MEDICAL LICENSURE GROUP
4400 Bayou Blvd., Suite 32B
Pensacola, FL 32503

ACQUISITION FORM

Please complete this form and return to Admin@MedicalLicensureGroup.com.
You may attach your current Curriculum Vitae in lieu of completing any applicable sections below.

Contact Information

First Name	Middle	Last	MD/DO/PA

Maiden/Previous/Alternate Names	
Date of Change	Reason for Change

Home Address		Work Address	
City, State Zip		City, State Zip	
Home Phone		Work Phone	
Cell Phone		Other Contact	

Home E-mail		Work E-mail	

Preferred Contact Method ◯ Work ◯ Home/Cell ◯ E-mail

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	Naturalization Date (if applicable)

Gender ◯ Male ◯ Female

U.S. Military Service ◯ Yes ◯ No

Branch	Rank	Dates of Service: From	To

Discharge Status	Discharge Date

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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 where your medical school is located? ◯ 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

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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

If applicable, how many years to complete the USMLE exam sequence? ____

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 # ____ 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

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Specialty Board Certification

Are you board certified? ◯ Yes ◯ No

If not, are you eligible to sit for the exam? ◯ Yes ◯ No

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

Adverse Actions

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

Has a claim for malpractice **ever** been made against you, regardless of the outcome? ◯ Yes ◯ No If yes, how many? ☐

Note: Additional documentation will be requested as needed.

Have **any** adverse actions **ever** been taken against you by a school, employer, hospital, medical board, etc.? ◯ Yes ◯ No

If yes, please provide details on a separate piece of paper.

Have you **ever** been arrested, charged, or convicted of a violation of any local, state, or federal statute? ◯ Yes ◯ No

If yes, please provide details on a separate piece of paper.

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.).

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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 eligibility requirements and deadlines 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

Initial License or Reinstatement: *Select this option to obtain licensure in a state for the first time, or if reinstating a previously-held license.*

List target state(s) ($650/ea) _____

Completion: *Select this option if you would like MLG to handle the completion of an already-filed state application.*

List target completion state(s) ($450/ea) _____

Interstate Medical Licensure Compact (IMLC): *Select this option to obtain licensure through the IMLC. Check eligibility at imlcc.org.*

List target state(s) ($450/first, $200/subsequent) _____

Additional Services

Express Processing: *Select this option for accelerated application preparation. Note: State Medical Boards review applications in date order.*

☐ $175 ea Express States _____

FCVS Profile Setup ☐ $175

Select this option if applying to a state that requires the use of the FCVS or would like us to establish a profile 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*

State Controlled Substance Registration ☐ $95/ea

CSR State(s) _____

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.

FCVS Profile Retrieval ☐ $75

Select this option if you have a profile established with the FCVS and would like us to retrieve it for use with the licensing process. Please enter the information below (if known).

Username _____ Packet ID # _____

Password _____ ☐ I forgot my FCVS login

DEA Registration ☐ $95/ea

☐ Initial / New

☐ Renewal

☐ Modification

Credentialing ☐ $550/ea

☐ Hospital Privilege Application(s)

May we access your CAQH profile?

Username _____

Password _____

License Maintenance & Renewal: *Select this option to have your currently-active license renewed on a continual basis.*

☐ $225/renewal Renewal States _____

By e-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

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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 ◯ Master Card ◯ 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

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Date:

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