Revised 08/08

Regular Mailing Address
STATE BOARD OF MEDICINE
P.O. BOX 2649
HARRISBURG, PA 17105-2649
717-783-1400/717-787-2381
Email: st-medicine@state.pa.us

Courier Delivery Address
STATE BOARD OF MEDICINE
2601 NORTH THIRD STREET
HARRISBURG, PA 17110

VOLUNTEER LICENSE APPLICATION

Instructions

1. Complete pages 1 and 2 of the application. No fee is required.
2. Attach an official letter on letterhead signed by the director or chief operating officer of an approved clinic that states you have been authorized to provide volunteer services in the named clinic by the governing body or responsible officer of the clinic. **If you change clinics, please submit another letter to the Board.**
3. **If your unrestricted license is on an active-retired or inactive status, you will need to submit proof of completing 20 hours of continuing education.** *Information regarding the current continuing education requirement can be found on the Board's website at www.dos.state.pa.us/med. Click on Continuing Medical Education Requirements.

NAME: _____
LAST FIRST MIDDLE

ADDRESS: _____
STREET CITY STATE ZIP CODE

SOCIAL SECURITY NUMBER: _____ DATE OF BIRTH: _____
MONTH/DAY/YEAR

NAME OF CLINIC WHERE YOU WILL BE PRACTICING: _____

ADDRESS OF CLINIC: _____
STREET CITY STATE ZIP CODE

NAME OF PROFESSION: _____ PA LICENSE NUMBER: _____

LICENSE STATUS: (CHECK ONE) NOTE, IF YOU ARE REQUESTING A STATUS CHANGE FOR YOUR UNRESTRICTED LICENSE, YOU MUST SUBMIT YOUR CURRENT LICENSE WITH THIS APPLICATION.

☐ Please place my unrestricted license on inactive status. (I am responsible for 20 hours of continuing medical education as long as I hold the volunteer license.)

☐ Please place my unrestricted license on active-retired status. (I am responsible for 20 hours of continuing medical education (Category 1 or 2) and payment of the active-retired status renewal fees as long as I hold the volunteer license.)

☐ Please keep my unrestricted license on active status as I still practice but I volunteer on a part-time basis. (I am responsible for completing 100 hours of continuing medical education as well as maintaining malpractice insurance and payment of renewal fees for the unrestricted license.)

***Information regarding the current continuing education requirement can be found on the Board's website at www.dos.state.pa.us/med. Click on Continuing Medical Education Requirements.**

VERIFICATION

Note that disclosing your social security number on this application is mandatory in order for the State Board of Medicine to comply with the requirements of the federal Social Security Act pertaining to child support enforcement, as implemented in the Commonwealth of Pennsylvania at 23 Pa. C.S. 4304.1(a). In order to enforce domestic child support orders, the Commonwealth's licensing boards must provide to the Department of Public Welfare information prescribed by DPW about the licensee, including the social security number. Additionally, disclosing the number is mandatory in order for this board to comply with the reporting requirements of the federal National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank. Reports to the NPDB/HIPDB must include the licensee's social security number.

I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18Pa.C.S. Section 4904 (relating to unsworn falsification to authorities) and may result in the suspension or revocation of my license.

I verify that I have completed the required continuing education credits, which are required for this license.

I CERTIFY THAT MY VOLUNTEER PRACTICE IS:

1. WITHOUT PERSONAL REMUNERATION FOR PROFESSIONAL SERVICES; AND
2. IS IN AN APPROVED CLINIC.
3. I CURRENTLY HOLD AN UNRESTRICTED LICENSE TO PRACTICE OR RETIRED FROM THE PRACTICE HOLDING AN UNRESTRICTED LICENSE TO PRACTICE IN GOOD STANDING.

_____ _____

APPLICANT'S SIGNATURE **DATE**