FOR OFFICE USE ONLY
Receipt #
ID #
Issue Date
License #

Rhode Island
Board of Medical Licensure and Discipline

Room 205
3 Capitol Hill
Providence, RI 02908-5097

Instructions and License Application for:

☐ Allopathic Medicine

☐ Osteopathic Medicine

☐ Academic Faculty
(Limited Medical Registration)

Applicant - Print Name (First/MI/Last)

☐ I am also applying for a RI Uniform Controlled Substances Registration (CSR) and I have attached the CSR application to this license application.

Phone: (401) 222-3855 **TTY/TDD: (800) 745-5555** **Fax: (401) 222-2158**

After your application is reviewed, you will be contacted in writing. Be advised that you may be required to appear for an interview. Please allow 2-6 weeks for your wallet size license card and wall certificate to be mailed to you. [Note: You may not practice in Rhode Island until you have received a license number.]

Please continue to review the remaining portions of this application packet for instructions and other materials necessary to complete the Board application. If you have any questions about this process or would like to check on the status of your Board application, please contact us at (401) 222-3855 or by email at Lauren.DixonLasso@health.ri.gov .

INSTRUCTIONS FOR COMPLETING THE BOARD APPLICATION

Read the following instructions and those throughout the online application carefully before completing the Board application. Failure to submit all required information and appropriate documentation may result in processing delays. All of the information provided is subject to change.

General Instructions

1. Type your information or print in blue or black ball-point pen. Board staff will not make assumptions about illegible information. Be sure to print your name in the box provided on the cover page.

2. Provide a response to each section or questions; otherwise, make "N/A" for Not Applicable.

3. We suggest that you make a copy of your completed application and addenda before submitting it to the Board.

4. **It is your responsibility to check on the status of your application.**

Completing Your Board Application

1. **Fees**: Make a check or money order (in U.S. funds only) for the application fee of $1,090.00 (or $1,290.00 if you are application for a Controlled Substance Registration (CSR)), payable to "Rhode Island General Treasurer" and staple it to the upper left-hand corner of the Addenda cover page. These application fees are NON-REFUNDABLE.

   NOTE: These are Board Application Fees. A separate one-tine service fee of $50.00 is charged upon complete of the UA. Fees for FCVS are located at http://www.fsmb.org/licensure/fcvs/cost-fees

2. **FCVS Application Process:** FCVS uses primary sources to verify core physician credentials as part of the credentialing and in accordance with established policies and procedures set forth by the Board. The documents that FCVS verifies and stores for you are in the following categories (some may not apply):

   - Identity
   - Medical Education
   - Postgraduate Training
   - Exam History (state licensing authorities only)
   - Board Action/Disciplinary History
   - ABMS Board Certification
   - ECFMG Certification (if applicable)

   When all information is received and reviewed for accuracy, FCVS will forward directly to the Board a non-interpretive "Physician Information Profile" containing certified photocopies of your credentials.

   Because the verification process is the most time consuming task, we recommend that you submit your FCVS application as soon as possible. You will deal directly with FCVS for all aspects of this verification.

For applicants who have an active and unrestricted license in another state, the Board may elect to consider granting licensure pending receipt of FCVS, provided the applicant has submitted documentation of payment to FCVS and a written statement confirming completion of the FCVS application.

Contact FCVS at 1 (888) 275-3287 with your FCVS ID or use the messaging toll within FCVS and ask them to designate the Board to receive your FCVS profile. You will also need to complete either an initial FCVS application (first-time users) or a subsequent application (for profile updates).

To begin your FCVS application, log in at http://www.fsmb.org/licensure/fcvs/ . To allow the data to process from FCVS, please wait three days after completing an initial FCVS application before proceeding to the UA.

3. **Uniform Application Process:** The Board was one the first boards to incorporate the Uniform Application (UA) into its Medical Licensing Application. Much like FCVS, after completing the UA for the first time, your information is securely stored and can be submitted to another participation state without reentering the same information. You only have to make updates as needed, complete the state-specific addenda, and fully comply with state requirements.

   Please read the following information carefully before completing and submitting your Uniform Application (UA). You will be asked to provide your licensure and employment history, account for all time since medical school education, and provide any information on medical malpractice claims. We recommend having this information on hand before you begin.

   The direct link to the UA portal is http://www.fsmb.org/licensure/uniform-application/ . If you receive an error while working in the UA, email your username, password, and a screenshot of the error or the description (**not** the error log number) to ua@fsmb.org. You may also call FSMB UA customer service at (800) 793-7939.

   In addition to the guidance below, make special note of the information and instructions appearing at the top of each screen.

   Personal Information Pages. Most of the information on these pages is pre-populated by your FCVS packet. If you need to update information in a pre-populated (grayed-out) field, contact FCVS at (888) 275-3287 or at fcvs@fsmb.org. The changes made by FCVS will transfer into the UA when you next log in to the UA.

