RUTGERS
New Jersey Medical School

Graduate Medical Education
Rutgers New Jersey Medical School
185 South Orange Avenue, MSB C 595
Newark, NJ 07107

njms.rutgers.edu/education/gme
kotharne@njms.rutgers.edu

p. 973-972-6049
f. 973-972-2229

2019 NJ STATE BOARD OF MEDICAL EXAMINERS 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 state 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, completed application and supporting documents to your program coordinator.

Thank you for your prompt attention,

Neil Kothari, MD
Associate Dean for Graduate Medical Education

GME OFFICE APPLICATION DEADLINE: 12/21/18
FINGERPRINTING DEADLINE: 06/01/2019

Applicant Name: _____

Training Program: _____

1. ____ $50 Application Fee (**Cashier's Check or Money Orders ONLY- NO PERSONAL CHECKS (MUST BE SIGNED AND HAVE NJ ADDRESS**)
2. ____ Permit Application (Application must be **notarized** & **all questions answered**) **(MUST HAVE NJ ADDRESS)**
3. ____ Curriculum Vitae (List ALL activities including periods of unemployment/time off, in month/year format i.e. **February, 2019 or 2/2019.)**
4. ____ Certification and Authorization FORM for Criminal History Background Checks **(MUST HAVE NJ ADDRESS)**
5. ____ Name Change Documentation (If applicable)
6. ____ Didactic Training Certification **(ONLY for International Medical School Graduates)**
7. ____ ECFMG Certification (If applicable)
8. ____ Medical Education Verification Form **(MUST HAVE ORIGINAL RAISED SEAL)**
9. ____ Medical School Diploma
10. ____ Official School Transcript (US/Caribbean Grads Only- see below for IMG's)
11. ____ Employer Certification Form
12. ____ Certification of Postgraduate Training (If applicable- for applicants with current or past residency/fellowship training) **(MUST HAVE ORIGINAL RAISED SEAL)**
13. ____ Verification of Postgraduate Training *(To be sent in separately on or after June 1, 2019)* **(MUST HAVE ORIGINAL RAISED SEAL)**

INTERNATIONAL GRADUATES (non-Caribbean):
IMG's are not required to provide original school transcripts. Instead, IMG's may provide notarized copies of the original, official documentation on standard, letter size (8x10) paper. The Notary Public must sign, date and affix his/her notary seal attesting that the documentation is a copy of the original document, along with the Notary's expiration date. Please do not double side copy or use legal size paper as these will not be accepted.
Please note that this ONLY applies to the International Graduates. Those that graduated from non-international schools and/or Caribbean schools, must still provide original transcripts from the medical school in a certified form with the school seal affixed.

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 permit 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: **State of New Jersey.** 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 Section1128E(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 notarized copies of the Mark Sheets 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. In lieu of the notarized copies of the Mark Sheets you may submit the completed Medical Education Verification Form.

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.

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 THE GME OFFICE AT THE HOSPITAL YOU WILL BE TRAINED.

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.
   - If applicable - Question #5 on the Certification and Authorization Form Please include a check or money order in the amount of $17.50 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 JUNE 1 TO ALLOW TIME FOR PROCESSING AND THUS ENSURE CLEARANCE BY JULY 1, 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 - the** curriculum vitae must be submitted in a **month/year format** from medical school to the present time.

5. Medical School Education - International Medical School Graduates from Asia, Africa, Central/South America and Europe – Submit notarized copies of the original, official Medical School Transcript to your program coordinator. In lieu of the notarized copies of the school transcripts you may submit the completed Medical Education Verification Form. 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.**

International Medical School Graduates, who submit notarized copies of their original official Documentation, the Notarized Copies must be on standard, letter size paper. Double-sided pages are not accepted and will be returned for re-submission.

Those that graduated from non-international schools and/or the Caribbean schools, must still provide original transcripts from the medical school in a certified form with the school seal affixed or the completed Medical Education Form.

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 legibly printed.

