Medicine Form 5B

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
Division of Professional Licensing Services
www.op.nysed.gov

Department Use Only

☐ 60 $105 PR

Approved
Rejected: _____

Date

Permit Number

Issued

Expires

Application for Limited Permit in Medicine for Applicants Who Have Not Applied for Licensure in New York State*

***If You are Renewing Your Limited Permit, You MUST use Medicine Form 5A**

Applicants seeking to work under a limited permit in a general hospital. Section 405.4 of the State Hospital Code (Title 10, New York Code, Rules and Regulations) established additional requirements for practice by foreign medical school graduates with limited permits. **Please be sure you have read these requirements carefully before completing the Limited Permit Application. Questions about this requirement may be directed to the New York State Department of Health by calling 518-402-1003.**

1 **Social Security Number**
(Leave this blank if you do not have a U.S. Social Security Number)

2 **Birth Date** Month Day Year

3 **Print Full Name**

Last

First

Middle

Licensee business address, phone and e mail address are public information. Failure to indicate business or home on this form for each item will deem it public information.

4 **Mailing Address: ☐ Home or ☐ Business**
(You must notify the Department promptly of any address or name changes.)

Line 1

Line 2

Line 3

City

State Zip Code

Country/ Province

5 **Telephone/E-Mail Address**

Daytime Phone: ☐ Home or ☐ Business

Area Code Phone Number

E-Mail Address (Please print clearly)**:**
☐ Home or ☐ Business

6 **Are you using FCVS to collect your credentials?**
☐ Yes ☐ No

7	Have you applied for a license to practice Medicine in New York State? **If yes, complete Form 5A instead of this form.**	☐ YES ☐ NO
8	Do you intend to apply for a license to practice Medicine in New York State?	☐ YES ☐ NO
9	Are you licensed in another state? If yes, what state? _____	☐ YES ☐ NO
10	Have you ever been found guilty after trial, or pleaded guilty, no contest, or nolo contendere to a crime (felony or misdemeanor) in any court?	☐ YES ☐ NO
11	Are criminal charges pending against you in any court?	☐ YES ☐ NO
12	Has any licensing or disciplinary authority refused to issue you a license or ever revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, refused to renew a professional license or certificate held by you now or previously, or ever fined, censured, reprimanded or otherwise disciplined you?	☐ YES ☐ NO
13	Are charges pending against you in any jurisdiction for any sort of professional misconduct?	☐ YES ☐ NO
14	Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges or have you ever voluntarily or involuntarily resigned or withdrawn from such association to avoid imposition of such measures?	☐ YES ☐ NO

NOTE: If you answer "Yes" to any questions numbered 10-14, submit a letter giving a complete detailed explanation. Include copies of any court records including a Certificate of Disposition. If there are offenses in multiple courts, please provide the same for each action. If the court can no longer provide documentation, you must request, from the court, a letter stating why they cannot provide the documents.

15 In the spaces below, give an accurate record of your educational preparation. **Be sure to complete items A-E for each school**. Please print. List diploma or degree titles in original language and translate. If no diploma or degree, indicate number of credits earned. Attach additional sheets if necessary.

A. NAME OF SCHOOLS ATTENDED AND LOCATIONS	B. NUMBER OF YEARS ATTENDED	C. ATTENDANCE		D. TITLE OF DIPLOMA OR DEGREE OBTAINED (INDICATE MONTH/YEAR OBTAINED)	E. IF NO DIPLOMA OR DEGREE, INDICATE NUMBER OF CREDITS EARNED
		Entrance Date	Leaving Date		
High School or Secondary School School Name _____ A City _____ State/Country _____	B	____ / ____ C ____ / ____ mo yr mo yr		D	E
Postsecondary Preprofessional School School Name _____ A City _____ State/Country _____	B	____ / ____ C ____ / ____ mo yr mo yr		D	E
Medical Education (Professional) School Name _____ A City _____ State/Country _____	B	____ / ____ C ____ / ____ mo yr mo yr		D	E

16 If you completed clinical clerkships in a country other than where your medical school is located, give the dates and location of these clerkships. Attach additional sheets if necessary.

