

MARYLAND BOARD OF PHYSICIANS

P.O. Box 2571
Baltimore, MD 21215

**NOTICE TO PHYSICIANS WHOSE LAST NAMES BEGIN
WITH A THROUGH L**

The Maryland Board of Physicians (the Board) reinstates licenses year round. Licenses are reinstated with an expiration date that is determined by the last name of the applicant. If deemed eligible for reinstatement of medical licensure, when would you like to be reinstated?

Please read page 2 and choose when you would prefer to be reinstated. Complete the form and mail it to the Board with your completed reinstatement application.

Thank you for your cooperation.

**IF YOUR LAST NAME DOES NOT BEGIN WITH THE LETTERS A THROUGH L,
PLEASE DISREGARD THIS FORM.**

IF APPLICABLE, PLEASE COMPLETE PAGE 2.

MARYLAND BOARD OF PHYSICIANS

P.O. Box 2571
Baltimore, MD 21215

APPLICATION FOR REINSTATING PHYSICIANS

APPLICANT'S PREFERRED DATE OF REINSTATEMENT

The Maryland Board of Physicians (the Board) reinstates eligible applicants year round. Licenses are issued with an expiration date that is determined by the last name of the applicant. Licenses of physicians whose last names begin with the letters **A through L** expire on September 30th of **even** years (example: 2016, 2018, etc.).

Instructions: If your last name begins with the letters **A- L**, please choose Option 1 or Option 2. Please print your name, sign and date the form and include it with your application for reinstatement.

Option 1

_____ If determined eligible for reinstatement of licensure, I wish to be reinstated **BEFORE** September 30, 2016. If reinstated, I understand that: (1) I will be required to renew the license and pay a renewal application fee before the license expires on September 30, 2016; and (2) the Board will issue the license only upon receipt of this signed and dated form.

Signature _____ Date _____

Name in Print _____

Option 2

_____ If determined eligible for reinstatement, I wish to be reinstated **AFTER** September 30, 2016. If reinstated, I understand that: (1) the license will be issued after September 30, 2016; (2) the license will expire on September 30, 2018; (3) I MAY NOT practice medicine in Maryland prior to receiving my license; and (4) the Board will only issue the license upon receipt of this signed and dated form.

Signature: _____ Date _____

Name in Print: _____

MARYLAND BOARD OF PHYSICIANS

Baltimore, Maryland

www.mbp.state.md.us

APPLICATION FOR REINSTATEMENT OF MEDICAL LICENSE

Dear Applicant:

Attached is an application packet for reinstatement of your license to practice medicine in Maryland.

The fee to reinstate a medical license is **\$600** or **\$700**. Fees are based on when the license expired. If the licensee's last name begins with the letters **A-L**, the license expires on September 30th of even years. If the licensee's last name begins with the letters **M-Z**, the license expires on September 30th of odd years.

If your license expired within the last 24 months prior to submitting your application for reinstatement, the reinstatement fee is **\$700**. If your license expired more than 24 months prior to submitting your application for reinstatement, the reinstatement fee is **\$600**. If you are unsure of which fee to pay, please contact the Board at 410-764-4777 before submitting your application.

The application fee is **non-refundable**. Please make your check or money order payable to: **Maryland Board of Physicians**.

Mail your **application and payment** to:

**Maryland Board of Physicians
P.O. Box 37217
Baltimore, MD 21297**

Applications and payments sent to any address other than the P.O. Box 37217 address will delay the processing of your application by at least one week. **Please note:** Federal Express (FedEx) or UPS do not deliver to post office boxes.

Applications are processed in the order they are received. **Please allow at least 4 to 6 weeks for the processing of your application.** Board staff will make every effort to process your application as quickly as possible. Incomplete applications and/or failure to submit the required information will delay the processing of your application.

The Board does not confirm receipt of the application and payment. Once the application has been reviewed, applicants will be notified via e-mail with the status of the application. Please do not call the Board to check on the status of your application, as constant interruptions slow down the process.

Supporting documentation must come directly from the source. For example, verification of other state licenses must come directly from the state board.

The Board will keep your application open for 120 days from the original date of receipt. All requirements for reinstatement must be met within the 120-day period. If the requirements are not met, your application will be closed, and you will be required to submit a new application and full reinstatement fee.

The Board's website is updated every 24 hours. You may wish to check the website at www.mbp.state.md.us before calling the Board to learn if a license was issued to you. When you visit the website, click Search Practitioner Profiles.

We look forward to receiving your completed application and will process it as quickly as possible.

