APPLICATION ADDENDUM
APPLICATION PART 2 INSTRUCTIONS

Addendum Instructions: Complete the Application Addendum – Application Part 2 as instructed. Only physicians without a U.S. Social Security Number should be submitting the paper version of the Application Addendum – Application Part 2. Return the completed Application Addendum, applicable forms, and application fee to the Iowa Board of Medicine.

___ **Application Addendum**: Each question must be completed by the applicant. Documentation must be provided for any "yes" answer(s). Supporting documentation can be mailed to the board via regular mail. **The Board expects full disclosure of events, whether you consider them to be minor or major in nature. It is better to disclose information than not to disclose it.**

___ **Verification of Hospital Privileges**: Applicants for permanent, special, and resident licensure and applicants for reinstatement of a permanent Iowa license may be asked to submit verification of hospital privileges during the review process, if the reviewer deems it necessary.

___ **Verification of Medical Condition**: Applicants are required to provide a statement explaining any medical condition experienced that has had an ongoing and/or adverse impact on their ability to function and practice. Complete the top portion of this form entering your name and date of birth and the authorization for release of information page only. Send the form to your treating physician. Request that the treating physician complete and mail the form directly to the Iowa Board of Medicine.

___ **Program Certification:** **For Resident License Applicants Only** – Forward this form to the Program Director at your proposed Iowa training program. The Program Director must complete and submit this form directly to the Iowa Board of Medicine.

___ **Temporary License Letter Guide**: **For Temporary License Applicants Only** – Provide this guide to the Iowa licensed physician that is requesting your services. This guide aids the physician in writing a letter that meets the requirements of the Iowa Board of Medicine. Physicians whose letters fail to address all necessary items will be requested to resubmit their letter with additional information. The letter should be mailed directly to the Iowa Board of Medicine.

IOWA BOARD OF MEDICINE

400 S.W. 8th Street, Suite C, Des Moines, IA 50309-4686
(515) 281-6641 www.medicalboard.iowa.gov

APPLICATION ADDENDUM – APPLICATION PART 2

1. Applicant Name (Last, First, Middle) & Contact Information:

_____
(Last) (First) (Middle) (Suffix)

Applicant Phone Number: _____

Applicant E-mail:_____

2. Please indicate the type of license you are applying for and submit the appropriate application fee.

☐ Permanent $495 ☐ Resident $145 ☐ Special $345 ☐ Temporary $145 ☐ Reinstatement $545

3. Physical Description: please complete the following items regarding your physical description. Describe any identifying marks, such as scars, birthmarks, or tattoos.

Height (ft./in.) _____ Weight (lbs) _____ Hair Color _____ Eye Color _____

Identifying Marks: _____ ☐Check if not applicable
(scars, tattoos, birthmarks, etc)

4. Birth Information:

Father's Full Name: _____

Mother's Full Name: _____

5. Are you currently serving in the Military? ☐ **YES** ☐ **NO**

Are you a Veteran? ☐ **YES** ☐ **NO**

Are you the spouse of a Veteran? ☐ **YES** ☐ **NO**

Pursuant to the 2014 Home Base Iowa Act, if you are currently serving in the Military or are a Veteran you may be eligible to request credit towards licensure (subject to the jurisdiction of the board) for verified Military education, training, or service toward licensing experience or educational requirements. Contact the Iowa Board of Medicine to request a military service application.

Veterans who have a fully completed application for licensure will be given priority and will be expedited. Veterans who hold an unrestricted professional license in another jurisdiction may be eligible for licensure through reciprocity.

6. If NOT a U.S. Citizen, please report Visa Type or Alien Registration Number: ☐Not Applicable

_____

7. Proposed Iowa Practice or Proposed Post-Graduate Training Program Address:
(Institution/Group, Street, City, State, Zip Code and Anticipated Start Date)

_____
_____
_____

If Unknown, please explain:

_____
_____
_____

8. **Are you certified by a specialty board of the American Board of Medical Specialties?** ☐ **YES** ☐ **NO**

Are you certified by a specialty board of the American Osteopathic Association? ☐ **YES** ☐ **NO**

Are you specialty certified in another country? ☐ **YES** ☐ **NO**

If "YES" to any of the above, list specialty/sub-specialty below:

1. _____ Date Certified: _____ Country: _____
2. _____ Date Certified: _____ Country: _____
3. _____ Date Certified: _____ Country: _____

9. MEDICAL EDUCATION - Provide an explanation if 1) it took you more than five (5) years or fewer than four(4) years to complete your medical education; 2) if you had a break in your medical education; or 3) the end date of your education is different than the date of your degree.