Inclusive Clerkship Dates	Clinical Area	Name of Health Care Facility And Address	Medical School with which Clerkship Affiliated and Address

17 Provide a chronological list of all activities since graduation from professional school to the present. Include vacation periods and periods of employment. Attach additional sheets if necessary. Your Application for Licensure (Form 1) will be considered incomplete if there are gaps in time.

Type of Activity, Beginning with Date of Graduation from Professional School. Include Name and Address of Employers.
PLEASE BE SURE THERE ARE NO GAPS IN TIME.

Dates (mm/dd/yy)		Enter Graduation Date From Medical School Here: _____ / _____ / _____ mo. day yr.
From:	To:	
From:	To:	
From:	To:	
From:	To:	
From:	To:	
From:	To:	
From:	To:	
From:	To:	
From:	To:	
From:	To:	

18 Are you licensed or have you ever been licensed as a physician in any other state or country? Yes ☐ No ☐

If **yes**, list each jurisdiction. If appropriate, you must also submit a Form 3A. See "Completing the Application Forms" section in instructions.

State or Country	Date License Issued	Number	Basis of Licensure			Any Limitations on License
			Examination (Date passed)	Endorsement	Other	

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Are you applying on the basis of a Fifth Pathway program? ☐ Yes ☐ No

If Yes, list name and location of Medical School or Hospital and the inclusive dates of attendance.

Name and Location of Medical School or Hospital	Inclusive Dates of Attendance

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Complete 19 only if you are a graduate of a program not registered by New York State or LCME or AOA accredited.

Have you completed all portions of the examination requirements for ECFMG certification? ☐ Yes ☐ No

Do you currently hold a valid ECFMG certificate? ☐ Yes ☐ No

Please submit the ECFMG form.

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CHILD ABUSE IDENTIFICATION AND REPORTING: (check only one of the following.)

☐ I graduated from a New York State medicine program after September 1, 1990.

☐ I completed the child abuse coursework and have enclosed a certificate of completion from an approved provider.

☐ I am filing for an exemption to the requirement and have enclosed the exemption form.

☐ I am going to take the Child Abuse Identification course and submit the required form.

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CITIZENSHIP/IMMIGRATION STATUS:

Federal law and the Regulations of the Commissioner of Education (8 NYCRR §59.4) limit the issuance of professional licenses, registrations and limited permits to United States citizens or qualified aliens. To comply with Federal law and Commissioner's regulation, you must complete this section of this form and check the appropriate box below which indicates your citizenship/immigration status.

I am:

☐ A. A United States citizen or National.
☐ B. An alien lawfully admitted for permanent residence in the United States.
☐ C. An alien granted asylum under Section 208 of the Immigration and Nationality Act.
☐ D. A refugee granted asylum under Section 207 of the Immigration and Nationality Act.
☐ E. An alien paroled into the United States under Section 212 (d)(5) of the Immigration and Nationality Act for a period of at least 1 year.
☐ F. An alien whose deportation is being withheld under Section 241 (b)(3) of the Immigration and Nationality Act.
☐ G. An alien granted conditional entry pursuant to Section 203 (a)(7) of the Immigration and Nationality Act as in effect prior to April 1980.
☐ H. Non Immigrant (Temporarily in U.S.) Please list Visa type or immigration status or attach a copy of your passport if you are not required to have a Visa to enter the United States: _____
☐ I. I am an alien not unlawfully present in the United States pursuant to the Deferred Action for Childhood Arrivals (DACA) relief or similar relief from deportation. Please specify: _____
☐ J. I do not reside in the United States.

If you checked any of the boxes from B-I, enter your alien registration number or control number issued by the United States Citizenship and Immigration Services (USCIS): USCIS number: _____

QUESTIONS ABOUT YOUR IMMIGRATION STATUS AND WHETHER OR NOT IT IS A QUALIFYING STATUS UNDER FEDERAL LAW SHOULD BE DIRECTED TO THE U.S. CITIZENSHIP AND IMMIGRATION SERVICES (USCIS) BY CALLING 1-800-375-5283, OR VISIT THEIR WEB SITE AT WWW.USCIS.GOV.

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GENDER AND ETHNICITY: (This item is optional.)

Information on gender and ethnicity is sought solely to allow the Education Department to collect and analyze data concerning diversity in the licensed professions. The ethnic and gender data you provide will be used only for statistical, research, and program evaluation purposes. It will not be released to the public. This information has absolutely no bearing on your qualification for licensure.

