MAINE BOARD OF OSTEOPATHIC LICENSURE
142 SHS, 161 CAPITOL STREET
AUGUSTA, ME 04333-0142

LOCUM TENENS APPLICATION FOR OSTEOPATHIC PHYSICIANS - $200

Application must be accompanied by a Letter of Need by Facility where you'll be working, on their letterhead and including dates of need (maximum of 6 months)

**** *Please print neatly!* ****

1. Demographics

Full Name: _____ Gender:_____

Full Mailing Address: _____

Work Phone: _(____)_____ Home Phone: _(____)_____

Email Address:_____

Date of Birth:_____ Place of Birth: _____

Soc Sec #: _____ DEA #: _____ NPI #: _____

2. Affidavit

I hereby certify that the information supplied in this application is true and accurate and that the attached is a true photograph of me. I understand that any false answers may result in denial, suspension, or revocation of my license to practice osteopathic medicine in Maine.

Applicant: Sign your full name in the presence of a notary public who must complete the affidavit and affix their seal over the lower portion of your photograph

Signed: _____
Licensee

NOTARY PUBLIC

Subscribed and sworn before me this _____ day of _____, 20____

Notary Signature: _____

My Commission Expires: _____
Notary Seal cover lower part of photo →

Applicant Photograph

Securely tape or glue a recent (less than 6 months old) front-view 2x2" passport-type color photo of yourself in this square.

Notary Seal must cover lower part of photo

3. Licensing Information – Please list all states where you hold/held a license.

State License# Expiration date (or status):

_____

_____

_____

4. Medical Education

FULL Name & Location of the osteopathic medical school you attended:

_____ Date of Graduation: _____

5. Specialty Information

Your specialty: _____ Board Certified? YES NO

AOA Board Certified in your field? YES NO

Specialty Board Name: _____ Date Certified:_____

6. Professional Training & Experience

List in Chronological order all professional education and experience. Include all time periods from date of graduation from medical school to the present. Provide full addresses.
If you need more than one additional sheet, a CV or resume is preferred.

From	*To*	*Name of Institution*	*Address*	*Nature of Experience*

7. Personal Data – Please answer all questions by circling YES or NO. *If any are answered "yes" you must supply full details on a separate sheet of paper and attach it to the application.* If details are not provided, the application will not be processed.

Have you **ever** had any of the following occurrences?

a. Been arrested, charged, summonsed, arraigned (even if charges were later dismissed), indicted, or convicted of any criminal offense (including minor vehicle offenses BUT NOT including minor traffic/parking violations)? **YES NO** ***OUI is NOT considered a minor offense.***

b. Had a finding of sexual misconduct made against you (including in the state of Maine) regarding a patient or others (including sexual harassment)? **YES NO**

c. Had any licensing authority (including state of Maine) deny your application for any type of license or take any form of disciplinary action against the license issued to you in the jurisdiction, including but not limited to a warning, reprimand, fine, suspension, practice restrictions, probation (with or without monitoring) or revocation? **YES NO**

d. Left a medical licensing jurisdiction (including state of Maine) while a complaint or investigation/allegation was pending? **YES NO**

e. Been notified of the existence of allegations involving you, filed with or by ANY licensing authority (including the state of Maine) which allegations are open as of the date of THIS application? **YES NO**

f. Been denied registration or licensure or had your ability to prescribe or dispense controlled substances modified, restricted, suspended, voluntarily suspended or revoked by either: a) any state or territory (incl Maine) or b) the US Drug Enforcement Administration? **YES NO**

g. Been sanctioned by Medicare or by any state Medicaid program (including Maine)? **YES NO**

h. Suffered from any physical, psychiatric, or addictive disorder that would impair or require limitations on your ability to function as a physician or that resulted in the inability to practice medicine for more than 30 days? **YES NO**

i. Been denied hospital, HMO, or any other health care entity privileges? **YES NO**

j. Been charged, had your hospital, HMO, or other healthcare entity privileges suspended, restricted, limited in any way, withdrawn, or revoked them voluntarily? **YES NO**

k. Been deselected from a managed care organization physicians' panel? **YES NO**

l. Been disciplined by a professional society or resigned while accusations were pending (incl Maine)? **YES NO**

m. Had a claim or lawsuit which alleged malpractice liability in which you were/are named as a/the defendant? **YES NO**
This includes cases adjudicated by a court in favor of the other party, settled by your insurance co and/or representatives without your consent, including nuisance lawsuits.

n. Do you have a/any open and/or pending malpractice claim(s)? **YES NO**

o. Do you have plans to practice osteopathic medicine within Maine without obtaining medical staff privileges at a Maine hospital? **YES NO**

Any supplemental correspondence must be addressed to: Maine Board of Osteopathic Licensure

Release of Information

I hereby authorize all hospitals, medical institutions or organizations, my references, personal physicians, employers (past & present) business and professional associates (past & present) and all governmental agencies and instrumentalities to release to this licensing Board any information, files, or records required by the Board for its evaluation of my professional and ethical qualifications for licensure in the State of Maine.

Full Printed Name of Applicant: _____

Signature: _____ Date: _____

Applicant's e-mail address: _____
license will be sent to this address – no 3rd party address allowed

PLEASE NOTE: Locum Tenens applications must be accompanied by a Letter of Need from the facility where you'll be working, on their letterhead, indicating start & end dates (up to 6 months).

PLEASE SUBMIT COMPLETED APPLICATION WITH ORIGINAL SIGNATURES VIA USPS MAIL/FEDEX/UPS TO:
Board of Osteopathic Licensure
142 SHS, 161 Capitol St
Augusta, ME 04333-0142

Any questions? Please email us at osteo.pfr@maine.gov

Janet T. Mills
GOVERNOR

State of Maine
BOARD OF OSTEOPATHIC LICENSURE
142 STATE HOUSE STATION
161 CAPITOL STREET
AUGUSTA, ME 04333-0142
Tel: (207) 287-2480 / Fax: (207) 536-5811
http://www.maine.gov/osteo

Melissa Michaud, PA-C
BOARD CHAIR

Rachel MacArthur
EXECUTIVE SECRETARY

CREDIT CARD PAYMENT

PAYMENT AMOUNT: $ **200.00**

For: Locum Tenens Application

PRINTED Name: _____
As shown on Credit Card

Credit Card#: _____

Exp Date: _____ CVV/CVC: _____

Address: _____
If different than application info

Signature: _____

Payment Receipt and Certificate will be emailed to address on application.