

# Wyoming Board of Medicine

*Application to Renew License to Practice  
Medicine in Wyoming for the period  
July 1, 2011, through June 30, 2012*

**Note to Physician:** Please carefully proofread your responses on this form before submitting it. You are responsible for all information on this form, including any errors or omissions.

## CHECK ONE BOX:

- Renew my license (**Submit \$275 fee**)  
 Do not renew my license (State reason)
- 
- I hold an emeritus license\*  
 I hold an inactive license\*

\* Applicant **must** complete and return the applicable status affidavit available at <http://wyomedboard.state.wy.us> or by calling the Board at 307.778.7053

### PLEASE PRINT:

**Last Name:** \_\_\_\_\_  
**First Name:** \_\_\_\_\_  
**Middle Name/Initial:** \_\_\_\_\_  
**License No.:** \_\_\_\_\_

**IMPORTANT:** Failure to (a) answer any question, (b) provide specific details regarding affirmative answers, or (c) **enclose the required \$275 renewal fee**, will delay the processing of your application for renewal.

**Answer questions ONLY as they relate to the period July 1, 2010, through present.**

<b>I. DISCIPLINARY, COMPETENCY AND HEALTH INFORMATION:</b>	<b>Yes</b>	<b>No</b>
<p><b>A. Since July 1, 2010, have you been convicted of, pled guilty or nolo contendere to, or had or have charges pending against you for any crime including felonies, misdemeanors, municipal ordinances, and/or Military Code of Justice violations (including, but not limited to, driving under the influence of any intoxicating substance, but not including non-moving traffic violations or moving violations which do not involve alcohol or substance impairment)?</b></p> <p><i>If your answer to this question is "Yes," please provide a complete written explanation including, but not limited to:</i></p> <p>a. The name and location of the court where you were charged and the docket number of your case;                      b. The offense(s) to which you pled or of which you were found guilty;                      c. All terms of the sentence imposed, including fines, restitution, etc.;                      d. Whether you have completed the sentence;                      e. The date the sentence was imposed; and,                      f. If applicable, the name, address and telephone number of your probation officer.  <u>Attach to this renewal application form a copy of the sentencing order and any orders indicating that the sentence has been completed.</u></p>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Yes</b>		<b>No</b>
<p><b>B. Since July 1, 2010, have you developed any medical condition which, in any way, impairs or limits, or might impair or limit, your ability to safely and skillfully practice medicine?</b></p> <p><i>If your answer to this question is "Yes," please provide a complete written explanation for each such condition including, but not limited to:</i></p> <p>a. The diagnosis;                      b. The treatment plan and prognosis;                      c. The name, address and telephone number of your treating physician(s);                      d. The manner in which the condition impairs or may impair your ability to safely and competently practice medicine;                      e. Any restrictions or conditions imposed upon your practice by any licensing agency or health care facility due to such condition; and,                      f. How you are accommodating the condition in your practice.  <u>Attach to this renewal application form the most recent medical records and/or a written report from your treating physician(s) describing the diagnosis, the current treatment regime, a prognosis and any limitations arising from the condition.</u></p>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Yes</b>		<b>No</b>

	Yes	No
<p><b>C. Since July 1, 2010, have you been hospitalized for, missed work because of, or been significantly impaired by any mental or emotional condition?</b></p>	<input type="checkbox"/>	<input type="checkbox"/>
<p><i>If your answer to this question is "Yes," please provide a complete written explanation for each such condition including, but not limited to:</i></p> <p>a. The circumstances and the diagnosis;</p> <p>b. The treatment you are undergoing and the prognosis;</p> <p>c. The name, address and telephone number of your treating professional(s);</p> <p>d. The manner in which the condition impairs or may impair your ability to safely and competently practice medicine;</p> <p>e. Any restrictions or conditions imposed upon your practice by any licensing agency or health care facility due to such condition; and,</p> <p>f. How you are accommodating the condition in your practice.</p> <p><u>Attach to this renewal application form the most recent medical records and/or a written report from your treating professional(s) describing the diagnosis, the current treatment regime, a prognosis and any limitations arising from the condition.</u></p>		
	Yes	No
<p><b>D. Since July 1, 2010, have you been evaluated, diagnosed or treated for any substance abuse disorder including, but not limited to, alcohol, tranquilizers, sedatives, psychoactive medications, cocaine, marijuana, opiates, benzodiazepines or any other narcotic or potentially-addicting substance? NOTE: If you have a fully-executed contract in force with the Wyoming Professional Assistance Program ("WPAP"), you may answer "No" to this question.</b></p>	<input type="checkbox"/>	<input type="checkbox"/>
<p><i>If your answer to this question is "Yes," please provide a complete written explanation for each such substance including, but not limited to:</i></p> <p>a. The substance(s) in question;</p> <p>b. The treatment you are undergoing and the prognosis;</p> <p>c. The name, address and telephone number of your treating professional(s);</p> <p>d. Any restrictions or conditions imposed upon your practice by any licensing agency or health care facility due to such condition; and,</p> <p>e. How you are accommodating the condition in your practice.</p> <p><u>Attach to this renewal application form any agreement between you and any professional assistance program, Alcoholics Anonymous, or any other rehabilitation and/or monitoring group.</u></p>		
	Yes	No
<p><b>E. Since July 1, 2010, have you been reprimanded, demoted, disciplined, cautioned, placed on probation, been placed on or taken leave (except vacation leave), or been terminated by any employer, educational institution or training program for any reason?</b></p>	<input type="checkbox"/>	<input type="checkbox"/>
<p><i>If your answer to this question is "Yes," please provide a complete written explanation for each such action taken against you including, but not limited to:</i></p> <p>a. A detailed description of the circumstances and event(s) leading to the action(s);</p> <p>b. The effective date of the action(s);</p> <p>c. The name, address and telephone number of the persons and/or entities taking action(s);</p> <p>d. Any restrictions or conditions imposed upon your practice due to such action(s);</p> <p>e. The resolution and/or current status of such action(s); and,</p> <p>f. How you are accommodating the action(s) in your practice.</p> <p><u>Attach to this renewal application form all documents pertinent to the action(s).</u></p>		
	Yes	No
<p><b>F. Since July 1, 2010, have you been under investigation or had or have any adverse charges or complaints filed against you by: any education training program or facility; medical licensing board; local, state, federal or military professional or disciplinary body; any hospital privileging or credentialing body or grievance committee; or any other medical group, including medical societies and specialty boards?</b></p>	<input type="checkbox"/>	<input type="checkbox"/>
<p><i>If your answer to this question is "Yes," please provide a complete written explanation for each such action taken against you including, but not limited to:</i></p>		

