Interstate Medical Licensure Compact

Summit Materials

Example Methods of Verifying

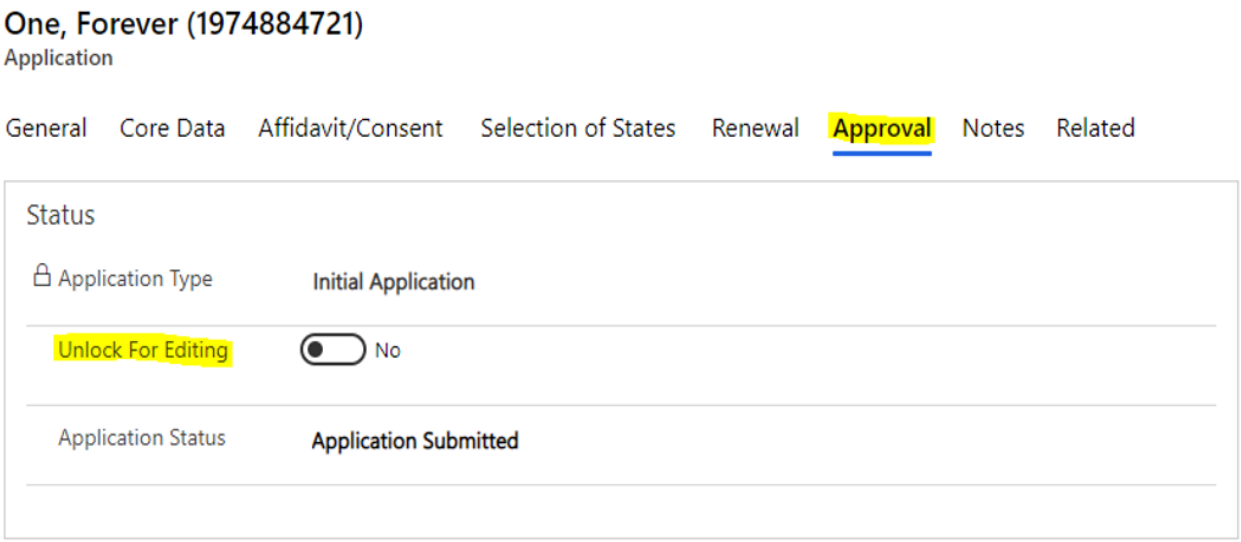
Tips & Tricks for Verifying 25% of Practice:

- Use a spreadsheet that determines what % of practice was completed in your state.
- Telemedicine – Request a list that contains where the physician's patients were located in the last year.

Core Data Corrections – Ways to Verify:

- **Medical School:**
  - Verify graduation date utilizing your Board's record retention documents.
    - If not available, you may request a copy of the applicant's diploma
  - Can verify institution and graduation year from the AMA/AOA and PDC
- **Qualifying Exam Taken:**
  - Verify qualifying exam by obtaining a copy of the transcript from your Board's record retention, or requesting the physician provide you with a copy (showing attempts and scores)
  - Request a primary sourced transcript from USMLE or NBOME/COMLEX
    - Any NBOME transcript **printed** prior to 2004 will not show attempts taken on each step. If applicant re-requests their NBOME transcript it will now show attempts taken
- **Residency Program:**
  - Verify program name, specialty, and completion date with information in your Board's records, or ask for a postgraduate training verification certificate or updated verification form from the program
    - Internships do not qualify for the IMLCC
      - If your Board licensed the applicant after completion of 1 year of PGT, verify a full residency completion prior to approval of the LOQ
  - Residency Information can be Verified using an AMA/AOA report

- **Specialty Board Certification:**
    - Verify certification using the AMA/AOA and/or PDC
        - Certification must be active at the time of applications
        - Verify certifying Board (no abbreviations accepted)
        - Verify expiration date (reverify date) or lifetime certification
    - If Specialty Board Certification is not listed on AMA/AOA or PDC, you can request a primary source document from the Certifying Body. If the physician recently obtained their Specialty Certification it may not yet be on the AMA/AOA or PDC
- **Making Data Corrections**
    - Editing rights are only given to the SPL before approving the LOQ
    - Data corrections can be made in the CRM tool by clicking on Unlock For Editing under the Approval heading
    - You may upload documents to support the corrections you are making. If for example an applicant lists the USMLE, but actually took the NBOME/COMLEX, you could upload a copy of their Score Report to the Notes section
    - You will be able to make corrections until the LOQ application file has been closed
    - Some fields may be drop down boxes, and others may be fillable



