

REQUIREMENTS AND INSTRUCTIONS - OSTEOPATHIC PHYSICIAN & SURGEON

Access this form via website at: www.state.hawaii.gov/dcca/pvl

REQUIREMENTS FOR LICENSURE: Pursuant to Section 460-6 of the Hawaii Revised Statutes, to be eligible for licensure, an applicant must meet the following requirements:

1. Be a graduate of a school or college of osteopathy which is approved by the American Osteopathic Association (AOA);
2. Served an internship of at least one year in a hospital approved by the American Osteopathic Association and the American College of Osteopathic Surgeons, or in a hospital approved by the American Medical Association; and
3. Passed all levels, parts or steps of the National Board of Osteopathic Medical Examiners examination (NBOME), the Federation Licensing Examination (FLEX), the United States Medical Licensing Examination (USMLE), or a combination of parts of the FLEX and the USMLE as approved by the Board.

Applicants are subject to requirements in effect at the time of filing.

APPLICATION Complete the attached application form. Type or print legibly in dark ink.

- **Failure to provide all the requested information will delay the processing of your application.**

SOCIAL SECURITY NUMBER Your social security number is used to verify your identity for licensing purposes and for compliance with the below laws. **For a license to be issued you must provide your social security number or your application will be deemed deficient and will not be processed further.**

The following laws require that you furnish your social security number to our agency:

FEDERAL LAWS:

42 U.S.C.A. §666(a)(13) requires the social security number of any applicant for a professional license or occupational license be recorded on the application for license; and If you are a licensed health care practitioner, **45 C.F.R., Part 61, Subpart B, §61.7** requires the social security number as part of the mandatory reporting we must do to the Healthcare Integrity and Protection Data Bank (HIPDB), of any final adverse licensing action against a licensed health care practitioner.

HAWAII REVISED STATUTES ("HRS"):

§576D-13(j), HRS requires the social security number of any applicant for a professional license or occupational license be recorded on the application for license; and

§436B-10(4) HRS which states that an applicant for license shall provide the applicant's social security number if the licensing authority is authorized by federal law to require the disclosure (and by the federal cites shown above, we are authorized to require the social security number).

QUESTIONS In the event the response to any of the questions numbered 3 through 9 is "YES", please file a typewritten or legible handwritten detailed explanation as directed on the application.

FEES ATTACH check made payable to: COMMERCE & CONSUMER AFFAIRS as follows:

Application for licensure without examination:

If licensed from July 1 of an even-numbered year to
June 30 of an odd-numbered year, pay \$400
(Application fee-\$50* + License fee-\$200 + \$55 Compliance
Resolution Fund)

If licensed from July 1 of an odd-numbered year to
June 30 of an even-numbered year, pay..... \$305* *
(Application fee-\$50* + License fee-\$200 + \$55 Compliance
Resolution Fund)