10. TEMPORARY LICENSE APPLICANTS ONLY - Please indicate which board-approved activity you will be participating in.

☐ Covering for an Iowa licensed physician who, unexpectedly, is not available to provide medical care to his/her patients

☐ Demonstrating or proctoring that involves providing hands-on patient care to patients in Iowa

☐ Conducting a procedure on a patient in Iowa when the consultant's expertise in the procedure is greater than that of the Iowa-licensed physician who requested the procedure

☐ Providing medical care to patients in Iowa if the physician is enrolled in an out-of-state resident training program and does not hold a resident or permanent license in the home state of the resident training program

☐ Serving as a camp physician

☐ Participating as a learner in a program of further medical education that allows hands-on patient care when the physician does not currently hold a license in good standing in any United States jurisdiction

☐ Another activity approved by the Board

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APPLICATION ADDENDUM – APPLICATION PART 2

IMPORTANT! These definitions apply to the questions that follow:

"Ability to practice medicine with reasonable skill and safety" means all of the following:
The cognitive capacity to make appropriate clinical diagnoses, to exercise reasoned medical judgments and to learn and keep abreast of medical developments; the ability to communicate medical judgments and information to patients and other health care providers; and the capability to perform medical tasks such as physical examinations and surgical procedures, with or without the use of aids or devices.

"Medical condition" means any physiological, mental or psychological condition, impairment or disorder, including drug addiction and alcoholism.

"Chemical substances" means alcohol, legal and illegal drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" The medical condition has had an ongoing or adverse impact on the ability to function and practice.

"Improper use of drugs or other chemical substances" means all of the following: The use of any controlled drug, legend drug or other chemical substance for any purpose other than as directed by a licensed health care practitioner; and the use of any substance, including, but not limited to, petroleum products, adhesive products, nitrous oxide and other chemical substances for mood enhancement.

"Illegal use of drugs or other chemical substances" means the manufacture, possession, distribution or use of any chemical substances prohibited by law (e.g. heroin).

Iowa Physician Health Program (IPHP)

The IPHP is a confidential, voluntary program offered to physicians who may be dealing with impairment issues, such as, but not limited to alcohol or drug abuse, dependency or addiction, neuropsychiatric disorder, or physical disability. The IPHP develops an individualized program for each physician, with the goal of allowing the physician to continue to practice with reasonable skill and safety. Oftentimes, the Licensure Committee of the Board will refer physicians with impairment issues to the IPHP for review and bases licensure decisions on its recommendations.

To self-report to the IPHP or obtain additional information, contact the Coordinator of IPHP at 515-281-6491.

Applicant Name: _____
(Last) (First) (Middle) (Suffix)

Respond "yes" or "no" to each item. The Board expects full disclosure of events, whether you consider them to be minor or major in nature. It is better to disclose information than to not disclose it.

For every "yes" response, you must provide a separate statement of explanation that is signed and dated. This statement must include full details, including dates, locations, actions, organizations or parties involved. You must also provide the requested supporting documentation. The Board may request additional supporting information, if needed.

A criminal background check packet will be sent to your home address after your application has been submitted. Your answer to question #6 of this addendum and the question on the background check waiver should contain the same information. Discrepancies between the two could result in disciplinary action. Some states have court records available online, which you may want to review if you are unsure how to answer this question. Iowa's court record website is www.iowacourts.state.ia.us.

Applicants must answer all questions. Current IPHP participants may answer "No" to questions 1 through 5.