GENDER: ☐ Male ☐ Female

ETHNICITY: ☐ White (not Hispanic) ☐ Black (not Hispanic) ☐ Asian ☐ Hispanic ☐ Native American

24 **CHILD SUPPORT OBLIGATION:**

Everyone applying for a professional license, permit, or registration, or any renewal thereof, must file a written statement that, as of the date of the filing, she or he is, or is not, under an obligation to pay child support*. **Individuals who are four months or more in arrears in child support or who have failed to comply with a summons, subpoena or warrant relating to a paternity or child support proceeding may be subject to suspension of their business, professional, drivers and/or recreational licenses and permits.** The intentional submission of false written statements for the purpose of frustrating or defeating the lawful enforcement of sup-port obligations is punishable under section 175.35 of the Penal Law.

You must complete this section before we can issue the credential for which you have applied. Individuals who are not in compliance with their obligation to pay child support can be issued a credential for no more than six months in order to comply with their child support obligations.

Check only A or B below. If you check B, you must check one of the five statements listed below it.

A ☐ I **am not** under an obligation to pay child support;

OR

B ☐ I **am** under an obligation to pay child support *and* (please check only one of the following)

- ☐ I am current and **am not** four months or more in arrears in the payment of child support; or,
- ☐ I am making payments by income execution or by court agreed payment plan or by a plan agreed to by the parties; or,
- ☐ The child support obligation is the subject of a pending court proceeding; or,
- ☐ I am receiving public assistance or supplemental security income; or,
- ☐ None of the above four statements apply.

*New York State General Obligations Law, section 3-503

SECTION II: APPLICANT AFFIRMATION

AFFIDAVIT WITH ACKNOWLEDGMENT (Notarization required.)

Applicant

I declare and affirm that the statements made in this application, including accompanying documents, are true, complete and correct. I understand that any false or misleading information in, or in connection with, my application may be cause for denial or loss of licensure and may result in criminal prosecution. **This form must be signed and dated in the presence of a Notary Public.**

Signature of applicant: _____

Date: _____ / _____ / _____
Month Day Year

Notary

State of _____ County of _____

On the _____ day of _____ in the year _____ before me, the above signed, personally appeared _____ , personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to this application and acknowledged to me that he/she executed the application and swore that the statements made by him/her in the application and all supporting materials are true, complete, and correct.
Applicant Name

Notary Public signature _____

Notary ID number _____

Notary Stamp

Expiration date: _____ / _____ / _____
Month Day Year

SECTION III: EMPLOYER CERTIFICATION

I hereby certify that I am the administrator or appointing officer of: _____

_____

(Official name and address of facility)

Which is a:

- ☐ General Hospital as defined below *
- ☐ Nursing Home
- ☐ State operated psychiatric, developmental or alcohol treatment center
- ☐ Incorporated, non-profit institution for the treatment of the chronically ill licensed under Article 31 of the Mental Hygiene Law

* According to section 2801 (10) of the Public Health Law, "General Hospital means a hospital engaged in providing medical and surgical services primarily to in-patients by or under the supervision of a physician on a twenty-four hour basis with provisions for admission of treatment of persons in need of emergency care and with an organized medical staff and nursing services, including facilities providing services relating to particular diseases, injuries, conditions or deformities. The term general hospital shall not include a residential health care facility, public health center, diagnostic center, treatment center, out-patient lodge, dispensary and laboratory or central service facility servicing more than one institution."

I certify that the physician named in this application is being appointed as a member of the staff of this hospital. The appointment is to be for

_____ years as a: (please check appropriate title and indicate field of specialty):

- ☐ Resident
- ☐ Fellow
- ☐ Staff physician in _____

under the supervision of a licensed physician in New York State.

Date to be issued: _____ / _____ / _____

Signature of Official _____ Date _____ / _____ / _____

Title of Official _____

Telephone ( ) ___ ___ ___ - ___ ___ ___ ___

E-mail Address: _____

Mail this form and appropriate fee to: New York State Education Department, Office of the Professions, PO Box 22063, Albany, NY 12201. DO NOT SEND CASH. Make check or money order payable to the New York State Education Department.