2015 PERMIT APPLICATION CHECKLIST

Dear Housestaff:

You are required by the NJ State Board of Medical Examiners to obtain a training permit for the duration of your training and medical licensure by the start of your PGY 6 year. In accordance with state regulations, please complete the permit application and documents requested no later than the deadline indicated below. Please submit your checklist, check, application and documents to your program coordinator.

Thank you for your prompt attention,

Stephen R. Baker, Associate Dean for GME-Rutgers NJMS

APPLICATION DEADLINE: 2/13/2015
FINGERPRINTING DEADLINE: 6/15/2015

Applicant Name: ________________________________

Program: ________________________________

1. ____ $50 Application Fee (Cashier’s Check or Money Orders ONLY- NO PERSONAL CHECKS)
2. ____ Permit Application (Application must be notarized & all questions answered)
3. ____ Curriculum Vitae (Please list ALL activities including periods of unemployment/time off, in month/year format i.e. February, 2015 or 2/2015.)
4. ____ Certification and Authorization FORM for Criminal History Background Checks
5. ____ Name Change Documentation (If applicable)
6. ____ Didactic Training Certification (ONLY for non LCME/non-AOA accredited school)
7. ____ ECFMG Certification (If applicable)
8. ____ Medical Education Verification Form (See instructions for further information)
9. ____ Certification of Postgraduate Training (If applicable- for applicants with current or past residency/fellowship training)
10. ____ Verification of Postgraduate Training (To be sent in separately on or after June 1, 2015)
11. ____ Original/Official Mark Sheets (Applicants from India, Pakistan, or Bangladesh ONLY)
Instructions for completing the permit Application for a New Jersey Residency Training Permit

(Resident’s Instructions)

Read the application and instructions before completing the application. Each section of the application is explained in these instructions - follow them carefully. You must request verifications and certifications from schools, etc.(third parties) using forms enclosed in this packet and follow-up with the third parties to ensure materials are sent directly to your Program Coordinator at the Medical Education Department. Do not substitute a different form/document for the one requested or those provided with the application.

The application must be submitted with a business/hospital check, or money order in the amount of $50.00 (non-refundable), made payable to the New Jersey State Board of Medical Examiners. Personal checks are not accepted.

The application must be typed or printed neatly. All questions must be answered. For "Yes" or "No" questions, circle the correct answer. If you determine a question does not apply to you, please have indicate that fact by writing "N/A" as your response. When space provided is insufficient, attach additional sheets of paper. Print your first name, middle initial and last name on each page of the application and on each attachment. Attachments are considered part of the application.

When preparing your curriculum vitae, it must be complete and accurate. List all activities chronologically, with the month and year dates for the beginning and ending of each period of your medical education, postgraduate training, professional experiences and activities. The list must begin with the first medical school in which you were enrolled and continue through to the present date with no gaps. Label all periods of unemployment as such, and identify your activities during any period of unemployment. Provide addresses for all employers.

The program coordinator will be notified of the status of each application as well as any deficiencies that are found. You should direct all questions to the program coordinator. If the program coordinator can not answer your questions, he/she will contact the Board Office.

Falsification or misrepresentation of any item or response on this application or any attachment hereto is sufficient basis for denying a Residency Training Permit and could subject you to disciplinary action by the Board.

Please do not return these instructions to the Board with your application!
Section One - Demographics - Instructions for the Applicant

1. Print your legal name. This is the name that will appear on your permit certificate. If you have changed your name, submit a copy of the associated legal document with this application. Print your current first name, middle initial and last name on the copy of the legal document.

2. Print any other name which may appear on documents you submit, or others may submit as part of this application (i.e., maiden name, legal name change, etc.).

3. Print your current mailing address and contact information. Your mailing address cannot be a post office box unless you also enter your street address. All residency permit applicants must provide a New Jersey address on both the Permit Application and the Certification and Authorization Form. If you are in transition from out of state and do not have a New Jersey address, please use your hospital/program address on the application and certification form. It is your responsibility to notify your program coordinator immediately, in writing by mail or FAX, of changes to your mailing address. They will notify the Board office of those changes.

