

**Regular Mailing Address**

State Board of Osteopathic Medicine  
P.O. Box 2649  
Harrisburg, PA 17105-2649  
717-783-4858

**Courier Delivery Address**

State Board of Osteopathic Medicine  
2601 North Third Street  
Harrisburg, PA 17110

**APPLICATION FOR A GRADUATE TRAINING TEMPORARY LICENSE**

- THIS APPLICATION IS TO BE USED FOR INITIAL GRADUATE LICENSE. DO NOT USE TO RENEW
- THIS APPLICATION MUST BE SUBMITTED AT LEAST 60 DAYS PRIOR TO THE START OF TRAINING

**PLEASE NOTE:** If the application process has not been completed within one year from the date it was received, applicants will be required to submit an updated application (another application processing fee) and supporting documents, as necessary.

**ALL APPLICANTS ARE REQUIRED TO: (Check when completed)**

- \_\_\_ 1. Complete pages 1 and 2 of the application.
- \_\_\_ 2. If documents will be submitted to the Board under a name different from your present name, submit a copy of the legal document evidencing the name change. I. E. marriage license, divorce decree, naturalization, etc.
- \_\_\_ 3. Attach **\$30.00** check or money order made payable to "Commonwealth of PA." **Fees are not refundable. Check or money order must be drawn on a US bank. No foreign fees can be accepted, even if marked US Funds.** NOTE: A processing fee of \$20.00 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment.
- \_\_\_ 4. Complete Section 1 of the Verification of Medical Education and forward to your medical school for completion of Section 2. **The school must return the completed verification directly to the Board in an official school envelope.**
- \_\_\_ 5. Attach a current Curriculum Vitae listing **all** periods of employment or unemployment (i.e., child rearing, research, etc.) from graduation from medical school to date. The list must be in chronological order and include the month and year.

- **PLEASE FOLLOW ALL DIRECTIONS. ANY DISCREPANCIES WILL CAUSE A DELAY IN THE ISSUANCE OF THE GRADUATE TRAINING TEMPORARY LICENSE. IT IS YOUR RESPONSIBILITY TO CONTACT THE HOSPITAL REGARDING THE STATUS OF YOUR APPLICATION. THE BOARD WILL BE IN DIRECT CORRESPONDENCE WITH THE HOSPITAL.**
- **IF THIS APPLICATION IS NOT COMPLETED WITHIN SIX MONTHS, UPDATES OF CERTAIN SECTIONS WILL BE REQUIRED.**
- **IT IS YOUR RESPONSIBILITY TO MAINTAIN A COPY OF THIS APPLICATION AND ALL DOCUMENTS SUBMITTED TO THE BOARD OR RECEIVED FROM THE BOARD.**
- **YOU MAY NOT PRACTICE IN THE COMMONWEALTH OF PENNSYLVANIA UNTIL THE PENNSYLVANIA STATE BOARD OF OSTEOPATHIC MEDICINE HAS ISSUED A GRADUATE TRAINING TEMPORARY LICENSE. THE GRADUATE TRAINING TEMPORARY LICENSE IS ONLY VALID FOR THE DATES, SPECIALTY, PGY LEVEL, AND HOSPITAL THAT ARE LISTED ON THE LICENSE/CERTIFICATE.**

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Phone: 717-783-4858  
Email [st-osteopathic@state.pa.us](mailto:st-osteopathic@state.pa.us)

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**HOSPITAL USE ONLY**

**TO BE COMPLETED FOR BULK CHECK USAGE**

Hospital Name: \_\_\_\_\_

HS# \_\_\_\_\_

Receipt # \_\_\_\_\_

**APPLICATION FOR A GRADUATE TRAINING TEMPORARY LICENSE**

**PLEASE NOTE:** If the application process has not been completed within one year from the date it was received, applicants will be required to submit an updated application (**another application processing fee**) and supporting documents, as necessary.

**Application fee:** \$50.00 not refundable. Make check payable to the "Commonwealth of Pennsylvania. Note: A processing fee of \$20.00 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment.

