DC HEALTH
Health Regulation & Licensing Administration

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

MEDICAL TRAINING LICENSE (MTL)
NEW LICENSE APPLICATION

All applicants must complete every section of this application and submit the original application and all required supporting documents. If more space is needed to fully answer questions, attach additional sheets with typed responses. False or misleading statements will be cause for disciplinary action and could be cause for criminal prosecution pursuant to ***DC Code 22-2405***. **YOU MUST INITIAL EACH PAGE OF THE APPLICATION.**

If you have any questions, call HRLA Customer Service at **(877) 672-2174, Monday through Friday, 8:30AM to 4:00PM EST.**

SECTION 1: LICENSURE TYPE & FEES

Professional Designation:	**Graduate Type:**	**Application Type & Fee:**
☐ Medicine & Surgery (MD)	☐ U.S./Canada (MTL I(A))	☐ MTL I(A) ($100.00)
☐ Osteopathy & Surgery (DO)	☐ International (MTL I(B))	☐ MTL I(B) ($100.00)
		☐ MTL II ($100.00)

SECTION 2: APPLICANT INFORMATION

First Name:	**MI:**	**Last Name:**
Date of Birth:		**SSN:**

Gender:
☐ Male ☐ Female

Degree(s) Held:
☐ MD ☐ DO ☐ MBBS ☐ MBA ☐ MPH ☐ PHD ☐ Other:

Race & Ethnicity (Optional):

☐ American Indian/Alaskan Native	☐ Asian/South Asian
☐ Black/African American	☐ Caucasian/White
☐ Native Hawaiian or Other Pacific Islander	☐ Hispanic or Latino
☐ Other: _____	☐ Choose Not to Disclose

Language(s) Spoken (Other than English):

☐ Spanish	☐ Vietnamese	☐ French
☐ Tagalog	☐ Amharic	☐ Mandarin
☐ Cantonese	☐ Russian	☐ German
☐ Korean	☐ Other: _____	

SECTION 3: OTHER NAME(S) USED

If your name has changed at any point since you have taken any exams or attended college or university, you must provide a copy of a legal name change document for each time that it has changed. Acceptable documents for individuals are marriage certificates, divorce decrees, court orders, copies of social security cards or a passport.

First Name:	**MI:**	**Last Name:**
First Name:	**MI:**	**Last Name:**
First Name:	**MI:**	**Last Name:**

SECTION 4: MAILING ADDRESS

Indicate your preferred mailing address by placing an "X" in the appropriate box. This will be the address to which all future licensing documents will be mailed.

☐ **HOME ADDRESS** ☐ **BUSINESS ADDRESS**

SECTION 5: HOME ADDRESS		
A P.O. Box may NOT be used for an address. Home address information will NOT be made available to the public.		
Current Home Address:		
City:	**State:**	**Zip Code:**
Phone Number:	**Email Address:**	

SECTION 6: BUSINESS ADDRESS(ES)		
A P.O. Box may NOT be used for an address. Business address information WILL be made available to the public.		
Current Business Address #1:	**Phone Number:**	
City:	**State:**	**Zip Code:**
Phone Number:	**Email Address:**	
Current Business Address #2:	**Phone Number:**	
City:	**State:**	**Zip Code:**
Phone Number:	**Email Address:**	

IMPORTANT MESSAGE RE: UPDATING CONTACT INFORMATION

Physicians are required to update changes to their name, home address or business address within thirty (30) days of the change. Failure to do so may result in disciplinary action. It is imperative that you update your information in writing, either via mail or email, to the point of contact listed below:

Attn.: District of Columbia Board of Medicine
899 N. Capitol St. NE, 2nd Floor
Washington, DC 20002
E: dcbomed@dc.gov

SECTION 7: MEDICAL SCHOOL(S) ATTENDED		
List all medical schools attended, in reverse chronological order, beginning with the most recent at the top. Transcripts should be provided in a sealed envelope from the issuing institution for each school that you attended and listed below. Use additional sheets if necessary.		
School #1 Name:	**Graduation Date:**	**Degree/Certificate Awarded:**
City:	**State:**	**Country (If not the United States):**
School #2 Name:	**Graduation Date:**	**Degree/Certificate Awarded:**
City:	**State:**	**Country (If not the United States):**

SECTION 8: USMLE/COMLEX RESULTS

Indicate below which Step(s) of the USMLE or COMLEX you have passed.

USMLE: ☐ Step 1 ☐ Step 2 ☐ Step 3	**COMLEX:** ☐ Step 1 ☐ Step 2 ☐ Step 3

SECTION 9: OTHER POST-GRADUATE MEDICAL TRAINING

List all post-graduate medical training you attended, regardless of whether you completed the program. Include both accredited and non-accredited internships, residencies and fellowships. Also include verification letters from your training programs. For "Type of Position", use the letter key code below. List experience in reverse chronological order, beginning with the most recent. Explain all gaps greater than three (3) months. Use additional sheets if necessary.