Yes	No	
☐	☐	1. Do you currently have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? **If yes,** provide a description of your medical condition and submit the "Verification of Medical Condition" form **(UA, Addendum 4)** which is to be completed by your treating physician(s).
☐	☐	2. Are you receiving ongoing treatment or participating in a monitoring program that reduces or eliminates the limitations or impairments caused by either your medical condition or use of alcohol, drugs, or other chemical substances? **If yes,** provide details of your treatment or program, copies of treatment evaluations, statements from the program indicating your progress and practice recommendations.
☐	☐	3. Does your field of practice, or the setting or the manner in which you have chosen to practice medicine, reduce or eliminate the limitations or impairments caused by your medical condition or use of alcohol, drugs or other chemical substances? **If yes,** provide a description of your practice and how it has changed since the diagnosis of your medical condition.
☐	☐	4. Are you currently engaged in the illegal or improper use of drugs or other chemical substances? **If yes,** provide an explanation.
☐	☐	5. Does your current use of alcohol, drugs or other chemical substances in any way impair or limit your ability to practice medicine with reasonable skill and safety? **If yes,** explain your current usage and how this impairs your ability to practice.

Applicant Name: _____

(Last) (First) (Middle) (Suffix)

Yes	No	
☐	☐	6. Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to a crime other than a minor traffic offense, in any jurisdiction? You must include all misdemeanors and felonies, even if adjudication was withheld by the court so that you would not have a record of conviction. (For example, you must report if your conviction was expunged, you received a deferred judgment, or you received an executive pardon.) Driving under the influence or driving while impaired is not a minor traffic offense. **If yes,** provide details of the charge and the final outcome. Provide copies of any court/legal documents related to each incident.
☐	☐	7. During medical school, were you ever terminated, requested to withdraw, asked to repeat training or education, or placed on probation? **If yes,** provide an explanation.
☐	☐	8. Have you ever received a certificate of non-compliance from the College Student Aid Commission regarding non-payment of a student loan? **If yes,** provide an explanation.
☐	☐	9. Have you ever been terminated, asked to withdraw, or asked to repeat a portion of an internship, residency, or fellowship? **If yes,** provide an explanation.
☐	☐	10. Have you ever received a warning or reprimand, been asked to participate in remediation or been placed on probation during an internship, residency or fellowship program? **If yes,** provide an explanation.
☐	☐	11. Have you ever taken a leave of absence for any reason (maternity, family, personal, financial, military service, research, study for licensure exam or board certification, etc.) during your medical school education, internship, residency, or fellowship? **If yes,** provide an explanation.
☐	☐	12. Have you ever been denied a license to practice medicine or a license to practice another profession? **If yes,** provide an explanation and a copy of the notice of denial.
☐	☐	13a. Have you ever surrendered any professional license for any reason? **If yes,** provide an explanation and a copy of all official documents relating to the surrender.
☐	☐	13b. If yes, was a license disciplinary action pending against you or were you under investigation by a professional licensing agency at the time you surrendered the license? **If yes,** provide an explanation and a copy of all related official documents.
☐	☐	14. Have you ever been denied a Drug Enforcement Administration (DEA) or state controlled substance registration certificate? **If yes,** provide an explanation and a copy of the notice of denial.

Applicant Name: _____

(Last) (First) (Middle) (Suffix)

