**Area for Licensure, Permitting, Registration and/or Certification**

Check all that apply. Specify the purpose and discipline of licensure application. Type or block print only. Do not use felt-tip pens.

- First medical license
- Licensure by endorsement
- Medicine & Surgery
- Institutional
- Osteopathy
- Acupuncture
- Podiatry

---

### I. Name(s) — Use full name.
Do not use initials or nicknames unless they are part of your legal name. Line 1: Surname (including Jr., Sr., II, etc.) and degree; Line 2: First and Middle Name(s). If name is hyphenated, include the hyphen. List your name as it appears on each document.

1a. License, Permit, Registration and/or Certification — This Is Your Legal Name. This is the name that will be printed on your license, permit, registration and/or certification and used for all reporting and on inquiries. Use this name on each page of the application.

1b. Medical/Professional Diploma.

1c. Internship / Residency
Include name and location of hospital(s).

1d. ECFMG Certificate.

1e. NBME, USMLE, FLEX, SPEX, PMLexis, Other Certificate(s).
Specify certificate by placing “X” in appropriate blank.

1f. State License(s), Permit, Registration and/or Certification.
Identify State.

1g. Specialty Board Certificate(s) Identify Board.

1h. Certificate of Naturalization, Declaration of Intention, Valid visa Specify.

1i. All other Alternate Names—Include all other names and nicknames (including names used for/in Board Actions).

**Statement of Legal Name**

I understand that the Louisiana State Board of Medical Examiners maintains all records in alphabetical order and that I will be listed alphabetically under my surname (last name) as stated in Item 1a of this Application.

__________________________
Signature

Subscribed and sworn on this ______ day of ______________________, in the year 200____.

__________________________
Notary Public

My Commission Expires ____________________________

**SEAL**
**2. Personal Interview**

State the preferred location for personal interview with original credentials. Personal interview shall not be made until application is otherwise complete.

<table>
<thead>
<tr>
<th>MD/DO</th>
<th>New Orleans</th>
<th>Morgan City</th>
</tr>
</thead>
<tbody>
<tr>
<td>MD/DO</td>
<td>Baton Rouge</td>
<td>Shreveport</td>
</tr>
<tr>
<td>MD/DO</td>
<td>Lafayette</td>
<td></td>
</tr>
</tbody>
</table>

If intern/resident, mark "X" here: _____

Podiatry

| MD/DO | New Orleans | Monroe |

**3. Addresses**

Address must include physical address (i.e. street number, street name). If applicable, include apartment number with physical address.

**3a. Mailing**—This is the address to which correspondence will be forwarded by the LSBME.

*This is the address that will appear in the **LSBME Official List** and will be provided to the public.

It is your responsibility to keep the LSBME apprised of all address changes.

<table>
<thead>
<tr>
<th>City</th>
<th>Parish/County</th>
<th>State</th>
<th>Zip/Postal Code</th>
<th>plus 4</th>
</tr>
</thead>
</table>

**3b. Permanent**—If same as mailing address, mark "X" here: □

<table>
<thead>
<tr>
<th>City</th>
<th>Parish/County</th>
<th>State</th>
<th>Zip/Postal Code</th>
<th>plus 4</th>
</tr>
</thead>
</table>

**3c. Business Address**

This is NOT the MAILING or PERMANENT addresses listed in items 3a and 3b.

<table>
<thead>
<tr>
<th>City</th>
<th>Parish/County</th>
<th>State</th>
<th>Zip/Postal Code</th>
<th>plus 4</th>
</tr>
</thead>
</table>

**4. Telephone Numbers**

International Country Code

<table>
<thead>
<tr>
<th>Business Phone</th>
<th>Ext.</th>
<th>Home Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Business Fax</td>
<td></td>
<td>Home Fax</td>
</tr>
<tr>
<td>Cell Phone</td>
<td>Ext.</td>
<td>Pager</td>
</tr>
</tbody>
</table>

**5. Website and E-mail Address**

List primary and secondary e-mail addresses, if applicable.

Website Address

Primary E-mail Address

Secondary E-mail Address, If Applicable
6. **Date and Place of Birth**

Notarized birth certificate or passport required. If passport submitted, explain on separate 8 ½ ” x 11” sheet of paper.

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

City

Parish/County

State (US only)

Province/Territory

Country

7. **Nationality/Citizenship**

If not native born U.S. citizen (born in U.S. or one of its territories), proof of U.S. citizenship or valid visa issued by U.S. Immigration and Naturalization required. Proof of U.S. citizenship can be by producing an original certificate of naturalization or certificate of birth to U.S. citizens traveling abroad. A valid visa is a visa issued by the Immigration and Naturalization Service authorizing a person to reside and work in the U.S.