Position Key Code:

A. Fellowship | **B.** Internship | **C.** Residency | **D.** Other

Program #1 Name:	**Start Date:**	**End Date:**	**Type of Position:**
City:	**State:**		**Country (if not the United States):**
Program #2 Name:	**Start Date:**	**End Date:**	**Type of Position:**
City:	**State:**		**Country (if not the United States):**

SECTION 10: DC TRAINING INSTITUTION

Indicate below the training institution you will be attending in the District. Please note, your MTL license will be limited to practicing solely at that training institution and only for training purposes. Use additional sheets if necessary.

Training Institution:

☐ Children's National Medical Center
☐ George Washington University Hospital
☐ Howard University Hospital
☐ Sibley Memorial Hospital
☐ MedStar National Rehabilitation Hospital
☐ MedStar Washington Hospital Center
☐ MedStar Georgetown University Hospital
☐ Providence Hospital
☐ Saint Elizabeth's Hospital
☐ Unity Health Care

Program Name:	**Start Date:**	**End Date:**	**Post Graduate (PG) Training Year:**

Accreditation:

☐ Accreditation Council for Graduate Medical Education (ACGME) ☐ American Osteopathic Association (AOA)

☐ Other (if applicable): _____

SECTION 11: PROGRAM SPECIALTY

Indicate your specialty in the boxes below. Use the specialty codes listed if applicable. If a specialty code is not listed, please write the full specialty in the boxes provided.

AC Academic Medicine
ADM Administrative Medicine
AI Allergy & Immunology
AN Anesthesiology
DE Dermatology
EM Emergency Medicine
FM Family Medicine
GE Geriatrics
HOS Hospitalist
IN Internal Medicine (General)
IN Internal Medicine
- **IN/CA** Cardiology
- **IN/EN** Endocrinology
- **IN/GI** Gastroenterology
- **IN/HEM** Hematology
- **IN/ID** Infectious Disease
- **IN/NEP** Nephrology
- **IN/NEU** Neurology
- **IN/ONC** Oncology
- **IN/PCC** Pulmon. Critical Care
- **IN/PUD** Pulmon. Disease
- **IN/RH** Rheumatology

MG Medicine Genetics
NU Nuclear Medicine
OB Obstetrics & Gynecology
OC Occupational Health
OP Ophthalmology
OMT Osteopathic Manipulative Treatment
ENT Otolaryngology
PA Pathology
PED Pediatrics (General)
PED Pediatrics
- **PED/AD** Adolescent Medicine
- **PED/CA** Cardiology
- **PED/EN** Endocrinology
- **PED/GI** Gastroenterology
- **PED/HEM** Hematology
- **PED/NEO** Neonatology
- **PED/NEP** Nephrology
- **PED/NEU** Neurology
- **PED/ONC** Oncology
- **PED/PCC** Pulmon. Critical Care
- **PED/PUD** Pulmon. Disease
- **PED/RH** Rheumatology

PMR Physical Medicine & Rehabilitation
PR Preventive Medicine/Public Health
PSY Psychiatry
RA Radiology
REM Research Medicine
SU Surgery (General)
SU Surgery
- **SU/BT** Burn/Trauma
- **SU/CS** Cardiac Surgery
- **SU/CO** Colon & Rectal Surgery
- **SU/GE** General Surgery
- **SU/NE** Neurological Surgery
- **SU/OR** Orthopedic Surgery
- **SU/PL** Plastic Surgery
- **SU/TH** Thoracic Surgery
- **SU/TP** Transplant
- **SU/UR** Urology
- **SU/VA** Vascular

Specialty #1:
Specialty #2:
Specialty #3:
Specialty #4:

SECTION 12: FELLOWSHIP PROGRAM (MTL II APPLICANTS ONLY)

Program Name:	**Hospital:**	**Start Date:**	**End Date:**

Accreditation:

☐ Accreditation Council for Graduate Medical Education (ACGME) ☐ American Osteopathic Association (AOA)

☐ Board Approved Program ☐ Other (if applicable): _____

SECTION 13: WORK EXPERIENCE			
List **ALL** medical work experience covering the five (5) year period prior to the submission of the application. Explain all gaps greater than three (3) months. Use additional sheets if necessary.			
Employer #1 Name:	**Start Date:**	**End Date:**	**Reason for Leaving:**
City:	**State:**		**Country (if not the United States):**
Employer #2 Name:	**Start Date:**	**End Date:**	**Reason for Leaving:**
City:	**State:**		**Country (if not the United States):**
Employer #3 Name:	**Start Date:**	**End Date:**	**Reason for Leaving:**
City:	**State:**		**Country (if not the United States):**
Employer #4 Name:	**Start Date:**	**End Date:**	**Reason for Leaving:**
City:	**State:**		**Country (if not the United States):**

SECTION 14: REQUIRED SCREENING QUESTIONS

Please answer questions 1 through 15 by placing an "X" in the appropriate boxes. If you answer "Yes" to any question, you must provide full information and complete details on a separate sheet of paper, as well as attach copies of all relevant documents such as final court orders. Failure to provide relevant information will delay the application processing time.

