WYOMING BOARD OF MEDICINE

APPLICATION FOR VOLUNTEER MEDICAL LICENSE

SECTION 1. IDENTIFYING INFORMATION

A. FULL NAME:

____
LAST

____
FIRST

_____________________ _____________________
MIDDLE MAIDEN

MOTHER'S MAIDEN NAME

Indicate Previous Names: ____
If name has changed, please attach written explanation of circumstances.

B. MAILING ADDRESS:

____
STREET ADDRESS OR POST OFFICE BOX

____
CITY

_____ __________-__________ _____________________
STATE ZIP (AREA CODE) PHONE NUMBER

E-MAIL ____

C. SOCIAL SECURITY NO:

NB: **Your Social Security Number will be used only for intra-office purposes, upon request from other state and federal agencies and, in the event of disciplinary action, as a required identifier for the National Practitioner, HIPDB and Federation of State Medical Boards data banks. YOUR SSN will NOT be divulged to any other group or person for any reason.**

D. BIRTHDATE:

E. BIRTH PLACE:

____
City State

F. GENDER

☐ FEMALE
☐ MALE

G. Height: ______________________
Weight: ______________________
Color of Hair: ______________________
Identifying Marks: ______________________

H. DEA CONTROLLED SUBSTANCE CERTIFICATION NUMBER:

SECTION 2. PRACTICE IN WYOMING:

A. Intended Wyoming Location: ____
(City)

B. Medical Specialty: ____

SECTION 3. BOARD CERTIFICATION:

A. Are you Board certified? Yes____ No ____ If Yes, Certification by American Board of
Date: Certificate No.: ______________________

Is your certification current? Yes ____ No ____ If Yes, Expiration Date: ______________________

B. If you are in the process of becoming board certified, indicate precise stage in certifying process:

SECTION 4. LICENSURE STATUS:

"I hereby certify that I retired from the active practice of medicine on ________ For at least ten (1 0) years prior to my retirement date I held a license to practice medicine, without any disciplinary encumbrance whatsoever, from the state of ________, License number _____________ (Provide verification form)

PLEASE SUBMIT THE ATTACHED CERTIFICATION FORMS FOR MEDICAL EDUCATION, POST GRADUATE MEDICAL TRAINING AND LICENSURE STATUS DIRECTLY TO THE STATE IN WHICH YOU PRACTICED FOR AT LEAST TEN (1 0) YEARS PRIOR TO RETIREMENT. REQUEST THAT STATE TO CERTIFY YOUR EDUCATION, POST GRADUATE TRAINING AND LICENSURE DIRECTLY TO THE WYOMING BOARD OF MEDICINE.

SECTION 5. CERTIFICATE OF MEDICAL EDUCATION:

Please produce a copy of your medical diploma. This copy must be certified as a true and accurate copy directly from the files of the jurisdiction/licensing authority where you practiced in good standing for at least ten (1 0) years prior to retirement.

SECTION 6. CERTIFICATE OF POSTGRADUATE MEDICAL TRAINING:

Please produce a copy of the certification of your postgraduate medical training. This copy must be certified as a true and accurate copy directly from the files of the jurisdiction/licensing authority where you practiced in good standing for at least ten (1 0) years prior to retirement.

SECTION 7. PERSONAL AND PROFESSIONAL INFORMATION:

IF YOU ANSWER "YES" TO ANY OF THE FOLLOWING QUESTIONS. YOU MUST ATTACH A DETAILED EXPLANATION OF THE EVENT(S) REFERRED TO IN YOUR AFFIRMATIVE RESPONSE AND PROVIDE COMPLETE AND LEGIBLE DOCUMENTATION REGARDING SUCH EVENT(S)-. YOUR APPLICATION WILL NOT BE PROCESSED FURTHER UNLESS AND UNTIL THE BOARD RECEIVED SUCH EXPLANATION AND DOCUMENTATION AND, IF APPROPRIATE, INVESTIGATES SUCH MATTERS.