4. Enter your date and place of birth.

5. Pursuant to N.J.S.A. 2A:17-56.44e of the New Jersey Child Support Enforcement Law, N.J.S.A. 54:50-25 of the New Jersey Taxation law, and Section 1128E(b)(2)A of the Social Security Act, the Board is required to obtain your Social Security number. The Board is further obligated to provide your Social Security number to the Director of Taxation, the Probation Division or any other agency responsible for child support enforcement, upon request, and to the National Practitioner Data Bank and the H.I.P. Data Bank when reporting adverse actions.

Pursuant to the Federal Privacy Act (5 U.S.C. Section 55a(note(b)), the Board is Requesting your consent to use your Social Security number for the following purposes: 1) to verify identity; 2) to aid in the collection of financial obligations due and owing the Board or any other State agency; and 3) to aid in the disclosure to State or federal law enforcement and licensing officials and agencies of information obtained in investigations pertaining to licensure and disciplinary proceedings.
Section Two - Education

Pre-Medical Education

Answer the questions by circling "Yes" or "No".

Print the information requested for each college/university you attended. Enter the dates in the following format: From: Month/Year - To: Month/Year.

Medical Education

List every medical school in which you were ever enrolled **EVEN IF NO CREDIT WAS GRANTED OR NO CREDIT WAS SOUGHT FOR THE STUDY.** Enter your full name at the top of **Medical Verification Form** and mail a copy of the form to every school you attended - **not just the school from which you graduated.** Direct the school(s) to return the form or an official transcript directly to your program coordinator at your Medical Education Department.

**Applicants educated in India, Pakistan or Bangladesh** - Submit an original/official Mark Sheet for each Bachelor of Science and/or Bachelor of Medicine (M.B.B.S.) Examination taken. Failed examinations must be included. Submit the certificate verifying completion of a year of compulsory rotating internship.

**International graduates must submit a copy of their transcript along with the original if they wish them to be returned.**

Didactic Training Certification

Applicants from a non LCME/non-AOA accredited school must complete the Certification form.

**Clinical Clerkships** - Circle **Yes** or **No** for each category. If the answers to these questions are "No", submit an explanation and the rotation(s) completed that was substituted for the core rotations.

**ECFMG Certification** - **Graduates of foreign medical schools** must be certified by the Educational Commission for Foreign Medical Graduates (E.C.F.M.G.). Submit a copy of your ECFMG Certificate.

Postgraduate Training

List each training program (including Fifth Pathway Program, internship, residency and/or fellowship) in which you have participated and the information requested on the form for each program. Postgraduate Training Information applies for the current or completed training only in the USA.
Section Three - Character, Ethics and Medical Conditions
Information regarding moral character and ethical professional responsibility

Answer all questions by circling either "Yes" or "No". For all "Yes" answers, attach a full explanation and any pertinent documentation. Print your first name, middle initial and last name on each page of any attachment.

Question a. asks about any arrests, charges or offenses you may have committed.

Carefully review the following definitions and instructions before answering the question.

Definitions for the purpose of this question:

"Arrest" includes any detaining, holding or taking into custody by any police or other law enforcement authorities to answer for the alleged performance of any "offense."

"Charge" includes any indictment, complaint, information, summons, or other notice of the alleged commission of any "offense."

"Offense" includes all felonies, crimes, high misdemeanors, misdemeanors, disorderly persons offenses, petty disorderly offenses, driving while intoxicated/impaired motor vehicle offenses, violations of probation or any other court order, and local ordinance violations.

Instructions for the purpose of question a. Answer "Yes" and provide all information to the best of your ability EVEN IF:

1. You did not commit the offense charged;
2. The charges were dismissed or subsequently downgraded to a lesser charge;
3. You completed a Pretrial Intervention (P.T.I.) or equivalent diversionary program;
4. You were not convicted;
5. You did not serve any time in prison or jail; or
6. The charges or offenses happened a long time ago.

Answer "No" IF:

1. You have never been arrested or charged with any crime or offense; or
2. The records relating to a charge, an arrest or conviction have been expunged by the Court or a government agency. (Check with the Court or government agency to make sure it has been expunged.)