Thank you,
The Licensure Division
Maryland Board of Physicians

MARYLAND BOARD OF PHYSICIANS

P.O. Box 37217

Baltimore, Maryland 21297

Telephone: 410-764-4777 or 800-492-6836

www.mbp.state.md.us

APPLICATION FOR REINSTATEMENT OF MEDICAL LICENSE

INSTRUCTIONS AND IMPORTANT INFORMATION

This application should only be completed by physicians who have an expired Maryland license to practice medicine and wish to reinstate it.

- 1. Maryland License Number:** Enter your license number. If you do not remember your license number, you may find it on the Board's website at <https://www.mbp.state.md.us/bpqapp/>. License numbers begin with a "D" or "H" prefix.
- 2. Expiration Date:** Provide the date your license expired. If your last name begins with the letters **A-L**, your license expires on September 30th of even years. If your last name begins with the letters **M-Z**, your license expires on September 30th of odd years.
- 3. Identifying Information:**
 - **Full Legal Name:** If the name on the application differs from the name on your supporting documentation, please submit a copy of a marriage license, divorce decree, or court order explaining the name change. The Board must be notified of any change in your name on a timely basis.
 - **Social Security Number:** Maryland law requires the Board to collect Social Security numbers from all persons applying for professional licenses or certificates. Disclosure of your Social Security number is mandatory. The Board is permitted by State or Federal law or regulation to use the Social Security number for the following purposes:
 - A. Verification of identity with respect to actions related to your license (Code of Maryland Regulations 10.32.01);
 - B. Administration of the Child Support Enforcement Program (Family Law Article, §10-119.3);
 - C. Identification by the Department of Assessments and Taxation of new businesses in Maryland (Health Occupations Article, §1-210);
 - D. Verification by the Maryland Medicaid program of licensure and sanctions for providers participating in Medicaid (42 U.S.C. §1396a(a)(49); 42 U.S.C. §1396r-2; 42 U.S.C. §1320a-7).
 - **Date of Birth:** Health Occupations Article §14-307(c), Annotated Code of Maryland, requires applicants to be at least 18 years old. Date of birth also will be used for identification and criminal background checks.
 - **Gender:** Disclosure of gender is not a requirement of licensure. The information provided will be used for identification purposes and for criminal background checks only.
- 4a. Non-Public Address:** The non-public (home) address will be the location to which the Board directs all correspondence. If your address changes during the application process, please notify the Board in writing.
- 4b. Public Address:** The public address (business address) is your address of record and is available to the public. However, if no public address is listed, the non-public address will be made available to the public upon request.

APPLICATION FOR REINSTATEMENT OF MEDICAL LICENSE

INSTRUCTIONS AND IMPORTANT INFORMATION CONTINUED

5. **Contact Information:** The Board will contact you using the information provided.
6. **School Information:** Please provide the name and location of the medical school from which you graduated. Also include the date you graduated.
7. **Employment Activities:** Please complete and include all employment history beginning with the date your license expired.
8. **Special Purpose Exam (SPEX) or Comprehensive Osteopathic Medical Variable-Purpose Exam (COMVEX):** A physician applying for reinstatement may be required to pass the SPEX or COMVEX-USA exam if the physician:
 - a. Passed a medical licensing exam more than 15 years before submitting the application for reinstatement;
 - b. Never passed a specialty board certification exam or passed a specialty board certification exam given by a member board of the American Board of Medical Specialties or the American Osteopathic Association (AOA) Bureau of Osteopathic Specialists more than ten years before the application;
 - c. Has not had a full, unrestricted medical license in at least one state of the U.S. or Canada within the ten-year period before submitting the application; or
 - d. Has not actively practiced clinical medicine in the U.S. or Canada for at least seven of the ten years before submitting the application.

Contact Information for the SPEX and COMVEX

SPEX: Contact the Federation of State Medical Boards at http://www.fsmb.org/licensure/spex_plas/

COMVEX: Contact the National Board of Osteopathic Medical Examiners - Client Services Department at clientservices@nbome.org or (866) 479-6828. The website address is <http://www.nbome.org/comvex.asp>.

