



Eric R. Greitens
Governor
State of Missouri

Kathleen (Katie) Steele Danner, Division Director
DIVISION OF PROFESSIONAL REGISTRATION

Department of Insurance
Financial Institutions
and Professional Registration
John M. Huff, Acting Director

STATE BOARD OF REGISTRATION FOR THE HEALING ARTS
3605 Missouri Boulevard
P.O. Box 4
Jefferson City, MO 65102-0004
573-751-0098
866-289-5753 TOLL FREE
573-751-3166 FAX
800-735-2966 TTY
website: <http://pr.mo.gov/healingarts.asp>

Connie Clarkston
Executive Director

Dear Doctor:

Attached you will find the materials you need to reinstate your license that was placed in an inactive status pursuant to Chapter 334.002 RSMo in the State of Missouri. If your license has lapsed due to non-renewal, a different application needs to be completed. This packet contains:

1. Documents and fee information;
2. Instructions for completing the application;
3. The reinstatement application;
4. Authorization for release of medical information and records form;
5. Verification of licensure form (if necessary, please make additional copies)

It is suggested that you read the documents and fee information and the instructions before beginning the application. Next, read the Medical Practice Act that is located at the website address listed above. This governs your professional conduct as a practitioner of the Healing Arts in the State of Missouri. Please note that all permanent Missouri licenses expire January 31st of each year regardless of the date of reinstatement.

No application will be considered by the Board until the entire file is complete. Therefore, you should not make any firm commitment to begin working until you have received notification of licensure from this office.

Please be advised that no application will be processed without a fee. You will be notified in writing one (1) time if your application is deficient in anyway. In addition to the material you are required to submit, the Board makes independent inquiries into your professional background. Therefore, you should allow a minimum of thirty (30) days for the processing of your application.

Please be reminded it is unlawful to misrepresent any material fact, in anyway, in connection with your application for a Missouri license. Proof of misrepresentation is grounds for denial of application.

If you have any questions during the process which are not answered in the enclosed material, you may contact the Board of Healing Arts at (573) 751-0098 or toll free at (866) 289-5753 or via email at licensure@pr.mo.gov

Sincerely,

Licensure Section

INACTIVE REINSTATEMENT

DOCUMENTS AND FEE YOU MUST FURNISH WITH YOUR APPLICATION

THE BOARD WILL NOT ACCEPT FAXED DOCUMENTS.

- 1. **FEES** – All fees must be submitted to this office in the form of a **MONEY ORDER OR CASHIER’S CHECK** made payable on or through a United States bank. **FEES ARE NON-REFUNDABLE. ALL FEES SHOULD BE PAID TO THE ORDER OF THE MISSOURI BOARD FOR THE HEALING ARTS.**

Reinstatement Fee \$75.00

- 2. **NOTARIZATIONS** – To assure that the copies of the documents you furnish with your application will not have to be returned to you to be notarized properly, please have the notarizations done as follows:

- a. Affidavits and statements should be notarized as “Subscribed and Sworn to” before the Notary Public. The Notary Public must sign, date and affix his/her notary seal to the document. Notary seal must show date of expiration.
- b. Canadian documents may be stamped, dated, and signed by the Commissioner of the appropriate Province if a Notary Public is not available.
- c. The Board will also accept a notarization done in a foreign country if it has an “Apostile” stamped on it.
- d. The Board will also accept a notarization by the American Embassy.

- 3. **VERIFICATION OF LICENSURE** – The enclosed form must be mailed to each licensing agency in which you are now or have ever been licensed to practice medicine. You may make additional copies as needed. It will be the applicant’s responsibility to provide this form directly to the state board(s).

- 4. **NATIONAL PRACTITIONER DATA BANK REQUEST FORM** – It will be necessary for you to contact the National Practitioner Data Bank at 1-800-767-6732 and advise them that you wish to do a self query. They will provide you with the appropriate documents to perform this self query. The self query form can be assessed on the internet at the following address: npdb-hipdb.com. When you receive the response from the data bank to your query, please forward the original to our office as soon as possible inasmuch as your application will not be considered complete until we receive this information. We require the original National Practitioner Data Bank Response and the Healthcare Integrity Data Bank Response.

- 5. **AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS** – If you answered yes to questions 16 and/or 23, this form must be completed and returned directly to our office.

