

Dear Doctor:

To be eligible for a Limited License you must retire your permanent license by completing the attached Retirement Affidavit.

The Limited License will restrict you whereby you may only provide, without compensation, primary care and preventive health care services to family members and/or facilities operated by a city or county health department, public elementary or secondary schools, federally funded community health centers and nonprofit community health centers.

Primary care and preventive health care services are limited to noninvasive procedures, and shall not include obstetrical care or any specialized care or treatment, but may include injections, the suturing of minor lacerations and incisions of boils or superficial abscesses.

Additionally, the Limited License does not authorize the prescribing of controlled substances.

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

Sincerely,

Licensure Section

Dear Doctor:

Enclosed are the materials you will need to make application for a Limited License to practice as a Physician and Surgeon in the State of Missouri. Included in the packet are:

1. Application with specific instructions for completing it;
2. Documents and Fee Sheet explaining the application process.

It is suggested that you read the statutes and rules that are located on our website listed above. Besides containing applicant information, this statute governs your professional conduct as a practitioner of the Healing Arts in the State of Missouri.

Please be advised that no application will be processed without a fee. Please allow thirty (30) days for the processing of your application once you have filed the completed application and the required documents in this office. This office does not accept faxed documents.

All applicants are considered on an individual basis. Please be reminded that it is unlawful to misrepresent any material fact in any way, in connection with application for Missouri licensure. Proof of misrepresentation on any material fact is grounds for licensure denial.

If you are issued a Limited Missouri License, you will be required by law to pay a biennial registration fee on or before February 1st of each even-numbered year regardless of date of issuance and provide proof of having completed ten (10) hours of AMA Category 1 or AOA Category 1A or 2A continuing medical education each reporting period.

The license will restrict you whereby you may only provide, without compensation, primary care and preventative health care services to family members, facilities operated by a city or county health department, public elementary or secondary schools, federally funded community health centers and nonprofit community health centers. Primary care and preventative health care services are limited to noninvasive procedures, and shall not include obstetrical care or any specialized care or treatment, but may include injections, the suturing of minor lacerations and incisions of boils or superficial abscesses. Additionally, the Limited License does not authorize the prescribing of controlled substances.

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Licensure Section

DOCUMENTS AND FEES YOU MUST FURNISH WITH YOUR APPLICATION

1. FEES –

A \$25.00 fee payable to the Missouri Board of Healing Arts. Fees will not be refunded.

2. NOTARIZATIONS –

- a. Copies should be notarized as being “True Copy” of the original document by the Notary Public.
- b. Affidavits and statements should be notarized as “Subscribed and Sworn to” before a Notary Public. The Notary Public must sign, date and affix his/her notary seal to the document. Notary seal must show date of expiration.
- c. Canadian documents may be stamped, dated and signed by the Commissioner of the appropriate Providence if a Notary Public is not available.
- d. The Board will also accept a notarization by the American Embassy.

3. NAME CHANGE –

If your name has changed, you will be required to submit one of the following documents for verification:

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

If any of these documents are not in English, contact the Board office for instructions.

INSTRUCTIONS FOR COMPLETING YOUR APPLICATION

The Board wishes to stress that you should give full details and dates, complete 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.

Question #1 – Please print your full name.

Question #2 – Please provide address to which all licensure material should be sent. Also indicate email address.

Question #3 – Please indicate Month-Day-Year.

Question #4 – Indicate home and office telephone numbers.

Question #5 – Indicate Social Security Number.

Question #6 – Indicate the date you plan to retire from the practice of medicine.

Question #7 – If your answer is “yes”, give full details on a separate notarized statement. This should include the States/Provinces, dates and reasons.

Question #8 – If your answer is “yes”, give full details on a separate notarized statement. This should include the name and address of the society/hospital, dates and reasons.

Question #9 – If your answer is “yes”, give full details on a separate notarized statement. This should include the States/Provinces, dates and reasons.

Question #10 – If your answer is “yes”, give full details on a separate notarized statement. This should include the States/Provinces, dates and reasons.

Question #11 – If your answer is “yes”, give full details on a separate notarized statement. This should include the States/Provinces, dates and reasons.

Question #12 – If your answer is “yes”, give full details on a separate notarized statement. This should include the States/Provinces, dates and reasons.

Question #13 – If your answer is “yes”, give full details 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, answer, the judgement, the settlement, and/or the disposition of case. If the case is still pending, your attorney must submit a letter stating the current status of the case.

Question #14 – If your answer is “yes”, give full 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, judgement, the sentence and/or the dismissal order, or other such documents which reflect the disposition of the matter.