I. DEFINITIONS: The following definitions apply to this Section:

A. "Ability to practice medicine" includes all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasonable medical judgments and to learn and keep abreast of medical developments;

2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids and devices, such as voice amplifiers; and

3. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

B. "Chemical substances" includes alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes in accordance with the prescriber's direction, as well as those used illegally.

C. "Medical condition" includes mental or psychological conditions or disorders such as, but not limited to, orthopedic, visual, speech and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

II QUESTIONS:

A. Have you ever been convicted of, pled guilty to, pled nolo contendere to or are charges pending against you for any crime including felonies, misdemeanors, municipal ordinances and/or any military code of justice violation, including driving under the influence of any intoxicating substance but <u>not</u> including non-moving traffic violations or moving violations which did not involve alcohol or substance impairment?

Yes __________ No __________

If your answer to this question is "Yes" please provide a complete written explanation of:

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 were found guilty;
c. all terms of the sentence imposed;
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 office.

<u>Attach a copy of the sentencing order and any orders indicating that the sentence has been completed.</u>

B. Do you have any medical condition which, in any way, impairs or limits, or might impair or limit, your ability to safely and skillfully practice medicine?

Yes __________ No __________

If your answer to this question is "Yes" please provide a complete written explanation of:

a. the diagnosis;
b. the treatment plan and prognosis;
c. the name, address and telephone number of your treating physician;
d. the manner in which the condition impairs your ability to safely and competently practice medicine;
e. any restriction or conditions imposed upon your practice by any licensing agency or health care facility due to such condition; and
f. how you intend to accommodate such condition in the practice you intend to conduct in the State of Wyoming.

<u>Attach to your answer the most recent medical records and/or a written report from your treating physician describing the diagnosis, the current treatment being undertaken, a prognosis and any limitations arising from such condition.</u>

C. Within the past five (5) years have you sought evaluation of, treatment for or been admitted (including outpatient admissions) by any provider and/or to any facility for the treatment of mental or emotional disability or substance use disorder? Yes __________ No __________

If your answer to this question is "Yes" please provide a complete written explanation of:

a. the circumstances and diagnosis;
b. the treatment you are undergoing and prognosis;
c. the name, address and telephone number of you treating physician;
d. the manner in which this condition impairs your ability to safely and competently practice medicine;
e. any restriction or conditions imposed upon your practice by any licensing agency or health care facility due to such condition; and
f. how you intend to accommodate such condition in the practice you intend to conduct in the State of Wyoming.

<u>Attach to your answer the most recent medical records and/or a written report from your treating physician describing the diagnosis, the current treatment being undertaken, a prognosis and any limitations arising from such condition.</u>

D. Within the past five (5) years have you been evaluated, diagnosed or treated in any manner for any substance use disorder including but not limited to alcohol, tranquilizers, sedatives, psychoactive medications, cocaine, marijuana, opiates, benzodiazepines or any other narcotic or potentially addicting substance? Yes _________ No _________

If you answer to the question is "Yes" please provide a complete written explanation of

a. the treatment;
b. the name, address and telephone number of your treating physician;
c. any restriction or conditions imposed upon your practice by any licensing agency or health care facility due to such condition; and
d. how you intend to accommodate such condition in the practice you intend to conduct in the State of Wyoming,

Attach to your answer any agreement between you and any professional assistance organization, AA or other rehabilitation and/or monitoring group.

E. Within the past five (5) year have you been reprimanded, demoted, disciplined, cautioned, placed on probation, taken leave for any reason or terminated by any employer, educational institution or training program for any reason? Yes _________ No _________

If your answer to this question is "Yes" please provide a complete written explanation of:

a. the circumstances leading to the action;
b. the effective date of the action;
c. the name, title, address and phone number of the person(s) taking such action; and
d. the resolution and/or current status of such action.