*a.* Are you an U.S. Citizen?  
☐ Yes  ☐ No

*b.* If not native born citizen of the U.S., provide following:

- Type VISA: __________________________________________
- If naturalized, provide certificate number: ________________
- INS number: __________________________________________
- Petition number: ______________________________________
- Date issued: __________________________________________
- District Court through which issued: ______________________
- Certificate of Citizenship certificate number: ______________

8. **Identification Numbers**

<table>
<thead>
<tr>
<th>U.S. Social Security Number</th>
<th>Driver’s License Number</th>
<th>Issuing State</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

National Identification Number

Issuing Country

9. **Gender**

_____ Male  _____ Female

10. **Physical Description**

See Instructions for LSBME Code Descriptions.

Use linear measure in feet and inches.

- Height _______ Ft.  _______ In.  
- Weight _______ Lbs.  
- Eyes _______ Color  
- Hair _______ Color  
- Race _______ Optional

- I have no physical mark(s).
- I have the following physical mark(s):

<table>
<thead>
<tr>
<th>Description of Mark</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Description of Mark</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

11. **Military**

U.S. Active Duty

Have you ever served in the U.S. Military?  
☐ Yes  ☐ No

*If yes,* Branch ______________________________________

Dates Served ___________________________  
Type Discharge _______________________
12. License/Permit/Registration/Certification History

List States in which you obtained a License, Permit and/or Certification.
Specify type, license number and date initially issued.
Include all licenses, whether permanent or temporary.
Does not apply, mark here □

<table>
<thead>
<tr>
<th>State</th>
<th>License Type</th>
<th>License Number</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Louisiana</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other States</td>
<td></td>
<td></td>
<td></td>
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<tr>
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<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
</tr>
</tbody>
</table>

To order criminal background materials, e-mail the LSBME here: lsbmemat@lsbme.org. Include the following information: Name, Mailing Address, and Telephone Number.

CONTINUE TO THE NEXT PAGE
THIRD PARTY AUTHORIZATION

I understand and acknowledge that the submission of an application to, as well as the acceptance or maintenance of, any license, permit, certificate and/or registration (hereinafter referred to as a "license") issued by the Louisiana State Board of Medical Examiners (the "Board") shall constitute and operate as a perpetual authorization by me to each educational institution at which I have matriculated, each state or federal agency to which I have applied for any license, permit, certificate and/or registration, each person, firm, corporation, clinic, office or institution by whom or with whom I have been employed in the practice of medicine or as an allied health professional, each physician or other health care practitioner whom I have consulted or seen for diagnosis or treatment and each professional organization or specialty board to which I have applied for membership, to disclose and release to the Board any and all information and documentation concerning me which the Board may deem material to the consideration of my initial application and during such period as I may hold or maintain a license. With respect to any such information or documentation, the submission of an application to or the acceptance or maintenance of a license from the Board shall equally constitute and operate as a consent by me to the disclosure and release of such information and documentation and as a waiver by me of any privilege or right of confidentiality which I would otherwise possess with respect thereto.

By submitting an application or accepting or maintaining a license issued by the Board, I shall be deemed to have given my consent to submit to physical or mental examinations if, when and in the manner so directed by the Board and to have waived all objections as to the admissibility or disclosure of findings, reports or recommendations pertaining thereto on the grounds of privileges provided by law. I acknowledge that the expense of any such examination shall be borne by me.

The submission of an application or the acceptance or maintenance of a license from the Board shall also constitute and operate as perpetual authorization and consent by me to the Board to disclose and release any information or documentation set forth in or submitted with my application, or which then or at any time thereafter may be obtained by the Board from other persons, firms, corporations, associations or governmental entities, to any person, firm, corporation, association or governmental entity having a lawful, legitimate and reasonable need therefor, including, without limitation, the medical and/or allied health professional licensing, permitting, certifying and/or registering authority of any state; the Federation of State Medical Boards of the United States; professional organizations, associations and societies; the American Medical Association and any component state, county or parish medical society, including but not limited to the Louisiana State Medical Society and component parish societies thereof; the American Osteopathic Association; the Louisiana Osteopathic Medical Association; the Federal Drug Enforcement Agency; the Louisiana Office of Narcotics and Dangerous Drugs, Office of Licensing and Registration, Department of Health and Hospitals; federal, state, county or parish and municipal health and law enforcement agencies and the Armed Services.

I understand that this authorization and consent is valid commencing on the date herein below subscribed and that such will remain in force and effect until and unless I withdraw my application for, or no longer possess or maintain, a license issued by the Board. I also acknowledge that a duplicate of this document may serve as an original.

Signature: ________________________________

Full Name

**TO BE SIGNED IN THE PRESENCE OF A NOTARY

Subscribed and sworn to before me this ___________ day

of ____________________________, 20__________.

_____________________________________

Notary Public

Seal

MY COMMISSION EXPIRES: ________________________________
### 14. Controlled Substance Permits

Drug Enforcement Administration (DEA) __________ Current? □ Yes □ No

State ________________

Does not apply □

### 15. Examination History Medical Doctors

If does not apply, mark “X” here: □

Provide the most recent examination date and total number of attempts for each examination you have taken for purposes of state medical licensure.

Many applicants confuse NBME Parts with USMLE Steps. Please be certain to accurately report your examination history. Incorrectly reported examinations will result in delays and additional verification surcharges.

