Instructions: You must attach a recent (less than 6 months old) passport quality, color photograph of yourself to this form. Take the form to a notary public and sign the form in the presence of the notary public. The notarized form then must be sent directly to the Kentucky Board of Medical Licensure.

Kentucky Board of Medical Licensure
Affidavit and Authorization for Release of Information

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have or shall make with respect thereto are true, that I am the original and lawful possessor and person named in the various forms and credentials furnished or to be furnished with respect to my application and that all documents, forms or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the Application for Medical/Osteopathic Licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge and exonerate the Kentucky Board of Medical Licensure, its agents or representatives and any person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the Board.

I will immediately notify the Board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice medicine being granted to me by the Board.

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my licensure or permit to practice medicine.

Applicant Photograph

Securely tape or glue in this square a current front-view 2" x 2" passport color photo of yourself.

_____
Applicant's Signature (must be signed in the presence of a notary)

_____
Applicant's Printed Name (Last, First MI, Suffix)

_____
Date of Signature

NOTARY

Dated _____ Signed _____

State of _____ County of _____

Subscribed and Sworn to before me this _____day of, _____ 20_____.

My commission expires: _____

(PLEASE AFFIX NOTARY SEAL HERE)

MAIL FORM TO KBML

Kentucky Board of Medical Licensure
Application Appendix

Applicant Name _____
Last First MI Degree

Applicant Signature _____ **Date:** _____

Medical School:

List name, location and dates of attendance of every college and medical school you have attended:

Name	City/State/Country	Dates (From – To)	Degree

Postgraduate Training:

List name, location and dates of attendance of every postgraduate training program you have attended:

Name	City/State/Country	Dates (From – To)	Program Completed (Y/N)

State or Professional Licensure:

List **ALL** states and Canadian provinces where you currently hold or have ever held **ANY** type of medical/osteopathic license. In addition, you must order verification of each license from each medical board. The verifying entity must forward all documentation directly to the Kentucky Board of Medical Licensure. Please note some state boards charge a fee for this information. Contact the state board where you currently hold or have held a license to determine their requirements.

Original (Full Unrestricted) Licensing State _____ Date License Issued _____
(This blank MUST BE FILLED IN: if there is no original full license, write "NONE")

State Licensed: _____ License # _____ License Type _____

State Licensed: _____ License # _____ License Type _____

State Licensed: _____ License # _____ License Type _____

Hospital/Clinic Affiliations:

IF you have practiced at hospitals and/or clinics outside of your training, have had an locum tenens assignments, or have done any moonlighting within the past 5 years, you will need to list them here.

Name of Facility	Position Held	Dates Affiliated