



# State of Utah

## DIVISION OF OCCUPATIONAL & PROFESSIONAL LICENSING

160 East 300 South, P.O. Box 146741  
Salt Lake City, Utah 84114-6741  
Telephone (801) 530-6628  
[www.dopl.utah.gov](http://www.dopl.utah.gov)

- License(s) Applying For:
- PHYSICIAN AND SURGEON** (\$200.00 Non Refundable Application Fee)
  - OSTEOPATHIC PHYSICIAN AND SURGEON** (\$200.00 Non Refundable Application Fee)
  - TEMPORARY LICENSE** (\$50.00 Non Refundable Application Fee)
  - CONTROLLED SUBSTANCE** (\$100.00 Non Refundable Application Fee)
  - CONTROLLED SUBSTANCE TEMPORARY** (\$50.00 Non Refundable Application Fee)

**NOTE:** You cannot apply for a temporary license separately.

(Note: Microsoft Word users can fill in the blanks, print the form and save it for their records)

<b>***Please list your full legal name as it appears on your driver's license, Social Security Card, etc.***</b>				
Last Name:		First Name:		Middle Name:
Social Security Number:    -    -			Maiden Name:	
I certify under penalty of perjury that:				
<input type="checkbox"/> I am a citizen of the United States and I have a valid US Driver License or US State ID. License/State ID Number: _____ State: __				
<input type="checkbox"/> I am a citizen of the United States currently living outside the United States and do not have a valid US Drivers License or US State ID. Please attach a legible copy of your valid passport or other documentation to verify you are a legal citizen of the United States.				
<input type="checkbox"/> I am a non-citizen of the United States, who is lawfully present in the United States and I have a valid US Drivers License or US State ID. License/State ID Number: _____ State: __				
<input type="checkbox"/> I am a non-citizen of the United States, who is lawfully present in the United States and I do not have a valid US Drivers License or US State ID. Please attach a legible copy of your current and valid government issued document showing evidence of authorization to work in the United States.				
<input type="checkbox"/> I am a foreign national not physically present in the United States.				
Mailing Address:				
City:			State:	ZIP:
<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:	Phone #:	E-Mail:	
List all other licenses, registrations, or certifications issued by any state which you now hold or have ever held in any profession. (Use additional sheets if necessary.)				
Profession:		Issuing State:		
License Number:		License Status:	Issue Date:	
Profession:		Issuing State:		
License Number:		License Status:	Issue Date:	
Profession:		Issuing State:		
License Number:		License Status:	Issue Date:	
Profession:		Issuing State:		
License Number:		License Status:	Issue Date:	
Profession:		Issuing State:		
License Number:		License Status:	Issue Date:	

**DO NOT WRITE IN THIS SECTION - FOR DIVISION USE ONLY**

License/Certificate Number: \_\_\_\_\_

Date License/Certificate Approved/Denied: \_\_\_/\_\_\_/\_\_\_ by \_\_\_\_\_

Reason for Denial/Other Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Bureau Manager Review: QQ Yes answers or Education or Exam     Approve     Deny

**AFFIDAVIT and RELEASE AUTHORIZATION FOR APPLICANT**

1. I certify under penalty of perjury that I am a United States citizen, a qualified alien as defined in 8 U.S.C. Sec. 1641, or I am lawfully present in the United States.
2. I certify that am qualified in all respects for the license for which I am applying in this application.
3. I certify that to the best of my knowledge, the information contained in the application and its supporting document(s) is free of fraud, forgery, misrepresentation, omission of material fact; is truthful, correct, and complete; discloses all material facts regarding the applicant; and that I will update or correct the application as necessary, prior to any action on my application.
4. I authorize all persons, institutions, organization, schools, governmental agencies, employers, references, or any others not specifically included in the preceding characterization, which are set forth directly or by reference in this application, to release to the Division of Occupational and Professional Licensing, State of Utah, any files, records, or information of any type reasonably required for the Division of Occupational and Professional Licensing to properly evaluate my qualifications for licensure/certification/registration by the State of Utah.
5. I understand that it is the continuing responsibility of applicants and licensees to read, understand, and apply the requirements contained in all statutes and rules pertaining to the occupation or profession for which you are applying, and that failure to do so may result in civil, administrative, or criminal sanctions.
6. I understand that as holder of a Utah Controlled Substance licensee that I must comply with Utah Code Annotated §58-37f-401(3). This statute requires me to register with the Controlled Substance Database in order to hold a Utah Controlled Substance License.