Questions h. through k. - Under N.J.S.A. 2A:17-56-44d, an answer of "Yes" to any of questions h.(a), h.(b), I., j., k. will result in a denial of a permit. Furthermore, any false certification of these questions may subject you to a penalty, including, but not limited to, immediate revocation or suspension of the permit.

Resident's Instructions Page 4/7
Section Three - Character, Ethics and Medical Conditions (Continued)

Medical Conditions/Chemical Substances
Answer all questions by circling "Yes," "No" or "Not Applicable" (N/A), unless you are asserting your Fifth Amendment Privilege against self-incrimination. If you are asserting your Fifth Amendment Privilege, write that in the space under the first paragraph on the page.

If you are answering the questions, attach a detailed explanation for answers of "Yes," and include your printed first name, middle initial and last name on each page of the attachment.

Definitions for the purpose of this question:

For the purposes of these questions, the following phrases or words have the following meanings:

"Ability to practice medicine" is to be construed to include all of the following:
1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments; and
2. The ability to communicate those judgments and medical information to patients and other health care providers with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks with or without the use of aids or devices such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, H.I.V. disease, tuberculosis, drug addiction and alcoholism.

"Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of the application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or within the past two years.

"Illegal use of controlled substances" means the use of controlled dangerous substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled dangerous substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.
DOCUMENTS TO BE COMPLETED AND RETURNED TO YOUR PROGRAM COORDINATOR

1. Completed Application- All sections of the application which are applicable to you must be completed in full.

2. Certification and Authorization Form for a Criminal History Background Check
   • Applicants seeking residency training permits in New Jersey must go to a Morpho facility in New Jersey to have their fingerprints taken/processed. Use of fingerprint cards will not be accepted.
   • All residency permit applicants must provide a New Jersey address on both the Permit Application and the Certification and Authorization Form. If an applicant is in transition from out of state and does not have a New Jersey address, the applicant must use the hospital/program address on the application and certification form.
   • Upon receipt and processing of the Certification and Authorization form, the Board will provide the residency program with a Fingerprint Form, which is unique, for each applicant. The resident/applicant will need this form to schedule an immediate appointment for fingerprinting at a Morpho facility. He/she must also take the form to his/her appointment.
   • If applicable - Question #5 on the Certification and Authorization Form Please include a check or money order in the amount of $22.00 payable to the State of New Jersey for archived fingerprint re-submission.

NOTE: IT IS ESSENTIAL TO COMPLY WITH THE FINGERPRINTING PROCESS BY NO LATER THAN MID-JUNE TO ALLOW TIME FOR PROCESSING AND THUS ENSURE CLEARANCE BY END AUGUST DEADLINE FOR PERMIT ISSUANCE. OUT-OF-STATE RESIDENTS COMING TO NEW JERSEY WILL BE GIVEN ADDITIONAL TIME.

3. Waiver and Certification - Print your first name, middle initial and last name at the top of the form. Read, complete and sign the form in the presence of a Notary Public. Applications must be submitted to the N.J.B.M.E. within 6 months of notarization.

4. Complete and Accurate Curriculum Vitae
5. **Medical School Education** - In Lieu of the completed Medical Education Form, you may submit an official Medical School Transcript to your program coordinator. Keep track of the forms you mail, and follow-up with the school(s) to ensure the form is completed and mailed directly to the Hospital's Medical Education Department in a timely fashion. Applicants educated in India, Pakistan or Bangladesh, who submit their original official Marksheets must submit photocopies with the original transcripts. Copies must be standard, letter size paper. Double-sided pages will not be accepted. Failure to submit the copies in this fashion will result in the Board office maintaining the originals submitted. The Board will no longer return the original medical transcripts from all American/Caribbean Schools submitted with permit applications.

6. **Didactic Training Certification**
   (If applicable)

7. **ECFMG Certification** - Submit a copy of your ECFMG Certificate.
   (If applicable)

8. **Certification of Postgraduate Training** - Enter your full name at the top of the Certification of Postgraduate Training and give a copy of the form to each training program you list whether you received credit, no credit or partial credit. Direct the training program to mail the form directly to your Program Coordinator. Keep track of the forms you submit and follow-up with the facility(ies) to ensure the form is completed and returned in a timely fashion.