   Education and Certification Pages. Most of the information on these pages is pre-populated by your FCVS packet. If you need to update information in a pre-populated (grayed-out) field, contact FCVS at (888) 275-3287 or at fcvs@fsmb.org. The changes made by FCVS will transfer into the UA when you next log in to the UA.

   Licensure and Employment History Pages. On the State or Professional Licensure page, list ALL professional licenses you have held (Medical, Osteopathic, EMT, PA, nurse, etc.) in the United States and/or Canada, whether active or inactive. On the Chronology of Activities page, if the Type of Activity you choose is a non-working activity (Health Activity, Military Service, Seeking Employment, or Vacation), describe the activity in the next field instead of listing practice/employment name. For example, enter "vacation" if you have "Vacation" as your Type of Activity. Check the "Staff Privileges" box for all locations where you have had hospital privileges. If you have military or locum tenens assignments, you must list each location/assignment separately.

   Malpractice Liability Claims Information Page. Report all medical malpractice court judgements, medical malpractice arbitration awards and settlements, within the past ten (10) years, in which payment was made to a complaining party.

   > Special Note about Malpractice Information: Pursuant to R.I.G.L § 5-37.9.2, the Rhode Island Board of Medical Licensure and Discipline must collect data regarding your malpractice history. You are required to report all actual settlement or jury verdict amounts in the past ten (10) years. The Board will not make actual settlement or verdict amount available to the public. I must report the fact that a payment was made and how it compared to other payments made in your specialty. For each incident you report, you must include documentation that verifies the date, place, reason, and disposition of the matter.

Forms and Affidavit. DO NOT COMPLETE FORMS 1-4. In lieu of the licensure verification form, you will obtain licensure verification on the Reciprocity Release Form (Addendum 1). FCVS provides the information needed on Forms 2-4 as needed on your behalf.

On the Affidavit and Authorization for Release of Information, attach a recent (less than 6 months) two inch by two inch (2" x 2") passport quality, color photograph of yourself (head and shoulders only) in the space provided. Proof photos, negatives, and digital photos are not acceptable. This Affidavit/Authorization form must be notarized and returned to the Rhode Island Board. Do not send the UA Affidavit to FSMB.

State Addendum. The addenda are located in this document after these instructions for your convenience. Each addendum should be completed as instructed. Please type or print all responses.

Review and Submit. Please review your information before submitting your online UA. We recommend that you print a copy for your records and keep a copy of all forms and documentation sent to the Board.

- To submit your UA, read and accept the Terms and Conditions, then click on "Submit Application" at the bottom of the screen. Once you submit your UA, no changes can be made to that particular application.
- To make changes to an already submitted application, click on the "Start New/Edit" in the yellow box at the top of the screen. If the box is not there, go to the Navigation Options drop down list in the upper right corner and select "UA Main." Reselect the Board from the map, make changes, and resubmit your UA.
- For a copy of your UA receipt, go to the Navigation Option drop down list in the upper right corner and select "Itemized Receipt."

4. **National Practitioner Data Bank Report:** submit a "self-query" of the National Practitioner Data Bank (NPDB) by going to https://www.npdb.hrsa.gov/ext/selfquery/SQHome.jsp and clicking on "Start a Self-Query on an Individual (Search on Myself)." Complete the required information on the following screens. When you receive a response from the Data Bank, send the ORIGINAL, UNOPENED response to the Board. The Board must have this response in order to complete your application so you are encouraged to make this request as soon as possible.

Again, the application process is not considered complete until your Board application (UA) applicable forms, FCVS Physician Information Profile, and NPDB Report are received in a manner satisfactory to the Board. Neither the Board nor FSMB (FCVS and UA) will accelerate processing of one application at the expense of others for any reason.

Complete all application materials as instructed. Do not submit an application without all applicable information, documentation, and fee. You must repost to all components of the application as instructed. Mail these components of the application:

Rhode Island Board of Medical Licensure and Discipline
Room 205, Three Capitol Hill
Providence, RI 02908

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Board of Medical Licensure and Discipline

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ADDENDUM INSTRUCTIONS

Complete the addenda as instructed below. Return the completed addenda to the Board at the address above.

☐ **Addendum 1: Reciprocity Release Form.** Obtain licensure verification from all states where you hold or have ever held a license to practice medicine. Complete the top portion of the Reciprocity Release Form and then mail to each licensing authority in which you are/were licensed. If you are licensed in Canada, send a copy to each province in which you are/were licensed. This form may be duplicated as necessary. This form will be completed in lieu of the Uniform Application Licensure Verification Form (Online Uniform Application, Affidavit and Forms Section).

☐ **Addendum 2: Additional Physician Information.** You must complete each question as instructed. Include all requested information and documentation. Please either type or print your responses. If not applicable, please respond with N/A. If you need additional space please attach a separate sheet.

☐ **Addendum 3: Verification of Social Security Number.** This form is mandatory. You must complete this form as instructed.