- 6. **NAME CHANGE** - If your name has changed, you will be required to submit one of the following documents for verification:

- a. Marriage - Furnish a **copy** no larger than 8½ x 11 of your marriage certificate.
- b. Divorce Decree - Furnish a **copy** no larger than 8½ x 11 of your divorce decree.
- c. Adoption - Furnish a **copy** no larger than 8½ x 11 of your adoption order.
- d. Court Order - Furnish a certified court copy of the name change document.

NATURALIZATION - If you had a name change by naturalization, you will be required to hand carry your original Naturalization Certificate to this office for inspection, since it is unlawful to copy that particular document.

INSTRUCTIONS FOR COMPLETING YOUR INACTIVE REINSTATEMENT APPLICATION

The Board wishes to stress that you should provide complete details, dates, names, addresses and zip codes as required in your application. Answer all questions. If you do not, the processing of your application may be delayed indefinitely. Allow thirty (30) days for processing your application. Please type or print your application in black ink. The following information is provided to assist you in answering the questions.

ITEM #1 - Print your full name.

ITEM #2 - Provide address to which all licensure material should be sent.

ITEM #3 - Indicate month-day-year of birth.

ITEM #4 - Indicate Social Security Number.

ITEM #5 - Indicate your specialty.

ITEM #6 - Indicate home and office telephone numbers and email address.

ITEM #7 - Indicate the type of practice in which you are currently involved.

ITEM #8 - Indicate intended Missouri practice address. Provide the name of the institution/group, street, city, state and zip. If unknown, please explain.

ITEM #9 - Indicate the type of practice that you intend to be involved within the State of Missouri.

ITEM #10 - If your answer is "yes", provide the name of the American Specialty Board(s).

ITEM #11 - List all licenses held, whether active and inactive, permanent, temporary, or institutional, date issued and license number.

ITEM #12 - If your answer is "yes", provide complete details on a separate notarized statement. This should include the states, provinces or country, dates and reasons.

ITEM #13 - If your answer is "yes", provide complete details on a separate notarized statement.

ITEM #14 - If your answer is "yes", provide complete details on a separate notarized statement. This should include the states, provinces or country, dates and reasons.

ITEM #15 - If your answer is "yes", provide complete details on a separate notarized statement. This should include the states, provinces or country, dates and reasons.

ITEM #16 - If your answer is "yes", provide complete details on a separate notarized statement.

ITEM #17 - If your answer is "yes", provide complete details on a separate notarized statement. This should include the states, provinces or country, dates and reasons.

ITEM #18 - If your answer is "yes", provide complete details on a separate notarized statement. This should include the states, provinces or country, dates and reasons.

ITEM #19 - If your answer is "yes", provide complete details, dates, etc. on a separate notarized statement. If you have ever been a

defendant in any legal action, FURNISH A CERTIFIED COURT COPY (WITH COURT SEAL AFFIXED) OF THE ORIGINAL COMPLAINT, THE ANSWER, THE JUDGMENT, THE SETTLEMENT, AND/OR THE DISPOSITION OF THE CASE. If the case is still pending, please indicate. Your attorney should submit a letter regarding the current status of the case if the case is still pending.

ITEM #20 - If your answer is "yes", provide complete details of the arrest, the dates, places and disposition of the case on a separate notarized statement. FURNISH A CERTIFIED COURT COPY (WITH COURT SEAL AFFIXED) OF THE ORIGINAL CHARGE, THE JUDGMENT, THE SENTENCE AND/OR THE DISMISSAL ORDER, OR OTHER SUCH DOCUMENTS WITH THE DISPOSITION. This does not include any minor traffic or parking violation fines, which are under \$100.00. We suggest that if you have ever had an arrest record (no matter how minor), you answer the question "yes" on your application and furnish all details of the incident leading up to, and including, the arrest and the disposition of the case.

ITEM #21 - If your answer is "yes", provide complete details on a separate notarized statement. FURNISH A CERTIFIED COURT COPY (WITH COURT SEAL AFFIXED) OF THE ORIGINAL COMPLAINT, THE ANSWER AND THE DISPOSITION OF THE CASE. If the case is still pending, please indicate. Your attorney should submit a letter regarding the current status of the case if it is still pending.

ITEM #22 - If your answer is "yes", provide complete details, dates and names on a separate notarized statement. This should include the states, provinces or country, dates and reasons.

ITEM #23 - If your answer is "yes", provide complete details on a separate notarized statement.

ITEM #24 - If your answer is "yes", provide complete details on a separate notarized statement.

ITEM #25 - Provide chronological listing of medical and non-medical activities since the inactivation of your Missouri license.

ITEM #26 - Indicate what you have done to keep current with the practice of medicine.

