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

**APPLICATION FOR FELLOWSHIP TRAINING PERMIT**

**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 (MD/DO)** | |
| **List all names in which you have ever been known:** | | | | | | | | | | | | | | | | | | | | | |
| **Social Security Number** | | | | | | | **Driver’s License Number & State** | | | | | **One Year Fellowship to be served:**  **From:**       **To:** | | | | | | | | | |
| **Addresses** | **Fellowship Address** | **Name of Hospital & Department** | | | | | | | | | | **City** | | | | | | | | | **State** |
| **Zip + 4** | | | **County/Parish** | | | | **Country if not U.S.** | | | **Telephone (Area code, #, Ext.)** | | | | | | **Pager Number** | | | |
| **Home Address** | **Street & Number** | | | | | | | | | | **City** | | | | | | | | | **State** |
| **Zip + 4** | | | **County/Parish** | | | | **Country if not U.S.** | | | **Telephone (Area code+#)** | | | | | **Email Address:** | | | | |
| **Preferred Mailing Address** | **Street Number or Post Office Box** | | | | | | | | | | **City** | | | | | | | | | **State** |
| **Zip + 4** | | | **County/Parish** | | | | **Country if not U.S.** | | | **Telephone (Area code, #, Ext.)** | | | | | | | **Pager Number** | | |
| **Identification** | **Race** | | **Sex** | | | **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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| **Education** | | | | | | | **Post Graduate Training** | | | |
| **High School** | | | | | | | **Hospital/Program** | | | |
| **City, State & Country, if not U.S.** | | | | | | | **City, State & Country, if not U.S.** | | | |
| **Month/Year Started** | | | | **Month/Year Graduated** | | | **Month/Year Started** | | **Monty/Year Ended** | **Specialty** |
| **College/University** | | | | | | | **Hospital/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** | | **Monty/Year Ended** | **Specialty** |
| **College/University** | | | | | | | **Hospital/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** |
| **College/University** | | | | | | | **Hospital/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** |
| **Professional School** | | | | | | | **Hospital/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** |
| **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 MO/YR** | **To MO/YR** | | **City** | | | **State or Country** | | **Employer or practice setting**  **(Clinic, Hosp., Solo/Group, Etc.)** | | **Specialty or Activity** |
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| **States in which license/certificate obtained and basis of licensure/certification:** | | | | | | | | | | |

**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)**.**