Useful Acronyms

Acronym	Broken Down	IMLC Relation	What it means…
IMLC & IMLCC	Interstate Medical Licensure Compact & Interstate Medical Licensure Compact Commission		
SPL	State of Principal License	member state where a physician holds a license to practice medicine and which has been designated as such by the physician for purposes of registration and participation in the Compact.	The state the physician selected as their primary state. The SPL is responsible for verifying information to approve/deny the physician's application for a LOQ. SPL is not an application, it is a memberstate.
LOQ	Letter of Qualification	a notification issued by a state of principal license that expresses an applicant's eligibility or ineligibility for expedited licensure through the process set forth in the Compact.	The SPL will approve/deny the LOQ. Approval of a LOQ is the "key" to the Compact pahtway of licensure in other Member States. LOQ is not a member state, it is an application/letter.
iStars (iStars2)	Interstate Medical Application Routing System	Application Tool (DocuSign Envelopes)	Where all applications originate
CRM	Customer Relationship Management	To Be Named Later (Dynamics database)	Database where all physician data is stored: Personal info, SPL, licenses issued, application core data, etc.
PDC	Physician Data Center		Report that can be run to confirm Board actions, NPI, Medical School, Board Certification, licensure
NPDB	National Practitioner Data Bank		Report that can be run to confirm Board actions, malpracice information, etc.
AMA	American Medical Association		Physician profile of medical school, NPI, DOB, PGT, licensure, Board certification.
AOA/AOA Profile	American Osteopathic Association	1 of the options for accredited PGT required for physicians. For DO physicians only. Physicians are required to be "Board Certified" at the time of LOQ application. AOA is one of the cerifying Boards approved by the IMLCC.	Physician profile of medical school, DOB, PGT, Board certification. Accreditation of PGT specialty. Is the main certifying Board for numerous specialties. An example includes: AOBS (American Osteopathic Board of Surgery). For DO physicians only.
ACGME	Accreditation Council for Graduate Medical Education	1 of the options for accredited PGT required for physicians. For DO and MD physicians.	Accreditation of PGT specialty.
ABMS	American Board of Medical Specialties	Physicians are required to be "Board Certified" at the time of LOQ application. ABMS is one of the cerifying Boards approved by the IMLCC.	Is the main certifying Board for numerous specialties. An example includes: ABIM (American Board of Internal Medicine)
CBC	Criminal Background Check	Required for all LOQ applications (at the time of application)	Report must come back clean of criminal history, as defined by your state.
PGT	Postgraduate Training	Residency Program	Required completion of program to be eligible for LOQ.

AMA, AOA and PDC Data Comparison

Information Provided	AMA	AOA	PDC
Aliases/Maiden Names		✓	✓
DOB	✓	✓	✓
NPI	✓		✓
Medical School Name	✓	✓	✓
Graduation Year	✓	✓	✓
ACGME Accredited PGT	✓		
Public Board Action			✓
AOA Accredited PGT		✓	
Non-accredited PGT			
Institution Name of Accredited PGT	✓	✓	
State Location of Accredited PGT	✓	✓	
Dates of Accredited PGT	✓	✓	
Specialty of Accredited PGT	✓	✓	
ABMS Board Certification	✓	✓	✓
AOA Board Certification		✓	✓
Lifetime/MOC Certification	✓	✓	✓
Initial Certification Date	✓	✓	✓
Current Expiration Date of Certification	✓	✓	✓
Reverification Date of Certification	✓		✓
Permanent Licenses Ever Held	✓	✓	✓
Resident licenses Ever Held	✓		✓
License #'s	✓		✓
Initial Licensure Date	✓	✓	✓
Expiration of Current License	✓	✓	✓
Current Status of License	✓		✓
ECFMG Number (if applicable)	✓		
DEA Numbers and Status	✓	✓	✓

Interstate Medical Licensure Compact

Checklist Example

IMLC Letter of Qualification Checklist – Physician Name: _____

Core data set reviewed – matches our information..... _____

Fingerprint Card and Waivers sent to home address ..... _____

Copy of Qualification Application sent to applicant for signature ..... _____

Applicant emailed..... _____

No Open Iowa Investigations or Public Discipline: ……. …… _____

Signed copy of Qualification Application & Affidavit returned from applicant ……. ..... …….. _____

