Physician's Check List:

-Endorsement/Initial (license from another jurisdiction)-

____Application

____Nonrefundable application & license fee of $300 payable to CNMI TREASURER

____2x2 Photo

____Copy of Diploma showing a degree of Doctor of Medicine or Doctor of Osteopathy or a document showing proof that applicant holds a valid ECFMG certificate (if applicable)

____Copy of 3-year Postgraduate training (residency, internship, board certificates)

____Copy of valid and current license from another jurisdiction

____Curriculum vitae including a detailed education and experience history which shall include dates, places, institutions, educational programs and description of all prior education and work experience

____National Practitioner's Data Bank (NPDB) or FSMB's BADB (Board Action Data Bank) report

-Schedule of Fees

Application fee	$100
Initial license fee	$200
Renewal fee	$200
Delinquent fee (double the license fee for renewal)	$200
Replacement/Duplication of license	$75
Replacement/Duplication of wallet size card	$25
Letter of Good Standing/Verification fee	$25

Commonwealth of the Northern Mariana Islands
HEALTH CARE PROFESSIONS LICENSING BOARD
P.O. Box 502078, Bldg., 1242 Pohnpei Court
Capitol Hill, Saipan, MP 96950
Tel No: (670) 664-4808/4809 Fax: (670) 664-4814
Email: info@cnmilicensing.gov.mp
Website: www.cnmilicensing.gov.mp

Attach a recent 2x2 ID photo here taken within 6 months of the application.

APPLICATION FOR PHYSICIAN

☐ Endorsement ☐ Temporary

HCPLB STAFF USE ONLY
Date Received:

APPLICATION INFORMATION – Please Type or Print

1. Last:	First:	Middle:	**2.** Social Security No:
3. Birthdate: (Mo/Day/Yr)	**4.** Color of Eyes: Color of Hair:	**5.** Height: Weight:	**6.** Sex:
7. Mailing Address:		**8.** Email Address:	
9. Residence Address:		**10.** Phone No: (W): (H):	
11. NPI # (if available):	**12.** Specialty:	**13.** Citizenship: ____U.S. ____Other Specify:	

14. MEDICAL EDUCATION – (*Provide a copy of your degree*)

Medical School	Location (City/State or Country)	Degree Earned	Dates (Mo/Yr) From	To

15. POSTGRADUATE TRAINING – *(List internship, residency, or fellowship training programs chronologically)*

Hospital	Location (City/State or Country)	Dates (Mo/Yr) From	To

16. LICENSES – (*List of all jurisdictions where you are licensed or applied for a license.*)

Name of Jurisdiction	Date Issued	Expiration Date	License Number	Current Status

17. HOSPLITAL AFFILIATIONS (if none, state "None")

Name of Hospital	Location (City/State or Country)	Dates (Mo/Yr) From	To

18. Name/Address of Intended Employment within the CNMI:

19. *Questionnaires:*

If you answer "yes" for any of items 20-37 you must attach a detailed explanation on a separate sheet, which includes state or country where action is pending or took place, relevant dates, action taken and reasons for such action. (Include Findings of Fact, Conclusion of Law, Final Order and whether you have been reinstated. If reinstated, date and conditions of license.)

20. Have you ever been charged with, or been found to have committed dishonorable, unprofessional conduct, negligence, incompetence, misconduct, or repeated negligent acts or malpractice by any medical licensing board, other agency, or hospital?	Yes ☐	No ☐
21. Has a claim or an action ever been filed against you for the practice of medicine which resulted in a malpractice settlement, judgment, or arbitration award of $25.000 or more?	Yes ☐	No ☐
22. Has any medical licensing board, other agency, or disciplinary authority refused to issue you a license, renew your license, suspended, revoked, accepted surrender of your license, placed on probation or conditioned your license, held by you now or previously, or ever fined or otherwise disciplined you?	Yes ☐	No ☐
23. Is there any ongoing or pending investigation against you?	Yes ☐	No ☐
24. Is there any disciplinary action pending against you?	Yes ☐	No ☐
25. 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 ☐
26. Have your DEA or state-controlled substance registration ever been denied, suspended, restricted, or terminated?	Yes ☐	No ☐
27. Have you ever entered into any arrangement or plea or agreement in lieu of a federal prosecution for a drug violation regulated by the DEA?	Yes ☐	No ☐
28. Have you ever been terminated, sanctioned, and penalized, had to repay monies to or been denied provider participation in any Medicaid, Medicare or other publicly funded healthcare program?	Yes ☐	No ☐
29. Has your ability to practice medicine in a competent and safe manner ever been impaired or limited by any condition, behavior, impairment, or limitation of a physical, mental, or emotional nature?	Yes ☐	No ☐
30. Have you used or are you currently using any chemical substance(s), legal or illegal, that in any way impaired or limited, or is currently impairing or limiting, your ability to practice medicine in a safe and competent manner?	Yes ☐	No ☐