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**UTAH CONTROLLED SUBSTANCES  
LAW AND RULES EXAMINATION**

This examination is not intended to be difficult. The purpose of the exam is to bring to your attention specific practice issues you need to know in order to avoid violating Utah statute as well as Utah law and rule. If you are uncertain about any of the questions listed below, please refer to the references listed in order to become familiar with Utah's controlled substance prescribing practices.

Utah Controlled Substances Act, 58-37 <http://dopl.utah.gov/laws/58-37.pdf>

Utah Controlled Substances Act Rule, R156-37 <http://dopl.utah.gov/laws/R156-37.pdf>

Answer "True" or "False" for each statement. Submit this completed examination with your application for licensure.


<input type="checkbox"/> True <input type="checkbox"/> False	1. A prescription for a schedule II controlled substance may be filled in a quantity not to exceed a 30 day supply.
<input type="checkbox"/> True <input type="checkbox"/> False	2. A prescription for a schedule III or IV controlled substance may be refilled 5 times within a six month period from the issue date of the prescription.
<input type="checkbox"/> True <input type="checkbox"/> False	3. All prescription orders must be signed in ink or indelible pencil to prevent anyone from altering a legitimate prescription.
<input type="checkbox"/> True <input type="checkbox"/> False	4. Licensed prescribing practitioners must make their controlled substance stock and records available to DOPL personnel for inspection during regular business hours.
<input type="checkbox"/> True <input type="checkbox"/> False	5. All records of purchasing, prescribing, and administering controlled substances must be maintained by the licensed prescribing practitioner for at least five years.
<input type="checkbox"/> True <input type="checkbox"/> False	6. The name, address, and DEA registration number of the prescribing practitioner, and the name, address and age of the patient are required to be included on the prescription for a controlled substance.
<input type="checkbox"/> True <input type="checkbox"/> False	7. A controlled substance is taken according to the prescriber's instructions. A refill may be dispensed after 80% of the medication has been consumed.
<input type="checkbox"/> True <input type="checkbox"/> False	8. After the discovery of any theft or loss of a controlled substance, the prescribing practitioner is required to file the appropriate forms with the DEA, report the incidence to the local police, and send copies of the filed DEA forms to DOPL.
<input type="checkbox"/> True <input type="checkbox"/> False	9. The maximum number of controlled substances that can be written on a single prescription form is one.
<input type="checkbox"/> True <input type="checkbox"/> False	10. An emergency verbal prescription order for a schedule II controlled substance requires that the patient be under the continuing care of the prescribing practitioner for a chronic disease, the amount of drug prescribed is limited to what is needed to adequately treat the patient for no more than 72 hours, and a written prescription shall be delivered to the filling pharmacy within 7 working days of the verbal order.
<input type="checkbox"/> True <input type="checkbox"/> False	11. Issuing a prescription for a schedule II or III controlled substance for yourself is considered unprofessional conduct and may result in disciplinary action.
<input type="checkbox"/> True <input type="checkbox"/> False	12. A prescribing practitioner is using a schedule IV controlled substance in the treatment of weight reduction for obesity. The practitioner has completed a medical history of the patient, has performed a complete physical examination, has ruled out contra-indications, and has determined that the health benefits of treatment greatly out-weigh the risks. An informed consent signed by the patient is also required prior to initiating treatment.
<input type="checkbox"/> True <input type="checkbox"/> False	13. The Division will immediately suspend the Utah controlled substance license if the DEA registration is denied, revoked, surrendered, or suspended.
<input type="checkbox"/> True <input type="checkbox"/> False	14. The Division may: refuse to issue a license, refuse to renew a license, or revoke, suspend, restrict, or place on probation the license of an individual who does not register with the controlled substance database and take the controlled substance tutorial and examination.

## QUALIFYING QUESTIONNAIRE

**Read thoroughly, and answer the questions. Do not leave any question blank.**

(Note: If you have formally expunged a criminal record you do not need to disclose that criminal history.)