Fingerprint Card and Waivers Returned ……. .....…….. _____

Criminal Background Check Results Received ……. ..... ……. _____

State of Principal License:

____ **Resident** (Attestation + County Assessor Site) ____ **Employer Location** (Attestation + Hospital/Clinic site for bio or letter from employer)

____**Federal Taxes** **25% Practice** (Attestation + Verification Form. May also request a list of past and future assignments)

Reports:

NPDB ……..……. _____

Federation PDC Report ……..……. _____

AMA Physician Profile…….... _____

AOA Physician Profile (D.O. only) ..... _____

Eligibility Requirements:

SPL Confirmed (Resident – 25% Practice – Employer Location – Federal Taxes) … ..... ……. _____

Active, Full, Unrestricted Iowa License……..... …… _____

Medical School (LCME - AOA – ECFMG or World Directory) ……. ..... _____

Post-Graduate Training (ACGME/AOA Specialty Program Completed) ……..... _____

Exam (3 attempts on each component) ……..... … _____

ABMS or AOA Board Certification (see PDC Report or AMA) ……..... … _____

No Criminal History (DCI & FBI results must be returned) ……. .....…….. _____

No license ever disciplined (see NPDB – PDC Report – AMA) ……..... _____

Controlled substance license never suspended or revoked (see NPDB – PDC – AMA) ..... _____

Not under investigation by licensing authority or law enforcement (physician attestation) … ..... _____

Interstate Medical Licensure Compact

Example of Letters/Emails to Applicants Requesting Additional Information

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

January 10, 2020

Physician Name, Title
Mailing Address Line 1
Mailing Address Line 2
City, State Zip

Subject: Interstate Medical Licensure Compact Commission – Letter of Qualification

Dear Dr._____,

The Department of Health and Human Services, Public Health, Licensure Unit, received an application for an IMLC Letter of Qualification. Below you will find instructions and some additional information on the next steps. Please note, the Letter of Qualification process is not expedited. In Nebraska, and on average, the processing time is 6 – 12 weeks.

All deficiencies here.

- **Criminal Background Check by Fingerprint** – Included is a Background check packet, which contains fingerprint cards and instructions for processing the background check. ***Complete this as soon as possible as we anticipate the background check to the longest part of the process (average of 6-8 weeks).***

You have 60 days from the date of this letter to comply with the above requests to avoid automatic withdraw.

Should further information be needed I will be in contact.
Thank you for your cooperation in the IMLC process. If you have further questions or concerns, please do not hesitate to contact my office.

Sincerely,

Tara Anderson, Specialist
DHHS, Division of Public Health, Licensure Unit
PO Box 94986
301 Centennial Mall South
Lincoln, NE 68509
Phone: 402-471-2118
Fax: 402-742-8355
Tara.Anderson@nebraska.gov

TA/enclosures

January 13, 2020

LICENSEE NAME
LICENSEE ADDRESS
LICENSEE ADDRESS

SUBJECT: IMLCC LETTER OF QUALIFICATION
RESPONSE DEADLINE: <DATE-60 DAYS>

Dear Dr. :

The Utah Division of Occupational and Professional Licensing has received an application for an IMLC Letter of Qualification. Below you will find additional requirements and instructions as per Utah code 58-67-302(1)(d) or 58-68-302(1)(d). Please note, the Letter of Qualification process is not expedited and **will be withdrawn unless you respond** and submit all required materials **no later than <Date-60 Days>, your response deadline.** This date is your response deadline and does not reflect the date that your LOQ you will be processed by. This is the only notice you will receive.

- **Utah Fingerprint/IMLC Privileges**. Submit the application of Interstate Medical Compact Privileges. **NOTE:** The Licensee Declaration of Primary State of Residence portion of this form will require additional documentation be submitted.

- **Supporting Documentation**. Submit supporting documentation for any "yes" answers provided on either the "Qualifying Questionnaire" or "Medical Qualifying Questionnaire".

- **Fees**. Submit $35.00 non-refundable fingerprint processing fee, made payable to "DOPL".

- **Fingerprint Card(s)**. Submit fingerprints to be used by DOPL for a fingerprint search through the files of the Utah Bureau of Criminal Identification (BCI) and the Federal Bureau of Investigations (FBI). Information on Fingerprinting can be found on the Checklist page of the Application of Interstate Medical Compact Privileges.