1.	Have you ever been arrested, charged, convicted, pled guilty to, or pled no contest to the violation of any federal, state or other statute or ordinance constituting a felony or misdemeanor, including driving under the influence or while impaired, but excluding minor traffic violations?	☐ Yes ☐ No
2.	Have you been a defendant or respondent to a claim for damages or a malpractice action? If you answer "Yes", please complete the Malpractice Claims Form and submit it along with all relevant court documents (e.g., Complaint, Answer, and Final Order/Decision). A separate Malpractice Claims Form MUST be completed for each malpractice case.	☐ Yes ☐ No
3.	Have you ever voluntarily surrendered a license or registration certificate, or allowed it to lapse, after formal charges had been brought against you or while you were under investigation?	☐ Yes ☐ No
4.	Have you ever surrendered your clinical privileges, voluntarily or involuntarily, or had your clinical privileges denied, revoked, or suspended at any hospital or health care facility?	☐ Yes ☐ No
5.	Have you ever been terminated or resigned, voluntarily or involuntarily, from a clinical or professional training program for any reason?	☐ Yes ☐ No
6.	Has any licensing authority, in any healthcare field, taken adverse action against your license or privileges or informed you of any pending charges?	☐ Yes ☐ No
7.	Has any licensing authority, health facility, or peer review board, in any healthcare field, informed you of any pending charge(s) or investigation(s) against you?	☐ Yes ☐ No
8.	Are you presently now, or have you ever been, under a corrective action plan imposed by an employer, medical facility or educational program?	☐ Yes ☐ No
9.	Do you have a medical condition or have you become aware of any medical condition that impairs or limits your ability to practice your profession?	☐ Yes ☐ No
10.	Have you ever engaged in any conduct that either indicated an impairment, or actually impaired, your ability to practice your profession?	☐ Yes ☐ No
11.	Have you ever entered into a monitoring program for purposes of monitoring your abuse of alcohol, drugs, or other controlled substances?	☐ Yes ☐ No
12.	Have you ever entered into a monitoring program for purposes of monitoring your professional behavior including recordkeeping, billing, boundaries, quality of care or any other matter related to the practice of your profession?	☐ Yes ☐ No
13.	Within the last ten (10) years have you voluntarily resigned, been asked to resign, terminated, or disciplined by any employer?	☐ Yes ☐ No
14.	Have you ever withdrawn a license application or have you been denied a license or denied the privilege of taking a license examination by any professional licensing board or agency?	☐ Yes ☐ No
15.	Have you ever been excluded from any federal or state run insurance program, including Medicare and/or Medicaid?	☐ Yes ☐ No

SECTION 15: CLEAN HANDS

Clean Hands Before Receiving a License or Permit Act of 1996 Certification Requirement

Please read the information below carefully before responding to this yes or no question, as any false information provided requires that the Department of Health proceed to revoke your license or permit for which you are now applying, and fine you one thousand dollars ($1,000.00), pursuant to D.C. Official Code § 47-2864 (2001).

IF YOU ANSWER "YES" TO THIS QUESTION, PLEASE SUBMIT PROOF OF THE ARRANGEMENTS YOU HAVE MADE TO PAY THE OUTSTANDING DEBT. IF YOU DO NOT HAVE AN APPROVED PAYMENT SCHEDULE TO PAY THE AMOUNT YOU OWE OR IF NO APPEAL IS PENDING, THE LAW REQUIRES THAT YOUR NEW LICENSE APPLICATION BE DENIED.