ITEM #27 - Applicant's Oath - you must sign this oath before a Notary Public. The Notary Public must complete his/her portion and sign, date and seal your signature and photograph. You should also attach a recent photograph no larger than 3" x 5" in the space provided. Copies of photographs and magazine clippings are not acceptable.

PLEASE BE ADVISED THAT ALL QUESTIONS MUST BE ANSWERED OR THE APPLICATION WILL BE RETURNED.



STATE OF MISSOURI
 DIVISION OF PROFESSIONAL REGISTRATION
 STATE BOARD OF REGISTRATION FOR THE HEALING ARTS
APPLICATION FOR MISSOURI LICENSURE - INACTIVE REINSTATEMENT

BOARD OF REGISTRATION FOR THE HEALING ARTS
 3605 MISSOURI BLVD. • P.O. BOX 4
 JEFFERSON CITY, MO 65102
 573-751-0144 OR
 TOLL FREE 866-566-3928
 TTY: (800) 735-2966

Pursuant to Section 324.010 RSMo:

CHECK THIS BOX ONLY IF IN ALL OF THE LAST THREE (3) YEARS: YOU WERE NOT A MISSOURI RESIDENT, YOU DID NOT HAVE ANY MISSOURI INCOME, AND YOU ARE NOT SUBJECT TO ANY TYPE OF MISSOURI INCOME TAX.

False statements are subject to criminal penalties and/or license discipline.

If you have any questions regarding taxes contact the Department of Revenue at 573-751-7200 or e-mail income@dor.mo.gov.

SEE INSTRUCTIONS FIRST

1. APPLICANT NAME (LAST, FIRST, MIDDLE, SUFFIX, MAIDEN) M.D. D.O.

2. CURRENT MAILING ADDRESS (STREET, CITY, STATE, ZIP)	FEE RECEIVED DATE

3. DATE OF BIRTH	4. SOCIAL SECURITY NUMBER (USED FOR IDENTIFICATION PURPOSES)	RECEIVED DATE

5. MEDICAL SPECIALTY

6. TELEPHONE (HOME)	TELEPHONE (OFFICE)	EMAIL ADDRESS

7. TYPE OF PRACTICE YOU ARE CURRENTLY INVOLVED IN (CHECK ONE)

INTERN
 RESIDENT
 PRIVATE
 FACULTY
 OTHER (PLEASE EXPLAIN) ▶

8. PROPOSED MISSOURI PRACTICE ADDRESS (INSTITUTION/GROUP, STREET, CITY, STATE, ZIP) (IF UNKNOWN, PLEASE EXPLAIN)

9. TYPE OF PRACTICE THAT YOU WILL BE INVOLVED IN IF MISSOURI LICENSE REINSTATED

INTERN
 RESIDENT
 PRIVATE
 FACULTY
 OTHER (PLEASE EXPLAIN) ▶

10. ARE YOU A DIPLOMATE OF ANY AMERICAN SPECIALTY BOARD?

YES
 NO
 IF YES, WHICH? ▶

11. List all of the states in which you hold or have ever held a permanent, temporary or institutional license to practice medicine, in order of attainment. Please indicate state, license number and issue date.

A.	B.	C.	D.	E.
F.	G.	H.	I.	J.
K.	L.	M.	N.	O.

THE FOLLOWING QUESTIONS PERTAIN TO THE TIME PERIOD SINCE THE INACTIVATION OF YOUR LICENSE TO THE PRESENT DATE. PLEASE ANSWER THE FOLLOWING QUESTIONS WITH THE APPROPRIATE CHECKMARK. IF ANY ARE ANSWERED YES, SEE SEPARATE INSTRUCTIONS.