☐ **Addendum 4: Rhode Island Uniform Controlled Substances Act Registration (CSR).** In order to dispense, prescribe, store, or order controlled substances, you must obtain a Rhode Island Controlled Substance Registration (CSR) and a Drug Enforcement Administration (DEA) Registration. If applying for a CSR you must complete this Registration form and submit it along with your license application. If you are NOT applying for a CSR, please write N/A across the form. After you obtain your Rhode Island CSR, you can apply for a federal DEA Number by using the forms at http://www.deadiversion.usdoj.gov/drugreg/reg_apps/. For federal DEA registration help, email DEA.Registration.Help@usdoj.gov.

☐ **Addendum 5: Voluntary Race/Ethnicity Questions.** The completion of this form is **voluntary** and will **NOT** affect your Application in any way.

☐ **Addendum 6: Academic Faculty – Limited Medical Registration.** This form only needs to be completed if the applicant is applying for Academic Faculty – Limited Medical Registration. Complete the top portion of this form and forward to the Dean of the Medical School. Letters or other forms submitted in lieu of this form will not be accepted. The board must receive this form(s) and attachments directly from the Medical School.

Applicant Name: _____ Date: _____

Rhode Island Board of Medical Licensure and Discipline

Room 205, 3 Capitol Hill
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(401) 222-3855

ADDENDUM 1
Reciprocity Release Form

Substitute forms are not acceptable. This form may be duplicated as needed.

THIS SECTION TO BE COMPLETED BY THE APPLICANT

I am applying for a license to practice medicine in the State of Rhode Island. The Rhode Island Board of Medical Licensure and Discipline requires that the following form be completed by the jurisdiction in which I am now or was previously licensed. This constitutes your authority to release all information in your files, favorable or otherwise, directly to the Rhode Island Board of Medical Licensure and Discipline at the above address.

_____ _____ _____
Print/Type Full Name Signature Date

_____ _____ _____
Previous Names Used Social Security Number Date of Birth

_____ _____
License Number Date Issued

THIS SECTION TO BE COMPLETED BY THE MEDICAL BOARD

Basis for issuing license:

☐ NBME ☐ NBOME ☐ USMLE ☐ LMCC ☐ FLEX _____ State Sponsor ☐ State Exam _____(State)

If a combination of exams were taken, please list the specific combination: _____

License Status: ☐ Active ☐ Inactive ☐ Lapsed	**Original Date Issued**: _____	**Expiration Date**: _____

Questions:

1. Has this physician ever been investigated by your Board? ☐ Yes ☐ No
2. Has this physician incurred any disciplinary proceedings in your state, or is any action pending? ☐ Yes ☐ No
3. Has the applicant's license ever been denied, surrendered, reprimanded, suspended, revoked or placed on probation? ☐ Yes ☐ No
4. Are you aware of any information about this physician submitted to the National Practitioner Data Bank? ☐ Yes ☐ No
5. Do you know of any information that may discredit this person? ☐ Yes ☐ No

If you answer "Yes" to any of the above questions, please provide a written explanation below, and attach a copy of all supporting documentation (e.g. Board order, complaint, etc.). Use a separate sheet if necessary.

_____
_____
_____
_____

Certification:

_____ _____
Signature Date

_____
Type or Print Name

_____
Title

_____
Full Name and of Licensing Board including State

Please Affix
Board Seal Here

Please return directly to the Board at the above address. Thank you for your prompt cooperation.

Rhode Island Board of Medical Licensure and Discipline
Room 205, 3 Capitol Hill
Providence, RI 02908-5097
(401) 222-3855

ADDENDUM 2
Additional Physician Information

Complete each section as instructed.

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1. **Specialty of Practice**: Refer to the ABMS Certification Codes List (pages 4 and 5 of this addendum) when completing this section. You must provide a copy of your ABMS certificate(s). You may report "None", "Other", or "Unknown" if necessary.

_____ Board Certified? ☐ Yes ☐ No
Primary Specialty Code — If Yes, Year Certified/Recertified: _____

_____ Board Certified? ☐ Yes ☐ No
Secondary Specialty Code — If Yes, Year Certified/Recertified: _____

_____ Board Certified? ☐ Yes ☐ No
Secondary Specialty Code — If Yes, Year Certified/Recertified: _____

_____ Board Certified? ☐ Yes ☐ No
Secondary Specialty Code — If Yes, Year Certified/Recertified: _____

2. **Practice Information**: Specify where in this State do you intend to practice, and list type of practice using the codes below. (If additional space is needed, attach a separate sheet)

ACD = Academia
ADM = Administration
FTY = Faculty
FEL = Fellowship
GRP = Group
HSP = Hospital
HMO = HMO
OFC = Office
RES = Research
OTH = Other

Location #1: _____
City: _____ Practice Type (See Code): _____

Location #2: _____
City: _____ Practice Type (See Code): _____

Location #3: _____
City: _____ Practice Type (See Code): _____

Identify any translational services that may be available at your primary practice location: _____
_____

3. **Medical School Faculty Appointments**: Identify any appointments to medical school faculties and indicate as to whether you have had responsibility for graduate medical education within the most recent ten (10) years.

