State of New Hampshire

OFFICE OF PROFESSIONAL LICENSURE AND CERTIFICATION
DIVISION OF LICENSING AND BOARD ADMINISTRATION
Board of Medicine
7 Eagle Square, Concord, NH 03301-2412
Phone: 603-271-2152

LINDSEY B. COURTNEY
Executive Director

JOSEPH G. SHOEMAKER
Director

TO WHOM IT MAY CONCERN:

In order for a physician to be eligible for a locum tenens license, the Board must receive the following:

1. The completed application and the $150.00 fee.

2. A letter from **each hospital/health facility** in New Hampshire stating the name of the locum tenens physician **and the dates he/she will be practicing is required**.

3. A letter from the state in which the locum tenens physician holds a full, unrestricted
medical license which is current and in good standing. **This medical license must be valid for the entire 100-day locum tenens license period.**

4. Original letters of reference, on letterhead and addressed to the board, from the following: The chief medical officer or president of the medical staff in every hospital in which you currently hold staff privileges OR letters of reference from 2 practicing physicians.

5. Has any medical malpractice suit been brought against you or has any claim been settled on your behalf in the last ten years? (**If yes, you will be required to provide the date of the suit or settlement and a description of the circumstances**.)

6. **Please be advised pursuant to RSA 329:14, VII, you must have a full unrestricted**
license in another state to be eligible.

If you should have any questions regarding this process, please call the Board office at (603) 271-6935.

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APPLICATION FOR LOCUM TENENS LICENSE

PERSONAL INFORMATION:

Name:____Gender (Circle One): M or F__

Home Address:____

_________________________________(Phone)______________________________

Present Place of Practice:____

Address:____

_______________________________________(Phone)______________________________

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

____ Telephone: ________________

Date of Birth:___________________Place of Birth:__________________________________

Social Security Number: ____

EDUCATION AND TRAINING:

Medical School:_________________________________Year of Graduation:________

Post Graduate Training Institution: Dates of Training:

____ __________________

____ __________________

LICENSURE INFORMATION:

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

Verification of good standing from the state in which you primarily practice and 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.

Please answer the following:

1. 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.

2. Have you ever had any medical malpractice suit brought against you, or have you had any claim settled on your behalf in the last ten years? _______ If yes, please provide the date of the suit or settlement and a description of the circumstances.

3. 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 each New Hampshire health care facility at which you will be practicing. **Each New Hampshire health care facility at which you will be practicing must send a letter confirming the dates of service before the license will be issued.**

PRIMARY FACILITY:

NAME_________________________________Telephone Number__________________

ADDRESS____

SECONDARY FACILITY: (if applicable)

NAME_________________________________Telephone Number__________________

ADDRESS____

DATES:

BEGINNING:________________________ ENDING:____________________________

(Valid for 100 consecutive days within one twelve-month period)

____

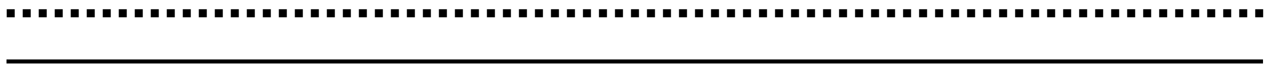
(YOUR SIGNATURE)

____

(PLEASE PRINT/TYPE YOUR NAME)

DATE: ______________________________

Please enclose a check in the amount of $150.00 (nonrefundable) made payable to: TREASURER, STATE OF NEW HAMPSHIRE.



FOR BOARD USE ONLY:

Received: __________________ Fee Paid: _____________________ Check No. __________________

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 each jurisdiction in which I am now or was previously licensed. 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 EAGEL SQUARE
CONCORD, NEW HAMPSHIRE 03301
Tel: (603) 271-2152

Biographic Information:

____

Last Name | First Name | Middle Name | Gen. Suffix

____

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

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

Please affix official

Board

Seal here

____

Signature/Title

____

Date