State Board examinations are those that were developed and administered specifically by state licensing authorities. Some states have never administered state board examinations and therefore do not apply. Do not confuse these examinations with national licensing examinations such as the NBME, NBOME or USMLE.

If additional space is necessary to report multiple attempts for any test listed, specify here or provide additional information on separate 8 ½” x 11” paper.

<table>
<thead>
<tr>
<th>Examination</th>
<th>Most Recent Attempt (Month/Year)</th>
<th>No. of Attempts</th>
<th>State Board Sponsor</th>
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<tbody>
<tr>
<td>State Board Exam</td>
<td>________________________________</td>
<td>______________</td>
<td>____________________</td>
</tr>
<tr>
<td>FLEX Pre-1985</td>
<td>________________________________</td>
<td>______________</td>
<td>____________________</td>
</tr>
<tr>
<td>FLEX Component I</td>
<td>________________________________</td>
<td>______________</td>
<td>____________________</td>
</tr>
<tr>
<td>FLEX Component II</td>
<td>________________________________</td>
<td>______________</td>
<td>____________________</td>
</tr>
<tr>
<td>NBME Part I</td>
<td>________________________________</td>
<td>______________</td>
<td>____________________</td>
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<tr>
<td>NBME Part II</td>
<td>________________________________</td>
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<tr>
<td>NBME Part III</td>
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<td>____________________</td>
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<tr>
<td>SPEX</td>
<td>________________________________</td>
<td>______________</td>
<td>____________________</td>
</tr>
<tr>
<td>USMLE Step 1</td>
<td>________________________________</td>
<td>______________</td>
<td>____________________</td>
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<tr>
<td>USMLE Step 2</td>
<td>________________________________</td>
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<td>____________________</td>
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<tr>
<td>USMLE Step 3</td>
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<tr>
<td>NBOME 1</td>
<td>________________________________</td>
<td>______________</td>
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<tr>
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<td>________________________________</td>
<td>______________</td>
<td>____________________</td>
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<tr>
<td>National Boards</td>
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<tr>
<td>Part 1</td>
<td>________________________________</td>
<td>□ Pass □ Fail</td>
<td></td>
</tr>
<tr>
<td>Part 2</td>
<td>________________________________</td>
<td>□ Pass □ Fail</td>
<td></td>
</tr>
</tbody>
</table>

Additional Information

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________
**16. Premedical Education**

If you are a graduate of a medical school in the U.S. or Canada, complete this item and Item 17. Do not complete Item 18.

If you are a graduate of a medical school outside the U.S. or Canada, completed this item, Item 17 and Item 18. Fifth Pathway, if applicable.

List high school and all colleges and/or universities you attended prior to medical and/or allied health school in chronological order, most recent listed first.

You may photocopy this page to report more than four (4) institutions, if necessary.

Account for ALL time since high school. If a break of six (6) months or more occurred during the attendance dates you provide, report the beginning and ending dates of this break at section 17B. It is not necessary to report breaks between institutions.

Combined MD/PhD programs should be reported in Item 17.

**Note:** LSBME does not verify premedical education (except in cases where credits were granted towards the medical degree.) The information provided will be reported exactly as it appears on this page.

<table>
<thead>
<tr>
<th>Name of Institution #1</th>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Country</th>
<th>Zip Code</th>
<th>Plus 4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>From</th>
<th>To:</th>
<th>Month</th>
<th>Year</th>
<th>Month</th>
<th>Year</th>
<th>Degree:</th>
<th>High School</th>
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<tbody>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>None</td>
<td>☐ B.A. ☐ B.S.</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td>☐ M.A.  ☐ M.S.</td>
<td></td>
</tr>
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<td></td>
<td></td>
<td></td>
<td>☐ Other:</td>
<td></td>
</tr>
</tbody>
</table>

Was any part of this education used as credit towards your medical degree? ☐ Yes ☐ No

<table>
<thead>
<tr>
<th>Name of Institution #2</th>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Country</th>
<th>Zip Code</th>
<th>Plus 4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>From</th>
<th>To:</th>
<th>Month</th>
<th>Year</th>
<th>Month</th>
<th>Year</th>
<th>Degree:</th>
<th>High School</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>None</td>
<td>☐ B.A. ☐ B.S.</td>
</tr>
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<td></td>
<td></td>
<td>☐ M.A.  ☐ M.S.</td>
<td></td>
</tr>
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<td></td>
<td></td>
<td></td>
<td>☐ Other:</td>
<td></td>
</tr>
</tbody>
</table>

Was any part of this education used as credit towards your medical degree? ☐ Yes ☐ No

<table>
<thead>
<tr>
<th>Name of Institution #3</th>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Country</th>
<th>Zip Code</th>
<th>Plus 4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>From</th>
<th>To:</th>
<th>Month</th>
<th>Year</th>
<th>Month</th>
<th>Year</th>
<th>Degree:</th>
<th>High School</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
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<td></td>
<td></td>
<td>None</td>
<td>☐ B.A. ☐ B.S.</td>
</tr>
<tr>
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<td>☐ M.A.  ☐ M.S.</td>
<td></td>
</tr>
<tr>
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<td></td>
<td></td>
<td></td>
<td>☐ Other:</td>
<td></td>
</tr>
</tbody>
</table>

