LOUISIANA STATE BOARD OF MEDICAL EXAMINERS

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**Emergency Temporary Permit Application**

**\*\* Complete this form PRIOR to printing\*\***

What category of licensure are you applying for:

|  |  |  |  |
| --- | --- | --- | --- |
| **Physician** | **Allied Health** | | **Clinical Laboratory** |
| Physician  Osteopathy  Medical Psychologist  Physician Acupuncturist | Acupuncture Detoxification Specialist  Athletic Trainer  Clinical Exercise Physiologist  Licensed Acupuncturist  Licensed Respiratory Therapist  Midwife  Occupational Therapist | Occupational Therapy Assistant  Perfusionist  Physician Assistant  Podiatrist  Polysomnography  Private Radiological Technology | CLS-Generalist  CLS-Specialist  CLS-Technician  Cytotechnologist  Laboratory Assistant  Phlebotomist |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **NAME:** LAST | FIRST | | MIDDLE | | SUFFIX (SR, JR) | TITLE |
| SOCIAL SECURITY NUMBER: | DRIVER’S LICENSE # & STATE: | | | | | |
| **HOME ADDRESS:** STREET & NO. | | CITY | | STATE & ZIP CODE | | |
| HOME PHONE: | | CELL: | | EMAIL: | | |
| **MAILING ADDRESS**: STREET & NO. | | CITY | | STATE & ZIP CODE | | |
| **FACILITY IN LOUISIANA WHERE YOU WILL BE PROVIDING HEALTHCARE SERVICES:** | | | | | | |
| NAME OF FACILITY / STREET & NO. | | CITY | | STATE & ZIP CODE | | |
| **IDENTIFICATION:**  RACE:       SEX      WEIGHT:       HEIGHT:  EYES:       HAIR:       MARKS:  PLACE OF BIRTH:       DATE OF BIRTH: | | | | | | |
| **OTHER STATE LICENSES:** Have you ever been licensed to practice in any other state, territory, province, or country?  STATE:       LICENSE #:       ISSUE DATE:       EXPIRATION DATE:  STATE:       LICENSE #:       ISSUE DATE:       EXPIRATION DATE:  STATE:       LICENSE #:       ISSUE DATE:       EXPIRATION DATE:  STATE:       LICENSE #:       ISSUE DATE:       EXPIRATION DATE: | | | | | | |

Do you have a supervising physician: Yes No

If yes, list: