qualifying questionnaires. See pages 2 and 3 of the application for more information.
- 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](http://www.fsmb.org/fcvs.html). You must have received an email from FCVS 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 Law and Rule 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.

### LICENSURE BY ENDORSEMENT

If you are currently licensed in *good standing* as an osteopathic 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 Osteopathic Physician and Surgeon application fee.
- Additional \$50.00 non-refundable Temporary Controlled Substance License application fee, if applicable.
- Complete the Temporary Licensure section on page 4 of this application.
- Written statement from one of the following:
  - A healthcare facility stating that you will be practicing under the invitation of that facility.
  - Two individuals licensed and in good standing 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, 1<sup>st</sup> 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