_____
_____
_____

4. **Medical Licensure**: List all countries (other than the U.S. and Canada) in which you are now, or ever have been licensed to practice medicine, or any other profession.

_____ ☐ Active ☐ Inactive
Country

_____ ☐ Active ☐ Inactive
Country

_____ ☐ Active ☐ Inactive
Country

5. **Board Discipline**: List any disciplinary actions by licensing boards in other states. Please describe any prior or pending Board action or investigation. Please attach any relevant supplemental materials. If necessary, you may continue on a separate sheet.

☐ Check here if not applicable

Licensing Board (abbreviate) and Nature of Action (e.g. TX – Professional Misconduct):	Month/Year	Type of Discipline:
_____	____/_____	_____
_____	____/_____	_____
_____	____/_____	_____
_____	____/_____	_____
_____	____/_____	_____

6. **Hospital Discipline**: Please explain any disciplinary actions and attach any relevant supplements materials. List any revocation of hospital privileges for reasons related to competence or quality of patient care that have been taken by the hospital's governing body or any other official of the hospital after procedural due process has been afforded. Also, report resignation from or the non-renewal of medical staff privileges or the restriction of privileges at a hospital during the course or threat of investigation. If necessary, you may continue on a separate sheet.

☐ Check here if not applicable

_____
(1) Name of Hospital

_____/ _____/ _____ _____
Month Day Year Type of Action

_____
(2) Name of Hospital

_____/ _____/ _____ _____
Month Day Year Type of Action

_____
(3) Name of Hospital

_____/ _____/ _____ _____
Month Day Year Type of Action

_____
(4) Name of Hospital

_____/ _____/ _____ _____
Month Day Year Type of Action

7. **Criminal Convictions**: Respond to the questions below, then list any criminal convictions(s) in the space provided. If necessary, you may continue on a separate sheet.

Have you ever been convicted of a violation, plead Nolo Contendere, or entered a plea bargain to any federal, state or local statute, or ordinance, or are any formal charges pending; including use of illicit substances or operating a motor vehicle while intoxicated (Please include any offenses which have been expunged from your record)? ☐ Yes ☐ No

Abbreviation of State and Conviction* (e.g.CA – Illegal possession of a controlled substance)	Month/Year
_____	_____/_____
_____	_____/_____
_____	_____/_____
_____	_____/_____

*For purposes of this section, a person shall be deemed to be convicted of a crime if he/she please guilty or if he/she was found or adjudged guilty by a court of competent jurisdiction or has been convicted of a felony by the entry of Nolo Contendere in any state.

8. **Questions**: Check either "Yes" or "No" for each question below. **Note: if you answer "Yes" to any question**, you are required to furnish complete details, including date, place, reason and disposition of the matter on a separate sheet.

		YES	NO
1.	During any Professional/Medical Education, were you ever dismissed, suspended, restricted, put on probation, or otherwise acted against or did you take a leave of absence for medical reasons?	☐	☐
2.	During any Professional/Medical Education, were you ever requested to leave or did you leave, temporarily or permanently, prior to completion of training?	☐	☐
3.	During any Post Graduate Training, were you ever dismissed, suspended, restricted, put on probation, or otherwise acted against or did you take a leave of absence for medical reasons?	☐	☐
4.	During any post graduate training, were you ever requested to leave or did you leave temporarily or permanently, prior to completion of training? (excluding maternity leave)	☐	☐
5.	Are there any charges or investigations pending, in any state, against you?	☐	☐
6.	Have your staff privileges at any hospital, nursing home, or other health care facility or health care provider or HMO ever been reduced, revoked, or suspended or have you voluntarily surrendered your clinical privileges from any such unit or facility while under investigation in any state?	☐	☐
7.	Have you ever had any disciplinary action(s) taken, or is any pending, against your License to practice medicine, DEA permit, State Controlled Substances Registration, Medicare Privileges, Medicaid Privileges, or are any complaints pending in any state?	☐	☐
8.	Have you ever had a membership in a professional society revoked, suspended, or limited in any manner or have you voluntarily withdrawn while under investigation?	☐	☐
9.	Have you ever failed to pass an examination for medical licensure (including National Boards, FLEX, USMLE)? If you have failed to pass any segment of the USMLE within three (3) attempts you do not meet the requirements for licensure. Please contact Lauren Lasso at (401) 222-7887 to discuss.	☐	☐

9. **Physician Honors and Peer-Reviewed Publications (Optional)**: List any information regarding professional or community service awards and/or information regarding publication in peer-reviewed medical literature within the last ten (10) years. Do **not** submit your curriculum vitae to satisfy the requirements of this section. If necessary, you may continue on a separate sheet.

