

## STATE OF CONNECTICUT DEPARTMENT OF PUBLIC HEALTH

# HOMEOPATHIC PHYSICIAN APPLICATION

PLEASE INDICATE (X) THE EXAMINATION(S) YOU CO	
National Board of Medical Examiners (NBME)	Federation Licensing Examination (FLEX)
State Board Licensing Exam(St Year Taken:	ate) Licentiate of the Medical Council of Canada (LMCC)
United States Medical Licensing Examination (USMLE)	Combination of Segments (please specify)
Last Name: MI: Firs	t Name: Maiden Name:
Social Security No.:	
	address will appear on your official license, your address of record f
nailings from this office and releasable pursuant to Freedom of	Information requests.
Name on License:	
Address:	
City, State, Zip:	
City, State, Zip:	
City, State, Zip: Date of	
Phone Number: () Date of <u>RACE/ETHNIC DATA</u> : (This section is voluntary. Informational demographics of Connecticut licensees. This data will not be use evaluation of your application.)	Birth:/ Gender: on gathered will be used solely for the purpose of examining the ed for discriminatory purposes and will not be considered in the aving origins in any of the original peoples of North America, and w
Phone Number: ( ) Date of <u>RACE/ETHNIC DATA</u> : (This section is voluntary. Informatic lemographics of Connecticut licensees. This data will not be us evaluation of your application.)           AMERICAN INDIAN OR ALASKAN NATIVE: Persons ha maintain cultural identification through tribal affiliation or construction.           ASIAN OR PACIFIC ISLANDER: Persons having origins in	Birth:/ Gender: on gathered will be used solely for the purpose of examining the ed for discriminatory purposes and will not be considered in the aving origins in any of the original peoples of North America, and w
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M.D. DEGREE AWARDED BY: \_\_\_\_\_

\_\_\_\_\_ DATE AWARDED: \_\_\_\_\_

### **MEDICAL LICENSURE:** List *all* states in which you have ever been licensed to practice medicine:

STATE	LICENSE/PERMIT NUMBER	DATE ISSUED

### SPECIALTY:

If certified by a specialty board approved by the American Board of Medical Specialties (ABMS), indicate name of American Board:

### AMERICAN BOARD OF: \_\_\_\_\_\_ DATE CERTIFIED: \_\_\_\_\_

#### MEDICAL PRACTICE:

List all medical practice you h	have engaged in since graduation from medical school (ider	ntify internship and residency):
Hospitals Associated With	Location	Dates

At the exam, do you require accommodation for any disabling condition? Yes 🗌 No 🗌 If Yes, attach a separate written statement to the application, briefly describing the nature of your disability and the accommodation you are seeking. Upon review of your request, this office will contact you for appropriate documentation.

STATEMENT OF PROFESSIONAL HISTORY: Please answer the following questions referring to the instructions, if applicable.

1.	<ul> <li>Have you ever been censured, disciplined, dismissed or expelled from, had admissions monitored or restricted, had privileges limited, suspended or terminated, been put on probation, or been requested to resign or withdraw from any of the following:</li> <li>-Any hospital, nursing home, clinic, or similar institution;</li> <li>-Any health maintenance organization, professional partnership, corporation, or similar health practice organization, either private or public;</li> </ul>	
	<ul> <li>-Any professional school, clinical clerkship, internship, externship, preceptorship or postgraduate training program;-Any third party reimbursement program, whether governmental or private?</li> <li><i>If your answer is "yes", give full details, names, addresses, etc. on separate notarized statement.</i></li> </ul>	Yes 🗌 No 🗌
2.	Have you ever had your membership in or certification by any professional society or association suspended or revoked for reasons related to professional practice? If your answer is "yes", give names of professional society or association, date and reasons your membership or certification was suspended or revoked on a separate notarized statement.	Yes 🗌 No 🗌
3.	Has any professional licensing or disciplinary body in any state, the District of Columbia, a United States possession or territory, or a foreign jurisdiction, limited, restricted, suspended or revoked any professional license, certificate, or registration granted to you, or imposed a fine or reprimand, or taken any other disciplinary action against you? <i>If your answer is ''yes'', give full details, names, addresses, etc. on a separate notarized statement.</i>	Yes 🗌 No 🗌
4.	Have you ever, in anticipation or during the pendency of an investigation or other disciplinary proceeding, voluntarily surrendered any professional license, certificate or registration issued to you by any state, the District of Columbia, a United States possession or territory, or a foreign jurisdiction? <i>If your answer is "yes" give full details, names, addresses, etc. on a separate notarized statement.</i>	Yes 🗌 No 🗌

5.		you currently have pending, any complaint, investigation, charge, ional licensing or disciplinary body in any state, the District of	
	Columbia, a United States possessio	n or territory, or a foreign jurisdiction or any disciplinary a armed services? You need not report any complaints	
	dismissed as without merit.	e armed services? Fou need not report any complaints	Yes 🗌 No 🗌
	If your answer is "yes" give full de	tails, names, addresses, etc. on a separate notarized statement.	
6.		ou currently have pending, a consent agreement of any kind,	
		ofessional licensing or disciplinary body in any state, tates possession or territory, any branch of the armed services	
	or a foreign jurisdiction?		Yes 🗌 No 🗌
	If your answer is 'yes' give full det copy of agreement.	tails on a separate notarized statement and submit notarized	
7.		convicted as a result of an act which constitutes a felony under the laws of another jurisdiction and which, if committed within r the laws of this state?	Yes 🗌 No 🗌
	If your answer is "yes" give full de	tails on a separate notarized statement and furnish a Certified ) of the original complaint, the answer, the judgment, the	
8.	•	ndered a state or federal controlled substance registration,	
	had it revoked or restricted in any w by the responsible agency?	ay, or been warned, reprimanded or fined	Yes 🗌 No 🗍
		tails, dates, etc., on a separate notarized statement.	
On	this day of	( month/ year)(	(annlicent's name)
		ng duly sworn says that she/he is the person referred to in the foregoi	
pho	otograph attached hereto is a true pictu	are of self and that the statements made herein are true in every respo	ect.
		All of the above statements	
	Affix a recent	contained herein are true an	d
	photograph here.	correct to the best of my	

DO NOT STAPLE

SIGNATURE OF APPLICANT

Sworn to me this \_\_\_\_\_ day of \_\_\_\_\_ (month/year) \_\_\_\_.

Notary Public Signature\_\_\_\_\_ My Commission Expires\_\_\_\_\_

knowledge and belief.

Please return this application, the fee for \$565.00 (certified bank check or money order) and a separate certified bank check or money order for \$4.75 made payable to, "Treasurer, State of Connecticut" to:

Department of Public Health Homeopathic Physician Licensure 410 Capitol Ave., <u>MS# 12MQA</u> P.O. Box 340308 Hartford, CT 06134-0308

*IMPORTANT:* Please do not send this form and fee unless you have read and understood the licensing policies and requirements. All fees are nonrefundable.