As of this date, do any of the below statements apply to you:

- I owe more than $100 in fines, penalties, or interest assessed pursuant to D.C. Official Code Title 2, Chapter 18 (Civil Infractions Act of 1985);
- I owe more than $100 in fines, penalties, or interest assessed pursuant to D.C. Official Code Title 8, Chapter 8 (Litter Control Administrative Act of 1985);
- I owe more than $100 in fines, penalties, or interest assessed pursuant to D.C. Official Code Title 8, Chapter 9 (Illegal Dumping Enforcement Act of 1994);
- I owe more than $100 in fines, penalties, or interest assessed pursuant to D.C. Official Code Title 31, Chapter 24 (The Compulsory/No-Fault Motor Vehicle Insurance Act of 1982);
- I owe more than $100 in fines, penalties, or interest assessed pursuant to D.C. Official Code Title 50, Chapter 3 (Department of For-Hire Vehicles Establishment Act of 1985);
- I owe more than $100 in fines, penalties, or interest assessed pursuant to D.C. Official Code Title 50, Chapter 15 (Registration of Motor Vehicles);
- I owe more than $100 in fines, penalties, or interest assessed pursuant to D.C. Official Code Title 50, Chapter 23 (Traffic Adjudication Act of 1978);
- I owe more than $100 in fines, penalties, or interest assessed by another jurisdiction; provided, that a reciprocity agreement is in effect between the jurisdiction and the District;
- I owe more than $100 in past due taxes;
- I owe more than $100 in any outstanding fines, penalties, or interest due to the District of Columbia;
- I owe any amount of past due District of Columbia Water and Sewer Authority service fees;
- I owe any amount of a vehicle conveyance fee pursuant to D.C. Official Code Title 50, Chapter 23;
- I owe any amount of past due fines, penalties, or past due restitution on behalf of an employee due to a violation of D.C. Official Code Title 32, Chapters 1A, 10, 13 or Title 2, Subchapter X-A; or
- I have failed to file required District tax returns.

☐ Yes ☐ No

The information presented above is in compliance with the requirement to submit with your application for licensure or permit under the *Clean Hands Before Receiving a License Permit Act of 1996*, effective May 11, 1996 (D.C. Law 11-118, D.C. Code §47-2861, et seq.).

SECTION 16: DOCUMENT CHECKLIST

Please indicate the supporting documents you have included with this package or requested to be sent to the DC Board of Medicine. Please keep a photocopy of any submitted documents for your records, as they will not be returned.

☐ **Two (2) recent and identical passport type photos of the applicant's face (approx. 2" x 2") with the applicant's name printed on the back**

☐ **One (1) photocopy of a current government issued photo ID**

☐ **Social Security Number (SSN) Affidavit**

Applicants without a SSN must submit the SSN affidavit.

☐ **Criminal Background Check (CBC)**

To access the CBC form and instructions, go to www.doh.dc.gov/service/criminal-background-check or contact the CBC unit at (877) 783-4187.

☐ **Three (3) Character Reference Forms**

Must be completed by an MD or DO in good standing in a jurisdiction of the United States who has knowledge of the applicants abilities and qualifications to practice medicine. If you have completed your postgraduate training within three years of the date of this application, at least one (1) reference letter needs to come from the director of your post-graduate clinical training program and one(1) from a supervising physician of your post-graduate clinical training program.

☐ **Medical School Transcripts**

Transcripts should be provided in a sealed envelope from the issuing institution for each school listed in Section 7.

☐ **Examination Scores**

Examination scores must be received from the examining body. For MTL I applicants, submit USMLE/COMLEX Parts 1 & 2. For MTL II applicants, must submit USMLE/COMLEX Parts 1, 2 & 3.

☐ **ECFMG Certificate (for foreign-trained applicants only)**

Must submit an original or notarized copy.

☐ **National Practitioner Databank (NPDB) Self Query Report**

The Self-Query Report must be requested from the NBPD (https://www.npdb.hrsa.gov/ext/selfquery/SQHome.jsp) no more than thirty (30) days prior to submission of the application.

SECTION 17: PAYMENT AND MAILING INFORMATION.

Make your check or money order payable to "**DC Treasurer**".

A charge of sixty-five dollars ($65.00) will be imposed for dishonored checks (Public Law 89-208).

ALL FEES ARE NON-REFUNDABLE.

Mail your completed application and check to:

Board of Medicine – MTL New Application HRLA 1
PO Box 37801
Washington, DC 20013

SECTION 18: APPLICANT'S AFFIDAVIT & WAIVER

I hereby attest that the information given in this application, including all writings and exhibits attached hereto, is true and complete to the best of my knowledge. I understand that the making of a false statement on this application, including all writings and exhibits attached hereto, is punishable by criminal penalties.

Furthermore, I hereby authorize the DC Board of Medicine to discuss my application, including and all information relevant to it, with the training institution and its staff identified in this application.

SIGNATURE OF APPLICANT:	**DATE:**

REPORT FRAUD, WASTE, AND ABUSE: To report fraud, waste, or abuse within the District government, contact the DC Office of the Inspector General's hotline by phone at 1-800-521-1639 (toll free) or 202-724-TIPS (8477), by email at hotline.oig@dc.gov, or by TTY at 711. For additional information, visit the Office of the Inspector General's website at https://oig.dc.gov.