*Application fee not refundable

**Subject to renewal June 30, even-numbered year.

FEE (CONTINUED)	<p>NOTE: One of the numerous legal requirements that you must meet in order for your new license to be issued is the payment of fees as set forth in this application. You may be sent a license certificate before the payment you sent us for your required fees is honored by your bank. If your payment is dishonored, you will have failed to pay the required licensing fee and your license will not be valid, and you may not do business under that license. Also, a \$25.00 service charge shall be assessed for payments that are dishonored for any reason.</p> <p><i>If for any reason you are denied the license you are applying for, you may be entitled to a hearing as provided by Title 16, Chapter 201, Hawaii Administrative Rules, and/or Chapter 91, Hawaii Revised Statutes. Your written request for a hearing must be directed to the agency that denied your application, and must be made within 60 days of notification that your application for a license has been denied.</i></p>
DOCUMENTS REQUIRED WITH APPLICATION	<p>ATTACH a copy of your:</p> <ol style="list-style-type: none"> 1. Osteopathic Medical School diploma, 2. Residency training certificate.
VERIFICATION OF LICENSE	<p>On the application, list all the licenses you hold or held, including those for residency training or locum tenens.</p> <p>ARRANGE to have verification of licensure sent directly to the HMB. To do this, contact all the jurisdictions that you are/were licensed in and request that they send a verification of licensure directly to the HMB.</p>
NATIONAL PRACTITIONER DATA BANK REPORT	<p>SUBMIT the original "NPDB Response to Self-Query" report from the National Practitioner Data Bank (NPDB). To obtain the report, go to the NPDB website: at www.npdb-hipd.com and click on Perform a Self-Query. If you are unable to go on-line, call NPDB at 1-800-767-6732 for assistance. After you receive this report, send the original report to the Hawaii Medical Board (HMB).</p>
AOA PHYSICIAN PROFILE	<p>Complete the AOA Physician Profile request, attach a check in the amount of \$40 and send to address noted on form. If you have internet access, you may go on-line to order a report at: www.aoa-net.org.</p> <p>(AOA charges a fee of \$40 for non-members. No fee for AOA members.)</p>
EXAMINATION SCORES	<p>Applicants who passed the NBOME examination</p> <p>ARRANGE to have all levels of the NBOME examination scores sent directly to the HMB. To do this, call the NBOME at (773) 714-0622 or go to their website at: www.nbome.org and click on Transcript Request Form.</p> <p>Applicants who passed the USMLE or FLEX examination:</p> <p>ARRANGE to have the Federation send an "Examination and Board Action History Report" (EBAHR) directly to the HMB. To do this, call the Federation at (817) 868-4041 or go to their website at: www.fsmb.org and click on Transcript Requests. (The EBAHR also provides a board action history report.)</p>
CERTIFICATE OF COMPETENCY	<p>ARRANGE to have two (2) osteopathic physicians complete the certificate of competency form and send it directly to the HMB.</p>
CERTIFICATE FO APPLICANT	<p>Please read the certification at the end of the application and sign and date it.</p>
RELEASE OF INFORMATION	<p>If an agency or individual is assisting you with the licensure process, we will not be able to release any information to them unless you provide us with authorization. If you wish to do so, please complete the portion on Release of Information to Third Party, sign and date it.</p>

**BOARD'S
ADDRESS**

Application and items are to be:
Mailed to:

Delivered to:

*Hawaii Medical Board
DCCA, PVL Licensing Branch OR
P.O. Box 3469
Honolulu, HI 96801*

*335 Merchant St., Room 301
Honolulu, HI 96813
Phone No. (808)586-3000*

**COMPLETE
APPLICATION**

We are unable to take action on an application unless it is complete. Therefore, please ensure that we have received all the documents necessary. To do this, you may call (808) 586-3000 to inquire about the status of your application. If an agency is assisting with your application, we will release this information to them when you provide us with written authorization. (See Release of Information)

ABANDONMENT

Pursuant to HRS §436B-9 your application shall be considered abandoned and shall be destroyed if you fail to provide evidence of continued efforts to complete the licensing process for two consecutive years. The failure to provide evidence of continued efforts includes but is not limited to: (1) failure to submit any required information and documents requested by the licensing authority within two consecutive years from the last date the documents and information were requested, or (2) failure to complete any additional requirements for licensure that remain after approval of your application, such as attempting to complete an exam requirement, within two consecutive years from the date your application was approved, or (3) failure to provide the licensing authority with any written communication during two consecutive years indicating that you are attempting to complete the licensing process. If an application is deemed abandoned the applicant shall be required to reapply for licensure and comply with the licensing requirements in effect at the time of the reapplication.

LICENSE DENIAL

If for any reason you are denied the license you are applying for, you may be entitled to a hearing as provided by Title 16, Chapter 201, Hawaii Administrative Rules, and/or Chapter 91, Hawaii Revised Statutes.

Your written request for a hearing must be directed to the agency that denied your application (HMB), and must be within 60 days of notification that your application for a license has been denied.

**LICENSE
RENEWAL**

Osteopath licenses expire on June 30 of **each even-numbered year**.

About 2 months before the license expiration date, a renewal application is mailed to all licensees at their address of record. If you do not receive a renewal application approximately one month prior to the license expiration date, contact the Licensing Branch (808-586-3000) for assistance. To ensure that you receive a renewal application, keep the Board informed of your address. Licenses that are not renewed by the deadline are forfeited and the holders of a forfeited license are considered unlicensed and may not practice. After two years license forfeiture, reapplication is required.

