Acquisition Form

Please complete each section of this packet thoroughly. Any omitted information can cause delays in processing your application. You may attach any supporting documents you think may be useful (medical diploma, training certificates).

Contact Information

First Name		Middle Name		Last Name	

Maiden/ Previous Names	
Date of change	Reason for change

Home Address		Work Address	
City, State Zip		City, State Zip	
Home Phone		Work Phone	
Cellphone		Other Contact	

Home E-mail		Work E-mail	

Preferred contact method ○ Work ◉ Home/Cell ○ E-mail

Preferred Mailing Address ○ Work ◉ Home

Identifying Information

Date of Birth		Place of Birth		Gender ○ Female ○ Male	

Eye color		Hair Color		Height	Ft	In	Weight		Race	

U.S. Citizen? ○ Yes ○ No		Social Security Number	
Naturalization Date (if applicable)		Driver's License Number	State

U.S. Medical Licensing

U.S. Military Service

Have you ever been in the U.S. Military?	◯ Yes	◯ No

Branch		Rank		Start Date		End Date	
Type of Discharge				Discharge Date			

Education Information

Starting with High School, list in chronological order all schools, colleges and universities attended, whether completed or not.

Name	City / State	Month / Year From	Month / Year To	Major / Degree

Medical Examination

List all nursing/advanced licensing examinations you have ever taken.

Examination	Date of Exam (Month / Year)	State	Results (Fail / Pass)

Specialty Board Certification

Are you certified by any Specialty Board?	◯ Yes	◯ No

Specialty Board Name	Certification or Specialty	Date Certified	Exp. Date

Medical Licenses

Please list **ALL** states where you hold or have ever held a license to practice medicine, regardless of current status.

State	Type of License	License Number	Issue Date	Expiration Date	Status

Employment History

Please list in chronological order all professional practice from date of completion of postgraduate training to present, including private or group practice, hospital appointments, locum tenens assignments, staff affiliations, etc. Explain all gaps of employment exceeding 30 days. Be sure to include

Employer #1			
Employer		Position	
Address		Contact Number	
Start Date (Month/Year)		End Date (Month/Year)	

Employer #2			
Employer		Position	
Address		Contact Number	
Start Date (Month/Year)		End Date (Month/Year)	

Employer #3			
Employer		Position	
Address		Contact Number	
Start Date (Month/Year)		End Date (Month/Year)	

Employer #4			
Employer		Position	
Address		Contact Number	
Start Date (Month/Year)		End Date (Month/Year)	

Employer #5			
Employer		Position	
Address		Contact Number	
Start Date (Month/Year)		End Date (Month/Year)	

Employer #6			
Employer		Position	
Address		Contact Number	
Start Date (Month/Year)		End Date (Month/Year)	

Employer #7			
Employer		Position	
Address		Contact Number	
Start Date (Month/Year)		End Date (Month/Year)	

Personal References

Please provide three personal references.

Name #1					
Name / Title					
Address					
City		State		Zip Code	

Name #2					
Name / Title					
Address					
City		State		Zip Code	

Name #3					
Name / Title					
Address					
City		State		Zip Code	

Third Party Release Information

Please list any and all names of individuals you wish U.S. Medical Licensing to discuss the application and or any other personal information with on your behalf. If no party is listed, U.S. Medical Licensing will only speak directly with the nurse during the application process.

Name / Title	Contact Number

Adverse Actions

Have any adverse actions ever been taking against you by a medical school, hospital, employer, medical board? ◯ Yes ◯ No
If yes, please provide an explanation

Have you ever been arrested, charged, or convicted of a violation of any national, federal, state or local statute? ◯ Yes ◯ No
If yes, please provide an explanation

Have you ever been treated or hospitalized for any mental illness, drug or alcohol abuse? ◯ Yes ◯ No
If yes, please provide an explanation

Do you have any condition which in any way impairs or limit your ability to practice medicine with reasonable skill and safety? ◯ Yes ◯ No
If yes, please provide an explanation

Have you been denied the privilege of taking an exam given by any licensing board? ◯ Yes ◯ No
If yes, please provide an explanation

Have you ever been disciplined, dismissed or expelled from, had any admissions monitored or restricted, had privileges limited, suspended, terminated, put on probation or requested to resign or withdraw from any of the listed items:

- Any Hospital or similar institution ◯ Yes ◯ No
- Any professional School or Training Program ◯ Yes ◯ No

Have you ever had your certification by any professional society or association suspended or revoked for any reason? ◯ Yes ◯ No
If yes, please provide an explanation

Has a claim for malpractice ever been made against you, regardless of the outcome? ◯ Yes ◯ No
If yes, how many? Please provide an Explanation

*Note: Additional documentation will be requested as needed. (i.e. copy of the complaint and settlement for each suit)

Useful Information

Please use the space below to provide any information that will be useful to us during the application process (i.e. closed facilities, timeline gaps, relocation date, etc.)

Service Agreement

I, (the undersigned), am hiring you (U.S. Medical Licensing, LLC) to assist me in applying for state medical licensure, registrations, and credentials as specified below, or as requested from time to time either verbally or in writing by myself, my employer or representatives. I agree to provide you all information and documents required for you to perform the Services, whether directly or via my employer or representatives. I affirm such information is and will be accurate and complete and such documents will be true, correct, and complete copies. I am aware of the deadlines and eligibility requirements for each license, registration, or credential for which I am applying with your assistance. I agree to pay any fees or other charges required or imposed by the licensing boards to file or process my applications for licensure, registration, or credentials that are the subject of the Services. I acknowledge you have no authority to grant or cause to be granted any licensure, registration, or credential and, therefore, you will not be liable to me or any other person regarding the final outcome of my applications for licensure, registration, or credentials. I acknowledge I have read and agree to the additional terms and conditions specified at www.usmedicallicensing.com/terms-conditions

State Licensure

Initial License or Reinstatement
List your targeted state(s)

Completion
List completion state(s)

Additional Services

Express Processing ☐ $100.00 ea
Select this option for accelerated application preparation. Note: State Medical Boards review applications in date order. **Express States**

License Maintenance / Auto - Renewal ☐ $ 125.00 ea renewal period
Forgetting to renew your medical license can be a costly mistake! Our license maintenance/auto-renewal service is designed to work with you when renewal time comes around. We will notify you when the renewal period is at hand and process the renewal paperwork through the state medical board. You only pay the maintenance fee in the year the renewal is due. **Renewal State(s)**

By e-signing below, I have read and agree to the above statement and terms and conditions.

Signature **Date**

Credit Card Authorization

I, (the undersigned) authorize you (U.S. Medical Licensing, LLC) to charge my credit card as payment for your services. I understand that the fee for this service includes the cost of U.S. Medical Licensing administrating and processing my License Application(s) and related documents. It does not include the fees charged by the regulatory board, various agencies that charge for direct source documentation, or postage/delivery fees.

U.S. Medical Licensing will initiate services upon receipt of this signed agreement and acquisition fee.

Target State(s)

Method of payment

◯ Visa ◯ MasterCard ◯ American Express ◯ Discover

Cardholder Name
Card Number
Billing Address
City, State Zip Code

Expiration Date
Security Number (CCV)

Please choose which charity you want us to donate 10% of our service fee.

◯ **Alzheimer's Association** ◯ **American Red Cross**

By e-signing below, I have read and agree to the above statement and terms and conditions.

Signature **Date**