- **Verification Documents**. Because your license verification documents are no longer on file you must submit **either** – An updated FCVS packet that includes your transcripts, completion of postgraduate training and exams via FCVS **or** you can submit copies of your transcripts or MD degree, postgraduate certificates and exam score report directly to the Utah Medical Board. **NOTE**: FCVS may be contacted via phone at 1-888-ASK-FCVS or via their website at www.fsmb.org/fcvs.html - You will need to notify us once you receive confirmation that your packet has been submitted complete to Utah.

January 13, 2020

LICENSEE NAME
LICENSEE ADDRESS
LICENSEE ADDRESS

SUBJECT: IMLCC MEMBER BOARD LICENSURE
RESPONSE DEADLINE: <DATE-30 DAYS>

Dear Dr.,

The Utah Division of Occupational and Professional Licensing has received an application for Utah IMLC Member Board Licensure. Your license has been issued. You are responsible for complying with Utah statute and regulations associated with your license and the practice of medicine in the state of Utah. Additional documentation is required for your licensure in Utah to remain in compliance.

You are responsible to submit all requested materials listed below, **no later than <Date-30 days>, your response deadline.** This is the only notice you will receive. Failure to comply with this request is considered unprofessional conduct and may result in disciplinary action up to and including revocation of licensure.

1. **Designation of Contact.** Submit the "Designation of Contact Person for Access to Medical Records" in accordance with Utah code 58-67-302(1)(j) **or** 58-68-302(1)(j). These contacts are for your patients to access their records, the contact information you provide is Public Record. You are welcome to list a medical records department, office administrator, the practice you are currently at or will be at, etc. The form is included for your convenience. Please fill out the highlighted portions.

2. **Driver's License.** Submit a copy of the driver license to confirm the issuing state as required by Utah code 63G-12-402.

Review the Interstate Medical Licensure Compact statute regarding your responsibilities prior to and once you have obtained a state issued IMLC license these can be found in:
IMLCC Rule – Chapter 5 – Expedited Licensure – Amended November 17 2017

Response Procedure:
Please respond by the deadline given above by submitting the item(s) listed above to:

<Licensing Specialist Name>
Division of Occupational and Professional Licensing
160 East 300 South, Box 146741
Salt Lake City, Utah 84114-6741

Failure to Timely Respond:
If you fail to respond by the deadline given above and later wish to obtain a license, you will be required to submit a new application and comply with the licensing requirements then in effect.

Presumption a Response is Complete:
Unless you specify otherwise, the Division will treat any response received from you by the deadline given above as a complete and final response, and may take final action immediately.

Questions or Request for Extension to Respond:
If you have any questions, or wish to request an extension of the deadline to respond given above, please call the person who signed this letter before your deadline to respond.

Due Process after Deadline to Respond:
You may request agency review of the denial of your incomplete application for licensure, **(1) no later than 30 days after the deadline to correct your incomplete licensure**. If you choose to file a request for agency review, you must adhere to the attached procedures.

Certificate of Mailing:
I certify that I properly served this document on the date of the letter by mailing it by first class mail with postage prepaid to the addressee shown above.

Sincerely,

Utah Licensing Specialist
FOR THE BUREAU MANAGER
<email>
801-530-6628

Subject Line: IMLC Medical Compact Next Actions Needed

Thank you for your application to the Interstate Medical Licensure Compact. The following actions will need to be completed to move forward with the process. All items below **must** be completed before the LOQ process can move forward:

1. Submit fingerprints in order for the Department to conduct a background check.

    - Schedule an appointment with Fieldprint, the Department's approved vendor, at:

      http://FieldprintWisconsin.com

      Use the Fieldprint code "FPWIPhysician" when prompted. The cost for digital fingerprints will be $34.75 and is expected at the time of reservation. **You must enter account number G3447 when prompted.**

      If you live outside of Wisconsin, you may electronically submit fingerprints at any Fieldprint site near you. You must use the Fieldprint code "FPWIPhysician" when prompted. **You must enter account number G3447 when prompted.**

    FAILURE TO ENTER THE CORRECT CODE OR ACCOUNT NUMBER WILL RESULT IN DELAYS AND/OR REQUIRE YOU TO OBTAIN THE FINGERPRINTS AGAIN.

