**L**ouisiana **S**tate **B**oard of **M**edical **E**xaminers

630 Camp Street, New Orleans, LA 70130

(504) 568-6820

**TELEMEDICINE PERMIT APPLICATION**

**READ CAREFULLY AND TAKE NOTICE:** This application and any subsequently issued license, permit, certificate, or other authority to practice in the State of Louisiana are subject to all Louisiana laws and administrative rules governing the practice of medicine and allied health. A copy of the laws and rules can be found on the LSBME website. All applicants are hereby PLACED ON NOTICE that they are responsible for knowing the laws and rules and for complying with them. By submitting this application, you expressly acknowledge and agree that you are responsible for knowing and complying with the laws and administrative rules governing the practice of licensure for which you are applying.

**FILL IN ONLINE PRIOR TO PRINTING**

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| **Name: Last** | | | | | **First** | | | | | **Middle** | | | | **Suffix (Sr., Jr.)** | **Suffix** |
| **List all names in which you have ever been known:** | | | | | | | | | | | | | | | |
| **Social Security Number** | | | | | **Driver’s License Number & State** | | | | | | **Controlled Substances Permit #’s**  **DEA #:**       **Exp. Date:**  **Louisiana State CDS #:** | | | | |
| **\*Public Address:** Address that is posted on the LSBME Website. **\*Mailing Address:** Mailings from the LSBME will go to this address. | | | | | | | | | | | | | | | |
| **BUSINESS ADDRESS Public Address** **Mailing Address** | | | | | | | **PHONE:**        **FAX:**        **E-MAIL:** | | | | | | | | |
| **HOME ADDRESS Public Address Mailing Address** | | | | | | | **PHONE:**        **FAX:**        **E-MAIL:** | | | | | | | | |
| **Race** | | **Weight** | **Height** | | | **Eyes** | | | **Hair** | | | **Marks** | | | |
| **Birth**  **(must submit ORIGINAL or Certified Copy of birth certificate)** | **Place** | | | | | | | **Date** | | | | | **Are you a U.S. Citizen?** | | |
| **If not native-born citizen of the U.S., give the following information:** | | | **Type of visa:** | | | | | | | | | | | |
| **If Naturalized, give certificate number:** | | | | | | | | | | | |
| **INS number:** | | | | | | | | | | | |
| **Petition number:** | | | | | | | | | | | |
| **Date issued:** | | | | | | | | | | | |
| **District court through which issued:** | | | | | | | | | | | |
| **Marital Status** | **Spouses First Name:** | | | **Last Name (if different from yours)** | | | | | | | | | | | |
| **U.S. Active Duty** | **Branch** | | | **Dates Served:**  **From:**       **To:** | | | | | | | | | | **Discharge** | |

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| **Have you ever taken any of the following written exams?**  **National Boards, other State Boards, USMLE, FLEX, COMLEX-USA, NBOME, SPEX/COMVEX-USA** **Yes** **No**  If yes, list name, location, date and result of each examination; failures must also be disclosed. Each examination agency must submit an original official Examination History Report directly to the LSBME. NOTE: Louisiana has a four time limit on all exams. | | |
| **Examination (indicate # of times taken)** | **Date** | **Result (Pass/Fail)** |
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**Name:**       **SS#:**

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| **Check box once the online course has been completed.** | **I have completed TMED Rules Review online course.** |

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| **Education** | | | | | | | **Specialized Training**  (Residency, professional training, vocational training, practical/clinical training) | | | | | |
| **College/University** | | | | | | | **Institution** | | | | | |
| **City, State & Country, if not U.S.** | | | | | | | **City, State & Country, if not U.S.** | | | | | |
| **Month/Year Started** | **Month/ Year Ended** | | | | **Degree Earned** | | **Month/Year Started** | | | **Month/ Year Ended** | | **Specialty** |
| **Professional School** | | | | | | | **Institution** | | | | | |
| **City, State & Country, if not U.S.** | | | | | | | **City, State & Country, if not U.S.** | | | | | |
| **Month/Year Started** | **Month/ Year Ended** | | | | **Degree Earned** | | **Month/Year Started** | | | **Month/ Year Ended** | | **Specialty** |
| **Work History and Non-Professional Activity**  Account for ALL time not specified above, in chronological order, from professional school to the present.  Attach separate 8 ½ x 11 sheet if necessary. | | | | | | | | | | | | |
| **From**  **Month/Year** | | **To**  **Month/Year** | | **City** | | **State or Country** | | **Employer or practice setting**  **(Clinic, Hosp., Solo/Group, Etc.)** | | | **Specialty or Activity** | |
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| **Have you ever been licensed to practice medicine in any state, territory, province, or country?** **Yes** **No**  If yes, list the State, License Number and Issue Date of license. Please include permanent, temporary, training, provisional, limited or permit. Verification is required for each. Attach separate 8 ½ x 11 sheet if necessary. | | | | | | | | | | | | |
| **State** | | | **License Number** | | | | | | **Issue Date** | | | |
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| **Do you practice Telemedicine across State lines? Yes No** | | | | | | | | | | | | |
| **Description of how Telemedicine will be used:** | | | | | | | | | | | | |
| **Identify address for the custodian of medical records:** | | | | | | | | | | | | |
| **What procedure/arrangements are in place for the patient to receive back-up, follow up and emergency care?** | | | | | | | | | | | | |

**By submitting this application, I expressly acknowledge that I understand and agree I am responsible for knowing and complying with the laws and administrative rules governing the practice of licensure for which I am applying. A copy of which are available for my review on the LSBME website.** [**CLICK HERE TO READ THE RULES BY SELECTING YOUR LICENSE CATEGORY**](https://www.lsbme.la.gov/licensure/rules)**.**