

Board of Medicine

P.O. Box 30192

Lansing, Michigan 48909

(517) 335-0918

www.michigan.gov/healthlicense**INSTRUCTIONS FOR A LIMITED MEDICAL LICENSE FROM
A CLINICAL ACADEMIC LIMITED LICENSE**Authority: P.A. 368 of 1978, as amended
This form is for information only.

NOTE: It is your responsibility to have all required documentation sent to the Board of Medicine. Questions regarding your application can be directed to the Michigan Board of Medicine at (517) 335-0918 four weeks after the date you sent the application. Please allow 6-8 weeks processing time. Applications submitted without the required licensing fee, applicant's signature, and date will be returned.

Section 16182(1) of the Michigan Public Health Code, states that the board may grant a limited license to individuals who have shown that they are able to practice medicine in a safe and competent manner. This application is only for individuals who have held a clinical academic license issued by the Michigan Board of Medicine and renewed that license five times. This license is intended for physicians who are seeking to continue practicing in a specialized area at a specific academic institution. If granted this license, the provisions of the clinical academic license will continue under the limited medical license. An individual who holds this limited license may practice only in the clinical academic position to which the individual is appointed. An applicant for this limited license must demonstrate the following:

1. That the applicant has been engaged in the practice of medicine for at least ten years after completing the requirements for a degree in medicine obtained in an institution outside of the United States or Canada.
2. That the applicant has completed not less than three years of postgraduate clinical training in an institution that is affiliated with the World Health Organization (WHO).
3. That the applicant has safely and competently practiced medicine under a clinical academic limited license for one or more academic institutions located in this state and that the clinical academic license has been renewed the maximum of five times preceding the date of application for this limited license and that during that time the applicant functioned at least 800 hours per year in the observation and treatment of patients.

THE FOLLOWING MUST BE RECEIVED IN THE BOARD OFFICE:

1. A completed application and a check or money order, drawn on a U.S. financial institution (made payable to the **STATE OF MICHIGAN**, for the appropriate amount. An application accompanied by the appropriate fee is valid for two years. If an applicant fails to complete the requirements for licensure within two years from the date of filing the application, the application is no longer valid.
2. **Effective October 1, 2008**, all applicants for a health profession license or registration in Michigan are required to submit fingerprints and undergo a criminal background check. Please see the attached instructions. The Michigan Board is not able to accept fingerprints that have been obtained for any other purpose. Your license or registration will not be issued until this process is complete.
3. Certification of medical education submitted directly from the medical school to the board on the attached form (unless already on file with this office).
4. Certification of successful completion of three years postgraduate clinical training. The Certification of Postgraduate Training form (attached) must be submitted directly to the Board by the Director of Medical Education where you completed your postgraduate training.
5. The Certification of Practice in an Academic Institution form (attached) must be submitted directly to the Board by the Director(s) of Medical Education where you practiced under the Clinical Academic license. You must have renewed your clinical academic license the maximum of five times to qualify

for the limited license.

6. The Certification of Appointment to a Michigan Academic Institution form (attached), certifying a teaching or research appointment to a Michigan academic institution, must be completed and submitted directly to the Board by the Director of Medical Education of the appointing institution.

GENERAL INFORMATION

1. **ACADEMIC APPOINTMENT CHANGES:** If you change to a different academic appointment, please have the Director of Medical Education from the new program submit a completed Certification of Appointment to a Michigan Academic Institution form. You must submit a letter to the Board explaining the change in appointment with a \$10 fee to print a new license.
2. **NAME CHANGES:** If your name changes please notify the Board of Medicine in writing. To change a name, you can download the [Data Change/Duplicate License Request Form](#) from our website www.michigan.gov/healthlicense and fax it to (517) 373-2179 or mail the form to Bureau of Health Professions, PO Box 30670, Lansing, MI 48909. Telephone calls are NOT acceptable for these changes.
3. **REFUND POLICY:** If you wish to withdraw your application, you may be eligible for a partial refund. You must notify the Board of Medicine in writing to request a refund.
4. **NOTE:** If you have ever been licensed in another state and you have a current disciplinary sanction on that license, (even if the license is inactive), you are **not** eligible for licensure in Michigan according to the Public Health Code, PA 368, as amended, Section 222.16174 (3) Sanctions include probation, limitation, suspension, revocation or fine. Upon resolution of the sanction and verification that the license is active with no disciplinary action in effect, you can proceed with the filing of an application for a Michigan license or registration.
5. **RENEWALS:** You will be required to verify continued appointment to an academic position prior to each renewal of this license.