Was any part of this education used as credit towards your medical degree? ☐ Yes ☐ No

<table>
<thead>
<tr>
<th>Name of Institution #4</th>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Country</th>
<th>Zip Code</th>
<th>Plus 4</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>From</th>
<th>To:</th>
<th>Month</th>
<th>Year</th>
<th>Month</th>
<th>Year</th>
<th>Degree:</th>
<th>High School</th>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>None</td>
<td>☐ B.A. ☐ B.S.</td>
</tr>
<tr>
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<td></td>
<td>☐ M.A.  ☐ M.S.</td>
<td></td>
</tr>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td>☐ Other:</td>
<td></td>
</tr>
</tbody>
</table>

Was any part of this education used as credit towards your medical degree? ☐ Yes ☐ No
### 17A. Medical Education

If does not apply, mark “X” here: □

List all of the medical schools attended in chronological order, beginning with most recent school attended.

Photocopy this page to report more than two (2) institutions, if necessary.

If medical school is outside of the U.S. and/or you participated in a Fifth Pathway program, also complete Item 18.

If necessary, you may continue your explanation of Unusual Circumstances on a separate 8 ½” x 11” sheet of paper. Your response may not exceed 100 words per question.

**DOCUMENTATION:**

Include a legible photocopy of medical school diploma. Provide a complete mailing address. The certificate of Dean/Registrar page will be mailed to the address you provide.

<table>
<thead>
<tr>
<th>Complete Name of Institution # 1 (Do Not abbreviate)</th>
<th>Street Address, City, State, Country (if not U.S.), Zip Code</th>
<th>Month / Date / Year Commenced</th>
<th>Month / Date / Year Graduated</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

___ MD  ____ D.O.  ____Podiatry  ____ Did not graduate.

Unusual Circumstances (check Yes or No):

Did you take a leave(s) of absence or break(s) from your medical education?..... □ Yes □ No

Were you ever placed on probation?................................................................. □ Yes □ No

Were you ever disciplined or placed under investigation?................................ □ Yes □ No

Were any negative reports ever filed against you?............................. □ Yes □ No

Were any limitations or special requirements imposed on you because of academic incompetence, disciplinary problems or for any other reason?......... □ Yes □ No

Please explain each “Yes” response from above:

________________________________________________________________________________________

________________________________________________________________________________________

Complete Name of Institution # 2 (Do Not Abbreviate)

<table>
<thead>
<tr>
<th>Street Address, City, State, Country (if not U.S.), Zip Code</th>
<th>Month / Date / Year Commenced</th>
<th>Month / Date / Year Graduated</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

___ MD  ____ D.O.  ____Podiatry  ____ Did not graduate.

Unusual Circumstances (check Yes or No):

Did you take a leave(s) of absence or break(s) from your medical education?..... □ Yes □ No

Were you ever placed on probation?................................................................. □ Yes □ No

Were you ever disciplined or placed under investigation?................................ □ Yes □ No

Were any negative reports ever filed against you?............................. □ Yes □ No

Were any limitations or special requirements imposed on you because of academic incompetence, disciplinary problems or for any other reason?......... □ Yes □ No

Please explain each “Yes” response from above:

________________________________________________________________________________________

________________________________________________________________________________________
**17B. Practice History and Non-Professional Activity**

(Do NOT include Training)
Account for ALL time, in chronological order, from High School to the present.

<table>
<thead>
<tr>
<th>From Month/Year</th>
<th>To Month/Year</th>
<th>Location City/State</th>
<th>Employer/Practice</th>
<th>Specialty/Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

**18. Fifth Pathway**

Complete this section only if you participated in a Fifth Pathway Program

The LSBME will contact you with special instructions upon receipt of your application and fees.

**DOCUMENTATION**

You must include a legible photocopy of your Fifth Pathway Certificate.

If does not apply, Mark “X” here □

---

Complete Name of Medical School that Awarded Fifth Pathway Certificate. (Do NotAbbreviate)

Street Address, City, Parish / County, State, Country (if not U.S.)

Month / Day / Year Commenced       Month / Day / Year Completed       Exact Date (Month / day / Year) Certificate Awarded

---

CONTINUE TO NEXT PAGE
## 19A. Postgraduate Medical Education

List all of the postgraduate medical education programs attended in chronological order. Use one page per institution.

Two pages in this application are provided to report this information. You must make a photocopy (ies) of this page to report more than two (2) institutions.

**IMPORTANT:**
Report incomplete postgraduate years (PGY) separate from those that were successfully completed.

If postgraduate year is currently in progress, indicate the *expected* completion date in the “To” field.

Report internships, residencies and fellowships separately.

Use one section per department.

If necessary, continue your explanation of Unusual Circumstances on a separate 8½” x 11” sheet of paper. Response may not exceed 100 words per question.

