PLEASE

COMPLETE

IN

BLUE

INK

ONLY

Thank you.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE

BOARD OF PHYSICIANS P.O. BOX 37217 BALTIMORE, MD 21297

410-764-4777 or 800-492-6836 Internet Address: www.mbp.state.md.us

REGISTRATION AND RE-REGISTRATION OF UNLICENSED MEDICAL PRACTITIONERS (UMPS)

REGISTRATION INSTRUCTIONS

Chief of Service- Responsibility

The Maryland Annotated Code, Health Occupations §14-302 (1) allows a medical school graduate in an accredited postgraduate clinical training program practice medicine without a license while performing the assigned duties at any office of a licensed physician, hospital, clinic or similar facility. This medical school graduate is otherwise referred to as an unlicensed medical practitioner (UMP).

It is the responsibility of each Chief of Service to verify that the UMP has indeed been registered with the Board. The Chief of Service* of the institution providing the accredited postgraduate clinical training program, or the Chief's designee*, shall register or re-register the UMP with the Board of Physicians (the Board).

An UMP who has been registered by a Maryland hospital Chief of Service for the current contract year and who will be on rotation in another Maryland institution within the said contract year does not have to be registered by the Chief of Service of the second institution.

A Maryland hospital Chief of Service must also register any UMP who has a training program contract with an out-of-state institution, but who is on rotation in a Maryland facility. The Maryland facility must have a written training program agreement with the out-of-state institution **indicating that the rotation is part of the postgraduate training program**. In addition, the training program in the out-of-state institution should be accredited by the Accreditation Council for Graduate Medical Education.

Completing the Registration Form for the Registration and Re-registration of UMPs

- 1. Part A is completed by the UMP
 - Indicate if this is an **Initial or Re- registration** UMP application
- <u>For re-registrations:</u> an UMP keeps the same UMP number while in training, regardless of the program, program location, or institution affiliation. Therefore, if you have previously been issued an UMP number, provide that "previous UMP number" when completing the re-registration form.
- 2. **Current Registration Period** This period refers to either (a) the full contract year or (b) the duration of an official rotation for which an UMP will be registered in order to practice medicine under COMAR 10.32.07.

- 3. **Character and Fitness questions-** all "yes" answers must be accompanied by additional documentation as specified on the application see application for details.
- 4. **Part B** this part of the Registration or Re-registration form is completed by the *Chief of Service or the *Chief of Service's designee.

Institutions - Forwarding Registration Forms to the Board of Physicians

- 1. UMP application should be funneled to the Board through one institutional office to insure that the proper precedures are followed. Send the completed application form along with the required fee of \$100.00 per UMP, by check or money order, payable to the Board of Physicians . The check must state " UMP registration" and be accompanied by a complete list of every UMP that is covered by the enclosed check or money order.
- 2. Send all UMP applications, including the registration fee and the list of UMPs to:

Maryland Board of Physicians P.O. Box 37217 Baltimore, Maryland 21297

DO NOT SEND TO THE PATTERSON AVENUE ADDRESS

- 3. Application due dates -
- Initial UMP registrations- the completed application and fee, must be received by the Board no later than 30 days from the contract start date between the accredited training program and the UMP.
- Re-registration of an UMP the completed application and fee, must be received by the Board no later than 60 days from the contract start date between the accredited training program and the UMP.
- 4. Failure to meet the deadlines may result in a violation of Md. Code Ann., Health Occ. 14 404 (a)(3) and 18 and COMAR 10.32.07.04F.
- 5. Institutions may duplicate the registration form which is available on the Board website at www.mbp.state.md.us, Download Forms, Physician Forms, "Registration and Re-registration of UMPs".

03/23/2004

Instruction sheet

^{*}The Chief of Service and the Chief's designee must be physicians currently licensed to practice medicine in Maryland.

MARYLAND BOARD OF PHYSICIANS

P.O. Box 37217 Baltimore, Maryland 21297 (410)764-4777

UNLICENSED MEDICAL PRACTITIONER APPLICATION

	FOR BANK USE ONLY
	DATE:// 200
	CHECK NUMBER:
	AMT PAID: \$
	NAME CODE:APPID: 33
	For Board use only
	Date registered:
	UMP number: P
1	

