MAINE BOARD OF OSTEOPATHIC LICENSURE
142 SHS, 161 CAPITOL STREET AUGUSTA, ME 04333-0142
OSTEO.PFR@MAINE.GOV

LOCUM TENENS APPLICATION FOR OSTEOPATHIC PHYSICIANS - $200

1. Full Name: ____ M F

   Address:____

   ____

   Work Phone: ________________________ Home Phone: ________________________

   Email Address:____

   Date of Birth: ________________________ Place of Birth: ________________________

   Soc Sec #: ________________________ DEA #: ________________________

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

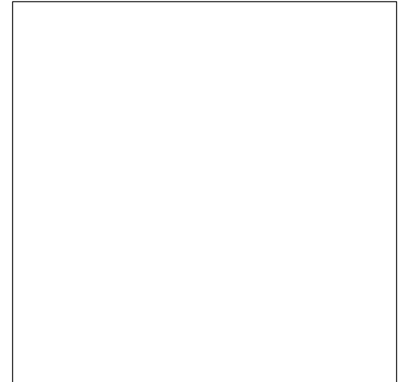
   Signed:____
   Licensee

   NOTARY PUBLIC

   Subscribed and sworn before me this __________day of ___________, 20_____

   Notary Signature:____

   My Commission Expires:____



3. Licensing Information – Please list all states where you have ever held a license. List state, license number, & expiration date (or status):

   ____

   ____

   ____

4. Medical Education – List the name and location of the osteopathic medical school you attended and the year of your graduation:

   ____

5. Specialty Information – Please list your specialty: ________________________________

   Are you board certified? Y N AOA Board Certified in your field? Y N

   Specialty Board Name: ____

   Date of Certification: ________________________

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). **OUI is NOT considered a minor offense.** — a **YES** **NO**

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

d. Left a medical licensing jurisdiction (including state of Maine) while a complaint or investigation/allegation was pending? — d **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? — e **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 (including Maine) or b) the US Drug Enforcement Administration? — f **YES** **NO**

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

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

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

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

m. Had a claim or lawsuit which alleged malpractice liability in which you were/are named as a/the defendant? 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. — m **YES** **NO**

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

o. Do you have plans to practice osteopathic medicine within the state of Maine without obtaining medical staff privileges at a Maine hospital? — o **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

COMPLETED ORIGINAL APPLICATION WITH ORIGINAL SIGNATURES
MUST BE SUBMITTED VIA US MAIL/FEDEX/UPS TO:
Board of Osteopathic Licensure
142 State House Station
161 Capitol Street
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[1]: $________________

For: ____

PRINTED Name: ____
As shown on Credit Card

Credit Card#: ____

Exp Date: ______________________ CW: _______________

Address:____
If different than what is on file

Signature:____

Where would you like the documentation sent?
If left blank, forms will go to the addresses we have on file.

Mailing Address: ____

Email Address: ____

Return completed form to:
Email: osteo.pfr@maine.gov
Or mail Board of Osteopathic Licensure
142 State House Station
Augusta, ME 04333-0142

[1]Fees:
Camp: $200
LocumTenens: $200
Temp DO Instructor: $200
Licensee Roster: $42
License Verification: $42
Duplicate Wall License: $25