

Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222
(502) 429-7150
www.kbml.ky.gov

FACULTY LICENSE INSTRUCTIONS

Before proceeding any further, if you have answered “yes” to a Category question on your electronic application, you will need to provide the Board with a typewritten narrative explaining your response to that question in detail and submit the letter along your application forms.

Upon completion of the online application for the Faculty License and submission of your \$250 licensure fee, the following requirements will need to be completed:

FCVS Packet:

Federation Credentials Verification Service (FCVS) is a service of the Federation of State Medical Boards and is required by the Kentucky Board of Medical Licensure. The FCVS provides a permanent central depository for documents, which represent the core credentials of any physician. By using this service, the following core credentials are verified and kept in your lifetime portfolio for future credentialing by the FCVS:

- **Identity**
- **Medical Education Verification**
- **Postgraduate Training Verification**
- **Exam Scores**
- **ECFMG and/or Fifth Pathway**

To complete the FCVS application go to <https://portal.fsmb.org/>.

- Click on the FCVS icon in the **GOLD** “Credentialing Services” section.
- If you already have a profile established, log in with your FSMB User Name and Password.
- If you have no profile established, click on “Create an Account.”
- Read all information and follow the instructions provided on each screen.

Important:

- You will need to designate Kentucky as recipient of your FCVS Profile or your packet will not be sent to KBML.
- For questions regarding the FCVS process please go to: <http://www.fsmb.org/fcvs/fcvs-faq/>.
- Time frame on the FCVS process: 6 – 8 weeks.

Make sure to submit all of the required documents to the FCVS at the address below:

Federation Credentials Verification Service
Federation of State Medical Boards
400 Fuller Wiser Road, Suite 300
Euless, TX 76039

The FCVS will provide all support of their credentialing process.

- **Do not contact the Kentucky Board of Medical Licensure regarding the FCVS application.**
- To check the status of your FCVS packet, contact their Customer Service (888) 275-3287.
- Upon completion of all information and a final review for accuracy, the FCVS will forward your “Physician Information Profile” containing certified photocopies of your credentials directly to the Kentucky Board of Medical Licensure.

Important: The KY application forms provided to you in this document are fillable forms. You will be able to type in your information on each form in the fields highlighted in grey. All other fields are to be completed manually. You will need to print each fillable form from the “print form” button in the top right corner. Please note the applicable attachment is named in each requirement listed on the following requirements.

Application Appendix:

Complete the form in its entirety. Please note that ALL licenses must be listed regardless of status or type. (a. KBML FL Application Appendix Fillable.pdf) 156KB.

Affidavit and Release Form and Photograph:

Please read this form carefully. Attach (do not staple) a recent 2x2 passport photograph on application where indicated. Photograph must be no more than six months old and must be an original or scanned color photograph. This form must be signed in front of a notary and returned along with your application. (Affidavit and Release Fillable.pdf) 174KB

Hospital/Clinic Affiliation List

Include all facilities, other than training, where you have practiced medicine within the past 5 years. All columns must be completed. If, in the last 5 years, you have been in training ONLY, write, “In Training” on the page. Sign and date. Any gaps in time require a letter of explanation.

Specialty Board Certification:

Proof of Board Certification must be sent directly from your certifying Board.

Copy of Letter of Appointment:

You must provide the Board with copy of your letter of appointment from the university to which you have been appointed a faculty position.

Though not required, letters of support are helpful, especially from the faculty department chair.

Contact Information for your Licensure Coordinator:

Files with last name beginning A – H
Dusty Hughes, Licensure Coordinator
Email: dusty.hughes@ky.gov
Phone: 502-764-2610

Files with last name beginning I - P
Lillie Diane McFall, Licensure Coordinator
Email: lillie.mcfall@ky.gov
Phone: 502-764-2606

Files with last name beginning Q – Z
Chery Tabler, Licensure Coordinator
Email: cheryl.tabler@ky.gov
Phone: 502-764-2602

IMPORTANT INFORMATION REGARDING LICENSURE IN KENTUCKY

- The \$250.00 licensure fee is **non-refundable**.
- Once your payment has been submitted your application will automatically be active with the Board.
- **To check your application status, you will login into the KBML website using the login information you created.**
- Check carefully that all information provided on the forms to follow is accurate and complete to avoid delays. Illegible writing and inaccuracies on forms will delay processing time.
- **It is not the policy of the Board to expedite any application due to pre-mature commitments.** Please do not make firm commitments to start work on any certain date until you have your license in hand.
- **The application process takes approximately 60 – 90 days.**
- If you have malpractice, disciplinary history, or we receive any negative or derogatory information during the processing of your application, **you will need to allow an additional 30 – 60 days to complete**.
- **Faxed forms will not be accepted.**
- All documents must have an official notarized translation if from a country other than the United States.
- The Board requires written authorization from the applicant with signature in order to provide status updates to anyone other than the applicant.
- Be advised that a completed application by the board deadline means all verifications, including FCVS, have been received in our office and verified by office staff as being accurate and complete.
- Board approval is required in order for the faculty license to be issued; the Board meets quarterly to grant approval.
- For a list of the Board's dates and deadlines, please go to the Licensure Applications tab under Physician Licensure on the Board's website: www.kbml.ky.gov. There is a Board Dates and Deadlines pdf document available for print.
- You may not start a faculty position until your faculty license has been issued.
- Incomplete applications will remain in our office for one (1) year from the date your application is received by KBML. After one year, your file will be purged and you will have to start the application process over in its entirety including the fee.
- Once your Faculty License is issued your online username will become your license number and your password will become the last four digits of your social security number.