9. **VERIFICATION OF COMPLETION** - The verification of post-graduate training form is to be completed by your current program and returned to your program coordinator after June 1 when you are near the end of your current year of training. (This form is for out-of-state residents or residents who are currently training at another institution.)

10. **Name Change** - If your name as it appears on your medical school diploma is not the same as it appears on documentation submitted, include a copy of the legal document effecting this change, Print your current first name, middle initial and last name on the copy of the document.

11. **Employer Certification Form** - The Medical Education Director or Program Director must complete Employer Certification Form for each permit applicant.
State Board of Medical Examiners of New Jersey  
Residency Training Permit Application

This entire application must be typed or clearly printed.

Hospital ____________________________

Entering PGY Level _____ Starting Date ____________________________

Section One - DEMOGRAPHICS

1. Print Name:

First Middle Initial Last

2. List any other name which may appear on documents submitted as part of this application (See Instructions).

3. Contact Information:

<table>
<thead>
<tr>
<th>Street</th>
<th>City</th>
<th>State/Country</th>
<th>Zip/Postal Code</th>
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<th>Area Code</th>
<th>Telephone Number</th>
<th>Area Code</th>
<th>Cell Phone Number</th>
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<th>Work Telephone Number</th>
<th>Area Code</th>
<th>FAX Number</th>
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e-mail: ____________________________

4. Date of Birth: ____/____/____ Place of Birth ____________________________

Month Day Year City State/Country

5. Social Security Number: _______ _______ _______

I ______ consent ______ do not consent to the use of my Social Security number for any of the additional purposes set forth in the Instructions. I understand that my consent is voluntary and that if I do not consent, no adverse action or inference will be taken or drawn.

6. Have you previously applied for a New Jersey residency training permit?  Yes  No

If "Yes," specify and indicate the date submitted:

<table>
<thead>
<tr>
<th>Type</th>
<th>Month/Year</th>
<th>Type</th>
<th>Month/Year</th>
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7. Have you ever been licensed in any State? If Yes, list all state(s) in which you have or ever have had a medical license:

<table>
<thead>
<tr>
<th>STATE(S)</th>
<th>LICENSE NUMBER(S)</th>
<th>DATE(S) ISSUED</th>
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1/6  
Revised 2012
**Section Two - Education**

**Pre-Medical Education**

Did you take, pass and receive credit for a minimum of 60 (sixty) post-secondary, college level or equivalent credits prior to commencing medical school OR can you demonstrate that you have obtained the substantial equivalent? **Yes No**

Did you pass at least one college-level course in each of the subject areas listed below?

- **Biology**
  - Yes
  - No

- **Chemistry**
  - Yes
  - No

- **Physics**
  - Yes
  - No

*(If the answer to Pre-Medical Education is “No”, you must submit a copy of a pre-medical transcript and/or an explanation of courses taken in lieu of Biology, Chemistry and Physics.)*

List the name and location of every college or university attended where pre-professional, post-secondary instruction was received:

<table>
<thead>
<tr>
<th>Name</th>
<th>City/State/Country</th>
<th>Dates of Attendance (From - To)</th>
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<td><strong>/</strong>_ - <em><strong>/</strong></em></td>
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</tbody>
</table>

**Medical Education**

<table>
<thead>
<tr>
<th>Month</th>
<th>Year</th>
<th>Month</th>
<th>Year</th>
<th>Name of Medical School(s)</th>
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<tbody>
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<td>1st</td>
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Name of institution conferring degree: ____________________________________________

Date degree was awarded: ______________________________________________________

Type (circle one): **Medical Doctor**    **Doctor of Osteopathy**     **Doctor of Podiatry**
Section Two - Education (continued)

Clinical Clerkships

During your medical school training, did you complete clinical clerkships of at least four (4) weeks duration in the following core rotations or specialties?