If does not apply, mark “X” here □

---

### Phone Call or Department

<table>
<thead>
<tr>
<th>PGY</th>
<th>Internship</th>
<th>Residency</th>
<th>Fellowship</th>
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<tbody>
<tr>
<td></td>
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</tbody>
</table>

**Department:**

From: ________  - ________ to ________ - ________

Month                Year                Month               Year

Successfully Completed? ☐ Yes ☐ No ☐ In progress

---

### Phone Call or Department

<table>
<thead>
<tr>
<th>PGY</th>
<th>Internship</th>
<th>Residency</th>
<th>Fellowship</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

**Department:**

From: ________  - ________ to ________ - ________

Month                Year                Month               Year

Successfully Completed? ☐ Yes ☐ No ☐ In progress

---

### Phone Call or Department

<table>
<thead>
<tr>
<th>PGY</th>
<th>Internship</th>
<th>Residency</th>
<th>Fellowship</th>
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<tbody>
<tr>
<td></td>
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</tbody>
</table>

**Department:**

From: ________  - ________ to ________ - ________

Month                Year                Month               Year

Successfully Completed? ☐ Yes ☐ No ☐ In progress

---

### Unusual Circumstances (check Yes or No):

- Did you take leave(s) of absence or break(s) from your medical education? ☐ Yes ☐ No
- Were you ever placed on probation? ☐ Yes ☐ No
- Were you ever disciplined or placed under investigation? ☐ Yes ☐ No
- Were any negative reports ever filed against you? ☐ Yes ☐ No
- Were any limitations or special requirements imposed on you because of academic incompetence, disciplinary problems or for any other reason? ☐ Yes ☐ No

Explain each “YES” response from above:

________________________________________________________________________________________________________
**19B. Continued Postgraduate Medical Education**

List all of the postgraduate medical education programs you attended in chronological order. Use one page per institution.

Two pages (Items 19A and 19B) in this application are provided to report this information. You must make a photocopy (ies) of this page to report more than two institutions.

**IMPORTANT:**
Report incomplete postgraduate years (PGY) separate from those that were successfully completed.

If postgraduate year is currently in progress, indicate the expected completion date in the "to" field.

Report internships, residencies and fellowships separately.

If necessary, continue your explanation of Unusual Circumstances on a separate 8½” x 11” sheet of paper.

Response may not exceed 100 words per question.

---

<table>
<thead>
<tr>
<th>PGY</th>
<th>Internship</th>
<th>Residency</th>
<th>Fellowship</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Department:

From: ___________ - ___________ to ___________ - ___________
Month            Year            Month           Year

Successfully Completed? _____ Yes    _____ No    _____ In progress

---

<table>
<thead>
<tr>
<th>PGY</th>
<th>Internship</th>
<th>Residency</th>
<th>Fellowship</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

Department:

From: ___________ - ___________ to ___________ - ___________
Month            Year            Month           Year

Successfully Completed? _____ Yes    _____ No    _____ In progress

---

<table>
<thead>
<tr>
<th>PGY</th>
<th>Internship</th>
<th>Residency</th>
<th>Fellowship</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Department:

From: ___________ - ___________ to ___________ - ___________
Month            Year            Month           Year

Successfully Completed? _____ Yes    _____ No    _____ In progress

---

**Unusual Circumstances (check Yes or No):**

- Did you take leave(s) of absence or break(s) from your medical education? ... Yes ☐ No ☐
- Were you ever placed on probation? .................................................. Yes ☐ No ☐
- Were you ever disciplined or placed under investigation? .......................... Yes ☐ No ☐
- Were any negative reports ever filed against you? ................................... Yes ☐ No ☐
- Were any limitations or special requirements imposed on you because of academic incompetence, disciplinary problems or for any other reason? ........ Yes ☐ No ☐

Explain each “YES” response from above:

________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________
20. Specialty of Practice
See “Description of Codes” in Instructions.

**DOCUMENTATION:**
Provide a notarized copy of your ABMS certificate(s).

If necessary, you may continue your report of information regarding certification and recertification on a separate 8 1/2” x 11” sheet of paper.

If does not apply, mark “X” here:

<table>
<thead>
<tr>
<th>Primary Specialty Code(^1)</th>
<th>Board Certified/Recertified? Check one: □ Yes □ No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>If Yes, Year Certified: ______________________</td>
</tr>
<tr>
<td></td>
<td>If Yes, Year Recertified: ____________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Secondary Specialty Code(^2)</th>
<th>Board Certified? Check one: □ Yes □ No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>If Yes, Year Certified: _____________</td>
</tr>
<tr>
<td></td>
<td>If Yes, Year Recertified: ___________</td>
</tr>
</tbody>
</table>

21. Future Practice Information
Specify when and where in the State of Louisiana practice is intended and list type of practice.

