INSTRUCTIONS
FOR APPLYING FOR A CAMP LICENSE

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 camp facility in which the applicant will be practicing verifying the applicant’s name and dates of practice.

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 camp 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 camp facility listed on the application and must be posted at that facility during the term of the license.

6. License does not permit the holder to apply for or accept hospital privileges in New Hampshire.

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

PERSONAL INFORMATION:

Full Name: ________________________________________

Residence Address:__________________________________  Telephone: ______________________

Current Business Address:____________________________________________________________

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

Date of Birth: _____________________  Place of Birth: _________________________________

Social Security Number: _____________________________________________________________

EDUCATIONAL INFORMATION:

Medical School: ________________________________ Date of Graduation: __________

Post Graduate Training Institution: Dates of Training

___________________________________________________  _______________

___________________________________________________  _______________

Specialty: _______________________________ Board Certified?  Yes ______  No _______

For  office use only:

Received _______________________

Fee:____________Check #_________
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:________________________________________

CAMP INFORMATION:

List the name and address of the camp 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:

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Name</th>
<th>Gen. Suffix</th>
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Mailing Address
City
State
Zip Code

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.

Please affix official Board seal here

Signature/Title

Date

Revised 1-10-2020