



New Mexico Medical Board
2055 S. Pacheco Street, Bldg. 400
Santa Fe, NM 87505
505-476-7220



Post Graduate Training License Application
DEMOGRAPHICS:

Name: _____
Last First MI

Other Name(s) Used _____

Mailing Address _____
City State Zip

Telephone _____ Fax Number _____ Email Address _____

Social Security Number: _____ - _____ - _____ DEA Number: _____

Date of Birth: ____/____/____ Gender: _____ Male _____ Female

Place of Birth: _____

Citizenship: _____ Immigration Status: _____

MEDICAL EDUCATION:

Medical School: _____ Date of Graduation: _____

Address: _____

City _____ State _____ Zip _____ Country _____

ECFMG Certificate Number (if applicable): _____

POST GRADUATE TRAINING:

UNIVERSITY OF NEW MEXICO
 PGT Fields: _____

Date of entry into post graduate program in New Mexico: ____/____/____ Proposed total length PGT: _____

PRIOR POST GRADUATE TRAINING

1. Institution Name: _____

City: _____ State/County: _____ Zip Code: _____

Dates Attended: From: _____ To: _____ PGT Field: _____

2. Institution Name: _____

City: _____ State/County: _____ Zip Code: _____

Dates Attended: From: _____ To: _____ PGT Field: _____

LICENSURE:

List all states in which you have held or now hold a health care related license or registration to practice medicine.

State	License/Registration Number	Issued Date	Expiration Date
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

Professional Practice Questions Please answer all of the following Yes or No questions. If you answer YES to any question, please give details including name, address, and telephone number of significant parties on a separate sheet of paper.

1. Has your professional liability coverage ever been terminated by action of the insurance company except as a result of the company ceasing to offer insurance to physicians?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2. Have you ever been denied professional liability insurance coverage?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3. Has your professional liability carrier ever excluded any specific procedures from your coverage?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
4. Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any professional organization?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
5. Have you ever been excluded from or sanctioned by Medicare and/or Medicaid?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
6. Have you ever been arrested? If so explain the circumstance, regardless of the outcome (i.e. expunged, dismissed, sealed, vacated).	Yes <input type="checkbox"/>	No <input type="checkbox"/>
7. Have you ever been named as a defendant in any criminal proceedings?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
8. Have you ever been subject to investigation by a governmental entity or Board that either could have resulted or did result in licensure sanction or other adverse actions, irrespective of the outcome?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
9. Have you ever been named in any formal requests for corrective actions filed by any healthcare entity where you have had an appointment (a request which could result in either formal or informal proceedings).	Yes <input type="checkbox"/>	No <input type="checkbox"/>
10. a. Have your privileges at any healthcare entity ever been voluntarily or involuntarily suspended, restricted, diminished, revoked, surrendered, or not renewed, except for medical records delinquency?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
b. Have you ever agreed not to exercise your clinical privileges while under investigation?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
11. Have you ever resigned from a healthcare entity to avoid modification, suspension, or termination of privileges, or while under investigation?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
12. a. Has your application for licensure or license to practice in any jurisdiction ever been investigated, voluntarily or involuntarily limited, suspended, revoked, surrendered or denied?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
b. Are any currently held licenses pending investigation or being challenged?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
13. Have you ever been notified to appear before any licensing agency for a hearing or complaint of any nature?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
14. Has your federal or state narcotics registration certificate in any jurisdiction ever been voluntarily or involuntarily limited (stipulations), suspended, revoked, restricted, or are there currently challenges to any of these items?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
15. Have you ever been involved in a settlement, medical malpractice claim or suit, or have you ever received written notice of intent to file such a suit? If yes, please provide the following information on the attached Malpractice History form for each case: <ul style="list-style-type: none"> • Name, age, sex of patient/claimant. • Date(s) and type of treatment and/or surgery, which led to the allegations against you. • Nature of allegations in claims/suits. Specify whether a suit was ever filed. • Names of other practitioners and hospital, if any, involved in claims or suit. • Disposition or current status of claim or suit (be specific). • Name of insurance carrier defending you. • Name of defense attorney. 	Yes <input type="checkbox"/>	No <input type="checkbox"/>
16. Have you ever been reported to the National Practitioner Data Bank?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
17. Are you now, or were you in the past, addicted to, abusive of, or in treatment for abuse of any controlled substances, habit-forming drugs, illegal drugs, prescription medication or alcohol?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

<p>18. In the five (5) years prior to this application, have you had any physical injury or disease, or mental illness or impairment, which you are currently under treatment for or could reasonably be expected to affect your on-going ability to practice medicine safely and competently? If yes, please have your treating physician send the NM Medical Board a letter regarding your diagnosis and treatment.</p>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<p>19. Have you ever, for any reason:</p> <p>a) Resigned from a medical school or postgraduate training (PGT) program?</p> <p>b) Withdrawn from a medical school or postgraduate training program?</p> <p>c) Been suspended, dismissed, or expelled from a medical school or PGT program?</p> <p>d) Been placed on probation or remediation, including academic probation or remediation, by a medical school or PGT program?</p> <p>e) Taken a leave of absence or break from, or had any interruptions or extensions in, a medical school or PGT program for any personal or professional reason (including illness or disability, pregnancy or maternity, any academic issue, etc)?</p>	Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/>

If you answer YES to any question, please give details including name, address, and telephone number of significant parties on a separate sheet of paper.

Licensing Exam: (i.e. State Board Exam, FLEX, LMCC, National Board or USMLE)

Exam Taken _____	Date Passed _____	Month/ Year
Exam Taken _____	Date Passed _____	Month/ Year
Exam Taken _____	Date Passed _____	Month/ Year

APPLICANT'S OATH

I, _____, hereby certify that I am the person pictured below and named in this application for a license to practice as a Physician in the State of New Mexico; that all statements I have made herein are true; that I am the original and lawful possessor and person named in the various forms and credentials furnished to the New Mexico Medical Board (Board) with my application. I acknowledge and state that I have read the Information and Instructions that accompanied this application and I have answered all questions truthfully. I understand that the fee I submitted is not refundable.

I authorize and request every person, hospital, clinic, community, governmental agency, court, association, institution or other organization having control of any documents, records, and other information pertaining to me, to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Board or their agents or representatives to inspect and make copies of such documents, records and other information, in connection with this application.

I hereby release, discharge, and exonerate the Board, and their agents or representatives, and any person furnishing information, from any and all liability of every nature and kind arising out of the furnishing or inspection of such documents, records, other information, or the investigation made by the Board. I authorize the Board to release information, material, documents, orders, or the like relating to me or to this application to any other agency of the State of New Mexico or the appropriate licensing agency of any other state or Territory of the United States or any agency of the United States government.

**ATTACH
RECENT
PASSPORT-
QUALITY*
PHOTOGRAPH
THAT WILL FIT IN
THIS SPACE**

Applicant Signature

Date

*Passport-quality color photograph taken within six months prior to filing the application, approximate size 2 x 2 inches, head and shoulders only, full face, front view, plain white or off-white background, standard photo stock paper, scanned or computer-generated photographs should have no visible pixels or dots.