9. **List the reasons for allowing your Maryland medical license to expire.**
10. **List the reasons for seeking reinstatement of your Maryland medical license.**
11. **Licensure in Other States:** The Board requires primary source verification of medical licensure from other state boards/jurisdictions. The Board will make every effort to verify your license from each state board where you have held a license to practice medicine. If the Board cannot satisfactorily verify your license, you will be required to request a verification of licensure from the state board using the Verification of Other State Licenses form (**REIN 1**).
12. **Continuing Medical Education (CME):** A physician applying for reinstatement is required to earn at least 50 credit hours of Category 1 CMEs during the two-year period immediately preceding submission of the reinstatement application.
13. **Character and Fitness Questions:** Answer the Character and Fitness questions “YES” or “NO.” If you answer “YES” to any item, please provide a detailed explanation, on a separate sheet of paper, and attach any supporting documents. If you were discharged from the military, please provide documentation that includes, but is not limited to, the type of service, date and type of discharge, e.g. DD 214. *Failure to provide a detailed explanation and the required supporting documentation will delay the review process.*

APPLICATION FOR REINSTATEMENT OF MEDICAL LICENSE
INSTRUCTIONS AND IMPORTANT INFORMATION CONTINUED

- 14. Release:** Sign and date the release. You are giving the Board permission to request additional information to support your application for reinstatement.
- 15. Optional Third Party Release:** Board staff will not disclose the status of your application to another party unless you have completed the optional Third Party Release on Page 7 of the application. Please complete the third party release if you want your application disclosed to family members, friends, and future employers, etc.
- 16. Cooperation in an Investigation:** You are expected to cooperate fully with any request for information related to your application for reinstatement of your medical license.
- 17. Certification:** Sign and date the certification.

Expiration and Renewal: If your last name begins with the letters **A-L**, regardless of the date your license is reinstated, your license will expire on September 30 of the first even year following reinstatement.

If your last name begins with the letters **M-Z**, regardless of the date your license is reinstated, your license will expire on September 30 of the first odd year following reinstatement.

Approximately 60-90 days prior to the expiration date, you should receive a notice to renew your license. The renewal notice will be mailed/e-mailed to the current address on file with the Board.

You will be required to renew by September 30th of your renewal cycle year whether or not you receive the renewal notice.

PRACTICING AS A PHYSICIAN: A person may not practice, attempt to practice, or offer to practice as a physician in Maryland unless licensed to practice medicine by the Board. Individuals practicing without a license may be fined up to \$50,000.

The Maryland Board of Physicians supports the Americans with Disabilities Act (ADA) and will provide this material in an alternative format to facilitate effective communication with sensory impaired individuals (for example, Braille, large print, audio tape). If you need such accommodation, please notify the Board's ADA designee, Yemisi Koya, at 410-764-4777 or 1-800-492-6836. For the hearing impaired, please contact the Maryland Relay Services TTY/Voice number at 1-800-735-2258. If you have a complaint concerning the Board's compliance with the ADA, please contact Ms. Koya.

Please keep a copy of your application.



Maryland Board of Physicians

Check One:

Initial Licensure

Reinstatement

Name of Profession: _____

ATTENTION

If You Are a Veteran, Service Member or Military Spouse

PLEASE REVIEW AND COMPLETE BEFORE PROCEEDING

“Veteran” means a former service member who was discharged from active duty under circumstances other than dishonorable within one year before the date on which the application for license, certificate, or registration is submitted.

“Veteran” does not include an individual who has completed active duty and has been discharged for more than one year before the application for a license, certification, or registration is submitted.

“Military Spouse” means the spouse of a service member or veteran,

“Service Member” means an individual who is an active duty member of:

“Military Spouse” includes a surviving spouse of:

- * A veteran; or
- * A service member who died within one year before the date on which the application for license, certification, or registration is submitted.

- * The Armed Forces of The United States
- * A reserve component of the Armed Forces of the United States; or
- * The National Guards of any state

Complete ONLY if You Meet the Following Criteria

Check the appropriate box.

- Service Member – Currently serving in the U.S. Armed Forces, a reserve component of the Armed Forces or National Guards of any state. **Provide supporting documentation..**
- Veteran – Discharged from active military duty under circumstances other than dishonorable within the one year of submitting the application. **Provide supporting documentation.**
- Military Spouse: **Check the appropriate box**
 - Spouse is a Veteran. **Provide supporting documentation.**
 - Spouse was a service member who died within one year before the date of submitting the application. **Provide supporting documentation.**
 - Spouse is a Service Member currently serving in the U.S. Armed Forces, a reserve component of the Armed Forces or National Guards of any state. **Provide supporting documentation.**

Name of Applicant (PRINT)

Military Branch

7. Chronology of Employment Activities: Beginning with the most recent, describe your employment history since your license expired. Explain any lapse in time over one year in which you were not employed. Please do not attach a C.V. or resume.

