

**REQUIREMENTS AND INSTRUCTIONS - PHYSICIAN (MD License) or  
PHYSICIAN employed by Hawaii State or County Government  
(MDG License)**

Access this form via website at: [hawaii.gov/dcca/pvl](http://hawaii.gov/dcca/pvl)

This application is to be used by physicians seeking a regular physicians (MD) license or limited and temporary (MDG) license for Hawaii State or County government employment. Physicians seeking a limited and temporary license for education/teaching, sponsorship, or emergency/shortage are directed to use the "Limited and Temporary License - Physician" application form.

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**MD LICENSE** This is a full, regular license that expires on January 31 each even-numbered year.

**REQUIREMENTS**

**MD LICENSE**

*(U.S. and Canadian  
Medical Graduates)*

**U.S. and Canadian Medical School Graduates**

- MD degree from an LCME-accredited medical school in the U.S. or Canada.
- One year of residency training in an ACGME-accredited program in the U.S. **OR**  
One year of residency training in an RCPSC or CFPC-accredited program in Canada.
- Satisfactory completion of the NBME, FLEX, USMLE, MCCQE (Qualifying Exam of LMCC) **OR**  
Satisfactory completion, prior to 2000, of an acceptable combination of the NBME, FLEX and USMLE **OR**  
Satisfactory completion of the SPEX, provided that the physician was licensed in another state by virtue of having passed a state-produced examination.

**(Note: All three steps of the USMLE must be passed within seven years.)**

Items/documents required when applying:

- Application form
- Fees
- Verification of licensure
- Hospital affiliation form
- Evidence of MD degree
- Evidence of residency training
- National Practitioner Data Bank report
- AMA Profile
- Federation report
- Examination scores

**REQUIREMENTS**

**MD LICENSE**

*(Foreign Medical  
Graduates)*

**Foreign Medical School Graduates (FMG)**

There are two alternative pathways for FMG applicants.

Those who served in an ACGME-accredited residency program in the U.S., or an RCPSC or CFPC-accredited residency program in Canada, should refer to the **first pathway** for the licensure requirements.

All other applicants should refer to the **second pathway** for the licensure requirements.

**FIRST PATHWAY:**

- MD degree from a foreign medical school.
- Two years of residency training in an ACGME-accredited program in the U.S. **OR**  
Two years of residency training in an RCPSC or CFPC-accredited program in Canada
- Satisfactory completion of the NBME, FLEX, USMLE, MCCQE (Qualifying exam of LMCC) **OR**  
Satisfactory completion, prior to 2000, of an acceptable combination of the NBME, FLEX and USMLE **OR**  
Satisfactory completion of the SPEX, provided that the physician was licensed in another state by virtue of having passed a state-produced examination.

- ECFMG Certificate or MCCEE (Evaluating Exam of LMCC) **OR**  
Fifth Pathway Certificate.

**(Note: All three steps of the USMLE must be passed within seven years.)**

Items/documents required when applying:

- Application form
- Fees
- Verification of licensure
- Hospital affiliation form
- Evidence of MD degree
- Evidence of residency training
- Verification of ECFMG or Fifth Pathway Certificate or MCCEE
- National Practitioner Data Bank report
- AMA Profile
- Federation report
- Examination scores

**REQUIREMENTS  
MD LICENSE  
(Foreign Medical  
Graduates) (contd.)**

**SECOND PATHWAY:**

- MD degree from a foreign medical school.
- Three years of medical training or experience in a hospital approved by the AMA's Council on Medical Education and Hospitals for internship or residency.
- Satisfactory completion of the FLEX or USMLE **OR** Satisfactory completion, prior to 2000, of an acceptable combination of these examinations.
- (As an alternative to the ECFMG Certificate), satisfactory completion, prior to 1984, of the VISA qualifying examination of the ECFMG.

**(Note: All three steps of the USMLE must be passed within seven years.)**

Items/documents required when applying:

- Application form
- Fees
- Verification of licensure
- Hospital affiliation form
- Evidence of MD degree
- Evidence of medical training or experience
- Verification of VISA qualifying examination of the ECFMG
- National Practitioner Data Bank report
- AMA Profile
- Federation report
- Examination scores

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**MDG LICENSE**

This is a limited and temporary license for government employment that expires on January 31 each year.

