APPLICATION FOR A SHORT TERM CAMP PHYSICIAN LICENSE

Please allow 60 days for processing of this application.

*The State Board of Osteopathic Medicine permits an Osteopathic physician to obtain a Pennsylvania License to practice medicine and surgery in a camp or resort for no more than three months. Adequate arrangements must be made for back-up medical care if the physician is unable to continue to serve as an Osteopathic doctor for the camp or resort.

Required Documents:

1. Submit a $45.00 fee, check or money order, made payable to the "Commonwealth of Pennsylvania." FEES ARE NOT REFUNDABLE. **Note: A processing fee of $20.00 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment.**

2. Contact the State Board Office where you hold an unrestricted license to practice medicine and request a letter of good standing. The letter must include the following: license issue and expiration dates, license status, and disciplinary standing. The letter of good standing must be sent directly to the Pennsylvania State Board of Osteopathic Medicine in an official envelope.

3. Arrange for the camp to complete page 3 of the application. This form must contain an original signature,

4 Arrange for the collaborating or back-up physician to complete and submit page 4 of the application indicating in detail the acceptance of specific responsibilities. This form must contain an original signature.

5 Submit a letter from insurance company, which verifies malpractice insurance coverage at this facility during dates of practice in Pennsylvania. This letter must include the policy number. If self-insured, provide a statement to this effect.

6 Attach a Curriculum Vitae listing all periods of employment or unemployment (i.e., child rearing, research, etc.) from graduation from medical school to present. The list must be in chronological order, include the month and year, and indicate the state/territory in which the employment occurred.

Regular Mailing Address **Courier Delivery Address**

STATE BOARD OF OSTEOPATHIC MEDICINE
P.O. BOX 2649
HARRISBURG, PA 17105-2649
717-783-1400/717-787-2381
Email: st-osteopathic@state.pa.us

STATE BOARD OF OSTEOPATHIC MEDICINE
2601 NORTH THIRD STREET
HARRISBURG, PA 17110

APPLICATION FOR A SHORT TERM CAMP PHYSICIAN LICENSE

Application Fee: $**45.00** not refundable. Make check payable to the "Commonwealth of Pennsylvania." Note: A processing fee of $20.00 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment.

(PRINT OR TYPE)

Applicant Information

Name _____
LAST FIRST MIDDLE

Address _____
STREET

_____
CITY STATE ZIP CODE

Date of Birth _____ Social Security Number _____

Name of Medical School (s) Attended _____

Date of Graduation _____

Identify which state license you are using to apply for the temporary license _____

Name and address of Pennsylvania Health Care Facility, Camp, or Organization of Employment

Name _____

Address _____
STREET

_____
CITY STATE ZIP CODE

Name and address of Attending Physician, Supervisor, or Agency Head

Name _____

Address _____
STREET

_____
CITY STATE ZIP CODE

Answer the following questions. If "YES" is answered to #2 through #7, provide complete details on a separate sheet as well as certified copies of relevant documents. Sign and date below.

NOTE: The failure to provide sufficient information may result in a delay in processing or the return of your application.

	YES	NO
1) Do you hold or have you ever held an unrestricted license, certification, or registration (active or inactive, current or expired) to practice osteopathic medicine and/or surgery in any other state or jurisdiction? **If yes, list the jurisdiction(s) here:**		
2) Have you ever withdrawn an application for a license, certificate or registration, had an application denied or refused, or agreed not to reapply in another state, territory or country?		
3) Have you had disciplinary action taken against your license, certification issued to you in any profession in any other state or jurisdiction?		
4) Have you been convicted, pleaded nolo contendere, or received probation without verdict or accelerated rehabilitative disposition (ARD) as to any felony or misdemeanor, including any drug law violations, or do you have any criminal charges pending and unresolved in any state or jurisdiction? You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.		
5) Have you had practice privileges denied, revoked or restricted in a hospital or other health care facility, or have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?		
6) Have you had your DEA registration denied, revoked or restricted or have you had your provider privileges terminated by any medical assistance agency for cause?		
7) Are you, or have you ever been, addicted to the intemperate use of alcohol or to the habitual use of narcotics or other habit-forming drugs? **Note: You may answer "NO" if you are currently a participant in or have successfully completed the requirements of the Board's Professional Health Monitoring Program.)**		

SIGNED STATEMENT

Note that disclosing your social security number on this application is mandatory in order for the State Board of Medicine to comply with the requirements of the federal Social Security Act pertaining to child support enforcement, as implemented in the Commonwealth of Pennsylvania at 23 Pa. C.S. 4304.1(a). In order to enforce domestic child support orders, the Commonwealth's licensing boards must provide to the Department of Public Welfare information prescribed by DPW about the licensee, including the social security number. Additionally, disclosing the number is mandatory in order for this board to comply with the reporting requirements of the federal National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank. Reports to the NPDB/HIPDB must include the licensee's social security number.

I verify that the statements in this application are true and correct to the best of my knowledge information and belief. I understand that false statements are made subject to the penalties of 18 Pa. C.S. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my license or certificate.

Signature of Applicant Date

CAMP VERIFICATION FORM

Name and Address of Pennsylvania Health Care Facility, Camp, or organization of employment:

Name_____

Address_____
Street

_____
City State Zip Code

Name of Temporary License Applicant_____

Dates of service for the Applicant_____

List in detail the anticipated practice of the applicant. This must include the type of practice and frequency of practice.

Signature_____

Title _____

Date_____

COLLABORATING/BACK UP DOCTOR FORM

Collaborating/Back-Up Doctor's Name_____

License Number of Collaborating/Back-Up Doctor _____

Name of Temporary License Applicant_____

Dates You Will Serve as the Collaborating/Back-Up Doctor_____

Name and Address of Pennsylvania Health Care Facility, Camp, or organization of employment:

Name_____

Address_____
Street

_____
City State Zip Code

I Agree to Serve as the Collaborating/Back-Up Doctor for the Above Named Applicant in the Performance of the Following Listed Duties/Procedures**:**

Signature of Collaborating/Back-Up Doctor_____

Date_____