Yes	No	
☐	☐	15. Have you ever surrendered your state or controlled substances registration or had it restricted in any way? **If yes,** provide an explanation and a copy of all official documents relating to this.
☐	☐	16. Aside from ordinary initial requirements of proctorship, have you ever had your clinical privileges or medical staff status at any hospital or health care entity, nursing facility, clinic, or other professional health care organization limited, suspended, revoked, not renewed, voluntarily relinquished, denied, or subject to other disciplinary or probationary conditions? **If yes,** provide an explanation and a copy of all related official documents.
☐	☐	17. Have you ever been terminated, sanctioned, penalized, had to repay monies to or been denied provider participation in any Medicaid, Medicare or other publicly funded healthcare program? **If yes,** provide an explanation and a copy of all related official documents.
☐	☐	18. Have you ever been denied membership or renewal or been subject to any disciplinary action, sanction or warning in any medical or osteopathic organization or professional society? **If yes,** provide an explanation and a copy of all related official documents.
☐	☐	19. Have you ever been investigated or subject to an inquiry/review by any professional licensing agency, including investigations or reviews which resulted in no formal action? (Answer "Yes" if you have ever been contacted by an investigator or Board agent to review a complaint or report filed against you.) **If yes,** provide an explanation of the inquiry, including dates, state, charges, final outcome and a copy of all related official documents.
☐	☐	20. Has any jurisdiction of the U.S. or other nation ever limited, restricted, warned, censured, placed on probation, suspended, revoked or filed charges against any license you held? **If yes,** provide an explanation and a copy of all related official documents.
☐	☐	21. Are you in violation of any child support order or written agreement to pay child support? **If yes,** provide an explanation.
☐	☐	22. Have any professional liability suits ever been filed against you? **If yes,** complete the **"Malpractice Liability Claims Information"** section of the Online Uniform Application for Physician State Licensure (UA) for each suit. If the suit is pending, provide a copy of the Complaint & a letter from your attorney indicating the status of the case. If the suit was dismissed, provide a copy of the Dismissal Order.
☐	☐	23. Have any judgments or settlements been paid on your behalf as a result of a professional liability case? **If yes,** complete the **"Malpractice Liability Claims Information"** section of the Online Uniform Application for Physician State Licensure (UA) for each suit. Provide a copy of the courts' Complaint, Final Disposition, and Settlement/Release.

Applicant Name: _____ **Signature:**_____
(Last, First Middle, Suffix) **Date:**_____

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HOSPITAL PRIVILEGE VERIFICATION

Applicant: You may be asked to submit this form to hospitals where you have held privileges at by the staff person who reviews your application. If requested, complete the top portion of this form only and submit the form to the hospital.

Hospital: Complete and mail the form directly from the hospital to the Iowa Board of Medicine. Any processing fees are the applicant's responsibility.

Applicant's Name (Print Legibly): _____

Applicant's Date of Birth (Month/Day/Year): _____

It is hereby certified that _____
(Name of Applicant)

had hospital privileges at _____
(Name of Hospital)

located at _____
(Address, City, State, Zip, Country)

From _____ To _____
(Month/Year) (Month/Year)

Was any disciplinary action ever taken against the applicant?
Yes _____ No _____
If yes, provide details of the disciplinary action and a copy of any documentation related to the event.

Is there any derogatory* information on file?
Yes _____ No _____
If yes, provide details of the derogatory information and a copy of any documentation related to the event. *Derogatory information can include probation, investigation, remediation, and/or other disciplinary actions.

Institutional Seal

(If your institution does not have an official seal, this form must be notarized.)

Completed by the Medical Staff Office:

Print Name: _____

Signature: _____

Date (month/day/year): _____ Phone: _____

Fax: _____ E-mail: _____

Authorization for Release of Information – Hospital Privilege Verification

The applicant must sign this form and submit it with the Hospital Privilege Verification form. The hospital may retain this release of information for their records.

I, _____ (print name), do hereby authorize a disclosure of records concerning myself to the Iowa Board of Medicine (IBM). This release includes records of a public, private or confidential nature.

I acknowledge that the information released to the IBM may include material that is protected by federal and/or state laws applicable to substance abuse and mental health information. If applicable, I specifically authorize the release of confidential information to and from the IBM relating to substance abuse or dependence and/or mental health.

I further agree that the IBM may receive confidential information and records, including, but not limited to the following records:

- Medical Records
- Education Records
- Personnel or employment records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Postgraduate training (internship, residency & fellowship) records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Any information the IBM deems reasonable necessary for the purposes set forth in this release.

Release of Liability. I do hereby irrevocably and unconditionally release, covenant not to sue, and forever discharge any person or entity, including but not limited to any medical school, residency or fellowship training program, hospital, health care provider, health care facility, licensing board, impaired practitioner program, agency, or organization, which releases information to the IBM pursuant to this release from any liability, claim, or cause of action arising out of the release of such information. I further irrevocably and unconditionally release, covenant not to sue, and forever discharge the IBM, the State of Iowa, and its employees and agents from any liability, claim, or cause of action arising out of the collection or release of information pursuant to this release.