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**APPLICATION FOR LIMITED LICENSE FROM A
CLINICAL ACADEMIC LIMITED LICENSE
AND CONTROLLED SUBSTANCE LICENSE**

Authority: Public Act 368 of 1978, as amended
If this form is not completed, a license will not be issued.

A controlled substance license is required for every person who prescribes, manufactures, distributes, or dispenses any controlled substance in Michigan as described in Article 7 of Public Act 368 of 1978, as amended. Information on obtaining a Federal controlled substance license may be obtained by contacting the Regional Branch, Drug Enforcement Administration, 431 Howard Street, Detroit, MI 48226 (Telephone 1-800-882-9539).

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Board Use Only
License Number
C.S. License Number
Date of Licensure

Type or Print Only

I AM APPLYING FOR THE FOLLOWING:

Limited License and Controlled Substance Fee: 170.00 71-43-01-375705

Your check or money order drawn on a U.S. financial institution and made payable to the **STATE OF MICHIGAN** must accompany this application. **DO NOT SEND CASH.** Fees are deposited upon receipt and can only be refunded under refund rules promulgated by the Department.

First Name	Middle Name	Last Name
U.S. Social Security Number	Date of Birth	Previous MI License Number and Expiration Date, If applicable
Daytime Phone Number	All Previous Names and/or Birth Name Used (if applicable)	
Have you ever held a health professional license in Michigan? <input type="checkbox"/> Yes <input type="checkbox"/> No		E-Mail Address
Name of Appointing Academic Institution		
Street Address of Academic Institution		
City	State	ZIP Code

Check the appropriate answer to each of the following questions. NOTE: Attach a detailed explanation for any Yes answer you check.

1. Have you ever been convicted of a felony?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Have you ever been convicted of a misdemeanor punishable by imprisonment for a maximum term of 2 years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Have you ever been convicted of a misdemeanor involving the illegal delivery, possession, or use of alcohol or a controlled substance (including motor vehicle violations)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Have you been treated for substance abuse in the past 2 years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Have you had 3 or more malpractice settlements, awards, or judgments totaling \$200,000 or more in any consecutive 5 year period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Have you had one or more malpractice settlements, awards, or judgments totaling \$200,000 or more in any consecutive 5 year period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Have you ever had a federal or state health professional license or registration revoked, suspended, or otherwise disciplined; been denied a license; or currently have disciplinary action pending against you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Name

8. Have you ever been censured, or requested to withdraw from a health care facility's staff or had your health care facility staff privileges involuntarily modified? Yes No

9. Do you hold or have you held a medical license in any state? If yes, list each state, the license or registration number, the date issued, and how the license was obtained **DO NOT LIST TEMPORARY LICENSES. You must have each state board verify licensure directly to this board office. (Attach additional sheets if necessary.)** Yes No

State	License Number	Date of Issue	How obtained (Endorsement or examination)

**Provide a complete chronological record of your educational preparation.
Attach additional sheets if necessary.**

Name and Address of Institution	Dates of Attendance		Degree
	From	To	

**Provide a description of your professional medical experience.
Attach additional sheets if necessary.**

Name and Address of Employer	Dates of Practice		Duties
	From	To	

CERTIFICATION

I understand that it is the policy of this agency to secure a criminal conviction history as part of their pre-licensure screening process. I authorize this agency to use the information provided in this application to obtain a criminal conviction history file search from the Central Records Division of the Michigan Department of State Police or other law enforcement or judicial record-keeping organization.

I further consent to the release of information to this agency regarding any disciplinary investigations conducted by a similar licensure, registration, or specialty certification board of this or any other state, of the United States military, of the federal government, or of another country.

The statements in this application are true and correct. I have not withheld information that might affect the decision to be made on this application. In signing this application, I am aware that a false statement or dishonest answer may be grounds for denial of my application or revocation of my license and that such misrepresentation is punishable by law.

Signature of Applicant	Date
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Board of Medicine

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**CERTIFICATION OF MEDICAL EDUCATION FOR
FOREIGN MEDICAL SCHOOL GRADUATES**

Authority: Public Act 368 of 1978, as amended
If this form is not completed, a license will not be issued.