TO BE COMPLETED BY APPLICANT (Please Print or Type):

NAME: \_\_\_\_\_  
Last First Middle

ADDRESS: \_\_\_\_\_  
Street  
City State Zip Code

SOCIAL SECURITY # \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
MONTH/DATE/YEAR

If your medical/licensure records are listed under another name or names list below:

NAME & ADDRESS OF MEDICAL SCHOOL	DATES OF ATTENDANCE	DATE OF GRADUATION
_____	_____	_____
NAME & ADDRESS OF HOSPITAL(S)	DATES OF PREVIOUS TRAINING	SPECIALTY
_____	_____	_____

TO BE COMPLETED BY HOSPITAL LOCATED IN PENNSYLVANIA:

NAME OF HOSPITAL: \_\_\_\_\_ HS-- \_\_\_\_\_ --L

ADDRESS OF HOSPITAL \_\_\_\_\_

YEAR IN TRAINING: \_\_\_\_\_ SPECIALTY: \_\_\_\_\_ LEVEL IN TRAINING (PGY) \_\_\_\_\_

DATES OF TRAINING REQUESTED: \_\_\_\_\_ TO \_\_\_\_\_  
BEGINNING DATE-MONTH-DAY-YEAR ENDING DATE-MONTH-DAY-YEAR

NAME OF PROGRAM DIRECTOR: \_\_\_\_\_

SIGNATURE OF PROGRAM DIRECTOR: \_\_\_\_\_

Answer the following questions. If "YES" is answered to #2 through #8, provide complete details on a separate sheet as well as certified copies of relevant documents. Sign and date below.

	Yes	No
1. Do you hold or have you ever held an unrestricted license or certification or registration (active or inactive, current or expired) to practice osteopathic medicine and/or surgery in any other state or jurisdiction? <u>If yes, list below.</u>		
2. Have you withdrawn an application for a license, certificate or registration, had an application denied or refused, or agreed not to reapply in another state, territory or country?		
3. Has any disciplinary action been taken against your license, certificate or registration in another state, territory, or country?		
4. Have you been convicted, found guilty or pleaded nolo contendere, or received probation without verdict or accelerated rehabilitative disposition (ARD) as to any felony or misdemeanor, including any drug law violations, or do you have any criminal charges pending and unresolved in any state or jurisdiction? You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.		
5. Have you been arrested for criminal homicide, aggravated assault, sexual offenses or drug offenses in any state, territory or country?		
6. Have you had practice privileges denied, revoked or restricted in a hospital or other health care facility, have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?		
7. Have you had your DEA registration denied, revoked or restricted or have you had your provider privileges terminated by any medical assistance agency for cause?		
8. Are you, or have you ever been addicted to the imtemperate use of alcohol or to the habitual use of narcotics or other habit-forming drugs? (NOTE: You may answer "NO" if you are currently a participant in or have successfully completed the requirements of the PA Board's Health Monitoring Program.)		
9. Since May 19, 2002, have any malpractice complaints been filed against you? If yes, the Board requires that you submit a copy of the <u>entire Civil Complaint</u> which must include the <u>filing date</u> and the <u>date you were served</u> .		

SIGNED STATEMENT

Note that disclosing your social security number on this application is mandatory in order for the State Board of Osteopathic Medicine to comply with the requirements of the federal Social Security Act pertaining to child support enforcement, as implemented in the Commonwealth of Pennsylvania at 23 Pa. C.S. 4304.1(a). In order to enforce domestic child support orders, the Commonwealth's licensing boards must provide to the Department of Public Welfare information prescribed by DPW about the licensee, including the social security number. Additionally, disclosing the number is mandatory in order for this board to comply with the reporting requirements of the federal National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank. Reports to the NPDB/HIPDB must include the licensee's social security number.

I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa. C.S. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my license. I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Pennsylvania State Board of Medicine any information, files or records requested by the Board.

\_\_\_\_\_  
SIGNATURE OF APPLICANT

\_\_\_\_\_  
DATE

**VERIFICATION OF MEDICAL EDUCATION**

**SECTION 1: To be completed by applicant:**

Name: \_\_\_\_\_  
Last First Middle

Name of medical school: \_\_\_\_\_

Location: \_\_\_\_\_

**SUBMIT THE VERIFICATION OF MEDICAL EDUCATION FORM TO YOUR MEDICAL SCHOOL AND REQUEST YOUR SCHOOL TO RETURN THE COMPLETED FORM DIRECTLY TO THE BOARD IN AN OFFICIAL SCHOOL ENVELOPE.**

**SECTION 2: To be completed by Dean or Registrar of medical school:**

Name of medical student: \_\_\_\_\_

Date student began to attend this medical school: \_\_\_\_\_  
Month/Day/Year

Date of graduation: \_\_\_\_\_  
Month/Day/Year

**This form may be completed three months prior to graduation. If graduation does not take place, notify the Board immediately.**

[Seal of School]

I certify that all of the above information is correct.

Signature of  
Dean or Registrar: \_\_\_\_\_

Date: \_\_\_\_\_

**Upon completion, school must return this completed form directly to the Pennsylvania State Board of Osteopathic Medicine in official school envelope. DO NOT RETURN TO APPLICANT.**

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