Awards, Honors:

_____

_____

_____

Publications:

_____

_____

_____

10. **Professional and Community Memberships (Optional)**: List any professional and community memberships. Do **not** submit your curriculum vitae to satisfy the requirements of this section. If necessary, you may continue on a separate sheet.

_____

_____

_____

ABMS Codes and Abbreviations

Certification Codes

American Board of	General Certificate		Subspecialty Certificates	
Allergy and Immunology	**A&I**	Allergy and Immunology	**CLI**	Clinical & Laboratory Immunology 5
			DLI	Diagnostic Laboratory Immunology 5
Anesthesiology	**Anes**	Anesthesiology	**CCM**	Critical Care Medicine
			HPM	Hospice and Palliative Medicine
			PM	Pain Medicine 5
Colon and Rectal Surgery	**CRS**	Colon and Rectal Surgery		
Dermatology	**D**	Dermatology	**CLDI**	Clinical and Laboratory Dermatological Immunology 4
			DI	Dermatological Immunology/Diagnostic & Laboratory Immunology
			DP	Dermatopathology
			PedD	Pediatric Dermatology
Emergency Medicine	**EM**	Emergency Medicine	**HPM**	Hospice and Palliative Medicine
			MT	Medical Toxicology
			PEM	Pediatric Emergency Medicine
			SM	Sports Medicine
			UHM	Undersea & Hyperbaric Medicine
Family Medicine	**FM**	Family Medicine	**AM**	Adolescent Medicine
			Ger	Geriatric Medicine
			HPM	Hospice and Palliative Medicine
			SLP	Sleep Medicine
			SM	Sports Medicine
Internal Medicine	**IM**	Internal Medicine	**AI**	Allergy and Immunology
			AM	Adolescent Medicine
			CCEP	Clinical Cardiac Electrophysiology 5
			CCM	Critical Care Medicine
			CLI	Clinical & Laboratory Immunology 5
			Cv	Cardiovascular Disease
			DLI	Diagnostic Laboratory Immunology 5
			EDM	Endocrinology, Diabetes & Metabolism 5
			En	Endocrinology & Metabolism 5
			Ge	Gastroenterology
			Ger	Geriatric Medicine
			Hem	Hematology
			HPM	Hospice and Palliative Medicine
			Inf	Infectious Disease
			IntvCd	Interventional Cardiology
			Nep	Nephrology
			Onc	Medical Oncology
			Pul	Pulmonary Disease
			Rhu	Rheumatology
			SLP	Sleep Medicine
			SM	Sports Medicine
			TH	Transplant Hepatology
Medical Genetics	**MG CBCGn**	Clinical Biochemical Genetics	**MBG**	Medical Biochemical Genetics
	MG CBMG	Clinical Biochemical/Molecular Genetics 4	**MGP**	Molecular Genetic Pathology
	MG CCytG	Clinical Cytogenetics		
	MG CGen	Clinical Genetics (M.D.)		
	MG CMGn	Clinical Molecular Genetics		
	MG PhDMG	Ph.D. Medical Genetics 4		
Neurological Surgery	**NS**	Neurological Surgery		
Nuclear Medicine	**NuM**	Nuclear Medicine		
Obstetrics & Gynecology	**ObG**	Obstetrics & Gynecology	**CCM**	Critical Care Medicine
			GO	Gynecologic Oncology
			HPM	Hospice and Palliative Medicine
			MF	Maternal and Fetal Medicine
			RE	Reproductive Endocrinology/Infertility
Ophthalmology	**Oph**	Ophthalmology		
Orthopaedic Surgery	**OrS**	Orthopaedic Surgery	**HS**	Surgery of the Hand
			OSM	Orthopaedic Sports Medicine
Otolaryngology	**Oto**	Otolaryngology	**ON**	Neurotology 5
			PO	Pediatric Otolaryngology
			PSHN	Plastic Surgery within the Head and Neck
			SLP	Sleep Medicine
Pathology	**Path AP**	Anatomic Pathology	**BB**	Blood Banking 5
	Path AP/CP	Anatomic Pathology and Clinical Pathology	**BBTM**	Blood Banking/Transfusion Medicine 5
	Path CP	Clinical Pathology	**ChemP**	Chemical Pathology 5
	PathR	Pathology Recertification	**CytoP**	Cytopathology
			DP	Dermatopathology
			FPath	Forensic Pathology 5
			Hem	Hematology 5
			IP	Immunopathology 4
			MGP	Molecular Genetic Pathology 5
			MMB	Medical Microbiology 5
			NPath	Neuropathology
			PathF	Pathology-Forensic 5
			PChem	Pathology-Chemical 5
			PdP	Pediatric Pathology 5
			PHem	Pathology-Hematology 5
			PMG	Pathology-Molecular Genetic 5
			PMMB	Pathology-Medical Microbiology 5
			PPed	Pathology-Pediatric 5
			RIP	Radioisotopic Pathology 4