31. Have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program?	Yes ☐	No ☐
32. Have you been treated for or had a recurrence or a diagnosed addictive disorder?	Yes ☐	No ☐
33. Have you ever been diagnosed with a neurological or other physical condition that would impair your ability to practice medicine safely?	Yes ☐	No ☐
34. Do you have any other condition in which in any way impairs or limits your ability to practice medicine safely?	Yes ☐	No ☐
35. Have you ever been found guilty, pleaded guilty, no contest, or nolo contendere to a crime involving moral turpitude or crime related to the medical profession, or felony in any court?	Yes ☐	No ☐
36. Is criminal action pending against you in any court?	Yes ☐	No ☐
37. Are you required to register as a Sex Offender?	Yes ☐	No ☐

38. **DECLARATION:**

I hereby certify that I am the person herein named subscribing to this application. I have read the complete application, and I know the full content hereof. I declare that all of the information contained herein and evidence or other credentials submitted herewith are true and correct. I understand that any falsification or misrepresentation of any item or response in this application, or any attachment hereto or falsification on misrepresentation of credentials to support this application, is sufficient grounds for denying, revoking, or otherwise disciplining a license to practice medicine in the Commonwealth of the Northern Mariana Islands. I further certify that I have read and will abide by P.L. 15-105 and the Regulations for Licensing of Physicians or Podiatrists.

_____ _____

Signature of Applicant Date

Do not send cash.

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ (print name), do hereby authorize a disclosure of records concerning myself to the Health Care Professions Licensing Board (HCPLB). This release includes records of a public, private or confidential nature.

I acknowledge that the information released to the HCPLB may include material that is protected by federal and/or state laws applicable to substance abuse and mental health information. If applicable, I specifically authorize the release of confidential information to and from the HCPLB relating to substance abuse or dependence and/or mental health.

I further agree that the HCPLB may receive confidential information and records, including, but not limited to the following records:

- Medical Records
- Education Records
- Personnel or employment records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Post-graduate training (internship, residency, and fellowship) records, including records or any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Any information the HCPLB deems reasonably necessary for the purposes set forth in this release.

Release of Liability:
I do hereby irrevocably and unconditionally release, covenant not to sue, and forever discharge any person or entity, including but not limited to any medical school, residency or fellowship training program, hospital, health care provider, health care facility, licensing board, impaired practitioner program, agency, or organization, which releases information to the HCPLB pursuant to this release from any liability, claim, or cause of action arising out of the release of such information. I further irrevocably and unconditionally release, covenant not to sue, and forever discharge the HCPLB, the Commonwealth of the Northern Mariana Islands, and its employees and agents from any liability, claim, or cause of action arising out of the collection or release of information pursuant to this release.

A photocopy of this release form will be valid as an original thereof, even though the photocopy does not contain an original writing of my signature.

I have read and fully understand the contents of this "Authorization to Release Information".

_____ _____
Signature of Applicant Date

AFFIVDAVIT

I, the undersigned, being duly sworn, say that I am the person referred to in the foregoing application for license to practice _____ in the Commonwealth of the Northern Marianas, that the statements therein are true to the best of my knowledge and belief.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension or revocation of my license to practice as a _____ in the Commonwealth of the Northern Marianas.

_____
Signature of Applicant