Residency Form – Changing IP to R License

This form is to be completed when a resident holding an Institutional Practice Limited License would like to submit a request to the Board to change their IP to a R License (Residency Training License).

Requirements for the change from an IP License to a R License are as follows:

- Residency Form
- $75.00 Non-Refundable fee
- Step 3 transcript (Must be an official transcript & must be sent to KBML directly)
- Category I
- Category II

All must be completed by the deadline date in order to be presented to the following board meeting. See the Board Dates and Deadlines pdf document provided on our website: http://www.kbml.ky.gov/physician/applications.htm

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This portion of the form must be completed by your Program Director

I hereby confirm that ____ is in good standing in
(Applicant's Name)

his/her residency training program at ____.
(Residency Program and department)

I recommend the Board issue a Residency Training License for the above applicant to practice medicine in this institution and/or settings approved by this residency training program.

____

(Printed Name of Program Director) (Telephone Number)

____

(Program Director Signature) (Date)

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KBML Use Only:

___ $75.00 Fee
___ Step 3 Transcripts
___ Program Director Signature and Date
___ Category I
___ Category II

Applicant Name: ____ IP License Number: _____________

Category I

Please answer all questions on this application. Category I will help the Board determine if you meet the essential eligibility requirements for licensure by virtue of your background, education, training and experience. If you are qualified to practice under Category I, Category II will be reviewed to help the Board determine if you are qualified to practice safely and competently, with or without reasonable modification. If you answer “Yes” to any of the questions, you must attach a complete written explanation of the event(s) or condition(s), including dates, names, addresses, circumstances, and results along with your returned application.

NOTE: Intentional false answers or misrepresentation in applying for or procuring a license, registration or reactivation in Kentucky are grounds for disciplinary action, including denial or revocation of license, and are reported to the National Practitioner Data Bank and/or appropriate national professional credentialing organization. You must answer “yes” to any question if the event(s) described in that question has actually occurred. You must answer “yes” in such circumstance even if you have been advised by an attorney or other person that you may answer “no”. You must also answer “yes” in such circumstance even if the record of the event has been sealed or expunged by Court order, or has been designated “confidential” by the body involved. After answering “yes” to the appropriate question(s), you may advise the Board of any additional relevant information pertaining to your answer (i.e., record has been sealed or expunged, record is designated “confidential,” attorney has advised that you properly answer “no”). The Board will consider this additional information, along with your answer(s), in determining the appropriate action. If you have any question about whether or not you should answer “yes” to a question, you should err in favor of answering “yes” and providing an explanation, because any non-disclosure violation will likely result in denial of your application or disciplinary action against your license. This application may not be altered in any way.

1. Have you ever been dismissed from, resigned while under investigation, failed to complete an academic year, taken a leave of absence, or been placed on probation or reprimanded at a medical school or a postgraduate training program?
   ☐Yes ☐No

2. Are you currently in default on any student loan repayment obligations payable to the financial aid programs administered by the Kentucky Higher Education Assistance Authority?
   ☐Yes ☐No

3. Have you ever been denied a license or denied the privilege of taking a licensure examination by any State, Federal or International licensure jurisdiction?
   ☐Yes ☐No

4. Have you ever had any license, certificate, registration or other privilege as a health care professional denied, revoked, suspended, probated, restricted or limited, or subjected to any other disciplinary action, by a State medical/osteopathic licensing board, or Federal, or International authority?
   ☐Yes ☐No

5. Have you ever been disciplined by any licensed hospital (including postgraduate training) or the medical staff of any licensed hospital, including removal, suspension, probation, limitation of hospital privileges or any other disciplinary action if the action was based upon what the hospital or medical staff found to be unprofessional conduct, professional incompetence, malpractice or a violation of a provision(s) of a Medical Practice Act?
   ☐Yes ☐No

6. 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?
   ☐Yes ☐No

7. Have you ever resigned your privileges or failed to renew privileges at a licensed hospital or from the medical staff of the hospital, while under investigation or while you were subject to disciplinary proceedings by the hospital?
   ☐Yes ☐No

8. Have you ever been removed, suspended, expelled or disciplined by any professional medical facility, association or society?
   ☐Yes ☐No

Applicant Name: ____ IP License Number: ____________

9. Have you ever voluntarily or involuntarily surrendered a medical or osteopathic license, or controlled substance registration certificate issued to you?
☐Yes ☐No

10. Have you ever been or are you currently under investigation by any State, Federal or International licensure authority or any drug licensure/enforcement authority?
☐Yes ☐No

11. Are any legal proceedings regarding licensure presently pending against you by any State, Federal or International licensure authority or any drug licensure/enforcement authority?
☐Yes ☐No