**REQUIREMENTS  
MDG LICENSE  
(U.S. and Canadian  
Medical Graduates)**

**U.S. and Canadian Medical School Graduates**

- MD degree from an LCME-accredited medical school in the U.S. or Canada.
- One year of residency training in an ACGME-accredited program in the U.S. **OR** One year of residency training in an RCPSC or CFPC-accredited program in Canada.
- Licensed by written examination in another state or U.S. territory.

Items/documents required when applying:

- Application form
- Fees
- Verification of licensure
- Hospital affiliation form
- Evidence of MD degree
- Evidence of residency training
- Verification of state or county government employment
- National Practitioner Data Bank report
- AMA Profile
- Federation report
- Examination scores

**REQUIREMENTS  
MDG LICENSE  
(Foreign Medical  
Graduates)**

**Foreign Medical School Graduates (FMG)**

- MD degree from a foreign medical school.
- Two years of residency training in an ACGME-accredited program in the U.S. **OR** Two years of residency training in an RCPSE or CFPC-accredited program in Canada
- ECFMG Certificate **OR** Fifth Pathway Certificate.
- Licensed by written examination in another state or U.S. territory.

Items/documents required when applying:

- Application form
- Fees
- Verification of licensure
- Hospital affiliation form
- Evidence of MD degree
- Evidence of residency training
- Verification of ECFMG or Fifth Pathway Certificate
- Verification of state or county government employment
- National Practitioner Data Bank report
- AMA Profile
- Federation report
- Examination scores

**INSTRUCTIONS FOR FILING AN APPLICATION AND SUBMITTING THE REQUIRED ITEMS**

Type or print legibly in dark ink. Most items on the form are self-explanatory. Those that need explanation are discussed below.

**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).

**FEES**

ATTACH a check payable to: COMMERCE AND CONSUMER AFFAIRS

<b>MD License</b> issued between February 1, even-numbered year,	
to January 31, odd-numbered year, pay .....	\$ 290
(Application fee - \$50**, License - \$75, Compliance Resolution Fund - \$90, ½ renewal - \$75)	
<b>MD License</b> issued between February 1, odd-numbered year	
to January 31, even-numbered year, pay.....	\$ 170*
(Application fee - \$50**, License - \$75, Compliance Resolution Fund - \$45)	
<b>MDG License</b> .....	\$ 120***
(Application - \$25**, License - \$50, Compliance Resolution Fund - \$45)	

\* Subject to renewal January 31, even-numbered years – regardless of issue date.

\*\* Application fee is not refundable.

\*\*\* Subject to renewal January 31, annually.

**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.

**QUESTIONS**

In the event the response to any of the questions numbered 5 through 11 is "**YES**", please file a typewritten or a legible handwritten detailed explanation as directed on the application.

**EVIDENCE OF MD DEGREE**

ATTACH a copy of your MD diploma, medical school transcripts or letter from the dean of the medical school, which provides the date of your graduation from medical school. If your documents are in a foreign language, an accurate translation must be attached.

**EVIDENCE OF RESIDENCY TRAINING**

The following applicants are to provide evidence of residency training:

- All U.S. and Canadian medical school graduates
- FMG applicants for MD license through 1<sup>st</sup> pathway
- FMG applicants for MDG license

ATTACH a copy of your residency certificate or letter from the program director of your residency training, which provides the completed dates of residency training.

**EVIDENCE OF TRAINING OR EXPERIENCE**

FMG applicants for MD license through 2<sup>nd</sup> pathway are to provide evidence of medical training or experience:

ARRANGE to have the hospital in which you received at least 3 years of medical training or experience send evidence of this directly to the Hawaii Medical Board (HMB). To do this, contact the hospital and request that they provide:

- hospital's name and address
- dates of your training or experience
- verification that the hospital has been approved by the AMA's Council on Medical Education and Hospitals for internship or residency

**VERIFICATION OF LICENSE**

On the application, list all the licenses you hold or held, including those for residency training or locum tenens.

**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.

**HOSPITAL FORM**

On the application, list all the hospitals where (in the **last 3 years**) you:

- have held or applied for consultation, teaching appointments, privileges or locum tenens positions; or
- serve/served in an internship or residency program.

**ARRANGE** to have the hospital forms sent **directly** to the HMB. To do this, send copies of the attached "Hospital" form (MD-08) to the hospitals and request that they send the forms **directly** to the HMB.