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Yes</th>
<th>No</th>
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<tr>
<td>Medicine</td>
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<tr>
<td>OB/GYN</td>
<td>Yes</td>
<td>No</td>
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<td>Pediatrics</td>
<td>Yes</td>
<td>No</td>
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<td>Psychiatry</td>
<td>Yes</td>
<td>No</td>
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<td>Surgery</td>
<td>Yes</td>
<td>No</td>
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Did you achieve a passing score(s) on the ECFMG examination? Yes No

Are you certified by ECFMG? Yes No

Postgraduate Training

List below each training program (including Fifth Pathway Program, internship, residency and/or fellowship) in which you have participated.

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<tr>
<th>Dates (From - To)</th>
<th>Institution</th>
<th>Specialty</th>
<th>Credit/No Credit/Partial Credit</th>
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<td>PGY1</td>
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<td>Month Year</td>
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<td>PGY2</td>
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<td>Month Year</td>
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<td>PGY3</td>
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<td>PGY4</td>
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<td>Month Year</td>
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<td>Other</td>
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<td>Month Year</td>
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3/6 Revised 2012
Section Three - Character, Ethics and Medical Conditions

Information regarding moral character and ethical professional responsibility

a. Have you ever been arrested for, formally accused of, charged with, indicted for or convicted of the commission of any crime or offense, whether state, federal, or in other countries, including offenses categorized as misdemeanors, high misdemeanors or felonies? (NOTE: If you have been arrested or had a conviction for which you have been informed the record has been expunged, please verify that the expungement has in fact been implemented prior to answering “No” to this question.) (A dismissal is not an expungement.)  
   Yes  No

b. Have you ever been denied a license to practice medicine or eligibility to sit for a licensing exam in this State or in any other state or jurisdiction, foreign or domestic?  
   Yes  No

c. Has any action been taken or is any action now pending against your professional license or have you been permitted to surrender or otherwise relinquish your license to avoid inquiry, investigation or action by any other licensing authority or regulatory agencies?  
   Yes  No

d. Have you ever been denied eligibility to participate in a graduate medical education program in this State or any other state or jurisdiction, foreign or domestic?  
   Yes  No

e. Have you ever been denied privileges or had your privileges to practice terminated or limited?  
   Yes  No

f. Have you ever been terminated from or have you ever been asked to resign from your hospital staff membership, internship, residency position or fellowship?  
   Yes  No

g. Have you ever been permitted to resign while you were under review or investigation by a health care facility or, in return for not conducting an investigation?  
   Yes  No

h. Do you currently have a child-support obligation?  
   Yes  No

   If “Yes,” you must answer (a) and (b) below:

   (a) Are you in arrears in payment of said obligation?  
      Yes  No

   (b) Does the arrearage match or exceed the total amount payable for the past six months?  
      Yes  No

i. Have you failed to provide any court-ordered health insurance coverage during the past six months?  
   Yes  No

j. Have you failed to respond to a subpoena relating to either a paternity or child-support related arrest warrant?  
   Yes  No

k. Are you the subject of a child-support-related arrest warrant?  
   Yes  No

4/6  Revised 2012
Section Three - Character, Ethics and Medical Conditions (continued)

Medical Conditions/Chemical Substances

If you have a good-faith reason to believe that answering these questions may expose you to possible criminal prosecution, you may assert the Fifth Amendment privilege against self-incrimination. If you do so, your application will still be processed. However, you may later be directed by the Attorney General to answer these questions, provided that the Attorney General first grants you immunity afforded by statutory law pursuant to N.J.S.A. 45:1-20.

a. Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? Yes No

b. Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? (NOTE: If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition to determine whether an unrestricted license should be issued, whether conditions should be imposed or whether you are not eligible for licensure.) N/A Yes No

c. Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting or the manner in which you have chosen to practice? N/A Yes No

d. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism? Yes No

e. Are you currently engaged in the illegal use of controlled dangerous substances? Yes No

If "Yes," are you participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? Yes No

f. Does your use of chemical substance(s) in any way impair or limit your ability to practice medicine with reasonable skill and safety? N/A Yes No

If you answered "Yes" to any of the questions above, you must explain in detail on a separate sheet of paper the reason for your responses.
Waiver

I hereby authorize all hospitals, institutions, organizations, my references, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the New Jersey State Board of Medical Examiners any information, files or records requested by the Board. I further authorize the New Jersey State Board of Medical Examiners to release to any organizations, individuals and groups listed above, any information which is material to my application, relating to clinical, residency or postgraduate programs as well as hospital privileges or staff appointments.