ABMS Codes and Abbreviations

Certification Codes (continued)

American Board of	General Certificate		Subspecialty Certificates	
Pediatrics	**Ped**	Pediatrics	**AI**	Allergy and Immunology [4]
			AM	Adolescent Medicine
			CCM	Pediatric Critical Care Medicine
			Cd	Pediatric Cardiology
			CAP	Child Abuse Pediatrics
			CLI	Clinical & Laboratory Immunology [5]
			DBP	Developmental-Behavioral Pediatrics
			DLI	Diagnostic Laboratory Immunology [5]
			HPM	Hospice and Palliative Medicine
			En	Pediatric Endocrinology
			Ge	Pediatric Gastroenterology
			HO	Pediatric Hematology-Oncology
			Inf	Pediatric Infectious Diseases
			MT	Medical Toxicology
			ND	Neurodevelopmental Disabilities
			Ne	Pediatric Nephrology
			NP	Neonatal-Perinatal Medicine
			PEM	Pediatric Emergency Medicine
			Pul	Pediatric Pulmonology
			Rhu	Pediatric Rheumatology
			SLP	Sleep Medicine
			SM	Sports Medicine
			TH	Pediatric Transplant Hepatology
Physical Medicine and Rehabilitation	**PMR**	Physical Medicine and Rehabilitation	**HPM**	Hospice and Palliative Medicine
			NeuroMed	Neuromuscular Medicine
			PedRM	Pediatric Rehabilitation Medicine
			PM	Pain Medicine [5]
			SCInj	Spinal Cord Injury Medicine
			SM	Sports Medicine
Plastic Surgery	**PlS**	Plastic Surgery	**HS**	Surgery of the Hand
			PSHN	Plastic Surgery within the Head and Neck
Preventive Medicine	**PrM AeroM**	Aerospace Medicine	**MT**	Medical Toxicology
	PrM GPM	General Preventive Medicine [5]	**UM**	Undersea Medicine [5]
	PrM OM	Occupational Medicine	**UHM**	Undersea & Hyperbaric Medicine [5]
	PrM PH	Public Health [5]		
	PrM PHGPM	Public Health and General Preventive Medicine [5]		
Psychiatry and Neurology	**ChiN**	Neurology with Special Qualification in Child Neurology	**AdP**	Addiction Psychiatry
	N	Neurology	**ChAP**	Child and Adolescent Psychiatry [5]
	Psyc	Psychiatry	**ChiP**	Child Psychiatry [5]
			C/NPh	Clinical Neurophysiology
			FPsy	Forensic Psychiatry
			GPsyc	Geriatric Psychiatry
			HPM	Hospice and Palliative Medicine
			NeuroMed	Neuromuscular Medicine
			ND	Neurodevelopmental Disabilities
			PM	Pain Medicine [5]
			PsycoMed	Psychosomatic Medicine
			SLP	Sleep Medicine
			VascN	Vascular Neurology
Radiology	**Rad DR**	Diagnostic Radiology	**HPM**	Hospice and Palliative Medicine
	Rad DRnt	Diagnostic Roentgenology[4]	**NR**	Nuclear Radiology
	DRSCNR	Diagnostic Radiology with Special Competence in Nuclear Radiology[4]	**NRad**	Neuroradiology
			PR	Pediatric Radiology
	Rad NM	Nuclear Medicine[4]	**VIR**	Vascular and Interventional Radiology
	Rad NM	Nuclear Medicine Medallion		
	Rad R	Radiology[4]		
	Rad Rnt	Roentgenology[4]		
	Rad RO	Radiation Oncology [5]		
	Rad ROR	Radiation Oncology Recertification		
	Rad RT	Radium Therapy[4]		
	Rad TO	Therapeutic Roentgenology [4]		
	Rad TR	Therapeutic Radiology [5]		
Radiologic Physics	**Rad DRMNP**	Diagnostic & Medical Nuclear Physics[4]		
	Rad DRMNP	Diagnostic Radiology & Medical Nuclear Physics		
	Rad DRP	Diagnostic Radiologic Physics		
	Rad MNP	Medical Nuclear Physics		
	Rad RP	Radiologic Physics[4]		
	Rad RRP	Roentgen & Gamma Physics		
	Rad RRP	Roentgen Ray Physics		
	Rad TDRP	Therapeutic & Diagnostic Radiologic Physics[4]		
	Rad TRNP	Therapeutic & Medical Nuclear Physics[4]		
	Rad TRNP	Therapeutic Radiology & Medical Nuclear Physics		
	Rad TRP	Therapeutic Radiologic Physics		
	Rad XRP	X-Ray and Radium Physics[4]		
Surgery	**S**	Surgery	**HPM**	Hospice and Palliative Medicine
	VascS	Vascular Surgery	**HS**	Surgery of the Hand
			PdS	Pediatric Surgery
			SCC	Surgical Critical Care
Thoracic Surgery	**TS**	Thoracic Surgery	**CCS**	Congenital Cardiac Surgery
Urology	**U**	Urology	**PU**	Pediatric Urology

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ADDENDUM 3
Mandatory Addendum to Licensure Application
Verification of Social Security Number
Tax Payer Status Affidavit / Identity Verification

All persons applying or renewing any license, registration, permit or other authority (herein after called "licensee") to conduct a business or occupation in the state of Rhode Island are required to file all applicable tax returns and pay all taxes owed to the state prior to receiving a license as mandated by state law (RIGL 5-76) except as noted below.