2. Complete the attached forms and send them back to the Department via email at dspscredmedbd@wisconsin.gov.

3. Contact FSMB and request your USMLE/FLEX or other licensing exam scores to be sent to the Wisconsin Medical Examining Board or uploaded to the Board's portal. If you took the NBME or the NBOME/COMLEX please contact the NBME to have them send your exam scores directly to the Wisconsin Medical Examining Board.

4. Please verify the personal email address of the physician to have on file for future correspondence including LOQ application updates and renewal notices.

After we receive your fingerprint results and additional forms, we will move forward with the review of your application for a Letter of Qualification.

***NOTE: IF YOU DO NOT COMPLY WITH THE ABOVE REQUIREMENTS WITHIN 60 DAYS YOUR APPLICATION WILL BE AUTOMATICALLY WITHDRAWN. PAYMENT OF ANY FEES IS NON-REFUNDABLE PER IMLC POLICY.**

Please let us know if you have any questions.

Sincerely,

Interstate Medical Licensure Compact

Employment and/or 25% Practice Verification Examples

TELEPHONE: (601) 987-3079

FAX: (601) 987-4159

MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE

Employment Verification

Licensee: Submit this form to hospitals or clinics where you are practicing in Mississippi. Complete only the top portion and submit the form to the employer/hospital for completion.

Licensee's Name (Print Legibly): _____

Licensee's Date of Birth (Month/Day/Year): _____

Signature of Licensee: _____

Employer/Hospital: Complete and send form directly to the Mississippi State Board of Medical Licensure. Form may be emailed to mboard@msbml.ms.gov. Any processing fees are the physician's responsibility. This form should **not** be completed by a locums or credentialing company.

It is hereby certified that _____
(Name of Licensee)

Is/was employed at _____
(Name of Hospital/Clinic)

located at _____
(Address, City, State, Zip)

From _____ To _____
(Month/Day/Year) (Month/Day/Year)

Is the licensee currently practicing at your facility/location? YES_____ NO* _____
Indicate NO if the licensee continues to hold privileges, but is not currently practicing.

Is the licensee scheduled to return to your facility to provide services in the future?
YES*_____ NO _____
**If yes, indicate scheduled date(s) and duration of upcoming assignment:* _____

_____

To be completed by certifying entity:	**Institutional Seal**
Print Name: _____	
Signature: _____	
Date:_____Phone: _____	
E-mail: _____	**(If seal unavailable, form must be notarized.)**

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

State of Nebraska, Department of Health and Human Services
Division of Public Health, Licensure Unit
ATTN: Tara Anderson
301 Centennial Mall South
PO Box 94986, Lincoln NE 68509-4986
402-471-2118
Tara.Anderson@nebraska.gov

EMPLOYER VERIFICATION FORM

PHYSICIAN: Submit this form to your employer which is located in Nebraska. Complete **only** the top portion and submit the form to the employer for completion.

Physician's Name _____

Physician's Date of Birth (MM/DD/YYYY): _____

Signature of Licensee/Physician: _____

EMPLOYER: Complete and send the form directly to the address above **Attn: Tara Anderson**. Any processing fees are the physician's responsibility. This form should **not** be completed by a locums or credentialing company.

It is hereby certified that: _____
(Name of Physician)

Is employed by: _____
(Name of Employer)

Located at: _____
(Address, City, State, Zip)

From: _____ **To:** _____
(Month/Day/Year) (Month/Day/Year)
(i.e. current contract start/end dates)

INSTITUTIONAL SEAL

(If your institution does not have an official seal, this form must be notarized)

To Be Completed ONLY by Staff at the EMPLOYER above:

Print Name: _____

Signature: _____

Date (M/D/Y): _____

Phone: _____ Fax: _____

Email: _____

State of Utah
Department of Commerce
Division of Occupational and Professional Licensing

Official Use Only
Number: _____
Date Approved/Denied: _____
Approved/Denied By: _____

EMPOLYMENT VERIFICATION FORM

This is NOT an application for licensure. **Licensee/Physician:** Submit this form to all hospitals, facilities and employers in the state of Utah where 25% of your practice occurs. Complete only the top portion and submit the form to the employer/hospital for completion.