LAWS & RULES

The pertinent laws and rules are posted on our website free of charge at: www.hawaii.gov/dcca/pvl. Click on **Medical and Osteopathy**.

Alternatively, you may obtain copies by sending a written request to: Licensing Branch, PVL, P.O. Box 3469, Honolulu, HI 96801.

1. Chapter 460, Hawaii Revised Statutes
2. Chapter 93, Hawaii Administrative Rules
3. Chapter 436B, Hawaii Revised Statutes

**U.S. CITIZEN,
U.S. NATIONAL,
OR AN ALIEN
AUTHORIZED TO
WORK IN THE
U.S.**

Pursuant to section 436B-10, Hawaii Revised Statutes, and federal law, **all applicants are required to be a U.S. citizen, U.S. national, or an alien authorized to work in the United State.** This means that even if an applicant meets the education, training and examination requirements for licensure, that applicant will not be issued a license if that applicant is not a U.S. citizen, U.S. national or an alien authorized to work in the United States.

However, the Board may issue the applicant a conditional approval that signifies that the applicant has met the education, experience and examination requirements for licensure. This conditional approval is not a license to engage in the profession and does not authorize the applicant to work in Hawaii.

To obtain authorization to work in the United States, the applicant may contact the U.S. Citizenship and Immigration Services ("USCIS") at <http://uscis.gov> or 1-800-375-5283.

Once the applicant submits evidence to the Board that the USCIS has authorized the applicant to work in the U.S. (without conditions or other encumbrances), provides a Social Security Number and has met all of the licensing requirements, the applicant may be issued a license, provided that there is no change in the applicant's status or the information that was originally submitted. The Board may ask the applicant to submit up-to-date documents to determine whether there have been any changes and whether the applicant still qualifies for licensure.

The conditional approval is valid for two (2) years. An applicant must obtain the appropriate USCIS authorization within this two (2) years period in order to have a license issued. If the applicant is unable to meet this deadline, the applicant may be required to reapply for licensure and meet all of the requirements in effect at that time.

APPLICATION FOR LICENSE - OSTEOPATHIC PHYSICIAN & SURGEON

Read the attached instructions before completing this form.

LEGAL NAME (First, Middle)	(LAST)
Other names used (previous surnames, maiden name, etc.)	
Residence Address (include apt. no., city, state and zip code)	
Mailing Address (ONLY if different from above)	
Social Security No.	Phone No. (days)
Date NPDB Requested	Date AOA Profile Requested

FOR OFFICE USE ONLY

Approved:	Initials/Date
Effective Date	License No. DOS -

Circle answers:

1. Are you at least 18 years old?YES NO
2. Are you a U.S. citizen, a U.S. national, or an alien authorized to work in the United States?.....YES NO

Circle answers and provide details as directed for any "yes" response to the questions below:

3. Have you ever held a license in Hawaii?.....YES NO
If response "yes", specify type of license and dates below:

4. With regard to any medical license to practice in any state or country:
 - a) Has it ever been revoked, suspended, placed on probation, surrendered, reprimanded, admonished, or otherwise subject to disciplinary action; or have you ever been issued a letter of concern; or have you ever entered into a consent order or settlement agreement?YES NO
 - b) Is any disciplinary action pending against you?YES NO
 - c) Are you presently being investigated?YES NO
 - d) Have you ever been denied a license or withdrawn any application for licensure?YES NO

If response "yes", attach a detailed explanation on a separate sheet, which includes state or country where action is pending or took place, relevant dates, action taken and reasons for such action.

5. With regard to any educational training program or facility, state/federal controlled substance agency, local, state, federal or military professional or disciplinary body or any hospital privileging or credentialing body, grievance committee or any other medical group, including medical societies and specialty boards:
 - a) Have you ever been subject to disciplinary or adverse actions or entered into an agreement?YES NO
 - b) Is any disciplinary or adverse action pending against you?YES NO
 - c) Are you presently being investigated?YES NO
 - d) Have you ever been denied or withdrawn an application for privileges or membership or have you ever resigned, surrendered or failed to renew your privileges or membership?YES NO

If response "yes", attach a detailed explanation on a separate sheet, which includes the bodies of jurisdiction or organizations involved, relevant dates, action taken and reasons for such action.