In order to verify that the state is not owed taxes, licensees are required to provide their Social Security Number or Federal Tax Identification Number (for businesses) as appropriate. These numbers will be transmitted to the Division of Taxation to verify tax status prior to the issuance of a license.

Licensee Declaration

☐ I hereby declare, under penalty of perjury, that I have filed all required state tax returns and have paid all taxes owed.

☐ I have entered a written installment agreement to pay delinquent taxes that is satisfactory to the tax administrator.

☐ I am currently pursuing administrative review of taxes owed to the state.

☐ I am in federal bankruptcy. (Case # _____)

☐ I am in state receivership. (Case # _____)

☐ I have been discharged from bankruptcy. (Case # _____)

_____
Type of Professional License for which you are applying.

_____ _____
Full Name (Please Print or Type) Social Security Number

_____ (_____) _____ - _____
Signature Phone Number

_____
Date

This form must be completed, signed and attached to your license application for processing.

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ADDENDUM 4

Rhode Island Uniform Controlled Substances Act Registration (CSR)

IF Applying for CSR, this Application **MUST BE SUBMITTED ALONG WITH YOUR LICENSE APPLICATION**. Substitute forms are not acceptable.

I am applying for a Rhode Island Uniform Controlled Substance Act Registration (CSR). **I understand that this application MUST be submitted along with my Board Application. I also understand that there is an additional $200.00 fee for this Registration and that the check or money order for $1,290.00 (Non-Refundable Board Application fee ($1,090.00) PLUS CSR Application fee ($200.00) must be made out to the "RI General Treasurer." Note: To be issued a RI Controlled Substance Registration you must have a Rhode Island Business Address.**

Print/Type Full Name	Business Name
Signature	Business Address
Date	Business Telephone / Business Fax

Complete this application for registration to prescribe controlled substances in the State of Rhode Island.

A CSR is not required if there will be no controlled substances prescriptions prescribed in this state.

The CSR is renewed at the same time that the professional license is renewed.

Note: Read important information on the bottom of this application.

The Rhode Island Uniform Controlled Substances Act can be accessed at the following web site: http://www.rilin.state.ri.us/Statutes/Title21/21-28/index.htm

Drug Schedule (Check all that apply)

☐ Schedule II ☐ Schedule III ☐ Schedule IV ☐ Schedule V

A Copy of the DEA Registration must be provided to the Medical Board within 60 Days of its issuance by the DEA. The DEA Registration must be issued to your Rhode Island Practice Address in order for it to be valid. If you are relocating from another state, you need to apply for a DEA Registration that is specific to Rhode Island. See the bottom of this form for information on how to contact the DEA. *

All Applicants MUST answer the following:

A. Has the applicant been convicted of, or entered a plea of nolo contedere to a violation of any state or federal law relating to manufacturing, distributing, possessing, prescribing, administering or dispensing of drugs presently defined as controlled substances under Chapter 21-28, General Laws of Rhode Island? ☐ Yes ☐ No

B. Has the registration application or registration of the applicant, corporation, firm, partner, or officer of the applicant been surrendered, revoked, suspended or denied under any law of the United State or of any state relating to drugs presently defined as controlled substances under Chapter 21-28, General Laws of Rhode Island, or is such action pending? ☐ Yes ☐ No

If you answered "Yes" to question "A" or "B" attach an explanation to this form.

Important Information

Issuance of a Rhode Island Controlled Substances Registration is contingent upon registration by the U.S. Drug Enforcement Administration. If denied a "DEA Registration", the Rhode Island Controlled Substances Registration becomes "VOID." Licensed drug facilities and licensed practitioners with prescriptive privileges cannot dispense, possess, store or ship controlled substances in or into the State of Rhode Island without a valid drug facility or professional license. Rhode Island Controlled Substances Registration (CSR), and a federal Drug Enforcement Administration (DEA) Registration. Practitioners may only prescribe, dispense, possess, and store controlled substances within their particular "scope of practice." "Controlled Substances" for purposes of this application, means a prescription drug in Schedules II through V, pursuant to the Rhode Island Uniform Controlled Substances Act, and 21 CFR 1300 of the Federal Code of Regulations. Schedule I drugs are used by researchers, and require the submission of a protocol.