**SYNOPSIS OF MEDICAL PRACTICE**

On the application, provide a synopsis of your medical practice from the time you completed residency training to the present. If there have been breaks in your practice, please provide an explanation. Attach additional sheets if necessary.

**EVIDENCE OF ECFMG OR FIFTH PATHWAY CERTIFICATE**

**The following applicants are to provide evidence of the ECFMG or Fifth Pathway Certificate:**

- FMG applicants for MD license through 1<sup>st</sup> pathway.
- FMG applicants for MDG license.

**ECFMG Certificate**

**ARRANGE** to have the Status Report of ECFMG Certification sent **directly** to the HMB. To do this, contact ECFMG at (215) 386-5900 or go to [www.ecfm.org](http://www.ecfm.org).

**OR**

**Fifth Pathway**

**ARRANGE** to have verification of completion of your AMA Fifth Pathway sent **directly** to the HMB. To do this, contact AMA at [www.ama-assn.org](http://www.ama-assn.org) or call (312) 464-5199 for assistance.

**VISA QUALIFYING EXAMINATION**

**FMG applicants for MD license through 2<sup>nd</sup> pathway are to provide evidence of medical training or experience:**

**ARRANGE** to have ECFMG send the score of the VISA qualifying examination sent **directly** to the HMB. To do this, contact ECFMG at (215) 386-5900 or go to [www.ecfm.org](http://www.ecfm.org).

**VERIFICATION GOVERNMENT EMPLOYMENT**

**All applicants for MDG license are to provide verification of government employment:**

**ATTACH** a statement from an official of the state or county government agency confirming employment. This license is only valid for and while in the employment of the government agency and must be renewed annually.

**NATIONAL PRACTITIONER DATA BANK REPORT**

**ATTACH** the original "SELF-QUERY RESPONSE" report from the National Practitioner Data Bank (NPDB). To obtain the report, go to the NPDB-HIPDB website at [www.npdb-hipdb.com](http://www.npdb-hipdb.com) and click on **Perform a Self-Query**. If you are unable to go on-line, call NPDB-HIPDB at 1-800-767-6732 for assistance.

Although they are now making your NPDB available for you to download, the Hawaii Medical Board requires the ORIGINAL hard copy that is mailed to you.

**AMA PROFILE**

**ARRANGE** to have the American Medical Association (AMA) Profile sent **directly** to the HMB by going to the AMA website at: [www.ama-assn.org/amaprofiles](http://www.ama-assn.org/amaprofiles). Click on "**Physicians only-Requests for Profiles to be sent to Licensing Boards.**" then **Products and Services** and then on **Credentialing Products**. If you are unable to go on-line, call AMA at (312) 464-5199 for assistance. An AMA Profile is required of all physicians, including those who are not members of AMA.

**FEDERATION  
REPORT**

**Applicants who passed the NBME, state examination, MCCQE or MCCEE:**

**ARRANGE** to have the Federation Discipline Report sent **directly** to the HMB. To do this, send the attached "Federation Discipline Report" form (MD-07) to the Federation of State Medical Boards (Federation) and request that they send the form **directly** to the HMB.

**Applicants who passed the USMLE, FLEX, or SPEX examination:**

**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](http://www.fsmb.org) and click on **Transcript Requests**. (The EBAHR also provides USMLE, FLEX, and SPEX examination scores.)

**EXAMINATION  
SCORES**

**Applicants who passed the NBME examination:**

**ARRANGE** to have the NBME examination scores sent **directly** to the HMB. To do this, call the NBME Examinee Records office at (215) 590-9592 or go to their website at: [www.nbme.org/programs/nbmecert.asp](http://www.nbme.org/programs/nbmecert.asp).

**Applicants who passed the USMLE, FLEX, SPEX examination:**

**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](http://www.fsmb.org) and click on **Transcript Requests**. (The EBAHR also provides a board action history report.)

(Note: All three steps of the USMLE must be passed within seven years.)

**Applicants who passed a state-produced examination:**

**ARRANGE** to have the state (where you took the examination) send the scores **directly** to the HMB. (In addition, proof of satisfactory completion of the SPEX examination must be sent to the Board.)

**Applicants who passed the MCCQE or MCCEE:**

**ARRANGE** to have the Medical Council of Canada (MCC) send the scores or marks of the MCCQE or MCCEE **directly** to the HMB. To do this, call the MCC at (613) 521-6012 or go to their website at: [www.mcc.ca](http://www.mcc.ca).