INSTRUCTIONS TO APPLICANT:

Complete Section I. Type or print your name exactly as it appears on your application. For completion of Section II, send this form to the Dean of the medical school you attended. This certification must be submitted directly to the Michigan Board of Medicine by the medical school.

SECTION I - APPLICANT INFORMATION

First Name	Middle Name	Last Name
Social Security Number	Date of Birth	
Street Address		
City	State	ZIP Code
Daytime Telephone Number	All Previous Names and/or Birth Name Used (if applicable)	
Date of Admission	Date of Graduation	

Signature of Applicant	Date
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APPLICANT: UPON COMPLETION OF SECTION I, SEND THIS FORM TO THE DEAN OF YOUR MEDICAL SCHOOL FOR COMPLETION OF SECTION II.

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

Name

TO BE COMPLETED BY THE DEAN OR REGISTRAR OF THE MEDICAL SCHOOL

INSTRUCTIONS FOR COMPLETING SECTION II:

Please complete the following information. Return this completed certification directly to the Michigan Board of Medicine at the address shown on Page 1 of this form.

SECTION II - CERTIFICATION OF MEDICAL EDUCATION

Name of Medical School																				
Street Address of Medical School																				
City, State and ZIP Code																				
<p>I certify that _____ attended the (Applicant's Name)</p> <p>medical school named above from _____ to _____ (Month/Day/Year) (Month/Day/Year)</p> <p>and was granted the degree of _____ on _____ (Month/Day/Year)</p> <p>I also certify that the medical education program from which the applicant graduated was not less than 130 weeks and does not award credit for any courses taken by correspondence. I further certify that this medical education program included basic science courses in anatomy; physiology; biochemistry; microbiology; pathology; pharmacology and therapeutics; preventive medicine; and clinical sciences and clerkships completed at the hospitals or institutions listed below.</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; width: 25%;">Clinical Sciences</th> <th style="text-align: center; width: 45%;">Name and Address of Hospital</th> <th style="text-align: right; width: 30%;">Teaching Hospital</th> </tr> </thead> <tbody> <tr> <td>Internal Medicine</td> <td style="border: 1px solid black; height: 40px;"></td> <td style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>General Surgery</td> <td style="border: 1px solid black; height: 40px;"></td> <td style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Pediatrics</td> <td style="border: 1px solid black; height: 40px;"></td> <td style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Obstetrics and Gynecology</td> <td style="border: 1px solid black; height: 40px;"></td> <td style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Psychiatry</td> <td style="border: 1px solid black; height: 40px;"></td> <td style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> </tbody> </table>			Clinical Sciences	Name and Address of Hospital	Teaching Hospital	Internal Medicine		<input type="checkbox"/> Yes <input type="checkbox"/> No	General Surgery		<input type="checkbox"/> Yes <input type="checkbox"/> No	Pediatrics		<input type="checkbox"/> Yes <input type="checkbox"/> No	Obstetrics and Gynecology		<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatry		<input type="checkbox"/> Yes <input type="checkbox"/> No
Clinical Sciences	Name and Address of Hospital	Teaching Hospital																		
Internal Medicine		<input type="checkbox"/> Yes <input type="checkbox"/> No																		
General Surgery		<input type="checkbox"/> Yes <input type="checkbox"/> No																		
Pediatrics		<input type="checkbox"/> Yes <input type="checkbox"/> No																		
Obstetrics and Gynecology		<input type="checkbox"/> Yes <input type="checkbox"/> No																		
Psychiatry		<input type="checkbox"/> Yes <input type="checkbox"/> No																		
_____ Signature of Dean or Registrar	_____ Date of Signature																			
_____ Print or Type Name of Dean or Registrar	(SEAL) If school has no seal, please indicate																			

* Teaching hospital means that the hospital or institution offers a postgraduate clinical training program in the same content area of the clerkship.

Michigan Department of Community Health
Board of Medicine
 P.O. Box 30192
 Lansing, MI 48909
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**CERTIFICATION OF POSTGRADUATE TRAINING
 (CLINICAL ACADEMIC LIMITED LICENSE)**

Authority: Public Act 368 of 1978, as amended
 If this form is not completed, a license will not be issued.