Employment activities since your license expired:
Please type or print.

month	year	TO	month	year	Activity/Position:
Name :			Address:		
month	year	TO	month	year	Activity/Position:
Name:			Address:		
month	year	TO	month	year	Activity/Position:
Name:			Address:		
month	year	TO	month	year	Activity/Position:
Name:			Address:		
month	year	TO	month	year	Activity/Position:
Name:			Address:		
month	year	TO	month	year	Activity/Position:
Name:			Address:		
month	year	TO	month	year	Activity/Position:
Name:			Address:		
month	year	TO	month	year	Activity/Position:
Name:			Address:		
month	year	TO	month	year	Activity/Position:
Name:			Address:		

If you need more space than this page allows, please photocopy this page for your use or attach a separate sheet. Please sign and date each attachment.

8. SPEX/COMVEX Examinations: Please check either **Yes** or **No**.

Yes No

- a. Did you complete your licensure examination more than 15 years before submitting this application for reinstatement?
- b. Did you complete the certification or recertification examinations of the American Board of Medical Specialties or the AOA Bureau of Osteopathic Specialists more than ten years before submitting this application for reinstatement?
- c. Have you had a full, unrestricted medical license in at least one state in the U.S. or Canada within the ten-year period before submitting this application; or
- d. Have you actively practiced clinical medicine in the U.S. or Canada for at least seven of the ten years before submitting this application?

If you answered “YES” to any of the questions listed above, the Board may require you to pass the Special Purpose Examination (SPEX) or the Comprehensive Osteopathic Medical Variable-Purpose Examination (COMVEX). The SPEX is administered by the Federation of State Medical Boards and the COMVEX is administered by the National Board of Osteopathic Medical Examiners.

9. List the reasons for allowing your Maryland medical license to expire:

10. List the reasons for seeking reinstatement of your Maryland medical license:

13. Character and Fitness Questions (Check either YES or NO) Please answer questions “a through “q” on pages 5 and 6.

YES NO Since your last renewal:

- a. Has a state licensing or disciplinary board (including Maryland), a comparable body in the armed services or the Veterans Administration, denied your application for licensure, reinstatement, or renewal?
- b. Has a state licensing or disciplinary board (including Maryland), a comparable body in the armed services or the Veterans Administration, taken action against your license? Such actions include, but are not limited to, limitations of practice, required education admonishment or reprimand, suspension, probation or revocation.
- c. Has any licensing or disciplinary board in any jurisdiction (including Maryland), a comparable body in the armed services or the Veterans Administration, filed any complaints or charges against you or investigated you for any reason?
- d. Have you withdrawn your application for a medical license or other health professional license?
- e. Has a hospital, related health care institution, HMO, or alternative health care system investigated you or brought charges against you?
- f. Has a hospital, related health care institution, HMO, or alternative health care system denied your application; failed to renew your privileges, including your privileges as a resident; or limited, restricted, suspended, or revoked your privileges in any way?
- g. Have you pleaded guilty or *nolo contendere* to any criminal charge, or have you been convicted of a crime or received probation before judgment because of a criminal charge?
- h. Have you committed an offense involving alcohol or controlled dangerous substances to which you pled guilty or *nolo contendere*, or for which you were convicted or received probation before judgment? Such offenses include, but are not limited to, driving while under the influence of alcohol or controlled dangerous substances.
- i. Are there any charges pending against you in any court of law, are you currently under arrest, released pending trial with or without bond, or is there an outstanding warrant for your arrest?
- j. Do you currently have any condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or a physical, mental, emotional, or nervous disorder or condition) that in any way affects your ability to practice your profession in a safe, competent, ethical, and professional manner?

»»» **If you answered “YES” to any question, on a separate sheet of paper, please provide a signed and dated detailed explanation and attach any supporting documents. Failure to provide documentation and a signed and dated explanation will delay the processing of your application.**