Hospital _____

Entering PGY Level_____ Starting Date _____ Specialty Program_____

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:

_____
Street City State/Country ZIP/Postal Code

(_____)_____ _____ (_____)_____
Area Code Telephone Number Area Code Cell Phone Number

(_____)_____ (_____)_____
Area Code Work Telephone Number Area Code FAX Number

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:

_____ _____
Type Month/Year Type Month/Year

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:

STATE(S) **LICENSE NUMBER(S)** **DATE(S) ISSUED**

_____

_____

Print Name_____
First M.I Last

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:

Name	City/State/Country	Dates of Attendance (From - To)
_____	_____	__/__ - __/__
_____	_____	__/__ - __/__
_____	_____	__/__ - __/__

Medical Education

	Month	Year		Month	Year	Name of Medical School(s)
1st year	_____	_____	to	_____	_____	_____
2nd year	_____	_____	to	_____	_____	_____
3rd year	_____	_____	to	_____	_____	_____
4th year	_____	_____	to	_____	_____	_____
5th year	_____	_____	to	_____	_____	_____
6th year	_____	_____	to	_____	_____	_____

Name of Institution conferring degree:_____

Date degree was awarded: _____

Type (circle one): **Medical Doctor** **Doctor of Osteopathy** **Doctor of Podiatry**

Print Name:_____
First M.I Last

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?

Medicine	Yes	No	OB/GYN	Yes	No
Pediatrics	Yes	No	Psychiatry	Yes	No
Surgery	Yes	No			

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.

Dates (From - To)	Institution	Specialty	Credit/No Credit/ Partial Credit
PGY1 ____/____ - ____/____ (Month Year Month Year)			
PGY2 ____/____ - ____/____ (Month Year Month Year)			
PGY3 ____/____ - ____/____ (Month Year Month Year)			
PGY4 ____/____ - ____/____ (Month Year Month Year)			
Fellowship ____/____ - ____/____ (Month Year Month Year)			
Other ____/____ - ____/____ (Month Year Month Year)			

Print Name_____
First M.I Last

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**

Print Name_____
First M.I Last

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.

Print Name_____
First M.I Last

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)

AFFIX Seal Here

_____
Signature of Notary Public

_____
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.**

EMPLOYER CERTIFICATION FORM

This form is to be completed by Director of Medical Education or Program Director

Applicant's Name _____

I hereby certify that I am the Director of Medical Education of:

_____
(Official Name of Hospital)

_____
(Official Address of Hospital)

which is a licensed hospital in this State and I am the individual who is responsible for the general selection,
training and evaluation of residents in this hospital. I certify that the physician named in this application is being appointed as a member of the resident staff of this hospital.

The appointment is to be for the level PGY _____ in the area of _____
(Type of Residency)

from _____, 20_____ through _____, 20_____

I further certify that this program is accredited by the ACGME, AOA or the CPME/APMA.

I certify that I have personally reviewed the application of this individual who has accepted an offer of employment to ascertain that the person has attained the prerequisites set forth in subsection © of N.J.A.C. 13:35-1.5 and I am unaware of any information which would contradict any of the representations contained in that application.

I understand it is my responsibility to report to the Board any conduct by this resident which might represent cause for the withdrawal of registration or suspension of this permit.

(Hospital Seal)

_____ _____
(Signature of Director) (Date Form was Completed)

_____ _____
(Print Name of Director) (Telephone Number)

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? _____ (Month/Year) to _____ (Month/Year)

3. Did this physician graduate from this medical school? **Yes No** If no explain:

_____

_____

4. What was the date of graduation? _____ (Month/Year)

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

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

Certification of Postgraduate Training

Applicant's name: _____

Hospital: _____

Hospital address: _____
Street City State/Country Zip/Postal Code

Hospital telephone number: ( ) _____
Area Code

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.

	Dates (Month/Year)	Specialty	Credit None	Credit Partial	Credit Full
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

_____
Date

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

Official Use Only
☐ Dual License
License Type 1
_____
Applicant's Number
_____
License Type 2
_____
Applicant's Number
_____

New Jersey Office of the Attorney General
Division of Consumer Affairs
State Board of Medical Examiners
P.O. Box 183
Trenton, New Jersey 08625
(609) 826-7100

Official Use Only
☐ Resubmit
Board or Committee
_____

Certification and Authorization Form For a Criminal History Background Check

Directions: Answer all of the questions on this form.

1. Name ☐ Mr. ☐ Mrs. ☐ Ms. _____ (_____)
   Last First Middle Maiden Name
2. Address _____
   Street or PO Box City State ZIP code
3. Date of birth __ __/__ __/__ __ Sex: ☐ Male ☐ Female
   Month Day Year
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 record background check process. No payment is necessary as of 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 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 $17.50. 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.