**TO APPLY FOR  
EXAMINATION**

**TO APPLY FOR THE USMLE OR SPEX** call the Federation at (817) 868-4041 or go to their website at: [www.fsmb.org](http://www.fsmb.org). USMLE applicants click on **USMLE**. SPEX applicants click on **Post-licensure Assessment**, then **Special Purpose Examination (SPEX)**.

**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 States. 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) year 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.

**CERTIFICATION OF APPLICANT**

Please read the certification at the end of the application and sign and date it.

**RELEASE OF INFORMATION**

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.

**MAILING ADDRESS**

APPLICATION AND ITEMS are to be:

**Mailed to:**

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

**OR**

**Delivered to:**

Hawaii Medical Board  
DCCA, PVL Licensing Branch  
335 Merchant Street, Room 301  
Honolulu, HI 96813

(Phone: 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**

MD LICENSES expire on January 31 of each even-numbered year.  
MDG LICENSES expire on January 31 each 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 AND RULES**

The pertinent laws and rules are posted on our website free of charge at: [hawaii.gov/dcca/pvl](http://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 453, Hawaii Revised Statutes
2. Chapter 85, Hawaii Administrative Rules
3. Chapter 436B, Hawaii Revised Statutes

**Application for License - PHYSICIAN (MD License) or  
PHYSICIAN employed by Hawaii  
State or County Government  
(MDG License)**

Read instructions and requirements on attached sheet before completing this application.

Circle type of license applying for:		MD	MDG
Legal Name (First, Middle)		(Last)	
Residence Address (include apt. no., city, state and zip code)			
Mailing Address (ONLY if different from above)			
Social Security No.		Phone No. (days) ( )	
Other names used		Birth date:	

Approved	Denied	Initials/Date
Effective Date		License No. MD -
FOR OFFICE USE ONLY	MDG -	
	Circle Exam Taken:	
	NBME	FLEX
MCCQE	STATE-PRODUCED & SPEX	
COMBINATION OF NBME, FLEX & USMLE		

**Circle answers:**

- |   |       |     |    |
|---|-------|-----|----|
| 1) Are you at least 18 years of age?  | ..... | YES | NO |
| 2) Are you a U.S. citizen, a U.S. national, or an alien authorized to work in the U.S.? | ..... | YES | NO |
| 3) Are you a graduate of a U.S. or Canadian medical school?                             | ..... | YES | NO |
| 4) Are you a graduate of a Foreign medical school (FMG)?                                | ..... | YES | NO |

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

- |  |       |     |    |
|--|-------|-----|----|
| 5) Have you ever held a license in Hawaii? | ..... | YES | NO |
|--|-------|-----|----|

*If response "yes", specify type of license and dates below:*

- 6) 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 an 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. Arrange to have certified documents from each state in which disciplinary action was taken or is pending or being investigated sent directly to the Board. (Include Findings of Fact, Conclusion of Law, Recommended Order, Final Order and whether you have been reinstated. If reinstated, date and conditions of license.)***

- 7) 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 |
| e) Have you ever been issued a notice of contract non-renewal?  | ..... | 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.***

- 8) With regard to professional liability:
- |   |       |     |    |
|---|-------|-----|----|
| a) Have any claims of malpractice ever been filed against you?  | ..... | YES | NO |
| b) Has 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)

End: App/Lic	.....	323/312	.....	\$50/\$75
Gov: App/Lic	.....	323/312	.....	\$25/\$50
CRF	.....	324	.....	\$45/\$90
½ Ren	.....	300	.....	\$ 75
Service Charge	.....	BCF	.....	\$ 25

Name of Applicant: \_\_\_\_\_

- 9) 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.**
- 10) 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.**
- 11) 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.**

EDUCATION	Name of Medical School	Location (City/State or Country)		Degree Earned	Dates (mo/yr)	
					From	To
INTERNSHIP, RESIDENCY & FELLOWSHIP	Name of Residency Program	Location (City/State or Country)			Dates (mo/yr)	
					From	To
SYNOPSIS	Medical Practice (Attach additional sheets if necessary)				Dates (mo/yr)	
					From	To
LICENSES	Name of Jurisdiction (Attach additional sheets if necessary)	Date Issued	Expiration Date	License Number	Date Verification Requested	
HOSPITAL	Name of Hospital (If none, state "None")	Location (City/State or Country)		Dates (mo/yr)		Date Form Requested
				From	To	

**\*\*\* SIGNATURE REQUIRED ON PAGE 3 \*\*\***

**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 453-8, Hawaii Revised Statutes). I further certify that I have read and will abide by the provisions of Chapter 453 and Chapter 85.

