STATE OF NEW HAMPSHIRE

OFFICE OF PROFESSIONAL LICENSURE AND CERTIFICATION

7 EAGLE SQUARE, CONCORD, NH 03301-4980
Telephone: 603-271-2152
TDD Access: Relay NH 1-800-735-2964
www.oplc.nh.gov

APPLICATION FOR SPECIAL LICENSE/CAMP

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: _________________________________

Social Security Number: ____

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: ____

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 (nonrefundable) made payable to: TREASURER, STATE OF NEW HAMPSHIRE.
Click Camp Application Fee to confirm the current fee schedule.

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
7 EAGLE SQUARE
CONCORD, NEW HAMPSHIRE 03301
Tel : (603) 271-2152

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.

Please affix official
Board
seal here

____
Signature/Title

____
Date