F Have you ever been or are you now under investigation or have any adverse charges or complaints ever been filed against you by any educational training program or facility, medical licensing board, local, state, federal or military professional or disciplinary body or any hospital privileging or credentialing body, grievance committee or any other medical group, including medical societies and specialty boards? Yes _________ No _________

If your answer to this question is "Yes" please provide a complete written explanation of:

a. the charges against you;
b. the name, address and telephone number of the entity before whom such charges were brought;
c. the date the action was initiated;
d. the outcome of the action;
e. any restriction or conditions imposed upon your practice as a result of the action; and
f. how you intend to accommodate such restriction or condition in the practice you intend to conduct in the State of Wyoming.

Attach to your answer all the records of the action including final orders and/or findings.

G. Have you ever been denied licensure or privileges or membership by any licensing board, hospital, medical facility, professional society, specialty board or medical body?
Yes _________ No _________

If your answer to this question is "Yes" please provide a complete written explanation of:

a. the basis for denial;
b. the name, address and telephone number of the entity which denied your application;
c. the date the denial was issued.

Attach to your answer all records of the application and denial process including final orders and/or findings.

H. Have you ever withdrawn an application for privileges or licensure in any jurisdiction?
Yes __________ No__________

If the answer to this question is "Yes" please provide a complete explanation of:

a. the name, address and telephone number of the entity to which you had applied;
b. the license, privilege or membership applied for;
c. the date you withdrew the application;
d. the reason for the withdrawal; and
e. whether the withdrawal was permitted by the entity in lieu of a denial of the application.

Attach to your answer all records of the application and withdrawal process including final orders and/or findings..

1. **Have any professional liability claims ever been filed against you?**
Yes__________ No__________

If your answer to this question is "Yes" indicate how many, and for each claim please provide a complete, written explanation of:

a. the name and location of the court where the action was filed and the docket number of the case;
b. the allegations of the claim against you;
c. the manner in which the claim was resolved;
d. the amount, if any, paid to the claimant by you and/or your insurance carrier; and
e. the date the claim was resolved.

Attach a copy of any final |judgement, order or settlement documents that relate to the disposition of the claims against you.

J. Has a professional liability insurance carrier ever terminated your coverage:
Yes__________ No__________

if your answer is "Yes" please provide a complete written explanation of:

a. the name, address and telephone number of the company which terminated coverage;
b. the basis for termination; and
c. the date of termination.

Attach a copy of any correspondence and other documentation which relates to the denial of coverage.

SECTION 8. AFFIDAVIT:

I ___________________________________, being first duly sworn, certify under oath that I am the person named and pictured in this application and supporting documents and that I am the person named in the various forms and credentials furnished in support of this application and that all documents form or copies furnished or to be furnished are absolutely true and accurate.

I hereby authorize all hospitals, institutions or organizations, personal physicians, previous employers, past and present business associates and local state federal or foreign governmental agencies and instrumentalities to release to the Wyoming Board of Medicine all information, files or records requested by the Board in connection with the processing of this application. I further authorize the Wyoming Board of Medicine to release to the organizations, individuals and groups listed above any information which is or may be material to my application.

I swear or affirm that I will utilize this volunteer medical license to practice only on the premises of a Wyoming nonprofit health care facility and that I will devote my time under this license exclusively and totally to providing medical services to low income, uninsured persons. I swear that I will not accept any form of remuneration for these volunteer services.

I have carefully read the questions in the foregoing application and have answered them completely and without reservation of any kind and I declare, under potential penalty of false swearing, that my answers and all statements in this application are true, correct and current as of the date of this application. I hereby agree that failure to provide accurate information on this application shall constitute cause for denial, suspension or revocation of my volunteer's license to practice medicine in the state of Wyoming and have may have criminal ramifications. I further agree to furnish the Wyoming Board of Medicine any and all additional information pertaining to questions in this application which may come to light after the date of this application. Moreover, I understand that should I violate any provision of the Wyoming Medical Practice Act or should the Board receive satisfactory proof that I have practiced outside the scope of this volunteer's license, that the Board may revoke the license.

(Signature of Applicant)

County of ___________________________

State of ___________________________

Subscribed and sworn to before me this __________ day of

___________________________ ,20____

____

(Notary Public)

My Commission Expires: ___________________________

SEAL

Paste in this space a photograph of yourself, 3 x 2111", head and shoulder view, taken within three months of the date of application.