***** IMPORTANT NOTICE *****

Thank you for submitting an application to practice in the Commonwealth of Kentucky. While your application is being processed, it is imperative that the KBML and its staff be able to contact you.

Please check that the mailing address and e-mail address listed on your application are correct. If either of these addresses change, please notify KBML immediately.

Applicants/Licensees are responsible for ensuring that mailing and email addresses are up-to-date and correct. Applicants/Licensees are responsible for ensuring that they are able to receive communications sent from KBML to the listed mailing and email addresses at any time.

FCVS Packet ID # _____

Kentucky Board of Medical Licensure
Faculty License
Application Appendix

Applicant Name _____
 _____ Last _____ First _____ MI _____ Degree _____

Applicant Signature _____ **Date:** _____

Faculty appointment at the medical/osteopathic school in Kentucky: _____
 _____ (List the University and Department)

List boards in which you are certified in your specialty _____

Medical School:

List name, location and dates of attendance of every college and medical school you have attended:

<u>Name</u>	<u>City/State/Country</u>	<u>Dates (From – To)</u>	<u>Degree</u>

State or Professional Licensure:

List ALL states and Canadian provinces where you currently hold or have ever held ANY type of medical/osteopathic license. In addition, you must also complete the "Licensure Verification Form" and forward it to ALL of those states. The verifying entity must forward all documentation directly to the Kentucky Board of Medical Licensure. Please note some state boards charge a fee for this information. Contact the state board where you currently hold or have held a license to determine their requirements.

Original (Full Unrestricted) Licensing State _____ Date License Issued _____

State Licensed: _____	License #: _____	License Type: _____
State Licensed: _____	License #: _____	License Type: _____
State Licensed: _____	License #: _____	License Type: _____
State Licensed: _____	License #: _____	License Type: _____
State Licensed: _____	License #: _____	License Type: _____
State Licensed: _____	License #: _____	License Type: _____

COPY THIS PAGE TO LIST ADDITIONAL STATE LICENSES

Instructions: You must attach a recent (less than 6 months old) passport quality, color photograph of yourself to this form. Take the form to a notary public and sign the form in the presence of the notary public. The notarized form then must be sent directly to the Kentucky Board of Medical Licensure.

Kentucky Board of Medical Licensure
Affidavit and Authorization for Release of Information

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have or shall make with respect thereto are true, that I am the original and lawful possessor and person named in the various forms and credentials furnished or to be furnished with respect to my application and that all documents, forms or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the Application for Medical/Osteopathic Licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or 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 any of its 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 Kentucky Board of Medical Licensure, its agents or representatives and any person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the Board.

I will immediately notify the Board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice medicine being granted to me by the Board.

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my licensure or permit to practice medicine.

Applicant's Signature (must be signed in the presence of a notary)

Applicant's Printed Name (Last, First MI, Suffix)

Date of Signature

Applicant Photograph

Securely tape or glue
in this square a current
front-view 2" x 2"
passport color photo
of yourself.

NOTARY

Dated _____ Signed _____

State of _____ County of _____

Subscribed and Sworn to before me this _____ day of, _____ 20_____. _____

My commission expires: _____ (PLEASE AFFIX NOTARY SEAL HERE)

Hospital, Clinic, Facility Affiliation List

Physician's Name _____ M.D. / D.O. _____

List all hospitals, clinics, etc., other than training (see below) where you have practiced medicine within the last five (5) years. This includes moonlighting, administrative, and all locum tenens assignments. **If you have been in training or are still in training, please mark "in training."** If there is a gap in time, please provide an explanation. No substitutions for this form will be accepted; it can be copied as needed. The only attachments accepted will be explanations of disciplinary actions and gaps in time. There must be something written on this form. We cannot accept "N/A." The Board needs to know how you have been practicing medicine within the last five (5) years.

Dates (From – To)	Hospital/Clinic/Facility Office Name & Address	Disciplinary Action Must Write "Yes" or "No" If "Yes," Provide Explanation	Indicate Locum Tenens, Moonlighting or Type of Privileges

I attest that the information contained here is true, accurate, and complete to the best of my knowledge.

Physician's Signature

Date _____