<p>a. The charge(s) against you;</p> <p>b. A detailed description of the circumstances and event(s) leading to the action(s);</p> <p>c. The effective date of the action(s);</p> <p>d. The name, address and telephone number of the persons and/or entities taking action(s);</p> <p>e. Any restrictions or conditions imposed upon your practice due to such action(s);</p> <p>f. The resolution and/or current status of such action(s); and,</p> <p>g. How you are accommodating the action(s) in your practice.</p> <p><u>Attach to this renewal application form all documents pertinent to the action(s).</u></p>		
	<b>Yes</b>	<b>No</b>
<p><b>G. Since July 1, 2010, have you been denied licensure, privileges or membership by any licensing board, hospital medical facility, professional society, specialty board, or medical body?</b></p>	<input type="checkbox"/>	<input type="checkbox"/>
<p><i>If your answer to this question is "Yes," please provide a complete written explanation for each denial including, but not limited to:</i></p> <p>a. The basis for denial;</p> <p>b. A detailed description of the circumstances and event(s) leading to the denial(s);</p> <p>c. The name, address and telephone number of the entity making the denial(s);</p> <p>d. The date the denial was issued.</p> <p><u>Attach to this renewal application form all records of the application and denial process including, but not limited to, final orders and/or findings.</u></p>		
	<b>Yes</b>	<b>No</b>
<p><b>H. Since July 1, 2010, have you withdrawn an application for licensure or privileges in any jurisdiction?</b></p>	<input type="checkbox"/>	<input type="checkbox"/>
<p><i>If your answer to this question is "Yes," please provide a complete written explanation for each withdrawal including, but not limited to:</i></p> <p>a. The name, address and telephone number of the entity to which you had applied;</p> <p>b. The license, privileges or membership applied for;</p> <p>c. The date you withdrew the application;</p> <p>d. The reason for your withdrawal; and,</p> <p>e. Whether the withdrawal was permitted by the entity in lieu of a denial of your application.</p> <p><u>Attach to this renewal application form all records of the application process and your withdrawal including, but not limited to, final orders and/or findings.</u></p>		
	<b>Yes</b>	<b>No</b>
<p><b>I. Since July 1, 2010, have you entered into any agreements, consent decrees, stipulations, conditions or restrictions with any other licensing boards?</b></p>	<input type="checkbox"/>	<input type="checkbox"/>
<p><i>If your answer to this question is "Yes," please provide a written explanation for each situation including, but not limited to:</i></p> <p>a. A detailed description of the circumstances and event(s) leading to the agreement, consent decree, stipulation, condition or restriction;</p> <p>b. The name, address and telephone number of the licensing board with which you have the agreement, consent decree, etc.</p> <p>c. The effective date of the action(s);</p> <p>d. The resolution and/or current status of each agreement, consent decree, etc.; and,</p> <p>g. How you are accommodating the agreement, consent decree, etc. in your practice.</p> <p><u>Attach to this renewal application form all documents related to such actions including, but not limited to, the final agreement(s), consent decree(s), stipulation(s), condition(s), and restriction(s) and related orders and/or findings.</u></p>		

[REMAINDER OF THIS PAGE INTENTIONALLY LEFT BLANK.]