<table>
<thead>
<tr>
<th>Location #1</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>City</td>
<td>Practice Type (See Codes)</td>
</tr>
<tr>
<td>Date Anticipated</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Location #2</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>City</td>
<td>Practice Type (See Codes)</td>
</tr>
<tr>
<td>Date Anticipated</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Location #3</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>City</td>
<td>Practice Type (See Codes)</td>
</tr>
<tr>
<td>Date Anticipated</td>
<td></td>
</tr>
</tbody>
</table>

22. Medical Doctor Graduate Type

**DOCUMENTATION:**
If graduated from a medical school outside the U.S. or Canada, submit 1 requests for certification of ECFMG Certificate from the ECFMG. The LSBME will not accept certification from the applicant. See special instructions.

If does not apply, mark “X” here:

<table>
<thead>
<tr>
<th>_____ U.S./Canadian</th>
<th>_____ International (other than Canada)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ECFMG Number</td>
<td>__________________________</td>
</tr>
<tr>
<td>Date issued</td>
<td>Month       Day      Year</td>
</tr>
<tr>
<td>Current, Valid ECFMG Certification?</td>
<td>□ Yes □ No</td>
</tr>
</tbody>
</table>

\(^1\) You may report “None”, “Other” or “Unknown”, if necessary.
\(^2\) You may report “None”, “Other” or “Unknown”, if necessary.
# OATH OR AFFIRMATION

<table>
<thead>
<tr>
<th>ANSWER THE FOLLOWING QUESTIONS (YES ANSWERS MUST BE EXPLAINED IN SWORN AFFIDAVIT)</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. In the five years prior to this application, have you had any physical injury or disease or mental illness or impairment, which could reasonably be expected to affect your ability to practice medicine or other health profession?</td>
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</tr>
<tr>
<td>2. In the five years prior to this application, have you been addicted to or used in excess any drug or chemical substance including alcohol or treated through a drug or alcohol rehabilitation program?</td>
<td></td>
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</tr>
<tr>
<td>3. Have you ever, either as an adult or juvenile, been cited, arrested, charged, convicted or pled nolo contendere to, violation of any:</td>
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<tr>
<td>a) State statute?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) Federal statute?</td>
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</tr>
<tr>
<td>4. Has your application for examination or license ever been rejected or denied?</td>
<td></td>
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<tr>
<td>5. Have you ever failed a licensure/certification examination? If yes, how many times?</td>
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<tr>
<td>6. Have you ever been denied membership in a state, county, or local professional society?</td>
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</tr>
<tr>
<td>7. Has your membership in a state, county, or local professional society ever been revoked, suspended, placed on probation, or restricted in any manner?</td>
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<tr>
<td>8. Have you ever been denied, had suspended, revoked or restricted, or voluntarily relinquished, staff or clinical privileges in any hospital or other health care institution or organization?</td>
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<tr>
<td>9. Have you had any malpractice claims filed, settled or adjudicated against you within the last five (5) years?</td>
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<tr>
<td>10. Have you ever voluntarily surrendered, or did you have suspended, revoked or restricted, your narcotics controlled substances license or registration (state or federal)?</td>
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</tr>
<tr>
<td>11. Have you ever voluntarily surrendered, or did you have suspended, revoked, placed on probation, or restricted in any manner, any professional license issued by any licensing authority?</td>
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<tr>
<td>12. Have you ever been the subject of any type of disciplinary action or inquiry by any licensing agency, hospital, institution, society, etc.?</td>
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<tr>
<td>13. Have you ever agreed not to seek re-licensure in any licensing jurisdiction?</td>
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<tr>
<td>14. Have you ever been, or are you currently in the process of being denied, terminated, suspended, refused, limited, placed on probation or placed under other disciplinary action with respect to your participation in any private, state, or federal health insurance program (e.g., Medicare, Medicaid)?</td>
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<tr>
<td>15. Has any court determined you are currently in violation of a court’s judgment or order for the support of dependent children?</td>
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**OATH OR AFFIRMATION OF APPLICANT**

I HEREBY swear or affirm that all statements made and information provided in or with this application are true, correct and complete; that I am the person named in the credentials herewith presented and that I am the original and lawful possessor of such documents; that the photograph submitted to LSBME is a true likeness of me and that it was taken within the last 60 days; that in consideration of the issuance to me of a license/certificate to practice in Louisiana, I swear that I shall observe, abide by and uphold the laws of the State of Louisiana governing my practice and that I shall abstain from unethical, deceptive and fraudulent methods of practice and from immoral, unprofessional and unethical conduct, and that I shall not associate professionally with nor become a partner or employee of any person who resorts to such practices. I hereby agree that the violation of this oath shall constitute cause sufficient for the revocation of said license/certificate and surrender of the rights and privileges accorded me thereunder.

Signed _______________________________________________________

Full Name

Subscribed and sworn to before me this _____________day

of ________________ YEAR

________________________________________________

NOTARY PUBLIC

My commission expires_____________________________
**CERTIFICATE OF DEAN/REGISTRAR**

**APPLICANT’S NAME**

_________________________________________________________________________________________________________________________________________

**SOCIAL SECURITY NUMBER**

_________________________________________________________________________________________________________________________________________

---

## Section 1: To Applicant—Complete Section 1 before a Notary. Forward this form to your Medical, Osteopathic or Podiatry School.