A photocopy of this release form will be valid as an original thereof, even though the photocopy does not contain an original writing of my signature.

This authorization is valid until completion of the licensing process. I understand I have the right to revoke this authorization in writing, except to the extent that the IBM has already taken action in reliance upon this consent.

I have read and fully understand the contents of this "Authorization to Release Information".

_____ _____

Signature of Physician Date

PROHIBITION ON REDISCLOSURE

This form does not authorize redisclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by state law for mental health records, federal requirements (42 C.F.R. Part 2) and state requirements (Iowa Code Ch. 228) prohibit further disclosure without the specific written consent of the patient except as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse or mental health information.

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VERIFICATION OF MEDICAL CONDITION

Applicant: You are required to provide a statement explaining any medical condition you have experienced that has had an ongoing or adverse impact on your ability to function and practice. Physicians who had a condition that interrupted their education or training should also complete this form.

The physician who diagnosed and provides, or provided, treatment for the condition should complete this form.

Treating Physician: Complete and mail this form directly to the Iowa Board of Medicine. This form is also on our website as a PDF document which can be completed using the computer and printing the document. The applicant's signature on this form authorizes the release of information, favorable or otherwise, directly to the Board.

Applicant's Name (Print Legibly): _____

Applicant's Date of Birth (Month/Day/Year): _____

Nature of Medical Condition (Include specific diagnosis):

_____

_____

_____

Summary of Treatment:

_____

_____

_____

Treatment Period: From: _____ **To:** _____

Recommended Treatment:

_____

_____

_____

Is/Was the applicant in compliance with his/her treatment? Yes ☐ **No** ☐

If no, please explain.

_____

_____

_____

Is the applicant taking any prescribed medications for this condition? Yes ☐ No ☐
If yes, list the medication(s).

_____

_____

_____

Provide a summary of other prescription medications this applicant is taking.

_____

_____

_____

Has this medical condition in any way affected the applicant's ability to practice medicine with reasonable skill and safety? Yes ☐ No ☐
If yes, please explain.

_____

_____

_____

Do any limitations need to be in place with regard to the applicant's practice of medicine? Yes ☐ No ☐ If yes, please explain.

_____

_____

_____

If treatment were to cease for any reason, could the applicant's condition in any way affect his/her ability to practice medicine with reasonable skill and safety? Yes ☐ No ☐
If yes, please explain.

_____

_____

_____

Is ongoing monitoring warranted? Yes ☐ No ☐
If yes, please explain.

_____

_____

_____

Treating Physician Information

Physician's Name (print legibly):_____

Signature:_____ **Date:**_____

Address:_____

Phone:_____ **Fax:**_____

Authorization for Release of Information – Verification of Medical Condition

The applicant must sign this form and submit it with the Verification of Medical Condition form. The treating physician may retain this release of information for their records.

I, _____ (print name), do hereby authorize a disclosure of records concerning myself to the Iowa Board of Medicine (IBM). This release includes records of a public, private or confidential nature.

I acknowledge that the information released to the IBM may include material that is protected by federal and/or state laws applicable to substance abuse and mental health information. If applicable, I specifically authorize the release of confidential information to and from the IBM relating to substance abuse or dependence and/or mental health.

I further agree that the IBM may receive confidential information and records, including, but not limited to the following records:

- Medical Records
- Education Records
- Personnel or employment records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Postgraduate training (internship, residency & fellowship) records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Any information the IBM deems reasonable necessary for the purposes set forth in this release.

Release of Liability. I do hereby irrevocably and unconditionally release, covenant not to sue, and forever discharge any person or entity, including but not limited to any medical school, residency or fellowship training program, hospital, health care provider, health care facility, licensing board, impaired practitioner program, agency, or organization, which releases information to the IBM pursuant to this release from any liability, claim, or cause of action arising out of the release of such information. I further irrevocably and unconditionally release, covenant not to sue, and forever discharge the IBM, the State of Iowa, and its employees and agents from any liability, claim, or cause of action arising out of the collection or release of information pursuant to this release.