LICENSEE INFORMATION

Full Legal Name: _____
First *Middle* *Last*

All Previous Legal Names: _____

SSN:_____ **Date of Birth:**_____

EMPLOYMENT INFORMATION

Hospital/Facility/Employer, you must answer all of the following questions and provide any additional information in order for this form to be considered complete.

It Is Hereby Certified That:: _____
Name of Licensee/Physician

Is/Was Employed At: _____
Name of Hospital/Clinic

Located At: _____
Street Address (including Unit/Ste #) *City* *State* *Zip*

From:_____ **To:**_____
MM/DD/YYYY *MM/DD/YYYY*

Average Number of Days Worked in Utah Per Month: _____

Average Number of Hours Worked in Utah Per Week: _____

Is the licensee/physician currently practicing at your facility/location in Utah? Yes No
**Indicate NO if the licensee/physician continues to hold privileges, but is not currently practicing.*

Is the licensee/physician scheduled to return to your facility to provide services in Utah in the future? Yes N o

**If YES, indicate the scheduled date(s) and duration of upcoming assignment:* _____

<u>Completed By The Medical Staff Office</u>:

Title of Individual Supplying Information: _____

Print Name**:** _____ Signature: _____

Date:_____ Phone:_____ Email: _____

Wisconsin Department of Safety and Professional Services

Mail To: P.O. Box 8935
Madison, WI 53708-8935
FAX #: (608) 251-3036
Phone #: (608) 266-2112

Ship To: 4822 Madison Yards Way
Madison, WI 53705
E-Mail: dsps@wisconsin.gov
Website: http://dsps.wi.gov

MEDICAL EXAMINING BOARD

HOSPITAL, FACILITY, AND EMPLOYER VERIFICATION (IMLC)

APPLICANT: Please forward this form to all hospitals, facilities, and employers in the State of Wisconsin where 25% of your practice occurs.

HOSPITAL/FACILITY/EMPLOYER: The Medical Examining Board requests that you complete this form concerning the following individual:

Applicant/Physician's Name: _____

Name of Hospital/Facility/Employer: _____

Hospital/Facility/Employer's Address: _____

Hospital/Facility/Employer's Daytime Phone: ___ - ___ - ____

Hospital/Facility/Employer, you must answer all of the following questions and provide any additional information in order for this form to be considered complete.

1. What position does this Physician hold at your facility or under your employment?

_____

2. How often does this physician practice at your facility or provide services to patients located in Wisconsin (i.e. telemedicine)?

_____

Name/Title of Individual Supplying Information:

_____

Signature: _____ Date __ __ / __ __ / __ __

Hospital/Facility/Employer, please email with facility coversheet/letter and return directly to:
DSPSCredMedBD@wisconsin.gov.

Interstate Medical Licensure Compact

Post-Grad Training Verification Example

UA UNIFORM APPLICATION FOR LICENSURE

Postgraduate Training Verification Form (Form #3)

Institution Name: ______________________________

Institution Address: ______________________________

____

Affiliated School: ______________________________

Program Director or designated Official: Please complete Section 2, and mail this form and any other items to the designated state medical board at the address listed in Section 1. Thank you.

Section 1:
To be completed by the Applicant.

Name:______________________**Suffix**______**Practitioner type: M.D.** ☐**D.O.** ☐

Date of birth:__________**(mm/dd/yyyy) SSN*** ______________________

*The social security number is to be used for purposes of identification only and may not be used for any other reason.

Name if different when diploma awarded: ______________________

Board Information:
To be completed by the applicant.

Waiver for Release of Information: I request that the program director or a designated official complete Section 2 of this form as outlined below. I authorize the postgraduate training program listed above to provide any all information pertaining to my training there to the board listed below:

Board Name: Iowa Board of Medicine

Mailing address: 400 SW 8th St. Suite C, Des Moines, IA 50309

Applicant Please Sign Here →

Applicant Signature______________________**Date** __________

Section 2 :
Program Participation :

Important:

Report Incomplete Training Levels (years) separate from those that were successfully completed.

If the training level (year) is currently in progress report the expected completion date in the "To" field.

Use one section per Department/Specialty. If the Department/Specialty is rotating or transitional, please provide a schedule of rotations.

Report Internships, Residencies and Fellowships separately.