### Recent photograph
Passport quality photograph of applicant securely affixed. 2” x 2” clear, front view, full face without hat or dark glasses. Full-length photograph, black and white or computer-generated will not be accepted. Applicant is to sign name across bottom of photograph, partly on photograph and partly upon the page.

**Affix Photograph Here**
*(Follow directions carefully.)*

I certify that the photograph is a true likeness of __________________________________________ (Applicant).

On this the ___________ Day of ________________, 200______

____________________________________________________
Notary Public

My commission expires_________________________________

---

## Section 2: To Dean/Registrar of Medical/Osteopathic/Podiatry School
After completion of this form, return to Office of Licensure, Louisiana State Board of Medical Examiners, P. O. Box 30250, New Orleans, LA 70190-0250. DO NOT RETURN TO APPLICANT.

I hereby certify that ______________________________

Whose photograph appears above, was awarded the degree of, or certificate in, ______________________________________________________________

Dated _____________________________________________from this school.

**Name of school/program**

_________________________________________________________ **Signature of Medical Dean/Registrar, Allied Program Chairman/Head**

**Address**

_________________________________________________________ **Title**

_________________________________________________________ **Date**

*Affix School Seal Here*
VERIFICATION OF INTERNSHIP OR EQUIVALENT PROGRAM (MD and DO only)

Section 1: TO THE APPLICANT--In order to be eligible for licensure in Louisiana, an applicant who is a graduate of a U.S. or Canadian Medical School or college must present proof of having completed at least one year of postgraduate clinical training in a medical internship or equivalent program accredited by the American Council on Graduate Medical Education (ACGME) of the American Medical Association, or by the Royal College of Physicians and Surgeons (RCPS) of Canada and approved by the Board.

Complete the top section of this form and then forward it to the Director of Medical Education or Program Chairman for completion of the bottom section.

To Whom This May Concern at ______________________________________:

I am applying for license to practice medicine in the state of Louisiana. This is your authorization to release all information in your files concerning me, favorable or otherwise, to the Louisiana State Board of Medical Examiners.

__________________________________________________             ____________________________________________________
Print Or Type Your Full Name                                                        Signature

____________________________________________________
Address

____________________________________________________
City, State and Zip Code

Section 2: To be completed by the Director of the Hospital or by the Director of Medical Education and returned directly to: Office of Licensure, Louisiana State Board of Medical Examiners, P. O. Box 30250, New Orleans, LA 70190-0250. This form is NOT to be returned to the Applicant.

Re:______________________________
(Applicant’s name)

This to verify that the records of this institution indicate that the referenced physician served an Internship or Equivalent Program as follows:

Dates of Internship (PGY-1): Start Date:______________________________________________; End Date:______________________________________________

Type of Internship served: _____Transitional; _____Rotating; _____Categorical (specify specialty)____________________________________

Did the physician successfully complete the Internship? _____Yes; _____No.

Please explain
____________________________________________________________________________________________________________________________________
____________________________________________________________________________________________________________________________________
____________________________________________________________________________________________________________________________________

Date:_________________________        Signed:________________________________

Title:________________________________

(Seal of Institution)   Name of Institution:________________________________

Address:________________________________
SAMPLE LETTER OF RECOMMENDATION FROM DEAN/PRINCIPAL/ADMINISTRATOR
(Sample for International Medical Graduates Only)

Date____________________________

Louisiana State Board of Medical Examiners
Post Office Box 30250
New Orleans, LA 70190-0250

Gentleman:

This is on behalf of ________________________________ who has asked this office for a recommendation in support of (Applicant’s name)
his/her application to the Louisiana State Board of Medical Examiners.

The above-named applicant graduated from ____________________________________________
__________________________________________________________________________ after having completed the prescribed studies.

We remember him/her as a person of fine moral character and with good command of the English language.

We fully endorse his/her application and any assistance extended to him/her in his/her desire to practice his/her profession in your State will be highly appreciated.

_________________________________________  ______________________________
(Seal)                                           Signature

____________________________________________
Title
**To be completed if applying based on reciprocity**

**VERIFICATION / ENDORSEMENT**

**Section 1: To Applicant**— Complete Section 1 of this form and forward it to the licensing agency of each state in which you have ever obtained licensure/certification, whether permanent or temporary. If necessary, this form may be duplicated.

I hereby authorize the licensing agency of the State of ________________________ to release all information on file concerning me, favorable or otherwise, to the Louisiana State Board of Medical Examiners.

<table>
<thead>
<tr>
<th>TYPE OR PRINT YOUR FULL NAME</th>
<th>SIGNATURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>LICENSE NUMBER AND DATE ISSUED</td>
<td>ADDRESS</td>
</tr>
<tr>
<td>SOCIAL SECURITY NUMBER</td>
<td>CITY, STATE, ZIP CODE</td>
</tr>
</tbody>
</table>

**Section 2: THE SECTION BELOW IS TO BE COMPLETED BY THE VERIFYING/ENDORSENG STATE and returned to the Louisiana State Board of Medical Examiners, P.O. Box 30250, New Orleans, LA 70190-0250. This form is NOT to be returned to the Applicant.**

A. This is to certify that the records of the licensing Board of the State of ________________________ indicate that the above-named individual was issued license/certificate No. ________________________ dated ________________________ on the basis of written examination (state name of examination) ________________________; reciprocity with the state of ________________________; other basis (please name) ________________________.