I am the person referred to in the preceding application for a Residency Training Permit (Permit) to practice medicine and surgery in the State of New Jersey. I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my Permit to train in the practice of medicine and surgery in the State of New Jersey.

Certification

"I certify that the information entered on this form is true and complete to the best of my knowledge, and further acknowledge that if the above information is willfully false, I am subject to punishment and/or disciplinary sanction including Permit denial, suspension/revocation or the imposition of civil penalties as may be provided by law. I am also aware that as a condition of my Permit I am required to notify the State Board of Medical Examiners, in writing, within 21 days, of any subsequent changes to the information reported on my application."

_________________________________________
Signature of Applicant

_________________________________________
Name of Notary Public (please print)

_________________________________________
Signature of Notary Public

AFFIX
Seal
Here

Date Signed

This application, once complete, must be signed in the presence of a notary and submitted to your hospital’s Program Coordinator to be forwarded to the Board no later than March 1.
CERTIFICATION AND AUTHORIZATION FORM
FOR A CRIMINAL HISTORY BACKGROUND CHECK

Directions: Answer all of the questions on this form.

1. Name □ Mr.  □ Mrs.  □ Ms.  ___________________________ (___________)

2. Address ____________________________________________

   Street or P.O. Box  _____________  City  _____________  State  _____________  ZIP code

3. Date of birth ___/___/____  Sex: □ Male  □ Female

4. Social Security number _____________/___/____

5. Have you completed the fingerprinting process for any Board or Committee of the New Jersey Division of Consumer Affairs since November 2003? □ Yes  □ No

   If "No," you will receive a separate mailing from the Board or Committee regarding the criminal history background process. Please send no payment now.

   If "Yes," please provide the following information and follow the instructions outlined below:

   Board or committee requiring the fingerprinting  Month and year you were fingerprinted

   If you were fingerprinted after November 2003 as part of the criminal history background process for licensure or certification by any other any other Board or Committee of the New Jersey Division of Consumer Affairs (a background check conducted for the Department of Education, another state agency or another state does not apply) you will not be required to be fingerprinted a second time. However, the Division must perform a criminal history background check each time you apply for licensure or certification. The fee for this service is $22.00. Payment should be made in the form of a check or money order payable to the State of New Jersey and should accompany your application packet.

6. Have you ever been arrested and/or convicted of a crime or offense? (Minor traffic offenses such as a parking or speeding violations need not be listed.) □ Yes  □ No

   Every such conviction on record must be disclosed. A true copy of every police report, judgment of conviction, sentencing order and termination of probation order, if applicable, must be submitted with this form. Any documents (including employer or supervisor letters of reference, if applicable) which present clear and convincing evidence of rehabilitation must be submitted with this form. Failure to follow these instructions may result in the denial of an initial application.

   Note: Copies of judgments, sentencing and termination of probation orders may be obtained from the clerk of the county where those orders, disposing of the conviction, were issued and filed.

   Your continuing responsibility to disclose convictions of crimes or offenses: You must notify the Board or Committee within five (5) business days if you are convicted of any crimes or offenses after this form has been completed.
Didactic Training Certification

Pursuant to N.J.A.C. 13:35-1.5(c)(ii), I, ____________________________, (Name of Applicant)

certify that my didactic training (first two years of training) was completed
at ____________________________, in ____________________________, while I was
(Name of Medical School) (City and Country)
living at ____________________________, in the country (jurisdiction) where the
(Address, including country)
school is authorized to confer a medical degree.

I certify that the information entered on this form is true and complete to
the best of my knowledge, and further acknowledge that if the above
information is willfully false, I am subject to punishment and/or disciplinary
sanction including registration/permit denial, suspension/revocation or the
imposition of civil penalties as may be provided by law.