12. Have you ever been convicted of a felony or misdemeanor by any State, Federal or International court?
☐Yes ☐No

13. Are any criminal charges presently pending against you in any of those courts?
☐Yes ☐No

14. To your knowledge, are you the subject of an investigation for a criminal act?
☐Yes ☐No

15. In the past ten (10) years have you had to pay a settlement or judgment in a malpractice action or other civil action against your medical practice, or are there any malpractice or other civil actions against your medical practice presently pending in any court?
☐Yes ☐No

16. Have you ever applied for or been issued a Kentucky medical license? ☐Yes ☐No If yes, # __________

17. Are you currently certified by an American Specialty Board? ☐Yes ☐No

If yes, by what Board?________________________

18. List the Specialty that you will be practicing in KY and specify type of practice (Check only one type of practice):

Specialty: ________________________

☐Hospital Base	☐Occupational Medicine	☐Instructor	☐Military
☐Admin. Medicine	☐Research	☐Resident/Fellow	☐Emergency Medicine
☐Private Practice	☐Inactive/Semi-Retired	☐Locum Tenens	☐Teleradiology

I hereby state that the information contained in this application has not been altered in any way and is true, accurate, and complete to the best of my knowledge and belief. I understand that under Kentucky law the submission of any false, fraudulent or forged statement, document or other matter in connection with this application is grounds for criminal prosecution and the denial of licensure. I authorize the Board (KBML) or its agents to obtain from other sources any information necessary for determining my qualifications for licensure. I also authorize them to furnish any information they may now or in the future have concerning my qualifications and fitness to practice medicine/osteopathy to any person, institution, association, school, hospital or government entity.

____
(Signature of Applicant signed in presence of Notary) **(Date)**

____
(Print Name)

Subscribed and sworn to before me by the above named applicant on this ___day of ________________
(Month, Year)

Seal of Notary

____
(Signature of Notary)

My commission expires: ______________________________

"Only the applicant and person authorized by applicant may call regarding the credentialing of your application or be given information during the credentialing process."

Specify name of authorized person: ____

Applicant Name: ____ IP License Number: ____________

Category II

The answers to these questions are exempt from public disclosure under KRS 61.878(1)(a) and (I) 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 answers to these questions may be considered by the Board (KBML) and may be disclosed in any contested case proceeding, including a Show Cause proceeding, or appeal of a licensing decision based upon them. "Illegal drug use" means the use of an illegally obtained controlled substance or dangerous drug; the term "illegal drug use" also means the use of a legally obtained controlled substance or dangerous drug which is not taken in accordance with the direction of the licensed health care professional who prescribed the controlled substance or dangerous drug.

1. Do you currently, or have you had within the past 5 years, any physical, mental, or emotional condition which impaired, or might reasonably impair your ability to practice your health care profession safely and competently?
   ☐Yes ☐No
2. Within the past 5 years, have you been admitted to any hospital or other in-patient care facility for any physical, mental or emotional condition, which impaired, or might reasonably be considered to impair, your ability to practice your health care profession safely and competently?
   ☐Yes ☐No
3. Do you currently have, or have you had within the past 5 years, a dependency on or abuse of the use of alcohol or drugs, which impaired, or might reasonably impair, your ability to practice your health care profession safely and competently?
   ☐Yes ☐No
4. Within the past 5 years, have you engaged in the excessive use of alcohol or illegal drugs, or received any in-patient or outpatient or individual therapy/treatment or been hospitalized for alcoholism, or illegal use, or been arrested for a DUI (Driving Under The Influence)?
   ☐Yes ☐No
5. Within the past 5 years, have you been the subject of any chemical substance screening test which resulted in an indication of the presence in your body of any controlled substance, any dangerous drug, or alcohol level above .10% BAC? (This does not include those drugs taken by you as a result of a legitimate health care diagnosis, and prescribed for you in good faith by another licensed health care professional.)
   ☐Yes ☐No

I hereby state that the information contained in this application has not been altered in any way and is true, accurate, and complete to the best of my knowledge and belief. I understand that under Kentucky law the submission of any false, fraudulent or forged statement, document or other matter in connection with this application is grounds for criminal prosecution and the denial of licensure. I authorize the Board (KBML) or its agents to obtain from other sources any information necessary for determining my qualifications for licensure. I also authorize them to furnish any information they may now or in the future have concerning my qualifications and fitness to practice medicine/osteopathy to any person, institution, association, school, hospital or government entity.

____

(Signature of Applicant signed in presence of Notary) **(Date)**

____

(Print Name)

Subscribed and sworn to before me by the above named applicant on this ____day of __________________
(Month, Year)

____

(Signature of Notary)

Seal of Notary

My commission expires:____