PLEASE INDICATE THAT DATE OF WHICH THE PHOTO WAS TAKEN

WYOMING BOARD OF MEDICINE
COLONY BUILDING 2ND FLOOR, 211 W. 19TH STREET
CHEYENNE, WY 82002
(307) 778-7053

VERIFICATION OF LICENSURE

I ______________________________ hereby authorize ______________________________ to furnish to the Wyoming Board of Medicine the required information necessary for licensure in the State of Wyoming.

______________________ Signature

__________ License No.

______________________ Social Security No.

______________________ Type or Print Full Name

______________________ Current Address

______________________ City, State, Zip

Medical Board

Please provide the following information and return the completed form directly to the Wyoming Board of Medicine.

FULL NAME OF LICENSEE: ______________________________

GRADUATE OF: ______________________________ DATE: ______________

LICENSE NO.: ______________ DATE ISSUED: ______________________

CURRENT STATUS: ______________________ EXPIRATION DATE: ______________________

BASIS OF LICENSURE:

( ) USMLE ( ) LMCC
( ) NATIONAL BOARD ( ) FLEX
( ) RECIPROCITY/ENDORSEMENT WITH ______________________
( ) STATE BOARD EXAM ( ) OTHER ______________________
( ) Composite of FLEX or National Boards and USMLE

Is applicant currently the subject of a pending investigation by a licensing or disciplinary authority in your state? Yes ____ No ____

Have disciplinary proceedings ever been initiated against applicant by any licensing or disciplinary authority in your state? Yes ____ No ____

Has the applicant ever been warned, censured or in any other manner disciplined or has applicant's license been revoked, suspended or in any other manner limited by a licensing or disciplinary authority in your state? Yes ____ No ____

IF YES TO ANY OF THE ABOVE QUESTIONS, PLEASE ATTACH DETAILS AND SUBMIT CERTIFIED COPIES OF ORDERS.

Comments: ____

______________________ Signature

______________________ Name of Board

______________________ Title

______________________ Address

______________________ Date

______________________ City, State, Zip

SEAL

WYOMING BOARD OF MEDICINE
COLONY BUILDING 2ND FLOOR, 211 W. 19TH STREET
CHEYENNE, WY 82002
(307) 778-7053

CERTIFICATE OF MEDICAL EDUCATION

I ______________________________ hereby authorize

______________________________ to furnish to the Wyoming Board of Medicine
Name of Medical School
the required information necessary for licensure in the State of Wyoming.

______________________________	______________________________
Signature	Social Security No.
______________________________	______________________________
Type or Print Full Name	Current Address
______________________________	______________________________
Date	City, State, Zip

Medical School

Please provide statement below addressing periods of study and date diploma or certification awarded. Return this completed form directly to the Wyoming Board of Medicine,

____
____
____
____
____
____
____
____

______________________________	______________________________
Signature	Name of Medical School
______________________________	______________________________
Title	Address
______________________________	______________________________
Date	City, State, Zip

SEAL

WYOMING BOARD OF MEDICINE
COLONY BUILDING 2ND FLOOR, 211 W. 19TH STREET
CHEYENNE, WY 82002
(307) 778-7053

CERTIFICATE OF POSTGRADUATE TRAINING

I ______________________________ , hereby authorize

______________________________ to furnish to the
Name of Institution
Wyoming Board of Medicine the required information necessary for licensure in the State of Wyoming.

______________________________ Signature

______________________________ Social Security No.

______________________________ Type or Print Full Name

______________________________ Current Address

______________________________ Date

______________________________ **City, State, Zip**

Please provide statement below addressing periods of study, name of specialized medicine program and date certificate awarded. Return this form directly to the Wyoming Board of Medicine complete with the SEAL of your institution.

____
____
____
____
____
____
____
____

______________________________ Signature

______________________________ Name of Institution

______________________________ Title

______________________________ Address

______________________________ Date

______________________________ City, State, Zip

☐ NO SEAL ______________________________
(Check here if seal is not available)

______________________________ (Telephone)

SEAL