ONLICENSED MEDICAL I RACITIONER AFFLICATION	For Board use only				
	Date registered:				
PART A: Circle one: Initial Registration Re-registration UMP Number P	UMP number: P				
1) Last name and generational indicator (Jr., III, etc.)					
general genera					
First name and middle initial					
2) Date of Birth: 3) Social Security Number:					
(month) (day) (year)	ius American				
4) Gender: For M (circle one) 5) Race: (circle one)	ive American panic Other				
6) Medical Degree received from : Date of Graduation:					
7) Have you ever been licensed by a Medical Board? (circle one) Maryland Y N If yes, list license number	8) Degree:				
by a Medical Board? (circle one) Maryland Y N If yes, list license number Other Y N If yes, list state(s) and license number	(MD. DO				
9) Local Address of Accredited Training Program: (This is your address of record with the Boar					
Department:	u.,				
Name of Maryland Institution:					
THE JOHNS HOPKINS HOSPITAL					
Address:					
6000 N WOLFE STREET					
City/County State: Zip Code Plus 4					
B A L T I M O R E M D 2 1 2 8 7 - 1	8 2 4				
Daytime Phone: 4 1 0 - 9 5 5 - 6 5 5 3					
10) Current Contract Year of Registration: This should not precede the starting date of your cu	arrent contract year.				
From:/To://					
11) Answer the following questions. If you have had any legal actions taken against					
complete explanation and supporting documentation such as copies of all complaints, adverse or disciplinary actions, arrest pleadings, judgements or final orders. Sign and					
submitted.	date an pages				
Yes No					
Do you have a physical or mental condition that could impair your ability to that would cause reasonable questions to be raised about your physical, n					
competency including drug and alcohol abuse?	iental, or professional				
☐ b. Has any licensing or discipinary board of any jurisdiction or an entity of the					
denied your application for licensure, registration, certification, or limited licensure, registration, certification against your license, registration, certification					
including but not limited to reprimand, suspension, revocation, a fine, or no					

MBP Form33reg2 Rev 03/2004

	Yes	No	c.	Have you ever surrendered or allowed your medical or any other healthcare license, registration, certification, or limited license to lapse, or have you ever withdrawn an application for any of the above, while you were under investigation by any licensing or disciplinary board of any jurisdiction or		
			d.	an entity of the Armed Services? Have any complaints, investigations, or charges ever been brought against you, or are any currently pending in any jurisdiction by any licensing or disciplinary board, or an entity of the Armed Services?		
			e.	Have you pled guilty, nolo contendre, been convicted of, received probation before judgement or other diversionary disposition for any criminal act?		
			f.	Have you committed an offense involving alcohol or controlled dangerous substances to which you pled guilty or nolo contendere or for which you were convicted or received probation before judgement? Such offenses include, but are not limited to, driving while under the influence of alcohol and/or controlled dangerous substances.		
			g.	Excluding minor traffic violations, are you currently under arrest or released on bond, or are there any current or pending charges against you in any court of law?		
			h.	Has a malpractice claim or legal action for damages been filed, settled or awarded against you in any jurisdiction?		
			i.	Has any hospital, HMO, or other related healthcare institution, or military entity denied your privileges, denied any application for privileges, failed to renew your privileges, or limited, restricted, suspended or revoked your privileges for any reason except for medical record tardiness or non-payment of staff dues?		
			j.	Has your employment by any hospital, HMO, other healthcare institution, or military entity been terminated for any disciplinary reasons?		
			k.	Have you ever voluntarily resigned from any hospital, HMO, healthcare institution, or military entity while under investigation by that institution for disciplinary reasons?		
			I. ,	Has any postgraduate residency or fellowship training program ever denied your application, failed to renew your contract, or terminated any contract or appointment for any disciplinary reason or while you were under investigation for any disciplinary reasons?		
			m.	Have you voluntarily terminated any postgraduate residency training program or fellowship contract or appointment while under investigation by that program or related institution for any disciplinary reasons?		
			n.	Have you been suspended, placed on probation, formally reprimanded or asked to resign while in a postgraduate residency training program or fellowship?		
,	12) Affirmation:		in this ap	ead COMAR 10.32.07 and will comply with the regulations. I affirm that the information I have given oplication, including that given in response to questions in Item 11, is true and correct to the best of my ge and belief.		
,	Signature:			Date:		
ı	PART B: FO	OR CO	OMPLET	TION BY THE MARYLAND INSTITUTION CHIEF OF SERVICE OR DESIGNEE		
	13) Is the applicant in an ACGME accredited program? Yes No ACGME Accreditation Number					
14) Name of Maryland hospital, Maryland medical school, or Maryland facility:						
	Medical	Staff	Coordina	ator:Phone #:		
•	15) Attestat	0		t I have read COMAR 10.32.07 and will notify the Maryland Board of Physicians nination of a contract other than by natural expiration, and the reasons for the n.		
S	Signature:		-	Title: Date: Date:		
F	Print Name:_			(Cities of Designee)		
F	Phone #:			Maryland License Number:		