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

630 Camp Street, New Orleans, LA 70130

(504) 568-6820

*Initial Application for Licensure for Physicians*

**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**

Have you ever applied for a physician’s license in Louisiana prior to now? Yes No

Have you ever been licensed as a physician in Louisiana? Yes No

Intended Location/Date in Louisiana: City       Date:

Have you applied for FCVS for credentials verifications? Yes No

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| NAME: LAST | | FIRST | | | | | MIDDLE | | | | SUFFIX (SR, JR) |
| SOCIAL SECURITY NUMBER | | DRIVER’S LICENSE # & STATE | | | | | Controlled Substances Permit #’s  DEA #:       Exp. Date:  Louisiana State CDS #: | | | | |
| BUSINESS ADDRESS: \***This address will appear on the LSBME website.**  STREET & NO. (DO NOT USE P.O. BOX) | | | | | | CITY | | | | STATE | |
| ZIP + 4 | COUNTY/PARISH | | COUNTRY (IF NOT U.S.) | | | | | PHONE: | | | |
| FAX: | | | |
| EMAIL: | | | |
| HOME ADDRESS: STREET & NO. | | | | | CITY | | | | STATE | | |
| ZIP + 4 | COUNTY/PARISH | | | COUNTRY (IF NOT U.S.) | | | | PHONE: | | | |
| CELL: | | | |
| FAX: | | | |
| EMAIL: | | | |
| PREFERRED MAILING ADDRESS: STREET & NO. **\*Renewal notices will be sent to this address.** | | | | | CITY | | | | STATE | | |
| ZIP + 4 | COUNTY/PARISH | | | COUNTRY (IF NOT U.S.) | | | | PHONE: | | | |
| FAX: | | | |
| EMAIL: | | | |
| SPECIALTY:  1)       2)       3)       4) | | | | | | | | | | | |
| ABMS/AOA SPECIALTY BOARD CERTIFICATION/YEAR:  1)       2)       3)       4) | | | | | | | | | | | |
| IDENTIFICATION:  RACE:       SEX      WEIGHT:       HEIGHT:  EYES:       HAIR:       MARKS:  MARITAL STATUS:       SPOUSE’S FULL NAME:  PLACE OF BIRTH:       DATE OF BIRTH:       ARE YOU A U.S. CITIZEN?  IF NOT NATIVE-BORN CITIZEN OF THE U.S. GIVE FOLLOWING INFORMATION: TYPE OF VISA:  IF NATURALIZED, CERTIFICATE #:       INS #:       PETITION #  DATE ISSUED:       DISTRICT COURT THROUGH WHICH ISSUED:  U.S. ACTIVE DUTY: BRANCH:       DATES SERVED:       TYPE DISCHARGE:  HAVE YOU EVER HELD ANY TYPE OF LICENSURE IN LOUISIANA? Yes No  IF YES, TYPE & #: | | | | | | | | | | | |

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| ***Name (Printed or typed):******SS#:*** |

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| **Professional/Medical School** | | | | | | | | | | **Post Graduate Training Program** | | | | | | | |
| **City, State & Country, if not U.S.** | | | | | | | | | | **City, State & Country, if not U.S.** | | | | | | | |
| **Month/Year Started** | | **Month/ Year Ended** | | | | | **Degree** | | | **Month/Year Started** | | | **Month/Year Ended** | | **Specialty** | | |
| **Post Graduate Training Program** | | | | | | | | | | **Post Graduate Training Program** | | | | | | | |
| **City, State & Country, if not U.S.** | | | | | | | | | | **City, State & Country, if not U.S.** | | | | | | | |
| **Month/Year Started** | | | **Month/Year Ended** | | | | | **Specialty** | | **Month/Year Started** | | | **Month/Year Ended** | | | **Specialty** | |
| **Post Graduate Training Program** | | | | | | | | | | **Post Graduate Training Program** | | | | | | | |
| **City, State & Country, if not U.S.** | | | | | | | | | | **City, State & Country, if not U.S.** | | | | | | | |
| **Month/Year Started** | | | **Month/Year Ended** | | | | | **Specialty** | | **Month/Year Started** | | | **Month/Year Ended** | | | **Specialty** | |
| **Practice History and Non-Professional Activity (Do NOT include Training)** Attach separate 8 ½ x 11 sheet if necessary.  **Account for ALL time not specified above, in chronological order, from Professional/Medical school to the present.** | | | | | | | | | | | | | | | | | |
| **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 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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| **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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| **TELEMEDICINE – Complete the below if you will be practicing Telemedicine** | | | | | | | | | | | | | | | | | |
| I have completed the online Telemedicine course: Yes No | | | | | | | | | | | | | | | | | |
| Are you going to be practicing Telemedicine in LA? Yes No | | | | | | | | | | | | | | | | | |
| Are you going to be practicing 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)**.**