	YES	NO
12. Have you, or any license or right to practice held by you, been restricted or disciplined, such disciplinary action to include, but not be limited to, revocation, suspension, probation, censure, or reprimand, whether voluntarily agreed to or not, by any U.S. State, territory, federal agency, Canadian province, or other foreign country?	<input type="checkbox"/>	<input type="checkbox"/>
13. Have you had any disciplinary or corrective action taken against you, or had your right to practice restricted, by any professional medical or osteopathic association or society, or by any licensed hospital or medical staff of a hospital?	<input type="checkbox"/>	<input type="checkbox"/>
14. Have you surrendered a license issued to you by any U.S. state or any Canadian provincial licensing agency for reasons other than failure to renew?	<input type="checkbox"/>	<input type="checkbox"/>
15. Have any charges or complaints been filed against you with the federal government, any federal agency or any U.S. state or Canadian provincial licensing or disciplinary agency?	<input type="checkbox"/>	<input type="checkbox"/>
16. Have you been diagnosed or treated for any mental or physical illness or condition that has hindered or might serve to hinder your ability to practice medicine?	<input type="checkbox"/>	<input type="checkbox"/>
17. Have you been denied or surrendered a controlled substance license, registration, certificate or authority issued by the Drug Enforcement Administration (DEA) or any state bureau of narcotics or other agency concerned with controlled substances, or had such license, registration, certificate or authority restricted or disciplined, such disciplinary action to include, but not limited to, revocation, suspension, probation, censure, or reprimand, whether voluntarily agreed to or not?	<input type="checkbox"/>	<input type="checkbox"/>
18. Has any disciplinary action been taken against you, or has your authority to practice been restricted, by any federal or state agency, including, but not limited to, Medicare or Medicaid?	<input type="checkbox"/>	<input type="checkbox"/>
19. Have you forfeited collateral for breach or violation of any law, police regulation or ordinance whatsoever, been summoned into court as a defendant, or has any law suit (other than malpractice) been filed against you?	<input type="checkbox"/>	<input type="checkbox"/>
20. Have you been arrested, charged, indicted, found guilty, or entered a plea of guilty or nolo contendere, in a criminal prosecution under the laws of any state of the United States whether or not sentence was imposed, including suspended imposition of sentence or suspended execution of sentence?	<input type="checkbox"/>	<input type="checkbox"/>
21. Have you been a defendant in a legal action involving professional liability (malpractice) or had a professional liability claim paid in your behalf or paid such a claim yourself?	<input type="checkbox"/>	<input type="checkbox"/>
22. Have you been denied a license to practice medicine or denied the privilege of taking an examination administered by a U.S. state and/or Canadian provincial licensing agency?	<input type="checkbox"/>	<input type="checkbox"/>
23. Have you been chemically dependent or treated for chemical dependency in the past five (5) years?	<input type="checkbox"/>	<input type="checkbox"/>
24. Have you ever made application for licensure in another state and subsequently withdrawn said application?	<input type="checkbox"/>	<input type="checkbox"/>

**ALL APPLICANTS MUST PLACE
A PHOTOGRAPH IN THE SPACE PROVIDED. ▶**

PHOTO

27. APPLICANT'S OATH

State/Province of _____ County/Parish of _____

I, _____, hereby certify under oath that I am the person named in this application for a license to practice medicine in the State of Missouri; that all statements I have made herein are true; that I am the original and lawful possessor of and person named in the various documents and credentials furnished to the Board in connection with the application; that all documents submitted with this application or as part of the application process that are the originals have not been altered in any fashion whatsoever.

I acknowledge and state that I have read Chapter 334, RSMo, which contains the Statutes, Rules and Regulations governing the practice of medicine, that can be located on the Board's website; I have answered all questions truthfully and in compliance with the instructions provided; and I understand that the application fee submitted with this application is nonrefundable and cannot be transferred to another application.

I further state that by filing this application for a license to practice medicine in the State of Missouri, I hereby authorize and consent to have an investigation made as to my moral character, professional reputation and fitness for practice of medicine, when in the opinion of the Missouri Board such an investigation is deemed necessary. I agree to give any further information which may be required in reference to my past record.

I authorize and request every person, hospital, clinic, community, governmental agency (local, state, federal or foreign), court, association, institution or other organization having control of any documents, records and other information pertaining to me to furnish to the Missouri State Board of Healing Arts 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 Missouri State Board of Healing Arts or any of its agents or representatives to inspect and make copies of such documents, records, and other information, in connection with this application.

**MUST BE SIGNED IN
PRESENCE OF NOTARY**

APPLICANT'S SIGNATURE



NOTARIZATION AND NOTARY INFORMATION

STATE		COUNTY	
The applicant identified him/herself with a government issued photographic identification and bearing true likeness to the above photograph subscribed and swore to the truthfulness of this application before me, this _____ day of _____, _____ .			USE A RUBBER STAMP IN CLEAR AREA BELOW
NOTARY PUBLIC SIGNATURE		COMMISSION EXPIRES	NOTARY PUBLIC EMBOSSEER SEAL
NOTARY PUBLIC PRINTED NAME			



STATE OF MISSOURI
 DIVISION OF PROFESSIONAL REGISTRATION
 STATE BOARD OF REGISTRATION FOR THE HEALING ARTS
INACTIVE REINSTATEMENT
AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PERMANENT LICENSURE DEPARTMENT

