MEDICAL PROFESSIONAL REGISTRATION FORM

Registration Number: _____ License Number: _____

Personal Information:

Full Name: _____

Date of Birth (MM/DD/YYYY): _____

Social Security Number: _____

Address: _____

Phone Number: _____

Email Address: _____

Professional Information:

Medical Specialty: _____

Medical School: _____

Year Graduated: _____

Board Certification(s): _____

State(s) of Licensure: _____

DEA Number: _____

Employment Information:

Current Employer / Practice Name: _____

Address: _____

Phone Number: _____

Email Address: _____

Professional Background and Compliance:

Have you ever been disciplined by any licensing board or professional organization? (Yes/No) _____

Have you ever been convicted of a felony or misdemeanor related to medical practice? (Yes/No) _____

Have you ever surrendered a medical license or had a license revoked, restricted, or suspended? (Yes/No) _____

Are you currently under investigation in any jurisdiction? (Yes/No) _____

Do you have any physical or mental condition that impairs your ability to practice medicine safely? (Yes/No) _____

Have you ever been denied malpractice insurance or had coverage restricted or cancelled? (Yes/No) _____

Do you agree to comply with all applicable federal, state, and local laws, rules, and regulations governing medical practice in the Unite _____

Do you consent to the release of information necessary for verification of credentials to appropriate parties? (Yes/No) _____

Acknowledgment and Signature:

I hereby certify that the information provided in this Medical Professional Registration Form is true, complete, and accurate to the best of my knowledge. I understand that providing false information or omitting relevant facts may result in denial or revocation of registration and may subject me to legal penalties. I agree to comply with all applicable laws, regulations, and ethical standards governing the practice of medicine within the United States. I authorize the verification of all information provided and consent to any required background checks and credential verifications.

Signature: _____

Printed Name: _____

Date: _____

Applicant's Signature

Signature: _____

Registrar's Signature

Signature: _____