Medical License Direct, LLC
4020 Collingswood Rd.
Pensacola, FL 32514

PHONE: 850-471-8648 ~ fax 904-339-9671
www.medicallicensedirect.com
admin@medicallicensedirect.com

Service Packet

Please type responses directly on form, print to sign service agreement and release, and email, fax or mail to us. You may substitute a current CV for portions of form. Thank you for your business.

First Name | Middle | Last Name | Suffix | MD or DO? | Social Security #

Home address | City | State | Zip | Home Telephone # | Cell Phone #

Work address | City | State | Zip | Work Telephone #

Preferred mailing address: ☐ Home ☐ Work Email address:

Marital Status | Maiden or Previous Name/s | Dates when previous name was used | Birth Date

Birth Place (city/state/country) | US Citizen? | or Citizenship Status? | Languages spoken/read other than English?

U.S. Military Experience: Branch | Dates of Service | Rank | Discharge Status | Discharge Date

Physical Characteristics: Height: _____ Weight: _____ Gender: _____ Eye Color: _____ Hair Color: _____

Race: _____ Physical Marks: _____ Location: _____

Education - List all undergraduate, graduate and medical education beginning with high school:

Institution Name and Complete Address	Program of Study	Dates: From / To Months and Years	Degree Awarded

Exact medical school graduation date: _____
(mm/dd/yy)

Foreign Medical Graduates: **ECFMG Certificate:** Number: _____ Issue Date: _____

Did you attend a fifth pathway program? ☐ Yes ☐ No
Did you complete clinical clerkships in a country other than where your medical school is located? ☐ Yes ☐ No

Medical Exam History – List all licensing exams you have ever taken including FLEX, USMLE, SPEX, NBME, NBOME, LMCC or State Board Medical Exam.

Exam	Part/Step	Date Taken	State	# of Attempts

Post Graduate Training – List all U.S. internships, residencies and fellowships in date order whether completed or not:

Institution Name and Complete Address	* Program Type/Department	Dates: From / To Months and Years	Certificate Earned?

***All above programs were ACGME approved.** ☐ **Yes** ☐ **No**

Federal DEA #_____ Date Issued: _____ Date Expires: _____ State Issued: _____

Do you have a Federation Credential Verification Service (FCVS) Profile established or in process? ☐ **Yes** ☐ **No**
If yes, Profile #_____

Medical Licenses - List all ever held regardless of current status:

State	Type (MD, DO, PA, RN, etc.)	License number	Issue Date	Exp. Date	Status

List ALL Practice, Employment, Group and Hospital Affiliation History: Please list all activities (except training) including employment, hospital affiliations, groups, locum tenens assignments, unemployment and leaves of absences since graduation from medical school. You may substitute your CV if it's current, has start and end months and years for all activities since graduation from medical school and there are no gaps in time.

Practice or Employment or Hospital Name and Complete Address:	Type of position or affiliation:	Dates: From / To Months and Years

Certification: Are you Board Certified? ☐ Yes ☐ No If not, are you intending to sit for boards? Specify date/s: _____

Specialty Board Name	Date Certified	Date/s Recertified	Certificate #

Peer References: List four (4) MD's who will attest in writing to your current clinical abilities, ethical character and ability to work cooperatively with others.

Name	Telephone #	Email Address

1. Have you **ever** been named in a malpractice claim? ☐ Yes ☐ No If yes, how many? _____

2. Can you provide copies of initial complaint(s) and/or the settlement/dismissal for each case? ☐ Yes ☐ No

3. Please list: **any** adverse actions or any unusual circumstances with a medical school, hospital, licensing board, etc. or if you've ever been charged with, or found guilty of a violation of any federal, state, or local statute:

_____

_____

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Service Agreement

Service includes Medical License Direct, LLC (MLD) administrating and preparing my medical license application/s and related documents. It does not include the fees charged by the state medical board/s for application and licensure, various other agencies that charge for third party verification, or shipping and handling fees. MLD will provide an itemized invoice showing third party verification fees along with my completed medical license application for review and signature. MLD will begin processing application/s upon receipt of this signed agreement and payment. I understand that this application does not entitle me to a state medical license and that MLD does not issue medical licenses nor provide legal advice concerning the medical licensure process. Also, medical licensing boards issue medical licenses; therefore MLD cannot guarantee time estimates. I agree that MLD and its representatives who provide this information to the state medical board/s in good faith shall not be liable for any act or omission on my part related to the evaluation or verification of the information contained in my application. I also understand that incomplete or inaccurate information, or delays on my part may cause processing delays and additional fees. I agree to not hold MLD liable for these types of delays. Files placed on hold, after a period of inactivity of at least 45 days on my part, may later be billed at the current hourly rate to reactivate file or redo any stale documents. Files may be closed after a period of 90 days of inactivity on my part, and I understand that additional fees will be required if I decide to start over. By signing this agreement I acknowledge that I have read and agree with these statements and company policies and services listed on http://www.medicallicensedirect.com/policies.html

The fee for this service is:

- $525 per state for MDs and DOs
- $475 per state for MDs and DOs for ten (10) or more states at one time

I wish to obtain the administrative licensing services of Medical License Direct, LLC (MLD) for the following state/s: _____.

Client Signature: _____ Date: _____

Print Name: _____

Please select a method of payment:

$_____Check or money order enclosed

OR

$_____Amt. to charge

Please check one:

_____ VISA®
_____ MasterCard®
_____ Discover®

Cardholder Name: _____
(Please print name as it appears on the card)

Account Number: _____

Card Expiration Date: _____

Billing address: _____

Billing City, ST, Zip: _____

_____ _____
Cardholder Signature Current Date

How did you find us? Referred by: _____ **Search engine used:** _____
Search term used: _____

Thank you.

RELEASE AND AUTHORIZATION

I, _____, hereby make this release and waiver of rights for the purpose of allowing Medical License Direct LLC and its agents to carry out its duties pursuant to my request for a license to practice medicine/osteopathy in mutually agreed upon states.

I authorize the following to release information about me in their possession to the medical licensing board and/or Medical License Direct LLC or their agents: all hospitals, medical institutions or organizations, personal references, employers, business and professional associates, specialty boards, medical licensure boards, university transcript offices, medical schools, malpractice insurance companies, attorneys who have participated in civil or criminal actions in which I was named party that pertain to or directly affect my ability to obtain or retain a state medical license and/or practice medicine to release to the state medical licensing board and/or Medical License Direct LLC or their agents any information, files or records required by that particular state medical licensing board for its evaluation of my professional, ethical and physical qualifications for medical licensure.

I hereby release the above-named individuals and entities from all liability for the release of information to the state medical licensing board or its agents.

A photocopy of this Release and Authorization shall be as effective as the original.

Applicant's Signature: _____Date: _____

Print Name: _____

SS#: _____Date of Birth: _____

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