This does not include any minor traffic or parking violation fines which are under \$100. We suggest that if you have ever had an arrest (no matter how minor), you answer the question “yes” on the application and furnish full details of the incident leading up to and including the arrest and disposition of the case.

Question #15 – If your answer is “yes”, give full details on a separate notarized statement. Please indicate what state the claim was filed in.

PLEASE PROVIDE THE FOLLOWING INFORMATION IF YOUR CLAIM WAS FILED IN ANOTHER STATE:

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, your attorney must submit a letter stating the current status of the case. If your insurance company paid a claim without a formal case being filed, then include the dates, name of the patient(s) involved, insurance claim number, insurance carrier, and the facts and circumstances surrounding the claim and authorize them to submit directly to the Board all information they have on file regarding the claim.

Question #16-19 - If your answer is “yes”, provide full details and dates, including the names and addresses of individuals who treated you and any hospitals/institutions where you have been treated on a separate notarized statement. The Board also requires a letter from your treating professional indicating your diagnosis, prognosis and if your illness or condition affects your ability to practice.

Question #20 – If your answer is “yes”, provide complete details on a separate notarized statement. This should include why you are required to register, conviction, date and state. The Board also requires a certified copy of the conviction and any court orders (i.e. probation, parole, etc.) requiring registration.

Question #21 – You must sign this oath before a Notary Public. The Notary Public must complete his/her portion and sign, date and seal your signature.

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STATE OF MISSOURI

BOARD OF REGISTRATION FOR THE HEALING ARTS

3605 MISSOURI BOULEVARD – P.O. BOX 4

JEFFERSON CITY, MO 65102 (573) 751-0098 TOLL FREE (866) 289-5753

APPLICATION FOR MISSOURI LIMITED LICENSE WITH CURRENT MISSOURI LICENSE

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.

1. APPLICANT NAME (LAST, FIRST, MIDDLE, SUFFIX, MAIDEN)			<input type="checkbox"/> M.D. <input type="checkbox"/> D.O.
2. CURRENT MAILING ADDRESS (STREET, CITY, STATE, ZIP)		EMAIL ADDRESS	
3. DATE OF BIRTH	4. TELEPHONE HOME: OFFICE:	5. SOCIAL SECURITY NUMBER	
6. DATE YOU PLAN TO RETIRE FROM THE PRACTICE OF MEDICINE		MEDICAL/OSTEOPATHIC SCHOOL OF GRADUATION	

PLEASE ANSWER THE FOLLOWING QUESTIONS WITH THE APPROPRIATE CHECKMARK. IF ANY ARE ANSWERED YES, SEE SEPARATE INSTRUCTIONS.

	YES	NO
7. 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 foreign country?	<input type="checkbox"/>	<input type="checkbox"/>
8. 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"/>
9. 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"/>
10. 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"/>
11. 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"/>
12. 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"/>
13. 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"/>
14. 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 or 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"/>
15. 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"/>
16. Are you currently addicted to or dependent upon narcotics, intoxicating liquors, or other substances?	<input type="checkbox"/>	<input type="checkbox"/>
17. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism, or other sexual behavior disorder?	<input type="checkbox"/>	<input type="checkbox"/>
18. Have you in the last ten years or since the age of 18 been treated for or hospitalized for bipolar disorder, schizophrenia, paranoia or any other psychotic disorder?	<input type="checkbox"/>	<input type="checkbox"/>
19. Are you currently experiencing any medical condition or disorder that limits or impairs your judgment or that otherwise affects your ability to practice medicine in a safe and competent manner?	<input type="checkbox"/>	<input type="checkbox"/>
20. Are you now or have you ever been required by federal law or the law of any state to register as a sex offender?	<input type="checkbox"/>	<input type="checkbox"/>

21. 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 limited 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 this application.

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 limited 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 the 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.

I further state that I have been licensed to practice medicine in _____ for at least ten years and am retired from the practice of medicine and that all licenses which I previously held were in good standing at the time of my retirement. I understand with this limited license that I may only provide, without compensation, primary care and preventative health care services to family members or at facilities, operated by city or county health departments organized under Chapter 192, RSMo. or Chapter 205, RSMo., city health departments operating under city charters, combined city-county health centers, public elementary or secondary schools, federally funded community health centers, or nonprofit community health centers.

I understand that primary care and preventative health care services are limited to noninvasive procedures, and shall not include obstetrical care or any specialized care or treatment, but may include injections, the suturing of minor lacerations, and incisions of boils or superficial abscesses. I understand that I may not prescribe controlled substances as defined in Chapter 195, RSMo. I also understand that to renew this license, it will be necessary for me to provide the Board with documentation of ten (10) hours of AMA Category 1 or AOA Category 1A or 2A continuing medical education obtained each reporting period.

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			