________________________________________
Signature of Applicant

______________________________
Date Signed
Medical Education Verification Form

Applicant’s name: ____________________________________________________________

Medical school: ____________________________________________________________

Medical school address: ______________________________________________________

Telephone number: __________________________________________________________

1. Did this physician attend the medical school noted above? Yes No

2. What are the applicant’s dates of enrollment? __________ to __________

3. Did this physician graduate from this medical school? Yes No If no explain:
                                                                                   
                                                                                   
4. What was the date of graduation? __________

5. Did this individual take a leave of absence during his/her attendance at this medical school? Yes No If “Yes,” what was the reason for the leave of absence?
                                                                                   
6. Was this individual on probation during his/her attendance at this medical school? Yes No

7. Was this individual ever disciplined or under investigation during his/her attendance at this school? Yes No

8. Were any negative reports filed by instructors regarding this individual? Yes No

9. Were any special requirements imposed on this individual that were not required of all other students at his/her level of education? Yes No

Please supply any additional comments or information that the Board should consider prior to determining this applicant's eligibility for licensure.
                                                                                   
                                                                                   
Print Name of Registrar: ______________________________________________________

Signature of Registrar: _______________________________________________________

Date: ________________

Please return to:
Director of Medical Education
Hospital:
Address:

Seal of Medical School
Certification of Postgraduate Training

Applicant's name: ______________________________________________

Hospital: ______________________________________________________

Hospital address: ______________________________________________

\[ Street \quad City \quad State/Country Zip/Postal Code \]

Hospital telephone number: ( ) ________________________________

1. In what type and level(s) of training did this physician participate at your facility?
   Check each level in which this physician participated. Provide starting and ending dates of training, type of training and whether credit was awarded.

<table>
<thead>
<tr>
<th>Dates (Month/Year)</th>
<th>Specialty</th>
<th>Credit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>None</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Partial</td>
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<td></td>
<td>Full</td>
</tr>
</tbody>
</table>

   - PGY 1
   - PGY 2
   - PGY 3
   - PGY 4
   - Fellowship
   - Other

2. Was the residency/fellowship accredited by A.C.G.M.E. or A.O.A. or C.P.M.E.? Yes No

3. Was the physician placed on probation, suspended or in any way sanctioned/disciplined or placed under investigation while at your facility? Yes No

4. Was the physician granted a leave of absence or break from his/her training? Yes No

5. Were any restrictions placed on this physician's activities that were not placed on all other residents/fellows at his/her level of training? Yes No

6. Were any formal patient or staff complaints filed against this physician? Yes No

7. Were any malpractice actions filed naming this physician as a defendant that involved his/her period of training at your facility? Yes No

If you answered "Yes" to any one of questions 3-7, please attach an explanation, and sign and date the attachment. Also, please attach any additional comments or information that the Board should consider prior to determining this applicant's eligibility for licensure.

Date form completed: ________________________________

Printed Name of Program Director: ________________________________

Signature of Program Director: ________________________________

Please return to:
Director of Medical Education
Hospital:
Address:

Hospital Seal

If the hospital does not have a seal, a letter attesting to this fact, on hospital stationery, must accompany this
NEW JERSEY STATE BOARD OF MEDICAL EXAMINERS
VERIFICATION OF POST-GRADUATE TRAINING COMPLETION
(FOR PERMIT)

NAME ____________________________________________ DATE _____________
(First) (M.I.) (Last)

HOSPITAL: ___________________________ PROGRAM _______________________
(Name of Hospital) (Specialty)

We hereby certify that ___________________________ has successfully completed
the post-graduate year that began on __/__/____ and ended on __/__/____.

In addition, we certify that (Check off the statement applicable to this resident):

_____ The post-graduate year was completed in good standing; the resident was
given full credit for the year and the program is completed.

_____ The resident completed the post-graduate training year in good standing and
will progress to the next level of training in this program.

_____ The resident completed the post-graduate year of training, was given credit for
the year, but will not continue in this program.

Reason: __________________________________________
__________________________________________________

If the resident has not completed the full year, has not been given credit for the full
year, or is not progressing to the next level of training, please provide a full
explanation.

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

HOSPITAL SEAL

Medical Program Director

Please Return to:
Director of Medical Education
Hospital:
Address:

Date

1/1