<input type="checkbox"/> Yes <input type="checkbox"/> No	1. Have you ever applied for or received a license, certificate, permit, or registration to practice in a regulated profession under any name other than the name listed on this application?
<input type="checkbox"/> Yes <input type="checkbox"/> No	2. Have you ever been denied the right to sit for a licensure examination?
<input type="checkbox"/> Yes <input type="checkbox"/> No	3. Have you ever had a license, certificate, permit, or registration to practice a regulated profession denied, conditioned, curtailed, limited, restricted, suspended, revoked, reprimanded, or disciplined in any way?
<input type="checkbox"/> Yes <input type="checkbox"/> No	4. Have you ever been permitted to resign or surrender your license, certificate, permit, or registration to practice in a regulated profession while under investigation or while action was pending against you by any health care profession licensing agency, hospital or other health care facility, or criminal or administrative jurisdiction?
<input type="checkbox"/> Yes <input type="checkbox"/> No	5. Are you currently under investigation or is any disciplinary action pending against you now by any licensing agency?
<input type="checkbox"/> Yes <input type="checkbox"/> No	6. Have you ever had hospital or other health care facility privileges denied, conditioned, curtailed, limited, restricted, suspended, or revoked in any way?
<input type="checkbox"/> Yes <input type="checkbox"/> No	7. Have you ever been permitted to resign or surrender hospital or other health care facility privileges, while under investigation or while action was pending against you by any licensing agency, hospital or other health care facility, or criminal or administrative jurisdiction?
<input type="checkbox"/> Yes <input type="checkbox"/> No	8. Is any action related to your conduct or patient care pending against you now at any hospital or health care facility?
<input type="checkbox"/> Yes <input type="checkbox"/> No	9. Have you ever had rights to participate in Medicaid, Medicare, or any other state or federal health care payment reimbursement program denied, conditioned, curtailed, limited, restricted, suspended, or revoked in any way?
<input type="checkbox"/> Yes <input type="checkbox"/> No	10. Have you ever been permitted to resign from Medicaid, Medicare, or any other state or federal health care payment reimbursement program while under investigation or while action was pending against you by any licensing agency, hospital, or other health care facility, or criminal or administrative jurisdiction?
<input type="checkbox"/> Yes <input type="checkbox"/> No	11. Is any action pending against you now by Medicaid, Medicare, or any other state or federal health care payment reimbursement program?
<input type="checkbox"/> Yes <input type="checkbox"/> No	12. Have you ever had a federal or state registration to sell, possess, prescribe, dispense, or administer controlled substances denied, conditioned, curtailed, limited, restricted, suspended or revoked in any way by either the federal Drug Enforcement Administration or any state drug enforcement agency?
<input type="checkbox"/> Yes <input type="checkbox"/> No	13. Have you ever been permitted to surrender your registration to sell, possess, prescribe, dispense, or administer controlled substances while under investigation or while action was pending against you by any health care profession licensing agency, hospital or other health care facility, or criminal or administrative jurisdiction?
<input type="checkbox"/> Yes <input type="checkbox"/> No	14. Is any action pending against you now by either the Federal Drug Enforcement Administration or any state drug enforcement agency?
<input type="checkbox"/> Yes <input type="checkbox"/> No	15. Have you been named as a defendant in a malpractice suit?
<input type="checkbox"/> Yes <input type="checkbox"/> No	16. Have you ever had office monitoring, practice curtailments, individual surcharge assessments based upon specific claims history, or other limitations, restrictions or conditions imposed by any malpractice carrier?
<input type="checkbox"/> Yes <input type="checkbox"/> No	17. Have you ever had any malpractice insurance coverage denied, conditioned, curtailed, limited, suspended, or revoked in any way?
<input type="checkbox"/> Yes <input type="checkbox"/> No	18. If you are licensed in the occupation/profession for which you are applying, would you pose a direct threat to yourself, to your patients or clients, or to the public health, safety, or welfare because of any circumstance or condition?
<input type="checkbox"/> Yes <input type="checkbox"/> No	19. Have you ever been declared by any court of competent jurisdiction incompetent by reason of mental defect or disease and not restored?
<input type="checkbox"/> Yes <input type="checkbox"/> No	20. Have you been terminated, suspended, reprimanded, sanctioned, or asked to leave voluntarily from a position because of drug use or abuse within the past five (5) years?
<input type="checkbox"/> Yes <input type="checkbox"/> No	21. Have you ever had a documented case in which you were involved as the abuser in any incident of verbal, physical, mental, or sexual abuse?
<input type="checkbox"/> Yes <input type="checkbox"/> No	22. Are you currently using or have you recently ( <i>within 90 days</i> ) used any drugs ( <i>including recreational drugs</i> ) without a valid prescription, the possession or distribution of which is unlawful under the Utah Controlled Substances Act or other applicable state or federal law?
<input type="checkbox"/> Yes <input type="checkbox"/> No	23. Do you currently have any criminal action pending?
<input type="checkbox"/> Yes <input type="checkbox"/> No	24. Have you pled guilty to, no contest to, entered into a plea in abeyance or been convicted of a misdemeanor in any jurisdiction within the past ten (10) years? Motor vehicle offenses such as driving while impaired or intoxicated must be disclosed but minor traffic offenses such as parking or speeding violations need not be listed.
<input type="checkbox"/> Yes <input type="checkbox"/> No	25. Have you ever pled guilty to, no contest to, or been convicted of a felony in any jurisdiction?
<input type="checkbox"/> Yes <input type="checkbox"/> No	26. Have you, in the past ten (10) years, been allowed to plea guilty or no contest to any criminal charge that was later dismissed ( <i>i.e. plea-in-abeyance or deferred sentence</i> )?
<input type="checkbox"/> Yes <input type="checkbox"/> No	27. Have you ever been incarcerated for any reason in any federal, state or county correctional facility or in any correctional facility in any other jurisdiction or on probation/parole in any jurisdiction?