6. With regard to professional liability:
 - a) Have any claims of malpractice ever been filed against you?YES NO
 - b) Have any insurance carrier ever denied, conditioned, curtailed, limited, suspended, or revoked your coverage?YES NO

If response "yes", attach a detailed explanation on a separate sheet, which:

- ***Includes the date of the case (month/year), jurisdiction (State, etc.), nature of the case, allegations, and amount paid on your behalf. Information is to be provided on all settlements, judgments, awards, and claims (including those for which no money was paid); and/or***
- ***Provides the name and address of your insurance carrier, specific circumstances, date and action taken.***

(CONTINUED ON BACK)

App	464.....	\$50
Lic	466.....	\$200
1/2 Renewal	460.....	\$40
CRF	467.....	\$ 55/110
Service Charge.....	BCF.....	\$25

- 7) With regard to participation in any health plan or Federal or State health care program:
- a) Have you ever relinquished participation or certification, or been denied, terminated, sanctioned, penalized, decertified or otherwise excluded from participation?..... YES NO
- b) Have you ever been convicted of insurance fraud? YES NO
- If response "yes", attach a detailed explanation on a separate sheet, which includes the bodies of jurisdiction relevant dates, allegations, charges, disposition, action taken and reasons for such action.**
- 8) In the past five years, have you been addicted to, dependent on, or a habitual user of alcohol or of a narcotic, barbiturate, amphetamine, hallucinogen, or other drug having similar effects? YES NO
- If response "yes", attach a detailed explanation on a separate sheet.**
- 9) During the past twenty years, have you been convicted of a crime in which the conviction has not been annulled or expunged?..... YES NO
- Explain "yes", response on a separate sheet with detailed information and attach certified court documentation on the date, place, Violation of each conviction and fulfillment of conditions for each sentence.**

LICENSES	Name of Jurisdiction (Attach additional sheets if necessary)	Date Issued	Expiration Date	License Number	Date Verification Requested	
EDUCATION	Name of Osteopathic Medical School	Location (City/State or Country)	Degree Earned	Dates (mo/yr)		
				From	To	
RESIDENCY	Name of Residency Program	Location (City/State or Country)	Dates (mo/yr)			
			From	To		

CERTIFICATION OF APPLICANT:

I certify that the statements, answers, and representations made in this application and in the documents attached are true and correct. I understand that this certification and any misrepresentation are grounds for the denial, refusal or subsequent revocation of license and is a misdemeanor (Section 710-1017, and Sections 436B-19, and 460-12, Hawaii Revised Statutes). I further certify that I have read and will abide by the provisions of Chapter 460 and Chapter 93.

_____ Signature of Applicant _____ Date

Release of Information to Third Party:

To assist me in the licensing process, I authorize the HMB and staff to release any and all information regarding my application (including but not limited to, application status, examination scores, disciplinary or criminal history, National Practitioner Data Bank Report, AMA Profile) to:

Name of Individual who is assisting you: _____

Name of Organization: _____

Address of Organization: _____

_____ Signature of Applicant _____ Date

CERTIFICATE OF COMPETENCY - OSTEOPATHIC PHYSICIAN & SURGEON

Access this form via website at: www.hawaii.gov/dcca/pvl

INSTRUCTIONS TO APPLICANT:

Complete information ABOVE dotted line, then send a form to two (2) osteopathic physicians who will attest to your competence.