Without a Rhode Island CSR and federal DEA Registration, licensed drug facilities, and practitioners with prescriptive privileges, may dispense or possess non-controlled prescription medications under its facility or professional license. A CSR will not be granted to an applicant whose BOARD licensure application is "pending" in this state.

A Rhode Island CSR must be obtained prior to applying for DEA Registration. Federal regulations require that applicants comply with individual state requirements prior to issuance of a DEA Registration. Once the CSR is issued, applicants must apply to the U.S. Drug Enforcement Administration for a federal registration using that agency's DEA Form 224 (New Application for Retail Pharmacy, Hospitals/Clinics, Practitioner, Teaching Institution, or Mid-Level Practitioner). Applicants may apply on-line for the DEA Registration at the following website: www.deadiversion.usdoj.gov./drugreg/reg_apps/index.html

*You can also receive an application, or check the status of a pending DEA Registration by contacting the Drug Enforcement Administration at the following location: Registration Unit, US Drug Enforcement Administration, JFK Federal Bldg., 15 new Sudbury Street, Boston, MA 02203-0131, Telephone (888) 272-5174.

NOTE:

- Schedules II, III, and IV of section 21-28-2.08 will become void unless dispensed within thirty (30) days of the original date of the prescription.
- Prescriptions in schedules III, IV, and V cannot be written for more than one hundred (100) dosage units and not more than one hundred(100) dosage units may be dispensed at one time. For purposes of this section, a dosage unit shall be defined as a single capsule, tablet, or suppository, or not more that one (1) teaspoon of an oral liquid.
- Prescriptions in schedule II may be written for up to a 30-day supply, with a maximum of two hundred and fifty (250) dosage units, as determined by the prescriber's directions for use of the medication.

Applicant Name: _____ Date: _____

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ADDENDUM 5
Voluntary Race/Ethnicity Questions

This information is completely voluntary and will NOT affect your Application in any way.

Note: This information is voluntary and refusal to provide it will not impact on the renewal of your license. It will be confidential and used only in accordance with Title VI of the Civil Rights Act of 1964.

1. **Ethnicity**: Are you Hispanic or Latino? **(Mark "No" if not Hispanic or Latino)**
   ☐ No, not Hispanic or Latino ☐ Yes, Hispanic or Latino

2. **Race**: What is your race? (Mark one or more)
   ☐ American Indian or Alaska Native ☐ Black or African American ☐ White
   ☐ Asian ☐ Native Hawaiian or other Pacific Islander

For purposes of the above questions kindly use the "Federal Minimum Data Collection" explanations listed below:

1. **Ethnic Categories**:

   Hispanic or Latino – A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term, "Spanish Origin" can be used in addition to "Hispanic or Latino."

   Not Hispanic or Latino – A person who is not Hispanic or Latino.

2. **Racial Categories**:

   American Indian or Alaska Native – A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

   Asian – A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

   Black or African American – A person having origins in any of the Black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or African American."

   Native Hawaiian or other Pacific Islanders – A person having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands.

   White – A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

* This information is being collected in accordance with the Department of Health's policy for Maintaining, Collecting and Presenting Data on Race and Ethnicity. The mission of the Department is to protect and promote the health of the population and to prevent disease through life-style change, environmental change, and health services delivery. A copy of this policy is available upon request.

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ADDENDUM 6

Academic Faculty – Limited Medical Registration Applicants ONLY

Substitute forms are not acceptable. This form may be duplicated as needed.

I am applying for an Academic Faculty – Limited Medical Registration in the State of Rhode Island. The Rhode Island Board of Medical Licensure and Discipline requires these questions be answered as part o my application process. This constitutes your authority to provide information about my character and professional abilities, favorable or otherwise, directly to the Rhode Island Board of Medical Licensure and Discipline at the above address.

_____	_____	_____
Print/Type Full Name	Signature	Date
_____	_____	_____
Previous Names Used	Social Security Number	Date of Birth

THESE QUESTIONS ARE TO BE ANSWERED BY THE DEAN OF THE MEDICAL SCHOOL.

Please Note: Information must be typed or printed clearly and submitted under separate cover.

Please provide information pertaining to the following:

1. Describe this candidate's exceptional qualifications that warrant consideration for licensure as an Academic Faculty – Limited Medical Registration.

2. Describe fully the candidate's primary clinical and non-clinical activities.

3. Please state the anticipated faculty rank of the candidate.

4. Please describe the Formal Search/Recruitment efforts that led to the selection of this candidate including the number of candidates interviewed and duration of search.

5. Please describe system academic supervision of candidate's clinical practice.

PLEASE SEND THIS COMPLETED FORM TO
THE RHODE ISLAND BOARD OF MEDICAL LICENSURE AND DISCIPLINE
AT THE ADDRESS ABOVE. THANK YOU.

Applicant Name: _____ Date: _____