Using FCVS for source documents

Step 1: **Complete the online application in its entirety and submit the $400.00 fee**. **An incomplete application will delay processing. All fees are non-refundable. . When you provide a check as payment, you authorize the State of New Mexico to either use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction.**

Step 2: **The following documentation must be mailed to the New Mexico Medical Board (address below) after completion of the online application:**

a. Completed "Applicant's Oath" in its entirety, **including a passport-quality color photo of the applicant taken within the last six months.** **(see forms below)**
b. A copy of your specialty board certificate and re-certification, if applicable.

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Santa Fe, New Mexico 87505

Step 3: **Obtaining the FCVS Application.** You may obtain the Federation Credentials Verification Service (FCVS) application on-line at www.fsmb.org or by calling 1-888-275-3287. Submit the completed FCVS application directly to FCVS at the address shown on the application, along with appropriate fees. **Do not return the FCVS application to the Board**. Please refer any questions about the application to FCVS at 1-888-ASK-FCVS (1-888-275-3287).

Step 4: **The following documents *must be requested by the applicant* and submitted directly from the appropriate source to the Board.**

a. **Verification of Work Experience**. You must have the chief of staff or administrator in each hospital or health facility where you have held privileges or been employed during the past five (5) years (not including internship, residency, or fellowship) verify your work experience. **(see forms below)**

b. **Professional Recommendations**. In addition to the documents identified above and in place of "letters of recommendation," the NMBME requires two Professional Recommendation forms sent directly to the Board from physicians, chiefs of staff, department chairs or equivalent with whom the applicant has worked and who have personal knowledge of the applicant's character and competence to practice medicine. The recommending physicians must have personally known the applicant and have had the opportunity to personally observe the applicant's ability and performance. **(see forms below)**

c. **Verification of Licensure**. You must have each state or territorial licensing authority, which has **ever** issued you a license to practice medicine (including temporary licenses and education/training permits, ***regardless*** of the status of the license), verify the standing of that license directly to the Board. Use the enclosed form entitled "Verification of Licensure." Complete the release on the top of the form and send one copy to each jurisdiction **(see forms below)**

Step 5: **Personal Interview.** If you are required to schedule an appointment for a personal interview with the Board or the Board's designee, you will be notified after your application and all required documents have been received and are complete in every detail.

Step 6: **License.** Applicants whose applications are approved for licensure will be issued a license to practice in New Mexico. ***Medical licenses shall be renewed on July 1 following the date of issue.*** Initial licenses are valid for a period of not more than 13 months or less than 1 month.

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APPLICANT'S OATH

I, _____, hereby certify that I am the person pictured below and named in this application for a license to practice as a Physician in the State of New Mexico; that all statements I have made herein are true; that I am the original and lawful possessor and person named in the various forms and credentials furnished to the New Mexico Medical Board (Board) with my application.

I acknowledge and state that I have read the Information and Instructions that accompanied this application and I have answered all questions truthfully. I understand that the fee I submitted is not refundable.

I authorize and request every person, hospital, clinic, community, governmental agency, court, association, institution or other organization having 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 their 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 Board, and their agents or representatives, and any person furnishing information, from any and all liability of every nature and kind arising out of the furnishing or inspection of such documents, records, other information, or the investigation made by the Board. I authorize the Board to release information, material, documents, orders, or the like relating to me or to this application to any other agency of the State of New Mexico or the appropriate licensing agency of any other state or Territory of the United States or any agency of the United States government.

ATTACH RECENT PASSPORT-QUALITY* PHOTOGRAPH THAT WILL FIT IN THIS SPACE

_____
Applicant Signature Date

*Passport-quality color photograph taken within six months prior to filing the application, approximate size 2 x 2 inches, head and shoulders only, full face, front view, plain white or off-white background, standard photo stock paper, scanned or computer-generated photographs should have no visible pixels or dots.

Applicant Name _____ **Date** _____

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WORK EXPERIENCE VERIFICATION

I am applying for a medical license in the State of New Mexico. The New Mexico Medical Board requires this form to be completed by the Chief of Staff or facility's administrative staff. I hereby authorize release of all information in your files, favorable or otherwise, DIRECTLY to the NMMB, **2055 S. Pacheco St., Bldg. 400, Santa Fe, NM 87505**.

Applicant Name _____ Applicant Signature _____

Address _____ ***Dates of Privilege/Employment mm/yy to mm/yy (must be provided)**

City/State/Zip _____ Telephone Number _____

The section below should be completed by the chief of staff or facility's administrative staff.
Letters of Recommendation are ***NOT*** accepted in lieu of this form.

Type or Print Name of person completing this form _____

Title _____

Name of Institution _____

Address _____

City / State / Zip _____

1. This evaluation is based on: ___Observation of applicant ___Review of personnel file
2. In your estimation, is there any reason why this applicant should not be licensed to practice? ___Yes ___No
3. To your knowledge, is there any mental or physical reason why this applicant should not be licensed? ___Yes ___No
4. To your knowledge, is there any derogatory/disciplinary information regarding this applicant? ___Yes ___No
5. Are the dates of privilege/employment provided by the applicant on this form accurate?* ___Yes ___No

If not, please provide correct dates: Beginning _____ (Month/Year) Ending _____ (Month/Year)

If you answered "YES" to questions 2, 3, and/or 4, please provide a written explanation and/or any supporting documentation that may be relevant.