<b>II. LIABILITY INFORMATION:</b>		<b>Yes</b>	<b>No</b>
<b>A. Since July 1, 2010, have any professional liability claims been filed against you?</b>		<input type="checkbox"/>	<input type="checkbox"/>
<p><i>If your answer to this question is "Yes," please indicate how many claims have been filed and provide a complete written explanation for each claim including, but not limited to:</i></p> <p>a. The name and location of the court where the action was filed and the docket number of the case;</p> <p>b. The allegations of the claim against you;</p> <p>c. If applicable, the date and manner in which the claim was resolved; and,</p> <p>d. The amount, if any, paid to the claimant by you and/or your insurance carrier;</p> <p><u>Attach to this renewal application form all records of the application process and your withdrawal including, but not limited to, final orders and/or findings.</u></p>			
		<b>Yes</b>	<b>No</b>
<b>B. Since July 1, 2010, has any professional liability insurance carrier terminated your coverage?</b>		<input type="checkbox"/>	<input type="checkbox"/>
<p><i>If your answer to this question is "Yes," please provide a complete written explanation including, but not limited to:</i></p> <p>a. The name, address and telephone number of the company which terminated coverage;</p> <p>b. The basis for termination; and,</p> <p>c. The effective date of the termination.</p> <p><u>Attach to this renewal application form all records of the application process and your withdrawal including, but not limited to, final orders and/or findings.</u></p>			

<b>III. DEMOGRAPHIC INFORMATION:</b>			
<b>A. ADDRESS</b>			
Office Address: (Published in Directory and on Web Site)			
City:	State:	ZIP:	
Office Phone:	Fax:	E-mail: (Not published)	
<b>All Board correspondence with you will be sent to this address:</b>			
Mailing Address: (NOT published in Directory or on Web)			
City:	State:	ZIP:	
<b>B. AREA OF PRACTICE</b>			
<input type="checkbox"/> Direct Patient Care-01	<input type="checkbox"/> Medical Teaching-02	<input type="checkbox"/> Locum Tenens-03	<input type="checkbox"/> Consultant-04
<input type="checkbox"/> Administration-05	<input type="checkbox"/> Military-06	<input type="checkbox"/> Permanent Part-Time Clinic-07	<input type="checkbox"/> Resident-in-Training-08
<input type="checkbox"/> Retired-09	<input type="checkbox"/> Government-10	<input type="checkbox"/> Tele-Medicine-11	<input type="checkbox"/> Other: _____
<b>C. SPECIALTY</b>			
Specialty:	Sub-Specialty:		
Board Certified? <input type="checkbox"/> Yes <input type="checkbox"/> No	Board name:	Expires:	
	Board name:	Expires:	
	Board name:	Expires:	
	Board name:	Expires:	

**IV. CONTINUING MEDICAL EDUCATION:**

Physicians renewing an active or emeritus license to practice medicine in Wyoming must verify satisfactory completion of at least 60 hours of qualified CME in the preceding three years. Please indicate below whether you have completed the required 60 hours of qualified CME since July 1, 2008, or, if you have not, indicate the reason you are not subject to the requirement, or request an extension of the deadline for completion of CME:

1.  I verify that I have completed at least 60 hours of qualified CME since July 1, 2008

OR

2.  I am exempt from the CME requirement because (check one):

(a) As of July 1, 2011, I have held an initial Wyoming medical license for less than 3 years.

(b) In the past 3 years I have been certified or recertified by an ABMS-member board.

(c) I am currently, or in the last 3 years have been, enrolled in an ACGME- or RCPSC-approved residency program.

(d) I hold an inactive license to practice in Wyoming, and am submitting herewith an affidavit to that effect. **You must submit an affidavit to the Board office. The form is available on the Board's web page (<http://wyomedboard.state.wy.us>) or by calling the Board office (307-778-7053)**

(e) Due to circumstances **beyond my control** (ex: temporary disability, mandatory military service or officially-declared disaster), I request an exemption from (check one) part  all  of the CME requirements for this year. The reason(s) for requesting this exemption is (Please be specific in stating reason(s) and whether you are requesting a partial or full exemption):

You will be notified in writing whether your request for exemption has been granted and, if so, whether it is for part or all of the CME requirement.

OR

3.  I HAVE NOT COMPLETED at least 60 hours of qualified CME since July 1, 2008, and DO NOT QUALIFY FOR ANY EXEMPTIONS. I am requesting the Board to grant an extension of the deadline for up to one (1) year to complete the required CME credits. The good cause for granting me this extension is (Please be specific):

You will be notified in writing whether your request for an extension has been granted and, if so, the length of the extension (not to exceed one year).

**By my signature I certify that all information provided in and on this renewal application and any materials submitted herewith is true and accurate. I understand that the omission or misrepresentation of any information on this renewal application or attached materials constitutes grounds for possible investigation of, disciplinary action affecting, and/or denial of renewal, of my license to practice medicine in Wyoming.**

Signature	Printed/Typed Name	Date

**RETURN WITH RENEWAL FEE TO:**

Wyoming Board of Medicine  
320 W. 25<sup>th</sup> St., Suite 200  
Cheyenne, WY 82002

Current Status:

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

License No. \_\_\_\_\_