B. If State Board Examination, provide statement of grades or attach hereto.

C. Provide the following:

1. Is this license/certificate current? ________________________
   - Yes
   - No
   - Cannot Divulge

2. Is this license/certificate in good standing? ________________________
   - Yes
   - No
   - Cannot Divulge

3. Has this individual ever been warned or reprimanded? ________________________
   - Yes
   - No
   - Cannot Divulge

4. Has this individual license/certificate ever been revoked? ________________________
   - Yes
   - No
   - Cannot Divulge

5. Has this individual license/certificate ever been suspended? ________________________
   - Yes
   - No
   - Cannot Divulge

6. Has this individual license/certificate ever been placed on probation? ________________________
   - Yes
   - No
   - Cannot Divulge

7. Has this individual license/certificate ever been restricted in any manner? ________________________
   - Yes
   - No
   - Cannot Divulge

8. Has this individual ever had any charges filed against him/her? ________________________
   - Yes
   - No
   - Cannot Divulge

9. Do you know of any information that may be a discredit to this person? ________________________
   - Yes
   - No
   - Cannot Divulge

10. Do your files indicate any derogatory information whatsoever? ________________________
    - Yes
    - No
    - Cannot Divulge

REMARKS

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Date ________________________ Signature ________________________

Title ________________________

BOARD SEAL ________________________

Name and address of licensing agency

NOTE TO BOARD COMPLETING THIS FORM: If answer to 1 or 2 is “No”, or 3 through 10 is “Yes”, explain and attach certified copies of pertinent material (i.e., Notice of Hearing, Final Decision, Consent Order/Agreement, etc.).

(REV. 020201)
REQUEST FOR EXAMINATION SCORES

To request the FLEX, SPEX or USMLE scores, you must complete the Federation’s request form which can be obtained from their web site at www.fsmb.org.

To request the National Board scores, you must complete the National Board’s request form which can be obtained from their web site at www.nbme.org.

To request the NBOME/COMLEX-USA scores, you must complete the National Board’s Request form which can be obtained form their web site at www.nbome.org.

Contact the examination entity to determine monies necessary to request scores. See “Examination Contacts” on the LSBME application instructions. The LSBME will not accept scores from any source other than the examination entity.
CERTIFICATE OF MEDICAL/PROFESSIONAL SOCIETY (MD/DO only)

Section 1: To Applicant—This form is to be forwarded to the local/county/parish medical/professional society for completion. Applicant is to place his/her name in the blank for name in Section 2. Applicant who is not a member of the local/county/parish medical/professional society is to provide an explanation to the Board.

Section 2: To be completed by the local county/parish medical/professional society and returned to the Louisiana State Board of Medical Examiners, Office of Licensure, P. O. Box 30250, New Orleans, LA 70190-0250. DO NOT RETURN TO APPLICANT.

I hereby certify that

________________________________________________________________________________________

is a member in good standing of this society.

Name of Society

Signature of Executive Officer

Address

Title

SOCIETY SEAL
(If no seal, please so state)

Date
**VERIFICATION OF BOARD CERTIFICATION/CREDSNIALS**

The LSBME will NOT accept verification from any source other than the Certification/Credentialing Board.

<table>
<thead>
<tr>
<th>Section 1: To the applicant: Complete Sections 1 &amp; 2 then forward this form to the Board to which you have received Board Certification/Credentials.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Certification/Credentialing Board</td>
</tr>
<tr>
<td>Street Address</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section 2: To the Certification/Credentialing Board from the applicant:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gentlemen:</td>
</tr>
<tr>
<td>I am applying for licensure/reinstatement/re-licensure to practice in the State of Louisiana. This is your authorization to release any information in your files concerning me, favorable or otherwise, to the Louisiana State Board of Medical Examiners.</td>
</tr>
<tr>
<td>Print or Type Your Full Name</td>
</tr>
<tr>
<td>Street Address</td>
</tr>
<tr>
<td>Date of Certification/Credentialing</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section 3: To the Certification/Credentialing Board: Mail verification of certification/credentials to: Louisiana State Board of Medical Examiners, P. O. Box 30250, New Orleans, LA 70190-0250. DO NOT return to applicant. The LSBME will NOT accept verification from any source other than the Certification/Credentialing Board.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Re: ____________________________________________________________</td>
</tr>
</tbody>
</table>

Please certify that the records of the Board indicate the following regarding the above referenced physician:

- Certification/Credential Number
- Type of certification/credential
- Date of certification/credentialing
- Date of examination (if examination taken for certification/credentialing)
- Date certification/credentialing valid through
- Date of re-certification/credentialing
- Date of examination (if examination taken for re-certification/credentialing)
- Date re-certification/credentialing valid through