A photocopy of this release form will be valid as an original thereof, even though the photocopy does not contain an original writing of my signature.

This authorization is valid until completion of the licensing process. I understand I have the right to revoke this authorization in writing, except to the extent that the IBM has already taken action in reliance upon this consent.

I have read and fully understand the contents of this "Authorization to Release Information".

_____ _____

Signature of Physician Date

PROHIBITION ON REDISCLOSURE

This form does not authorize redisclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by state law for mental health records, federal requirements (42 C.F.R. Part 2) and state requirements (Iowa Code Ch. 228) prohibit further disclosure without the specific written consent of the patient except as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse or mental health information.

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POSTGRADUATE TRAINING PROGRAM CERTIFICATION
(For Resident License Applicants Only)

Applicants who are applying for a resident license must forward this form to the Resident Program Director at your proposed Iowa training program. The Program Director must complete and submit this form to the *Iowa Board of Medicine, 400 S.W. 8th Street, Suite C, Des Moines, IA 50309-4686*.

Resident Applicant's Name: _____
(First, Middle, Last)

Program Facility/Department: _____

Mailing Address: _____

City, State, Zip: _____

Proposed Training Program(s):_____
e.g. Family Practice, Internal Medicine. Residents, who have an initial contract to participate in a preliminary year of general training followed by specialized training, e.g. one year of internal medicine followed by three years of dermatology, may participate in both programs under one resident license if the resident's license application specifies a combined program under this section.

Expected Start Date: _____ **Expected Date of Completion:** _____

(The expected date of completion will be the expiration date of the license.)

Is this training program accredited? Yes ☐ No ☐ If yes, by whom? _____

Program Director's Name:_____

E-Mail:_____ **Phone:**_____

Program Coordinator's Name:_____

E-Mail:_____ **Phone:**_____

I, _____, hereby certify that the above-named physician will be employed by this institution for resident training program, provided he/she has been duly licensed as a resident physician by the Iowa Board of Medicine. I further certify that I believe this applicant is qualified to practice as a resident physician in the State of Iowa. I have carefully examined the statements made in this application and believe them to be true in every respect.

I understand that the resident license is a restricted license valid only for practice within the program and department(s) approved by the Board on this application, and valid only for practice under the supervision of a licensed practitioner of medicine and surgery or osteopathic medicine and surgery.

Signature _____ Date _____

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TEMPORARY LICENSE LETTER GUIDE
(For Temporary License Applicants Only)

Applicants who are applying for a temporary license must request a letter from the organization/individual seeking your service that explains the need for your participation in the board-approved activity, the time period involved, scope of practice, the exact location/facilities of the activity, and who the immediate supervisor will be.

Applicant Instructions: Provide this guide to the Iowa licensed physician that is requesting your services.

Iowa Licensed Physician Instructions: A requirement for temporary licensure is a letter from the physician requesting the applicant's services. Use this guide to write the letter and include information for each of the items below. Physicians whose letters fail to address the items below will be requested to resubmit their letter with additional information. This letter should be mailed directly to the board.

Observing in Iowa: Iowa rules allow physicians to observe without obtaining a license. Physicians who are going to observe do not qualify for a temporary license. Do not submit an application if the activity is solely observation. The board will not approve licenses for observation.

1. Applicant name
2. Name of Iowa licensed physician that requests the applicant's services and their contact information
3. Name of the applicant's immediate supervisor and their contact information
4. Length of time the applicant will be participating in the board approved activity
5. Location(s) of the activity
6. Description of the need to have the applicant licensed
7. Explain in detail the following information
    - Type of practice in which the applicant will be involved
    - Indicate if patient contact will occur
    - List the procedures the applicant will learn
    - List the procedures the applicant will perform
    - List any research projects in which the applicant will be involved
    - Indicate if the applicant will act as a consultant to the Iowa licensed physician
    - Provide any other details of the applicant's proposed practice in Iowa that is not covered by the above terms
8. Sign and date letter