<input type="checkbox"/> Yes <input type="checkbox"/> No	28. Has any owner, officer, manager, pharmacist, pharmacy technician or medical practitioner associated with or employed by the applicant ever had a license, certificate, permit, registration to practice a regulated profession denied, conditioned, curtailed, limited, restricted, suspended, revoked, reprimanded, or disciplined in any way?
	<p>If you answered "Yes" to question 15 you must submit a complete narrative of the circumstances and you must submit a National Practitioner Data Bank report outlining all professional liability claims made against your license and any settlements paid by or on your behalf.</p> <p>If you answered "yes" to any of the above questions, enclose with this application complete information with respect to all circumstances and the final result, if such has been reached. If you answered "Yes" to Questions 22, 23, 24, 25, 26, 27 or 28 you must submit a complete narrative of the circumstances that occurred for EACH and EVERY conviction, plea in abeyance, and/or deferred sentence. You must also attach copies of all applicable police report(s), court record(s), and probation/parole officer report(s).</p> <p>If you are unable to obtain any of the records required above, you must submit documentation on official letterhead from the police department and/or court indicating that the information is no longer available.</p> <p>If you have formally expunged a criminal record as evidenced by a court order signed by a judge, you do not need to disclose that criminal history. Expungement orders must be sent to the Bureau of Criminal Identification and the FBI to enable the expungement to be completed and the criminal history eliminated from the records.</p> <p>A "Yes" answer does not necessarily mean you will not be granted a license; however, DOPL may request additional documentation if the information submitted is insufficient.</p>

### DESIGNATION OF CONTACT PERSON FOR ACCESS TO MEDICAL RECORDS

In accordance with Subsection 58-67-302(1)(j) of the Utah Code and the Federal HIPAA Regulations every physician licensed in Utah must designate a contact person and an alternate contact person for access to his/her patients' medical records and provide such information to the DOPL. Each applicant is also required to establish a method of notifying patients of the identity and location of the contact persons (*i.e. a phone number or address where patients can obtain their medical records*).

If a hospital clinic or other medical facility is the owner of your patients' medical records the facility's records department could be listed as the primary contact. You may list yourself as the primary contact but you must also provide an alternate contact.

Please note that this statute became law in 2005 due to complaints from patients who could not gain access to their medical records. DOPL's responsibility is to collect each physician's contact information and to provide it to patients upon request. If you have not provided accurate information to DOPL you could be investigated for unprofessional conduct.

