MEDICAL LICENSURE GROUP

PHYSICIAN ACQUISITION FORM

Please complete this form and return to Admin@MedicalLicensureGroup.com.

Contact Information

Name (First Middle Last Suffix) _____ MD/DO/PA _____

Maiden or Previous Name(s) _____

Date of Change _____ Reason for Change _____

Home Address _____ City, State Zip _____

Work Address _____ City, State Zip _____

Home Email _____ Cell Phone _____

Work Email _____ Work Phone _____

Other Contact _____ Home Phone _____

Preferred Contact Method ○ Work ○ Cell/Home ○ Work Email ○ Home Email

Preferred Mailing Address ○ Work ○ Home

Identifying Information

Date of Birth _____ Place of Birth _____ Citizenship Status _____

Eye Color _____ Hair Color _____ Height Ft ___ In _____ Weight _____

Race _____ Social Security Number _____

Gender ○ Male ○ Female Naturalization Date (if applicable) _____

U.S. Military Service

○ Yes ○ No

Branch _____ Rank _____ Dates of Service From _____ To _____

Discharge Status _____ Discharge Date _____

PHYSICIAN ACQUISITION FORM

Education Information

Starting with high school, list in chronological order all schools, colleges and universities attended, whether completed or not.

Name	City / State	Month / Year From – To	Major / Degree

International Graduates

ECFMG Number _____ Issue Date _____

Did you attend a fifth pathway program? ○ Yes ○ No

Did you complete clinical clerkships in a country other than your medical school location? ○ Yes ○ No

Postgraduate Training

Please list all U.S. internship, residency and fellowship training in chronological order.

Name	City / State	Month / Year From – To	Program Type / Department

Were all programs ACGME approved? ○ Yes ○ No

Medical Examination

Indicate which licensing examination you took. (SBME, FLEX, USMLE, SPEX, NBME, COMLEX, LMCC, PANCE, PANRE)

Examination	Part / Step	Date of Exam	State	Number of Attempts

PHYSICIAN ACQUISITION FORM

Medical Licenses

List ALL states where you hold or have ever held a license to practice medicine, regardless of current status (including training).

State	Type	License Number	Issue Date	Expiration Date	Status

Federal DEA Registration Number _____ Issue Date _____ State _____

Practice History

List in chronological order all professional practice experience including private or group practice, hospital appointments, locum tenens assignments, etc. Explain any unaccounted for periods of time exceeding 30 days.

Name	City / State	Month/Year From - To	Position

Specialty Board Certification

Specialty Board Name	Specialty / Sub-Specialty	Date Certified / Recertified

PHYSICIAN ACQUISITION FORM

Adverse Actions

Attach details for any affirmative answers.

Has a claim for malpractice ever been made against you, regardless of the outcome? ○ Yes ○ No

If Yes, how many? _____

Any adverse actions taken against you by a school/university, hospital, medical board, etc.? ○ Yes ○ No

Been arrested, charged, or convicted of a violation of any local, state, or federal statute? ○ Yes ○ No

Note: Failure to report such events could result in processing delays, fines by the medical board, or denial of license!

Useful Information

Please use the space below to provide any information that will be useful to us during the application process (e.g. - closed facilities, timeline gaps, relocation date, etc.).

MEDICAL LICENSURE GROUP

PHYSICIAN SERVICE AGREEMENT

Office Use Only _____

Service Agreement

I, _____ (the undersigned), am hiring you (Medical Licensure Group, LLC) to assist me in applying for state medical licensure, registrations, and credentials as specified below (the "Services") or as requested from time to time either verbally or in writing by myself, my employer or representatives. I agree to provide you all information and documents required for you to perform the Services, whether directly or via my employer or representatives. I affirm such information is and will be accurate and complete and such documents will be true, correct, and complete copies. I am aware of, and remain responsible for, the deadlines and eligibility requirements for each license, registration, or credential for which I am applying with your assistance. I agree to pay any fees or other charges required or imposed by the licensing boards to file or process my applications for licensure, registration, or credentials that are the subject of the Services. I acknowledge you have no authority to grant or cause to be granted any licensure, registration, or credential and, therefore, you will not be liable to me or any other person regarding the final outcome of my applications for licensure, registration, or credentials. I further acknowledge that you make no guarantee of any timelines in which any license, registration or credential will be granted. I acknowledge I have read and agree to the additional terms and conditions specified at www.MedicalLicensureGroup.com/terms-and-conditions/.

