

WYOMING BOARD OF MEDICINE

REACTIVATION APPLICATION TO PRACTICE MEDICINE IN THE STATE OF WYOMING

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.:

D. BIRTHDATE:

G. Height:

Weight: _____

Color of Hair: _____

Identifying Marks: _____

E. BIRTH PLACE:

City

State

F. GENDER

FEMALE

MALE

H. DEA CONTROLLED SUBSTANCE CERTIFICATION NUMBER:

SECTION 2. PRACTICE IN WYOMING:

A. Intended Wyoming Location:

(City)

B. Do you plan to leave practice in your present location and practice primarily in Wyoming: _____

C. Are you applying for temporary license? _____ If so, when do you intend to begin practicing in Wyoming?

D. 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. MEDICAL SOCIETY MEMBERSHIP:

List current medical society memberships:

SECTION 5. EMPLOYMENT ACTIVITIES:

List employment activities and two references from each facility since graduation from medical school to present. Vacation and unemployed periods must be included. If necessary, list on separate sheet.

Employer/Activity	Location	From	Dates	TO
Reference: _____ (Name) (Address)				
Reference: _____ (Name) (Address)				

Employer/Activity	Location	From	Dates	TO
Reference* _____ (Name) (Address)				
Reference: _____ (Name) (Address)				

Employer/Activity	Location	From	Dates	TO
Reference: _____ (Name) (Address)				
Reference: _____ (Name) (Address)				

SECTION 6. LICENSURE IN OTHER STATES AND/OR COUNTRIES:Indicate states and/or countries in which you are or have been licensed. You must include all jurisdictions in which you have ever been licensed.

State	License No.	Date Issued	Obtained by (Exam/Reciprocity)	Valid Yes/No
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

IT IS NECESSARY TO SUBMIT THE ATTACHED VERIFICATION OF LICENSURE FORM TO EACH STATE/COUNTRY LISTED ABOVE AND REQUEST THAT JURISDICTION RETURN IT DIRECTLY TO THE WYOMING BOARD OF MEDICINE.

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 not 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.

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

B. 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?
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.

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

- C. Within the past five (5) years have been hospitalized for, missed work because of, or been significantly impaired by any mental or emotional condition? 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 may impair 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.

Attach to your answer the most recent medical records and/or a written report from your treating Physician describing the diagnosis, the current treatment regimen, a prognosis and any limitations arising from such condition.

- 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 have a fully executed contract with the Wyoming Professional Assistance program you may answer "NO" to this question)

- 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. Have you ever 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.

I. 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 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, forms or copies furnished or to be furnished are absolutely true and accurate.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, previous and present employers, past and present business and professional 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 have carefully read the questions in the foregoing application and have answered them completely, without reservation of any kind, and I declare under potential penalty of false swearing that my answer and all statements are true and correct and current as of the date of this application, I hereby agree that such act shall constitute cause for the denial, suspension or revocation of my license to practice medicine and surgery in the State of Wyoming and 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 Medical Practice Act of the State of Wyoming, my license may be subject to revocation, suspension or restriction or other disciplinary action.

 (Signature of Applicant)

County of _____

State of _____

Subscribed and sworn to before me this _____ day of

_____, 20____

 (Notary Public)

My Commission Expires: _____

Paste in this space a photograph of yourself, 3"x 2 1/2" head and shoulder view, taken within three months of the date of application.

PLEASE INDICATE THAT DATE OF WHICH THE PHOTO WAS TAKEN

SEAL

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	

REFERENCE LETTER INSTRUCTION SHEET

APPLICANT: Please forward one instruction sheet to each of the three (3) physicians (MD s or DO s only) who will be writing a letter of recommendation on your behalf.

Letter of Recommendation for Dr. _____
Applicant

AUTHOR PLEASE NOTE: In order to be acceptable, letters of recommendation must meet the following criteria:

1. Must be typed or printed legibly on your professional letterhead; and
2. Must be addressed to the Wyoming Board of Medicine; letters addressed "To Whom it May Concern" will not be accepted; and
3. Must be currently dated; and
4. Must contain the following outlined below:
 - a. your name, address, telephone number and professional affiliation;
 - b. how long you have known applicant and in what capacity;
 - c. describe applicant's medical acumen, experience and abilities;
 - (1) indicate applicant's strengths
 - (2) indicate if you have ever noticed or become aware of any difficulties or shortcomings;
 - d. describe applicant's interactions with patients, colleagues and staff,
 - e. describe any instances that you are aware of in which applicant has been sanctioned in any fashion by any licensing, privileging, credentialing or academic body;
 - f. describe any circumstances that you are aware of that might impede applicant's ability to safely and skillfully practice medicine, and
5. Must be signed and mailed directly to the Wyoming Board of Medicine, Colony Building 2nd Floor, 211 West 19th Street, Cheyenne, WY 82002. Please do not use a signature stamp. PLEASE CALL IF YOU HAVE QUESTIONS OR COMMENTS. (307) 778-7053.

Please feel free to add any additional comments you wish regarding this applicant. Thank you for your time and effort.

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