Please affix hospital or notary seal here

Printed name of person completing this form _____ Signature _____ Date _____

Signature of Notary (if applicable) _____ Date _____

My commission expires: _____

Please note on this form if there is no hospital or notary seal available.

Please return this form directly to the address above
Thank you for your cooperation.

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PROFESSIONAL RECOMMENDATION

The New Mexico Medical Board requires the completion of this Professional Recommendation by a physician or a Chief of Staff or a Department Chief with whom I have worked and who has personal knowledge of my character and competence to practice medicine. This form is required as part of my application for licensure. ***All*** elements in the section below ***must*** be completed. The lower half of the form may be used for narrative comment. This is my authorization to release all information in your files, favorable or otherwise, DIRECTLY to the NMMB, 2055 S. Pacheco St., Bldg. 400, Santa Fe, NM 87505.

Applicant's Name:_____ Date of Birth ____ ___/_____/_____

Applicant' Signature: _____Date:_____

Address: _____ City _____State_____

ALL ELEMENTS IN THIS SECTION MUST BE COMPLETED BY THE RECOMMENDING PHYSICIAN
The information on this form is NOT a public document.

1. Date and type of service: This individual served with me as_____

   from _____ to _____ at _____
   Month/Year Month/Year Location

2. Please evaluate: (Please indicate with check mark)

		Poor	Fair	Good	Superior
Professional knowledge					
Clinical judgment					
Relationship with patients					
Ethical/professional conduct					
Ability to communicate					
Clinical skills					

3. Recommendation: (please indicate with a check mark)

   1. Recommend highly and without reservation _____
   2. Recommend as qualified and competent _____
   3. Recommend with some reservation (explain) _____
   4. Concerns (explain) _____

4. Of particular value in evaluating the candidate is information regarding any notable strengths and weaknesses (including personal demeanor). We would appreciate your comments.

_____

_____

5. The above report is based on: (please indicate with check mark)

   1. Close personal observation _____ 3. A composite of evaluations _____
   2. General impression _____ 4. Other _____

Name (Please Print): _____Title: _____Phone:_____

Signature: _____ Date: _____

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VERIFICATION OF LICENSURE

I am applying for medical licensure in the State of New Mexico. The New Mexico Medical Board requires that your Board complete this form or its equivalent so that I may be considered for licensure. This is my authorization to release all information in your files, favorable or otherwise, to the NMMB, **2055 S. Pacheco St., Bldg. 400, Santa Fe, NM 87505**

Print/Type Full Name _____ Signature _____ Date _____

License Number _____ Date Issued _____ Address _____

City _____ State _____ Zip Code _____

THE SECTION BELOW SHOULD BE COMPLETED BY THE MEDICAL BOARD

Name of Licensing Authority: _____

Name of Licensee: _____

License Number: _____ Issue Date: _____ Expiration Date: _____

1. Is license current? ___Yes ___No If "No" why not? _____
2. Did you receive source documents verifying: Education? ___Yes ___No
   Postgraduate Training? ___Yes ___No
   Examination? ___Yes ____No
3. Has licensee ever been disciplined by your Board? ____Yes ____No
   If "Yes": Revoked ___Yes ___No Suspended ___Yes ___No
   Stipulated ___Yes ___No On Probation ___Yes ___No
   Dates:_____
4. Has his licensee's license ever been: Allowed to lapse for non-payment of fees? ___Yes ___No
   Placed on Retired or Inactive status? ___Yes ___No
   Surrendered Voluntarily ? ___Yes ___No
5. Are there any formal charges pending against this license? ___Yes ___No
6. Has licensee ever been investigated or requested to appear before your Board for any serious matter? ___Yes ___No

If you answered "YES" to questions 3-6 please provide a written explanation below, and attach a copy of all supporting documentation (e.g., Board order, complaint, etc.).

_____

_____

Please Affix
Board Seal Here

Signature of Board Official _____ Date _____

Title _____ Phone Number _____

Malpractice History

Provider Name: _____

Please DUPLICATE this form and complete for EACH case.

1. **Patient Name:_____**
2. **Diagnosis:**
   _____
   _____
   _____
3. **Your involvement in the case, i.e... Attending, Consulting, Etc.:**
   _____
4. **Allegation(s):**
   _____
   _____
5. **Clinical Case Summary:**
   _____
   _____
   _____
   _____
6. **Patient Outcome: _____**
7. **Other pertinent details:**
   _____
   _____
   _____
8. **Date of incident: _____ Date filed: _____**
   Date closed: _____
9. **Resolution of case, i.e. Dismissed, Settled Out of Court, Litigated, Pending, Other:**
   _____
   _____
10. **Settlement amount paid on your behalf (if any):**
    _____
11. **Professional liability insurer involved: _____**
    a. **Name of Insurer: _____**
    b. **Address of Insurer: _____**
12. **Defense attorney: _____**

_____ _____

Signature **Date**