Training Level: ______
(e.g., 1, 2, 3, etc.)
☐Internship
☐Residency
☐Chief Residency
☐Fellowship
☐Research

Specialty/ Subspecialty: ______________________

From: __/__/______ **To:** __/__/______

Successfully Completed?: ☐Yes ☐No ☐In Progress

Accredited by: ☐ACGME ☐AOA ☐LCGME ☐RSC ☐CFPC ☐RCPSC ☐APPAP ☐None of these

Training Level: ______
(e.g., 1, 2, 3, etc.)
☐Internship
☐Residency
☐Chief Residency
☐Fellowship
☐Research

Specialty/ Subspecialty: ______________________

From: __/__/______ **To:** __/__/______

Successfully Completed?: ☐Yes ☐No ☐In Progress

Accredited by: ☐ACGME ☐AOA ☐LCGME ☐RSC ☐CFPC ☐RCPSC ☐APPAP ☐None of these

Training Level:______
(e.g., 1, 2, 3, etc.)
☐Internship
☐Residency
☐Chief Residency
☐Fellowship
☐Research

Specialty/ Subspecialty: ______________________

From: __/__/______ **To:** __/__/______

Successfully Completed?: ☐Yes ☐No ☐In Progress

Accredited by: ☐ACGME ☐AOA ☐LCGME ☐RSC ☐CFPC ☐RCPSC ☐APPAP ☐None of these

Unusual Circumstances:

Check the appropriate responses and explain any "Yes" or omitted response(s) on a separate sheet of paper.
Attach pages as needed.

1. Did this individual ever take a leave of absence or break from his/her training? ---------------- ☐Yes ☐No

2. Was this individual ever placed on probation? --- ☐Yes ☐No

3. Was this individual ever disciplined or placed under investigation? -------------------------------- ☐Yes ☐No

4. Were any negative reports for behavioral reasons ever filed by instructors? -------------------- ☐Yes ☐No

5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? ---------------- ☐Yes ☐No

Certification: Affix your institutional seal in this space. If no seal is available, you must have this form notarized.

I CERTIFY THAT to the best of my knowledge and belief, the foregoing is a true, accurate and complete statement of the record of the individual named on this form. This section MUST be signed by the program director (M.D. or D.O. only). **(Signature by personnel other than an M.D. or D.O. must attach an authorization letter. Applicable only for Nevada State Board of Medical Examiners.)**

Signature: ______________________

Print name: ______________________

Title: ______________________

Email address: ______________________

Phone Number:______________________**Date:**__________

Interstate Medical Licensure Compact

Deficiency Comment Examples

- **State of Principal License** – You have claimed Nebraska as your state of principal license, indicating that your primary residence is located in Nebraska. Please provide a copy of your driver's license or copy of a monthly utility bill verifying your address located at _____.

- **State of Principal License** – You have claimed Nebraska as your state of principal licensure, indicating that 25% of your practice occurs in Nebraska providing telemedicine services.
  In order to prove that you worked 25% of your time with Nebraska patients please send in a log showing the state in which the practice occurred for all patient contacts for the past 12 months and the scheduled contacts for any future dates not to exceed 12 months. If you have any documentation that will prove the 25% threshold has been met please include that so we may determine eligibility.

- **State of Principal License** – You have claimed Nebraska as your state of principal licensure, indicating that 25% of your practice occurs in Nebraska.
  In order to prove that you worked 25% of your time in Nebraska or with Nebraska patients please have CompHealth send me your work schedule showing the state in which the practice occurred and the dates worked for the past 12 months and a schedule for any future dates not to exceed 12 months. If you have any documentation that will prove the 25% threshold has been met please included that so we may determine eligibility for Nebraska to be designated as your SPL.

- **Postgraduate Training Completion** – You were issued your permanent license in Iowa prior to completion of your residency program. Please submit the attached form to the program director at your residency program and ask that the completed form be sent back to this Board directly from the program.

- **Contact Information** – The information entered into your application does not match what this Board has on file for your contact information (home and work). Respond to this email providing updated contact information, as this Board requires all contact information be updated within 30 days of any change.

- **Contact Information** – There is a discrepancy in the contact information we have listed in our licensing system versus the information listed on your IMLC application. Please select which you would like listed for primary contact purposes:

  Mailing Address:
  Nebraska licensing system: _____
  IMLC application: _____
  Phone Numbers:
  Nebraska licensing system: (___)____–_____and (___)____– _____
  IMLC application: (___)____– _____
  Email Address:

  a) Nebraska licensing system: _____
  b) IMLC application: _____