State Licensure Services

- ○ **Initial License or Reinstatement ($750/each)** Select this option to obtain licensure in a state for the first time, or if reinstating a previously-held license. Target State(s) _____
- ○ **Completion ($550/each)** Select this option if you would like MLG to handle the completion of an already-filed state application. Target Completion State(s) _____
- ○ **Interstate Medical Licensure Compact (IMLC) ($500/1st, $250/addtl.)** Select this option to obtain licensure through the IMLC. Check eligibility at imlcc.org. Target State(s) _____
- ○ **Express Processing ($200/each)** Select this option for accelerated application preparation. Note: State Medical Boards review applications in date order. Express State(s) _____

Additional Services

- ○ **FCVS Profile Setup ($175)** Select this option if applying to a state that requires the use of the FCVS or would like one established for you. **States requiring FCVS profile:** KY, LA, MA, ME, NH, OH, RI, SC, UT, WY. **FCVS required for international medical graduates only:** NC, NY. **FCVS required for osteopathic physicians only:** NV.
- ○ **FCVS Profile Retrieval ($75)** ○ I forgot my login. Select this option if you have a profile with the FCVS and would like it retrieved for use with the licensing process.
  - Username _____
  - Password _____
  - Packed ID # _____
- ○ **State Controlled Substance Reg. ($125/each)** The following states require a state Controlled Substance Registration: AL, CT, DE, DC, HI, ID, IL, IN, IA, LA, MD, MA, MI, MO, NV, NJ, NM, OK, RI, SC, SD, UT, WY.
  - CSR State(s) _____
- ○ **DEA Registration ($125/each)**
  - ○ Initial / New ○ Modification
- ○ **Credentialing ($550/each)**
  - Number of Hospital Privilege Application(s) _____
  - Username _____
  - Password _____
- ○ **License Maintenance & Renewal ($225/each)** Select to have your currently-active license renewed on a continual basis. State(s) _____
- ○ **CSR Renewal ($125/each)** Provide a copy of registration. State(s) _____
- ○ **DEA Renewal ($125/each)** Provide a copy of registration. State(s) _____

By signing below, I have read and agree to the above statement and terms and conditions.

Signature _____ Date _____

Tel (850) 433-4600 | Fax (904) 212-0886 | Admin@MedicalLicensureGroup.com | 4400 Bayou Blvd., Suite 32B, Pensacola, FL 32503

CREDIT CARD AUTHORIZATION

Credit Card Authorization

I (the undersigned) authorize you (Medical Licensure Group, LLC) to charge my credit card as payment for your services and for payment of third party charges associated with your services, with all conditions of sale as if I were presenting the credit card to you in person. I represent and warrant to you that I am an authorized cardholder of the credit card, the charges to the credit card will be honored, and I will perform my obligations set forth in the cardholder agreement with the credit card issuer. I acknowledge no funds paid by me to you (by credit card or otherwise) may or will be subject to refund by you to me after you have used those funds to pay third party charges associated with your services performed for me.

Target State(s) _____

Method of Payment

○ Visa ○ Mastercard ○ American Express ○ Discover

Cardholder Name _____ Expiration Date _____

Card Number _____ Security Number (CCV) _____

Billing Address _____ City, State, Zip _____

Note: A 3% convenience fee will be added to all non-check payments.

By signing below, I have read and agree to the above statement and terms and conditions.

Cardholder Signature _____ Date _____