State of New Hampshire

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

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.

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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: _____________________________________

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? Yes No 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?
Yes No 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: ______________________________

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 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.

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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>

____

Signature/Title

____

Date