INSTRUCTIONS TO APPLICANT:

Complete Section I. Type or print your name exactly as it appears on your application. For completion of Section II, send this form to be completed by the Director of Medical Education where you completed your postgraduate training. This certification must be submitted directly to the Michigan Board of Medicine by the Director of Medical Education.

SECTION I - APPLICANT INFORMATION

First Name	Middle Name	Last Name
Social Security Number	Date of Birth	
Street Address		
City	State	ZIP Code
Daytime Telephone Number	All Previous Names and/or Birth Name Used (if applicable)	

Signature of Applicant	Date
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APPLICANT: UPON COMPLETION OF SECTION I, SEND THIS FORM TO THE DIRECTOR OF MEDICAL EDUCATION FOR COMPLETION OF SECTION II.

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

Name

TO BE COMPLETED BY THE DIRECTOR OF MEDICAL EDUCATION

INSTRUCTIONS FOR COMPLETING SECTION II:

Please complete the following information. Return this completed certification directly to the Michigan Board of Medicine at the address shown on Page 1 of this form.

SECTION II - CERTIFICATION OF POSTGRADUATE TRAINING

Name of Hospital

Street Address of Hospital

City	State	ZIP Code
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Identify all medical schools affiliated with the training hospital:

<p>I certify that _____ a graduate of the (Applicant's Name)</p> <p>_____ medical school, has successfully completed postgraduate clinical training offered by the hospital named above from _____ to _____ (Month/Day/Year) (Month/Day/Year)</p> <p>in the clinical area of _____</p>

_____ Signature of Director of Medical Education	_____ Date of Signature
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_____ Print or Type Name of Director of Medical Education	(S E A L) If hospital has no seal, please indicate
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NOTE: Certification of postgraduate training will not be accepted if certified and submitted more than 15 days prior to actual completion.

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CERTIFICATION OF PRACTICE IN AN ACADEMIC INSTITUTION

Authority: Public Act 368 of 1978, as amended
 If this form is not completed, a license will not be issued.

*** DO NOT COMPLETE THIS FORM UNLESS YOU HAVE HELD A CLINICAL ACADEMIC LICENSE ***

INSTRUCTIONS TO APPLICANT:

Complete Section I. Type or print your name exactly as it appears on your application. For Section II, send this form to be completed by your chief academic officer where you practiced under a **clinical academic limited license**. This certification must be submitted directly to the Michigan Board of Medicine by your Director of Medical Education.

SECTION I - APPLICANT INFORMATION

First Name	Middle Name	Last Name
Social Security Number	Date of Birth	
Street Address		
City	State	ZIP Code
Daytime Telephone Number	All Previous Names and/or Birth Name Used (if applicable)	

Signature of Applicant	Date
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APPLICANT: UPON COMPLETION OF SECTION I, SEND THIS FORM TO YOUR DIRECTOR OF MEDICAL EDUCATION WHERE YOU PRACTICED FOR COMPLETION OF SECTION II.

Name

TO BE COMPLETED BY THE DIRECTOR OF MEDICAL EDUCATION

INSTRUCTIONS FOR COMPLETING SECTION II:

Please complete the following information. Return this completed certification directly to the Michigan Board of Medicine at the address shown on Page 1 of this form.

SECTION II - CERTIFICATION OF PRACTICE IN AN ACADEMIC INSTITUTION

Name of Institution

Street Address of Institution

City, State and ZIP Code

I certify that _____ (Applicant's Name) practiced medicine under a clinical

academic limited license at the above institution in the clinical area of _____

from _____ (Month/Day/Year) to _____ (Month/Day/Year) and has functioned in the observation and treatment of

patients for not less than 800 hours per year and in so doing practiced medicine safely and competently.

I further certify that the above-named academic institution meets all of the following requirements:

- A. Was the sole sponsor or a co-sponsor, with either a medical school approved by the Michigan Board of Medicine or a hospital owned by the federal government and directly operated by the United States Department of Veterans' Affairs, of not less than 4 residency programs accredited by the Accreditation Council for Graduate Medical Education for not less than the 3 years immediately preceding the date of my signature below.
B. Has spent not less than \$2,000,000 for medical education during each of the 3 years immediately preceding the date of my signature below. (As used in this statement, "medical education" means the education of physicians and candidates for degrees or licenses to become physicians, including physician staff, residents, interns and medical students).

