FSM MEDICAL BOARD OF LICENSURE
APPLICATION FOR LICENSURE
LICENSING COMMITTEE FOR MEDICINE*
P.O.BOX PS - 70
PALIKIR, FEDERATED STATES OF MICRONESIA
Tel.: (691) 320-2619/9300
Fax: (691) 320-8460

NEW APPLICANT

PHOTO

Passport Type

Type of license: _____
Profession

Name: _____
(Last) (First) (Middle)

Mailing Address: _____

Local Residence: _____

Tel. No.: _____ Fax No.:_____ Email: _____

Date of birth: _____ Place of Birth: _____ Nationality: _____

Social Security No.:_____ Height: _____ Weight: _____

Notification in case of emergency:

Name of person to be contacted: _____ Relationship: _____

Address: _____ Telephone No._____

Educational Background:

Name and Address of School Dates Degree/Field of Study

High School: _____

College/University:

_____

_____

Medical School: _____

Other Training: _____

Internship/Residency/Board Certification:

Name and Address of Institution Dates Specialty

_____

Intended Place of Employment:

_____

EMPLOYMENT HISTORY: (last 5 years) attach resume if available

Name and Address of Employer Position Dates

_____

_____

_____

_____

Jurisdiction/Countries where currently licensed:

Jurisdiction/Country: _____Licensed since: _____ Expiration Date: _____

Jurisdiction/Country: _____Licensed since: _____ Expiration Date: _____

Jurisdiction/Country: _____Licensed since: _____ Expiration Date: _____

Letters of recommendation

Name and address of person giving recommendation Relationship to applicant Length of time known

_____

_____

Questions:

1. Has your license to practice in your chosen profession in any jurisdiction or country ever voluntarily or involuntarily been revoked, suspended or restricted? Yes: ____ No: _____

2. Have you ever been reprimanded or censured by any health professional association or licensing board regarding your health professional license? Yes: _____ No: _____

3. Have you ever been convicted of a felony? Yes: _____ No: _____

4. Have you ever personally use controlled substance (narcotics, amphetamines, and) or prescribe to anyone not for any non-medical use. Yes: _____ No: _____

If your answer to any of the foregoing questions was "Yes", please provide explanations and documentation:

_____

_____

I, the undersigned, state under penalty of perjury that the foregoing is true and correct to the best of my knowledge. I understand that any falsification may be subject to prosecution, up to and including the loss of licensure and employment and employment benefits:

Signature: _____ Date: _____

I, the authorized official undersigned for _____, state that the applicant is being hired or is currently employed by the above stated health institution. He or she is of current good moral standing at work and in the community.

Name: _____ Official Title: _____

Signature: _____ Date: _____

(Application will not be processed without the required signatures and the total fee payment)