How to Apply for a Physician License

The Iowa physician licensure application contains two parts: Application Part 1 - Uniform Application (UA) and Application Part 2 – State Specific Addendum. The Application Addendum is completed through the board's online services website and the UA is completed through the Federation of State Medical Board's website. To begin the processing of an application, the board must have both parts of the application.

Tip 1
For information on how to apply for a license, go to the Applying for a License page of the Iowa Board of Medicine website.

Tip 2
Download and print the instructions & application forms from the UA website and send them to the appropriate entities for completion. Print and submit applicable forms from within this packet.

Tip 3
To check the status of your application after both parts have been submitted:

- Log into your Online Services account,
- Click on Licensing,
- Click on Details to view the status and items needed to complete the application.

Questions?
Questions about content that needs to be entered on the UA, Application Addendum, eligibility requirements or the application process, contact the Iowa Board of Medicine at 515-281-6641.

If you experience difficulties in using or accessing the UA, contact the Federation of State Medical Boards at 817-868-5194 or ua@fsmb.org.

APPLICATION PART 2 – STATE SPECIFIC ADDENDUM
INSTRUCTIONS

Addendum Instructions: Complete the Application Addendum as instructed through the board's Online Services.

Return the completed forms (below), if applicable to the Iowa Board of Medicine.

___ **Application Addendum**: These questions must be completed by the applicant through the board's Online Services. **Each question must be completed by the applicant.** Documentation must be provided for any "yes" answer(s). Supporting documentation can be attached electronically to the Application Addendum before submitting or documents 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 or Employment**: Applicants for permanent, administrative, special, and resident licensure and applicants for reinstatement of a permanent Iowa license may be asked to submit verification of hospital privileges or employment 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

PRIVILEGE/EMPLOYMENT VERIFICATION

Applicant: You may be asked by the staff person who reviews your application to submit this form to hospitals or clinics where you have practiced or held privileges. If requested to do so, complete only the top portion and submit the form to the hospital/employer for completion.

Applicant's Name (Print Legibly): _____

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

Hospital/Employer: Complete and send the form directly to the Iowa Board of Medicine. Any processing fees are the applicant's responsibility.

It is hereby certified that _____
(Name of Applicant)

had hospital privileges/was employed at _____
(Name of Hospital/Clinic)

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

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

Was any disciplinary action ever taken against the applicant?
Yes _____ No _____
If yes, provide details of the disciplinary action and copies of all 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 may 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 –Privilege/Employment Verification

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

I, _____ (print name), do hereby authorize 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 reasonably 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".

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Signature of Physician Date

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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