OFFICE OF PROFESSIONAL LICENSURE AND CERTIFICATION
STATE OF NEW HAMPSHIRE
DIVISION OF HEALTH PROFESSIONS
Board of Medicine
121 South Fruit Street, Suite 301
Concord, N.H. 03301-2412
Telephone 603-271-1203 · Fax 603-271-6702

PETER DANLES
Executive Director

JOSEPH G. SHOEMAKER
Division Director

INSTRUCTIONS FOR APPLYING FOR A SPECIAL LICENSE/VISITING PROFESSOR

The following must be provided to the Board:

1. A completed application submitted with the $75.00 fee made payable to Treasurer, State of New Hampshire.

2. A letter from the New Hampshire hospital/facility in which the applicant will be practicing verifying the applicant's name and date(s) of practice. **This letter must include a statement indicating that this license is limited to practice for which the patient is not being charged.** The following can be found in the Board's rule, Med 305.02(b)(3):

   "Practice for which the patient is not being charged.
   a. The hospital/facility may charge the patient for its services and for the services of other health professionals;
   b. The hospital/facility may not charge the patient for the services rendered by the visiting professor; and
   c. The AMA Code of Medical Ethics Rule 6.10 shall provide for guidance on billing with multiple providers.

3. An original verification of licensure received directly from the state board in which the applicant currently holds a valid license in good standing. Verifications received from any source other than the state licensing board will not be accepted. Most states charge a fee for verification of licensure. Be sure to contact the state board prior to requesting verification.

4. Applications are processed in the order received. We will not accelerate the processing of one application at the expense of others. You should expect to submit an application for special licensure at least 4 weeks before the expected start date.

5. Licenses will be issued within 7-10 days after the application is complete. The license will be mailed to the New Hampshire hospital/facility listed on the application and must be posted at that facility during the term of the license.

6. **This license will be limited to practice only at a New Hampshire licensed hospital/facility in an educational capacity in which no patient is being charged, whether or not direct patient care is provided.**

Please contact the Board office between 8:00 AM and 4:00 PM if you have any questions.

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APPLICATION FOR SPECIAL LICENSE

For office use only:

Received _____

Fee:_____Check #_____

PERSONAL INFORMATION:

Full Name: _____

Residence Address:_____

_____ Telephone: _____

Current Business Address:_____

_____ Telephone: _____

Business Address for the prior three (3) years (if different from above):_____

_____ Telephone: _____

Date of Birth: _____ Place of Birth: _____

EDUCATIONAL INFORMATION:

Medical School: _____ Date of Graduation: _____

Post Graduate Training Institution: Dates of Training

_____ _____

_____ _____

Specialty: _____ Board Certified? Yes _____ No _____

LICENSURE INFORMATION:

State in Which You Presently Hold License(s):_____

Verification of good standing from at least one state in which you have a current license is required. Verification must be received directly from the licensing board **and the dates of that license must cover the dates in which you are practicing in New Hampshire**.

Many states require payment of a fee for verification. Please check with your state board before requesting verification of licensure.

Have you ever been subject to disciplinary action by any licensing or certifying agency or by any hospital or health care facility?_____If yes, please provide the date of that action and a description of the circumstances of the action.

Have you ever applied for or requested an application for licensure in the state of New Hampshire?_____
If yes, when:_____

NEW HAMPSHIRE FACILITY INFORMATION:

List the name and address of the facility in which you will be practicing.

Name:_____

Address: _____

_____ Telephone:_____

Dates of Practice:

Beginning: _____ Ending: _____

_____
(YOUR SIGNATURE)

_____
(PLEASE PRINT/TYPE YOUR NAME)

DATE:_____

Please enclose a check in the amount of $75.00 (nonrefundable) made payable to: TREASURER, STATE OF NEW HAMPSHIRE.

Licensure Verification Form

New Hampshire Board of Medicine

RELEASE OF INFORMATION FROM OTHER LICENSING AUTHORITIES

I am applying for a license to practice medicine in the State of New Hampshire. The NH Board of Medicine requires that the following form be completed by the jurisdiction in which I am currently practicing. This constitutes your authority to release any and all information in your files, favorable or otherwise, directly to the NH Board of Medicine. Kindly mail your response to:

BOARD OF MEDICINE
121 SOUTH FRUIT STREET, SUITE 301
CONCORD, NEW HAMPSHIRE 03301-2412
Tel: (603) 271-1203

Biographic Information:

Last Name _____ First Name _____ Middle Name _____ Gen. Suffix _____

Mailing Address _____ City _____ State _____ ZipCode _____

Social Security Number: _____ Date of Birth: _____

License Number (if known) _____ Signature _____

The following should be completed by the licensing authority and returned directly to the NH Board at the address above.

1. Name of Licensing Authority: _____
2. Full Name of Licensee: _____
3. License Number: _____
4. Is License Current? Yes No Expiration Date: _____
5. Is License Restricted? Yes No
6. Previous Disciplinary Action? Yes No
7. Pending Investigations? Yes No

If the answer is yes to questions 5, 6 or 7, please attach supporting information.

Signature/Title _____ Date _____

Please affix official
Board
seal here