Check Number: _____

Amount: _____

PAYMENT FORM

You may pay the fee by check or credit card. Please complete this form in its entirety if you are paying by credit card.

Please include the following with your request.

_____

First Name, Middle Initial and Last Name

_____

(City, State & Zip)

Credit Card Information:

Please circle type of card:

Visa
Mastercard
Discover
American Express

Payment Information – Circle type of card: Visa, MasterCard, Discover, American Express

Credit Card Number:

Expiration Date (MM-YY):

Security Code

Credit Card Holder Name: _____

Billing Address: _____

Billing City, State, Zip: _____

KY License Number: _____

Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222

2025 Renewal of Training License -- Registration Fee: $65.00

I, _____, hereby make application for renewal of my Training License to practice medicine within the parameters specified by my Program Director at the _____through June 30, 2026.

Email address: _____

*****If you answer "Yes" to questions 1 – 13 please attach a written explanation.*****

1) Since you last registered have you had any license, certificate, registration or other privilege to practice as a health care professional denied, revoked, suspended, probated, restricted, reprimanded, limited, or subjected to any other disciplinary action, by a state medical/osteopathic licensing board, or Federal, or International authority with the exception of the Kentucky Medical Board?
☐Yes ☐No
2) Since you last registered have you surrendered such credential, or placed it into an inactive status, to avoid disciplinary action or in connection with or in anticipation of a disciplinary investigation/action by the licensing authority of such jurisdiction with the exception of the Kentucky Medical Board?
☐Yes ☐No
3) Since you last registered have you been or are you currently under investigation by any State medical/osteopathic licensing board, Federal or International licensure authority or any drug licensure/enforcement authority with the exception of the Kentucky Medical Board?
☐Yes ☐No
4) Since you last registered has the Drug Enforcement Administration (DEA), or any state or International drug licensure/enforcement authority denied, revoked, suspended, restricted, limited, or otherwise disciplined a controlled substance registration certificate issued to you?
☐Yes ☐No
5) Since you last registered have you voluntarily or involuntarily surrendered a medical or osteopathic license with the exception of your Kentucky license, or controlled substance registration certificate issued to you?
☐Yes ☐No
6) Since you last registered has any hospital or hospital medical staff removed, suspended, restricted, limited, probated, reprimanded, or failed to renew your privileges for cause, or taken any other disciplinary action against your privileges?
☐Yes ☐No
7) Since you last registered have you resigned your privileges at any hospital under pressure or investigation or while you were subject of disciplinary proceedings?
☐Yes ☐No
8) Since you last registered are any legal proceedings regarding licensure presently pending against you by any State, Federal or International licensure authority or any drug licensure/enforcement authority with the exception of the Kentucky Medical Board?
☐Yes ☐No
9) Since you last registered have you been removed, suspended, expelled or disciplined by any professional medical association or society?
☐Yes ☐No
10) Since you last registered have you entered a guilty plea, nolo contendere plea or Alford plea, or been convicted, of any felony offense or any misdemeanor offense, or alcohol related offense in any court?
☐Yes ☐No
11) Since you last registered have you had to pay a judgment or settlement greater than $250,000 in a malpractice action or other civil action against your medical practice?
☐Yes ☐No
12) Since you last registered to your knowledge, are you the subject of any criminal investigation or are any criminal charges pending against you?
☐Yes ☐No

I hereby state that the information contained in this application is true, accurate and complete to the best of my knowledge and belief. I understand any false information on my application may subject my license to disciplinary action pursuant to KRS 311.595.

Signature:_____Date:_____

*****Incomplete Applications Or Applications Received Without Payment Will Be Returned.*****

Name:_____ **License Number:** _____

The answer to this question is exempt from public disclosure under KRS 61.878(1)(a) and KRS 311.619 and shall be subject to inspection only upon order of a court of competent jurisdiction, except that no court shall authorize the inspection by any party of any materials pertaining to civil litigation beyond that which is provided by the Kentucky Rules of Civil Procedure governing pretrial discovery. The answer to this question may be considered by the Board and may be disclosed in any contested case proceeding, including a Show Cause proceeding, or appeal of a licensing decision based upon them.

*** * * If You Answer "Yes" To Questions 1, Please Attach A Written Explanation. * * ***

1. Do you currently have any condition that is not being appropriately treated which is likely to impair or adversely affect your ability to practice medicine with reasonable skill and safety in a competent, ethical and professional manner?
   ☐Yes ☐No

I hereby state that the information contained in this application is true, accurate and complete to the best of my knowledge and belief. I understand any false information on my application may subject my license to disciplinary action pursuant to KRS 311.595.

Signature:_____ Date:_____

*****Incomplete Applications Or Applications Received Without Payment Will Be Returned.*****