Signature of Director of Medical Education

Date of Signature

Print or Type Name of Director of Medical Education

(SEAL)

If institution has no seal, please indicate

Michigan Department of Community Health
Board of Medicine
P.O. Box 30192
Lansing, MI 48909
(517) 335-0918

CERTIFICATION OF APPOINTMENT TO A MICHIGAN ACADEMIC INSTITUTION

Authority: Public Act 368 of 1978, as amended
If this form is not completed, a license will not be issued.

Please complete the following information. Return this completed certification directly to the Michigan Board of Medicine at the address shown above.

Name of Institution		
Street Address of Institution		
City	State	Zip Code
<p>I certify that _____ has been duly <small>(Applicant's Name)</small></p> <p>appointed to this academic institution in the clinical area of _____</p> <p>_____</p> <p>beginning _____ and ending _____ <small>(Month/Day/Year) (Month/Day/Year)</small></p> <p>The applicant is appointed to the following position:</p> <p><input type="checkbox"/> Medical school faculty</p> <p><input type="checkbox"/> Research</p> <p>I further certify that the above-named academic institution meets all of the following requirements:</p> <p>A. Was the sole sponsor or a cosponsor, with either a medical school approved by the Michigan Board of Medicine or a hospital owned by the federal government and directly operated by the United States Department of Veterans' Affairs, of not less than four residency programs accredited by the Accreditation Council for Graduate Medical Education for not less than three years immediately preceding the date of my signature below.</p> <p>B. Has spent not less than \$2,000,000 for medical education during each of the three years immediately preceding the date of my signature below (As used in this statement, "medical education" means the education of physicians and candidates for degrees or licenses to become physicians, including physician staff, residents, interns and medical students).</p>		
_____ Signature of Director of Medical Education	_____ Date of Signature	
_____ Print or Type Name of Director of Medical Education	<p>(S E A L)</p> <p>If school has no seal, please indicate</p>	

Michigan Department of Community Health
Bureau of Health Professions
P.O. Box 30670
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www.michigan.gov/healthlicense

VERIFICATION OF LICENSURE OR REGISTRATION IN ANOTHER STATE

Authority: Public Act 368 of 1978, as amended.

PART I: To be completed by the applicant and forwarded to the appropriate State Licensing Board for completion.

Check the profession for which you are requesting verification.			
<input type="checkbox"/> Audiology	<input type="checkbox"/> Medicine	<input type="checkbox"/> Osteopathy	<input type="checkbox"/> Psychology
<input type="checkbox"/> Chiropractic	<input type="checkbox"/> Nursing	<input type="checkbox"/> Pharmacy	<input type="checkbox"/> Respiratory Therapy
<input type="checkbox"/> Counseling	<input type="checkbox"/> Nursing Home Adm.	<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Sanitarians
<input type="checkbox"/> Dentistry	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Physician's Assistants	<input type="checkbox"/> Social Work
<input type="checkbox"/> Marriage & Family Therapy	<input type="checkbox"/> Optometry	<input type="checkbox"/> Podiatry	<input type="checkbox"/> Veterinary
First Name	Middle Name	Last Name	
Previous Names Used	Date of Birth	U. S. Social Security Number	
State Board	License Number	Date of Issue	

The applicant listed above has applied for licensure in Michigan and has indicated licensure in your State. Please complete Part II of this form and return it to the appropriate Michigan Board at the address shown above.

PART II: To be completed by the State Licensing Board.

Type of License:	Original Issue Date	Expiration Date
Basis for Issuance of License:		
<input type="checkbox"/> Examination - Please indicate type of exam (National, Regional, State, etc.) _____		
<input type="checkbox"/> Endorsement - Please indicate name of state _____		
License Status	Has the applicant incurred any formal or informal actions in your State?	
<input type="checkbox"/> Current <input type="checkbox"/> Lapsed <input type="checkbox"/> Inactive	<input type="checkbox"/> No <input type="checkbox"/> Yes - If Yes, Please attach certified copies of any actions.	
Are formal or informal actions pending?	Has the applicant's license ever been limited, denied, surrendered, reprimanded, suspended or revoked?	
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	

CERTIFICATION

I hereby verify, to the best of my knowledge, the information above is true to the records of this Board.

Signature

Date

Type or Print Name

(S E A L)

Title

Full Name of Licensing Board