13. Character and Fitness Questions Continued (Check either YES or NO)
Since your last renewal:

- | | YES | NO | |
|----|--------------------------|--------------------------|--|
| k. | <input type="checkbox"/> | <input type="checkbox"/> | Have any malpractice claims or other claims for money damages been filed against you? Include past claims as well as any claim that is now pending, has been dismissed, has been settled, or which has resulted in a damages award against you or your medical practice. |
| l. | <input type="checkbox"/> | <input type="checkbox"/> | Are you in default of a service obligation that you incurred by receiving State or Federal funds for your medical education? |
| m. | <input type="checkbox"/> | <input type="checkbox"/> | Have you failed to make arrangements to satisfy State or Federal loans that financed your medical education? |
| n. | <input type="checkbox"/> | <input type="checkbox"/> | Has your employment or contractual relationship with any hospital, HMO, other health care facility, health care provider, or institution, armed services or the Veterans Administration been terminated for disciplinary reasons? |
| o. | <input type="checkbox"/> | <input type="checkbox"/> | Have you voluntarily resigned or terminated a contract with any hospital, HMO, other health care facility, health care provider, or institution, armed services or the Veterans Administration while under investigation by that institution for disciplinary reasons? |
| p. | <input type="checkbox"/> | <input type="checkbox"/> | Have you surrendered your license or allowed it to lapse while you were under investigation by any licensing or disciplinary board of any jurisdiction, any entity of the armed services or the Veterans Administration? |
| q. | <input type="checkbox"/> | <input type="checkbox"/> | Have you been discharged from any military service of the U.S. Government? If so, attach a copy of your military discharge documentation that includes type of service, date of discharge, and type of discharge. |

»»» **If you answered "YES" to any question, on a separate sheet of paper, please provide a signed and dated detailed explanation and attach any supporting documents.
Failure to provide documentation and a signed and dated explanation will delay the processing of your application.**

RELEASE AND CERTIFICATION

14. Release: I agree that the Maryland Board of Physicians (the Board) may request any information necessary to process my reinstatement application from any person or agency, including but not limited to former and current employers, government agencies, the National Practitioners Data Bank, the Federation of State Medical Boards, hospitals and other licensing bodies. I agree that any person or agency may release the information requested to the Board. I also agree to sign any subsequent releases for information the Board may request.

Applicant's Name (Printed)

Applicant's Signature

Date

15. (OPTIONAL) Third Party Release: Although the Board encourages you to complete all aspects of your application on your own, if you plan to use an intermediary to receive information about the status of your application, please complete this release.

I agree that the Maryland Board of Physicians may release any information pertaining to the status of my application to the following person:

Name: _____

Phone: _____

Applicant's Signature

Date

16. Cooperation in an Investigation: I agree that I will cooperate fully with any request for information, or with any investigation related to my application for reinstatement as a physician in Maryland, including the subpoena of documents and/or records.

During the period in which my application is being processed, I shall inform the Board within 30 days of any change to any answer I originally gave in this application, any arrest or conviction, any change of address, or any action that occurs based on accusations that would be grounds for disciplinary action under Md. Code Ann., Health Occ. §14-404.

Applicant's Signature

Date

17. Certification: I certify that I have completed and attached at least 50 credit hours of Category 1 continuing medical education credits during the two years immediately preceding this application for reinstatement.

I certify that I have personally reviewed all responses to the items in this application and that the information I have given is true and correct to the best of my knowledge and that any false information provided as part of my application may be cause for the denial of my application. I also certify that I am thoroughly familiar with the Statute (MD. Code Ann., Health Occ. §14-317) and Code of Maryland Regulations (COMAR) 10.32.01.11 which govern the reinstatement of physicians in Maryland.

Applicant's Signature

Date

STOP! Mail completed application and fee to Maryland Board of Physicians; P.O. Box 37217; Baltimore, Maryland 21297. Mailing them to any other address will delay the process.

MARYLAND BOARD OF PHYSICIANS
P.O. Box 2571
Baltimore, Maryland 21215-0095
Telephone: 410-764-4777 or 800-492-6836

VERIFICATION OF OTHER STATE LICENSES

Part 1 **APPLICANT:** Complete and sign Part 1 and send a copy of this form to each state board that ever issued you a license, certificate or registration to practice as a Physician. Please copy this form if you need to send it to more than one state board.

State of Licensure: _____ License Number: _____
 Date: _____ Expiration Date: _____
 Name: _____
 (Print) Last (Generational Indicator, Jr., III) First Middle Maiden
 Social Security Number: _____ - _____ - _____ Date of Birth: ____/____/____
 Professional School of Graduation: _____ Year: _____
 Signature: _____ Date: _____

Part 2 **AUTHORIZED OFFICIAL OF STATE MEDICAL BOARD:** Please certify the following information regarding the above-listed individual and send this form directly to the Maryland Board of Physicians at the above address.

 License Number Date Issued Expiration Date
 Is/was the license in good standing? Yes No
 If not in good standing is/was it: Reprimanded Suspended Revoked Surrendered
 Was the license administratively revoked, suspended, or surrendered because the licensee did not renew? Yes No
 If yes, please explain: _____

 Other Derogatory Information or Pending Charges: _____

 Printed Name of Authorized Official

 Title of Authorized Official

 Signature of Authorized Official

 Direct Telephone Number

 Printed Name of State

 Date