Contact Person:		Telephone:	
Address of Contact Person:			
City:		State:	Zip:
Alternate Contact Person:		Telephone:	
Address of Contact Person:			
City:		State:	Zip:
Method of Notifying Patients of Location of Records: <i>(check all that apply)</i>			
<input type="checkbox"/> Phone		<input type="checkbox"/> Mail	<input type="checkbox"/> In Person

### ELECTIVE ABORTIONS

<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you perform elective abortions in Utah in a location other than a hospital? <i>(For purposes of the immediately preceding question, elective abortion means an abortion other than one of the following: removal of a dead fetus, removal of an ectopic pregnancy, an abortion that is necessary to avert the death of a woman, an abortion that is necessary to avert a serious risk of substantial and irreversible impairment of a major bodily function of a woman, an abortion of a fetus that has a defect that is uniformly diagnosable and uniformly lethal, or an abortion where the woman is pregnant as a result of rape or incest. 58-68-304.3.b.)</i>
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Business Information where the elective abortions are performed:			
Business Name:		Telephone:	
Mailing Address:			
City:		State:	ZIP:
Business Name:		Telephone:	
Mailing Address:			
City:		State:	ZIP:

### AFFIDAVIT IF APPLYING FOR LICENSURE FOR RESIDENCY TRAINING IN UTAH

I have successfully completed 12 months of resident training in an ACGME approved program after receiving a degree of doctor of medicine. I am successfully participating in an ACGME progressive residency program within Utah with no disciplinary action. I agree to surrender my license to DOPL without any proceedings under the Administrative Procedures Act and DOPL will automatically revoke my license as a physician and surgeon if I fail to continue in good standing in the ACGME approved residency program within Utah.

Signature of Applicant:	Date:
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<b>MEDICAL SCHOOL</b> <i>(Use additional sheets if necessary.)</i>			
<b>School Name:</b>		Dates Attended: _____ to _____	
Location: _____			
Degree Received: _____		Date of Graduation: _____	
<b>School Name:</b>		Dates Attended: _____ to _____	
Location: _____			
Degree Received: _____		Date of Graduation: _____	

<b>GRADUATE MEDICAL EDUCATION OR TRAINING</b> – Complete the information below and account for <b>all</b> periods of training or postgraduate work from the time you graduated from medical school. <i>(Use additional sheets if necessary.)</i>			
<b>Name of Hospital:</b>		Position <i>(intern, resident, fellow)</i> :	
Address of Hospital: _____			
City: _____		State: _____	Zip: _____
Department: _____		Date Began: _____	Date Ended: _____
<b>Name of Hospital:</b>		Position <i>(intern, resident, fellow)</i> :	
Address of Hospital: _____			
City: _____		State: _____	Zip: _____
Department: _____		Date Began: _____	Date Ended: _____

<b>PROFESSIONAL EXAMINATION REQUIREMENT</b>		
# Attempts	Examination	Date(s) Taken
	USMLE Step 1	
	USMLE Step 2	
	USMLE Step 3	
	NBOME Part I	
	NBOME Part II	
	NBOME Part III	
	FLEX Component 1	
	FLEX Component 2	
	LMCC Part 1	
	LMCC Part 2	
	SPEX Examination	
<b>List Tests Taken if Not Listed Above:</b>		
# Attempts	Examination	Date(s) Taken

<b>SPECIALTY BOARD CERTIFICATION</b> - List your ABMS or AOA specialty board certification(s) and date(s) of specialty certification(s): <i>(Use additional sheets if needed.)</i>	
Board: _____	Date: _____
Board: _____	Date: _____
Board: _____	Date: _____
Board: _____	Date: _____

**LICENSURE BY ENDORSEMENT**

You may apply by endorsement if you:

- are currently licensed in good standing in another state
- have been actively engaged in the legal practice of medicine for no less than 6000 hours in the past 5 years and
- do not have any action pending against your license.

**NOTE: If applying by endorsement you must still complete a FCVS application.**

Please list your professional work experience showing that you have been actively engaged in the legal practice of medicine in the United States. Account for all periods of time since you completed your post-graduate training. (Use additional sheets if necessary.)