STATE BOARD OF REGISTRATION
 FOR THE HEALING ARTS
 3605 MISSOURI BLVD. • P.O. BOX 4
 JEFFERSON CITY, MO 65102
 TELEPHONE 573-751-0144
 TOLL FREE 866-566-3928

I hereby authorize any physician, counselor, hospital, clinic, or any other health care provider, medical records custodian, or any person or corporation (including insurance companies) which have records relating to medical, psychiatric, counseling or evaluation received by me, to furnish the Missouri Board of Healing Arts, or its representative, oral or written statements or testimony in any hearing, any and all information with respect to any medical, psychiatric, counseling or evaluation and copies of all hospital, medical, psychiatric, counseling, and evaluation records.

A photocopy of this authorization shall be accepted the same as the original in all instances.

APPLICANT'S NAME (PRINT OR TYPE)	TELEPHONE NUMBER(S)
APPLICANT SIGNATURE ▶	DATE
ADDRESS (STREET, CITY, STATE, AND ZIP CODE) _____ _____	

IMPORTANT NOTICE

THIS AUTHORIZATION MUST BE NOTARIZED.

NOTARIZATION AND NOTARY INFORMATION		
STATE	COUNTY	
The applicant identified him/herself with a government issued photographic identification and subscribed and swore to the truthfulness of this application before me, this _____ day of _____, _____.		USE A RUBBER STAMP IN CLEAR AREA BELOW
NOTARY PUBLIC SIGNATURE	COMMISSION EXPIRES	NOTARY PUBLIC EMBOSSEER SEAL
NOTARY PUBLIC PRINTED NAME		



STATE OF MISSOURI
 DIVISION OF PROFESSIONAL REGISTRATION
 STATE BOARD OF REGISTRATION FOR THE HEALING ARTS
**INACTIVE REINSTATEMENT
 VERIFICATION OF LICENSURE**

BOARD OF REGISTRATION FOR THE HEALING ARTS
 3605 MISSOURI BLVD. - P.O. BOX 4
 JEFFERSON CITY, MO 65109
 TELEPHONE 573-751-0144
 TOLL FREE 866-566-3928

I, _____ hereby authorize and request the State Board of _____ having control of any documents, records and other information pertaining to me to furnish to the Missouri Board information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent information.

SIGNATURE OF APPLICANT	LICENSE NUMBER	ISSUE DATE
NAME IN FULL (PLEASE PRINT)	DATE OF BIRTH	SOCIAL SECURITY NUMBER

OTHER NAMES USED IN OBTAINING LICENSURE

CURRENT ADDRESS (STREET, CITY, STATE, AND ZIP CODE)

THE FOLLOWING SECTION MUST BE COMPLETED BY AN OFFICIAL OF THE STATE BOARD AND RETURNED DIRECTLY TO THE MISSOURI BOARD OF HEALING ARTS.

STATE, TERRITORY OR FOREIGN COUNTRY OF	FULL NAME OF LICENSEE	GRADUATE OF
LICENSE NUMBER	ISSUE DATE	EXPIRATION DATE

LICENSURE METHOD

NATIONAL BOARD STATE BOARD EXAM RECIPROCITY WITH _____

FLEX EXAMINATION LMCC OTHER (SPECIFY): _____

1. HAS THE APPLICANT EVER BEEN NOTIFIED OR REQUESTED TO APPEAR BEFORE ANY LICENSING OR DISCIPLINARY AUTHORITY IN YOUR STATE?
 IF YES, ATTACH DETAILS.
 YES NO

2. HAS THE APPLICANT EVER BEEN THE SUBJECT OF COMPLAINTS OR CHARGES RECEIVED BY A DISCIPLINARY AUTHORITY IN YOUR STATE?
 IF YES, ATTACH DETAILS.
 YES NO

3. HAS THE APPLICANT EVER BEEN WARNED, CENSURED OR DISCIPLINED IN ANY MANNER BY A LICENSING OR DISCIPLINARY AUTHORITY IN YOUR STATE?
 IF YES, ATTACH DETAILS.
 YES NO

4. HAS ANY APPLICATION BY THE ABOVE APPLICANT FOR INITIAL LICENSURE OR REINSTATEMENT EVER BEEN DENIED?
 IF YES, ATTACH DETAILS.
 YES NO

COMMENTS, IF ANY

BOARD SEAL	SIGNATURE AND TITLE	DATE
	STATE BOARD	