Kentucky Board of Medical Licensure

Provisional License

Instructions

The following are requirements for the Provisional License application.

1. Complete all requirements identified in the pdf forms available at the end of your online application. Once you have paid for the license, the forms will be immediately available and can be printed.
2. In addition to the forms identified above, please complete the Provisional License addendum providing information from your state sponsor. An official letter on letterhead will be required to provide proof of employment.
3. You will be required to verify that you have practiced as a medical professional performing the duties of a physician in your licensing country for no less than five (5) years. Please contact the licensing authority in your state/country to request a verification of licensure be sent to the Kentucky Board of Medical Licensure.
4. The Postgraduate Training Verification will be required to provide proof that you completed a residency or substantially similar postgraduate medical training program.
5. Please submit all information to your licensing coordinator. The licensing coordinator's information is below. All coordinators can be reached via email or by phone.

Physicians with last name A-E: Dusty Hughes (502) 764-2610
dusty.hughes@ky.gov

Physicians with last name F-J: Rebecca Marcum (502) 764-2546
Rebecca.marcum@ky.gov

Physicians with last name K-O: Lillie "Diane" McFall (502) 764-2606
Lillie.mcfall@ky.gov

Physicians with last name P-Z: Cheryl Tabler (502) 764-2602
Cheryl.tabler@ky.gov

Kentucky Board of Medical Licensure

Provisional License Sponsor Application Addendum

Name: _____ Last Four SSN: _____

A Provisional License requires an offer for employment as a physician with a sponsor that is:

1. A professional practice, healthcare entity, or corporation that operates and is licensed or authorized to provide healthcare in the Commonwealth; and
2. Located in a *medical underserved area defined by the Secretary of the United States Department of Health and Human Services.

Provide the name and address of the sponsor for your license below.

In addition to providing the information below, your sponsor is required to submit a letter on official letterhead providing the acceptance of your employment as well as the starting date.

Sponsor Name: _____

Address: _____

City, State, Zip: _____

Phone: _____

*The following websites can be used to determine if the area is defined as underserved by the Secretary of the United States Department of Health and Human Services. The location **must** be identified on the websites.

Find a Medically Underserved Area and Medically Underserved Population Area

Find Shortage Area by Address

Kentucky Board of Medical Licensure
Postgraduate Training Verification

Complete Section 1 of this form then send to your training program; request your Program Director or designated official to complete Section 3 of this form and return this form and the Program Director's recommendation letter directly to the Board.

SECTION 1: APPLICANT INFORMATION

Applicant Full Name: _____
Last First Middle Suffix

Name if different when diploma awarded: _____

Social Security Number: _____ Date of Birth: _____

The applicant's social security number is to be used for purposes of identification and may not be used for any other reason.

Waiver for release of information: I authorize the Postgraduate Training Program below to provide any and all information pertaining to my medical education at your institution to the below listed Medical Board.

Applicant's Signature_____ Date _____

SECTION 2: PROGRAM DIRECTOR OR DESIGNATED OFFICIAL OF POSTGRADUATE TRAINING PROGRAM

Please complete Section 3 of this form and attach a recommendation letter from the Program Director and forward this information directly to this Board to the following address:

Kentucky Board of Medical Licensure
310 Whittington Pkwy, Ste 1B
Louisville, KY 40222

SECTION 3: POSTGRADUATE TRAINING VERIFICATION

Institution Name: _____

Institution Address: _____
Street City State ZIP Code

Affiliated Medical School Name: _____

Program Type/Specialty: _____ Postgraduate Year: _____

Please circle one: Internship Residency Fellowship Research Chief Resident Other

From Date: ____/____/____ To Date: ____/____/____

Successfully Completed? ☐ Yes ☐ No ☐ In Progress

(The definition of Successfully Completed is: In each year of training, did the applicant demonstrate sufficient academic and clinical ability to qualify for advancement without conditional or probationary status to the next year and next progressive level of responsibility in a designated specialty program?)

Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Kentucky Board of Medical Licensure
Postgraduate Training Verification

Did this individual ever take a leave of absence or break from his/her training? ☐ Yes ☐ No

Was this individual ever placed on probation? ☐ Yes ☐ No

Was this individual ever disciplined or placed under investigation? ☐ Yes ☐ No

Were any negative reports ever filed by instructors? ☐ Yes ☐ No

Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? ☐ Yes ☐ No

Please explain any "Yes" response from above (attach additional pages if necessary): _____

_____

_____

_____

_____

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_____

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_____

_____

I certify that to the best of my knowledge and belief the foregoing is a true, accurate and complete statement of the record of the individual named on this form.

Signature: _____

Print name: _____

Title: _____

AFFIX INSTITUTIONAL SEAL HERE

Date: _____

(If no seal is available, this form must be notarized)

Phone number: _____

Fax: _____

E-mail: _____