From Date	To Date	Practice Experience and Location

I hereby certify:

I am currently licensed with a full unrestricted license in good standing in another state district / territory of the United States. I have been actively engaged in the legal practice of medicine for not less than 6000 hours during the five years immediately preceding the date of this application. I have no actions pending against any medical license.

I certify that I meet the endorsement qualifications for licensure in Utah.

Signature of Applicant:	Date:
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**REQUEST FOR TEMPORARY LICENSURE (Endorsement Applicants Only)**

If you are applying by endorsement you may also request a temporary license while waiting for this application to be processed. To qualify for a temporary license you must:

- meet all of the endorsement requirements listed above
- **submit a written statement from one of the following:**
  - ✓ a healthcare facility stating that you will be practicing under the invitation of that facility
  - ✓ two individuals licensed and in good standing in Utah who are extending an invitation to you to practice at the same clinical location as those two physicians

**If you meet all requirements listed above to qualify for a temporary license complete the following:**

Applicant Name:			
Employing Facility:		Telephone:	
Facility Address:			
Facility City:		State:	Zip:
Date Employment Begins:		Date Applicant Received Letter(s) of Invitation:	

I certify that I meet the qualifications for temporary licensure by endorsement in Utah.

I affirm that I will not practice in Utah until I have been granted a temporary physician license.

Signature of Applicant:	Date:
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**PLEASE NOTE.**

**A temporary license is non-renewable and expires the earlier of:**

1. issuance of a full license
2. the denial of application for full licensure as a physician and surgeon
3. one year from the date of issuance
4. a FCVS report is still required even if applying for a temporary license.

# REQUEST FOR VERIFICATION OF LICENSE

(Use this form to verify licensure from another state if applicable.)

Utah Division of Occupational and Professional Licensing  
160 E 300 S  
PO Box 146741  
Salt Lake City, UT 84114-6741

## TO BE COMPLETED BY THE APPLICANT:

Complete the first section of the form and submit it to a state in which you are **currently** licensed as a physician. Request that the verifying state complete the form and mail it directly to DOPL or return it to you for submission with your application.

Last Name:		First Name:		Middle Name:	
Maiden Name:		Social Security Number:    -    -			
Mailing Address:		City:		State:	ZIP:
Date of Birth:		E-Mail:		Date of Graduation:	
I am requesting licensure in the <b>STATE of UTAH</b> as a/an		<input type="checkbox"/> <b>PHYSICIAN AND SURGEON</b> <input type="checkbox"/> <b>OSTEOPATHIC PHYSICIAN AND SURGEON</b>			
I am/have been licensed in your state under the name:				License # in your state is/was:	
I have enclosed the necessary license verification fee in the amount of \$					
Signature of Applicant:				Date:	

## TO BE COMPLETED BY THE VERIFYING AGENCY:

Please furnish the information requested sign and verify the document and mail it directly to DOPL or place the completed form in a sealed envelope and provide it to the applicant in person or by mail. The applicant will include the sealed verification of licensure with his/her Utah application. Thank you.

Name of Verifying State: \_\_\_\_\_

Name of Licensee (as it appears in verifying state's records): \_\_\_\_\_

Classification of License Issued: \_\_\_\_\_

License Number: \_\_\_\_\_ Current Status: \_\_\_\_\_

Original Date of Licensure: \_\_\_/\_\_\_/\_\_\_ Expiration Date: \_\_\_/\_\_\_/\_\_\_

Continuously Licensed:

Yes  No please explain: \_\_\_\_\_

Licensed By:

Exam Type: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Endorsement: from what state? \_\_\_\_\_

Examination Scores: \_\_\_\_\_

Education Required for Licensure: \_\_\_\_\_

Disciplinary Action or Pending Disciplinary Action:

No  Yes please provide certified copies of all Petitions Orders etc.