\_\_\_\_\_  
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



**HOSPITAL FORM – PHYSICIAN**

Access this form via website at: [hawaii.gov/dcca/pvl](http://hawaii.gov/dcca/pvl)

**TO THE APPLICANT:** Complete the "Applicant" section of this form. Send a form to each hospital where you have held, or applied for, privileges, consultation, teaching appointments or locum tenens positions or served in an internship or residency **during any part of the most recent 3 years preceding your application** for a physician's license in Hawaii. Your residency program director may complete this form in place of each hospital's administrator. If more than one form is needed, please duplicate both sides.

<b>APPLICANT</b>	Name (First-Middle)	(LAST)	Social Security No.	Birthdate
	Date Served/Applied:	Capacity Served or Applied for	Name of Hospital/Residency Program	
	<p>To: CHIEF OF STAFF, ADMINISTRATOR OF HOSPITAL OR RESIDENCY PROGRAM DIRECTOR</p> <p>I am applying for a license to practice medicine and surgery in Hawaii. The board requires this form be completed by the Chief of Staff or Administrator in each hospital where I have held, or applied for, privileges, consultation, teaching appointments or locum tenens positions or served in an internship or residency. For my residency program, the program director may complete this form. This request relates to a background investigation that must be completed prior to my being considered for a Hawaii license.</p> <p>This is your authority to release any information, files, or records, favorable or otherwise, requested by the Hawaii Medical Board in connection with my application. Please complete the following questionnaire, <b>SUPPLY COPIES OF INFORMATION IN YOUR RECORDS</b> that would provide further information and <b>return the material directly to the address on the reverse side.</b></p> <p>Date _____</p> <p style="text-align:right;">_____ Signature of Applicant</p>			

<b>CHIEF OF STAFF or ADMINISTRATOR OF HOSPITAL</b>	<p><b>NOTE:</b> This form will be used to evaluate the past conduct and competency of the applicant. Any derogatory information reported on this form may, out of necessity, be shared with the applicant so that the applicant may respond to that information.</p>	
	<div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;"> <p><b>Please complete A and C or B and C as applicable</b></p> </div>	
	<p><b>A. POSTGRADUATE TRAINING:</b></p> <p>1. Is the applicant, or has the applicant been engaged in postgraduate training in your program? ..... YES NO</p> <p>2. Briefly evaluate applicant's competence and conduct during the program: _____</p> <p>3. Has the program ever had cause to restrict, suspend, terminate, or ask for a voluntary resignation of applicant's participation in the program? ..... YES NO</p> <p>4. Has the program ever issued a notice of contract non-renewal? ..... YES NO <i>If response "yes", questions 3 or 4, please explain and attach copies of material from your records:</i> _____</p> <p><b>B. HOSPITAL PRIVILEGES:</b></p> <p>1. Were privileges extended to the applicant? ..... YES NO</p> <p>2. Please describe privileges: _____</p> <p>3. Was applicant rejected privileges? ..... YES NO <i>If response "yes", please explain and attach copies of material from your records:</i> _____</p> <p>4. Were privileges ever limited, revoked, suspended or restricted? ..... YES NO <i>If response "yes", please explain and attach copies of material from your records:</i> _____</p> <p><b>C. SAFE PRACTICE COMMENTS:</b></p> <p>1. Is there anything in your files which could call into question applicant's ability to safely practice medicine? ..... YES NO <i>If response "yes", please explain:</i> _____</p> <p>2. Derogatory information, if any: _____</p>	

(CONTINUED ON BACK)

Applicant Name \_\_\_\_\_

PLEASE SUPPLY ANY COPIES OF INFORMATION IN YOUR RECORDS THAT WOULD PROVIDE FURTHER INFORMATION AND SEND TO:

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

Date \_\_\_\_\_

\_\_\_\_\_  
Signature of Chief of Staff, Administrator or Program Administrator

Print Name \_\_\_\_\_

Title \_\_\_\_\_

HOSPITAL/PROGRAM SEAL  
*(If none, please so indicate.)*

Hospital/Residency Program \_\_\_\_\_

Address \_\_\_\_\_

Phone No. (     ) \_\_\_\_\_