TO: *(Fill in name and address of person who will attest to your abilities);*

RE: *(Print your name)*

(Name of Applicant)

I am applying to the Hawaii Medical Board for a license to practice osteopathic medicine and surgery in Hawaii. It is required that I have two osteopathic physicians attest to my competence. Please complete the following form and mail it to:

*Hawaii Medical Board
DCCA, PVL Licensing Branch
P.O. Box 3469
Honolulu, HI 96801*

OR

Deliver to office location at:
335 Merchant St., Room 301
Honolulu, HI 96813
Phone No. (808) 586-3000

Applicant's Signature _____

1. Length of Acquaintance:

Date of Last Contact:

_____ yrs. _____ mos.

(month, year)

Circle Answer:

2. Is the applicant related to you? YES NO

IF YES, HOW? _____

3. What opportunities have you had to observe the applicant?

4. Do you consider the applicant: Sober and reliable? YES NO
Ethical? YES NO

5. Has applicant, to your knowledge, ever been guilty of:
a) Fraud or dishonesty? YES NO
b) Unprofessional conduct? YES NO
c) Habitual abuse of alcohol or narcotics? YES NO
d) Unprofessional advertising? YES NO
e) Practicing under an assumed name? YES NO

6. To your knowledge, has there ever been any question of his mental or physical fitness to practice osteopathic medicine/surgery YES NO

7. Circle one in each category:
a) Professional ability and competency EXCELLENT GOOD AVERAGE POOR
b) Attention to duties and reliability EXCELLENT GOOD AVERAGE POOR

(CONTINUED ON BACK)

Name of Applicant: _____

8. If you have any additional information with respect to this applicant's professional ability or conduct, state here:

List all state licenses held by you:

Name of State	License No.
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Completed by:

(Print or Type Name)

(Signature) (Date)

Address:

CERTIFICATE OF COMPETENCY - OSTEOPATHIC PHYSICIAN & SURGEON

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P.O. Box 3469
Honolulu, HI 96801*

OR

Deliver to office location at:
335 Merchant St., Room 301
Honolulu, HI 96813
Phone No. (808) 586-3000

Applicant's Signature _____

.....

1. Length of Acquaintance: _____ yrs. _____ mos. Date of Last Contact: _____ (month, year)

Circle Answer:

2. Is the applicant related to you? YES NO
IF YES, HOW? _____

3. What opportunities have you had to observe the applicant?

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Ethical? YES NO

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a) Fraud or dishonesty? YES NO
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d) Unprofessional advertising? YES NO
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6. To your knowledge, has there ever been any question of his mental or physical fitness to practice osteopathic medicine/surgery YES NO

7. Circle one in each category:
a) Professional ability and competency EXCELLENT GOOD AVERAGE POOR
b) Attention to duties and reliability EXCELLENT GOOD AVERAGE POOR

(CONTINUED ON BACK)

Name of Applicant: _____

8. If you have any additional information with respect to this applicant's professional ability or conduct, state here:

List all state licenses held by you:

Name of State	License No.
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Completed by:

(Print or Type Name)

(Signature)

(Date)

Address:

REQUEST FOR OSTEOPATHIC PHYSICIAN PROFILE

State of Hawaii
 Hawaii Medical Board
 P.O. Box 3469
 Honolulu, HI 96801

TO THE APPLICANT: Complete the Applicant section and mail to:

American Osteopathic Association
 Department of Membership and Information Services
 142 East Ontario Street
 Chicago, IL 60611-2864
 Toll-free phone: (800) 621-1773
 Fax: (312) 202-8200

APPLICANT	Name (First-Middle) _____ (LAST) _____		Social Security No. _____
	Address (Include Apt. No. and zip code) _____		AOA Number _____
			Date of Birth _____
	Osteopathic School of Graduation and Address _____		Date of Graduation _____
	<p>I am an applicant for licensure in the State of Hawaii. It is requested that you send my osteopathic physician profile directly to the Hawaii Medical Board at the address below. I authorize the AOA to indicate on this form if there is any previous or pending disciplinary action against my license in any state.</p> <p>Date _____ BY _____ (Signature of Applicant)</p>		

AOA	To AOA: Please complete and return to the Hawaii Medical Board, P.O. Box 3469, Honolulu, Hawaii 96801.	
	<input type="checkbox"/> Agrees with AOA records. <input type="checkbox"/> Does not agree with AOA records (include explanation).	
	Date _____	By _____ Member and Information Service