Signature: \_\_\_\_\_

Title: \_\_\_\_\_

Agency: \_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_

(SEAL)

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**(FOR TWO-SIDED PRINTING)**



# UTAH PHYSICIAN/OSTEOPATHIC SURGEON

## Application Instructions and Information

**Mandatory Attachment Checklist** (*Applications with incomplete attachments will not be considered and may be denied.*)

<input type="checkbox"/>	Submit a complete DOPL application form to the DOPL address below.
<input type="checkbox"/>	<p>Request an application packet from:  <b>Federation Credentials Verification Service (FCVS)</b>            Federation of State Medical Boards            400 Fuller Wisser Road, Suite 300            Euless, TX 76039            1-888-ASK-FCVS(1-888-275-3287)  <a href="mailto:fcvs@fsmb.org">fcvs@fsmb.org</a>  <a href="http://www.fsmb.org/fcvs.html">http://www.fsmb.org/fcvs.html</a> .</p> <p>Complete the FCVS application; return it to them with a request that they submit the report directly to DOPL.  <b>NOTE: A FCVS report is still required, even if applying for a temporary license.</b></p> <div style="border: 1px dashed black; padding: 5px; text-align: center;"> <p><i>Please note due to the slow and extended processing time at FCVS you should request your FCVS packet at least 90 days prior to submitting your application to DOPL. It would be preferable if the FCVS packet was complete before submitting your application in order to expedite your licensing process.</i></p> </div>
<input type="checkbox"/>	If currently licensed in another state, submit verification of licensure from the state that you are currently licensed in. Utah participates in the VeriDoc® Physician Verification System. To access this system go to <a href="http://www.veridoc.org">www.veridoc.org</a> . (You may also use VeriDoc® to send verification of your Utah license to any other state Medical or Osteopathic Board.)
<input type="checkbox"/>	If you are requesting <b>temporary licensure</b> , submit a letter of invitation from a healthcare facility or two licensed practitioners who are extending the invitation for you to practice. <i>NOTE: You cannot apply for a temporary license separately.</i>
<input type="checkbox"/>	<p><b>Submit Appropriate Application Fees</b></p> <ul style="list-style-type: none"> <li>• Physician and Surgeon (\$200.00 Non Refundable Application Fee)</li> <li>• Osteopathic Physician And Surgeon (\$200.00 Non Refundable Application Fee)</li> <li>• Temporary License (\$50.00 Non Refundable Application Fee)</li> <li>• Controlled Substance (\$100.00 Non Refundable Application Fee)</li> <li>• Controlled Substance Temporary (\$50.00 Non Refundable Application Fee)</li> </ul>

**You must hold** a Utah controlled substance license **and** a Drug Enforcement Administration (DEA) registration to administer possess or prescribe a controlled substance in your practice of medicine in Utah. **Contact the DEA at Salt Lake District Office 348 East South Temple Salt Lake City UT 84088. Telephone (801) 524-4389.**

All foreign medical graduates are required to hold a valid the Education Council for Foreign Medical Graduates (ECFMG) Certificate. Successfully complete 24 months of progressive resident training in a program approved by: ACGME the Royal College of Physicians & Surgeons or the College of Family Physicians of Canada. **Contact the ECFMG at (215) 386-5900.**

1. **Social Security Number:** Your social security number is classified as a private record under the Utah Government Records Access and Management Act. If an SSN is not provided, the application is incomplete and may be denied.
2. **Address of Record:** The address you provide on this application will be your address of record. You are responsible to directly notify DOPL of any change to your address of record.
3. **Laws and Rules:** You are required to understand Utah laws and rules pertaining to your practice. The following laws and rules are available on the Internet at [www.dopl.utah.gov](http://www.dopl.utah.gov).
4. **Controlled Substance License:** You must hold a Utah controlled substance license **AND** a federal DEA registration to administer, possess or prescribe a controlled substance in your practice in Utah.
5. **Acceptable Forms of Payment:** Licensure fees can be paid by check or money order, made payable to "DOPL." Cash and debit/credit cards (*American Express, MasterCard, and Visa*) are also accepted in person at DOPL's main office – but not over the telephone.
6. **Mail Complete Application to:**
  - By U.S. Mail*
  - Division of Occupational & Professional Licensing  
 P.O. Box 146741  
 Salt Lake City, Utah 84114-6741
  - By Delivery or Express Mail*
  - Division of Occupational & Professional Licensing  
 160 East 300 South, 1st Floor Lobby  
 Salt Lake City, Utah 84111
7. **Telephone Numbers:**
  - (801) 530-6628
  - (866) 275-3675 – Toll-free in Utah