Residency Training 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 Residency Training License and submission of your $75 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 [http://www.fsmb.org/fcvs.html](http://www.fsmb.org/fcvs.html). Choose Applications and Forms under the Physician section in “For Physician or Physician Assistants” column. Please be sure to read information and follow the instructions provided for you on each screen you come to.

Important information for when you are completing your FCVS application:

- You need to designate Kentucky as recipient of your FCVS Profile
- You need to designate your Residency Coordinator as Authorized to Speak To on your FCVS packet
- You need to indicate that the type of license you are applying for is Training

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. Please do not contact the Kentucky Board of Medical Licensure regarding the FCVS application. To check the status of your FCVS packet, please 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 state licenses must be listed regardless of status or type. (a. KBML R Application Appendix Fillable.pdf) 158 KB

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 photograph. (Copies and scanned photos are not accepted) This form must be signed in front of a notary and returned along with your application. (b. Affidavit and Release Fillable.pdf) 174KB

Licurese Verification Form:
Complete the top portion of this form and mail it directly to each state where you currently hold or have ever held a license, regardless of the type of license or its current status. Some states charge a fee for verification, you will need to make sure to enclose the proper fee along with the verification form. The state will then mail us a formal verification of your license. The only online verifications accepted by Kentucky are via Veridoc.org or the Indiana State Board’s digitally certified online verification. (c. Licensure Verification Form Fillable.pdf) 87KB

Hospital/Clinic Affiliation Form:
Complete this form ONLY IF you have practiced at hospitals and/or clinics outside of you training, have had any locum tenens assignments, and done any moonlighting, within the past 5 years. The form should be completed by administration or chairpersons at the facility and mailed directly to KBML. (Do not include training as this is verified by the FCVS.) (d. Affiliation Verification Form Fillable.pdf) 54KB

R Form:
This form must be completed by your Program Director from the program that you have been accepted to in Kentucky. The Board will not issue a license without this form from your Director indicating their recommendation for you to obtain the Residency Training License. (e. R Form Fillable.pdf) 47KB

Contact Information for your Licensure Coordinator:

Files with last name beginning A – K  
Christina Check, Licensure Coordinator  
Email: christina.check@ky.gov  
Phone: 502/429-7940

Files with last name beginning L - Z  
Cheryl Tabler, Licensure Coordinator  
Email: cheryl.tabler@ky.gov  
Phone 502/429-7933
Important Information Regarding Licensure in Kentucky

- The $75.00 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.**

- The application process is 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.**

- Once your application has been reviewed, an acknowledgment letter will be mailed to your program.

- **Faxed forms will not be accepted.**

- Board approval is required in order for a license to be issued; the Board meets quarterly to grant approval.

- You may not start your program until your Residency Training License has been issued.

- This license will be issued on an academic year, July 1 – June 30, and will limit your legal ability to practice medicine to the institution and/or setting(s) approved by the postgraduate training program.

- 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](http://www.kbml.ky.gov). There is a Board Dates and Deadlines pdf document available for print.

- 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 Residency Training 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.
Category I & II Questions

Category I will help the Board determine if you meet the essential eligibility requirements for licensure by virtue of your background, education, training and experience. If you are qualified to practice under Category I, Category II will be reviewed to help the Board determine if you are qualified to practice safely and competently, with or without reasonable modification. If you have answered "Yes" to any of these questions electronically, you must attach a complete written explanation of the event(s) or condition(s), including dates, names, addresses, circumstances, and results along with your returned application forms. The below are provided for your reference only as you have already answered these electronically.

Category I

1. Have you ever been dismissed from, resigned while under investigation, failed to complete an academic year, taken a leave of absence, or been placed on probation or reprimanded at a medical school or a postgraduate training program?
2. Are you currently in default on any student loan repayment obligations payable to the financial aid programs administered by the Kentucky Higher Education Assistance Authority?
3. Have you ever been denied a license or denied the privilege of taking a licensure examination by any State, Federal or International licensure jurisdiction?
4. Have you ever had any license, certificate, registration or other privilege as a health care professional denied, revoked, suspended, probated, restricted or limited, or subjected to any other disciplinary action, by a State medical/osteopathic licensing board, or Federal, or International authority?
5. Have you ever been disciplined by any licensed hospital (including postgraduate training) or the medical staff of any licensed hospital, including removal, suspension, probation, limitation of hospital privileges or any other disciplinary action if the action was based upon what the hospital or medical staff found to be unprofessional conduct, professional incompetence, malpractice or a violation of a provision(s) of a Medical Practice Act?
6. Have you surrendered such credential, or placed it into an inactive status, to avoid disciplinary action or in connection with or in anticipation of a disciplinary investigation/action by the licensing authority of such jurisdiction?
7. Have you ever resigned your privileges or failed to renew privileges at a licensed hospital or from the medical staff of the hospital, while under investigation or while you were subject to disciplinary proceedings by the hospital?
8. Have you ever been removed, suspended, expelled or disciplined by any professional medical facility, association or society?
9. Have you ever voluntarily or involuntarily surrendered a medical or osteopathic license, or controlled substance registration certificate issued to you?
10. Have you ever been or are you currently under investigation by any State, Federal or International licensure authority or any drug licensure/enforcement authority?
11. Are any legal proceedings regarding licensure presently pending against you by any State, Federal or International licensure authority or any drug licensure/enforcement authority?
12. Have you ever been convicted of a felony or misdemeanor by any State, Federal or International court?
13. Are any criminal charges presently pending against you in any of those courts?
14. To your knowledge, are you the subject of an investigation for a criminal act?
15. In the past ten (10) years have you had to pay a settlement or judgment in a malpractice action or other civil action against your medical practice, or are there any malpractice or other civil actions against your medical practice presently pending in any court?
Category II

1. Do you currently, or have you had within the past 5 years, any physical, mental, or emotional condition which impaired, or might reasonably impair your ability to practice your health care profession safely and competently?

2. Within the past 5 years, have you been admitted to any hospital or other in-patient care facility for any physical, mental or emotional condition, which impaired, or might reasonably be considered to impair, your ability to practice your health care profession safely and competently?

3. Do you currently have, or have you had within the past 5 years, a dependency on or abuse of the use of alcohol or drugs, which impaired, or might reasonably impair, your ability to practice your health care profession safely and competently?

4. Within the past 5 years, have you engaged in the excessive use of alcohol or illegal drugs, or received any in-patient or outpatient or individual therapy/treatment or been hospitalized for alcoholism, or illegal use, or been arrested for a DUI (Driving Under The Influence)?

5. Within the past 5 years, have you been the subject of any chemical substance screening test which resulted in an indication of the presence in your body of any controlled substance, any dangerous drug, or alcohol level above .10% BAC? (This does not include those drugs taken by you as a result of a legitimate health care diagnosis, and prescribed for you in good faith by another licensed health care professional.)