



New Mexico Regulation and Licensing Department
BOARDS AND COMMISSIONS DIVISION
Board of Osteopathic Medical Examiners
 Toney Anaya Building ▪ 2550 Cerrillos Road ▪ Santa Fe, New Mexico 87505
 (505) 476-4950 ▪ Fax (505) 476-4545 ▪ www.rld.state.nm.us/osteopathy

New Mexico Board of Osteopathic Medical Examiners

Non-refundable \$400 Application Fee

★ All licensing information provided is public information.

I. APPLICATION FOR LICENSURE

I hereby make application for a license to practice **Osteopathic Medicine** in the State of New Mexico. I am submitting the following information as the person named in this application. The photograph attached hereto is a true likeness of myself and was taken less than one year prior to the date of this application.

(LAST NAME)	(FIRST NAME)	(MIDDLE)	(MAIDEN)
BUSINESS ADDRESS:		HOME ADDRESS:	
(STREET)		(STREET)	
(CITY/STATE/ZIP)		(CITY/STATE/ZIP)	
(TELEPHONE NUMBER)		(TELEPHONE NUMBER)	
DATE OF BIRTH: _____		BIRTHPLACE: _____	
		(CITY/STATE/COUNTRY)	
SOCIAL SECURITY NUMBER: _____		DEA NUMBER: _____	

II. CERTIFICATE OF MEDICAL EDUCATION

This certifies that _____ D.O., entered the program on _____
 (PHYSICIAN'S NAME) (DATE MATRICULATED)

at the _____ located in _____
 (NAME OF UNIVERSITY) (CITY AND STATE)

The person named attended the required courses and received a diploma conferring the degree of Doctor of Osteopathy on

 (DATE GRADUATED)

 (SIGNATURE OF PRESIDENT, DEAN, REGISTRAR)

_____ (TITLE) _____ (DATE)

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III. EXAMINATION INFORMATION

This application is for licensure by endorsement of:

___ FLEX ___ National Board ___ USMLE ___ COMPLEX ___ State Exam (State _____)

Date final part of exam was passed: _____

VI. POST GRADUATE MEDICAL EDUCATION

Table with 4 columns: Hospital/Institution, Location, Month/Year to, Month/Year. Rows for Internship and two Residency entries.

V. SPECIALTIES AND BOARD CERTIFICATION

Table with 4 columns: Specialty, Board Certified?, Board Eligible?, Date Certified. Three rows for specialty entries.

VI. STATE LICENSES

LIST ALL STATES OR PROVINCES IN WHICH YOU ARE NOW OR HAVE EVER HELD A LICENSE OR PERMIT TO PRACTICE.

Table with 4 columns: STATE OR PROVINCE, LIC#, DATE ISSUED, DATE EXPIRED. Multiple rows for license entries.

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VII. HOSPITAL/CLINIC AFFILIATIONS

List all hospital/clinical staffs on which you have served in the past five (5) years.

Table with 3 columns: Dates, Hospital/Clinic Name, Location (Address, City, State). Includes horizontal lines for data entry.

VIII. GENERAL BACKGROUND

- 1. HAVE YOU EVER BEEN CHARGED WITH OR CONVICTED OF A FEDERAL, STATE, OR LOCAL STATUTE?
2. HAVE YOU, DURING THE PAST FIVE YEARS, HAD PERSONAL OR LEGAL PROBLEMS WITH ALCOHOL, NARCOTICS, STIMULANTS OR HABIT FORMING DRUGS?
3. HAVE YOU DURING THE PAST 5 YARS BEEN TREATED OR HOSPITALIZED FOR MENTAL ILLNESS?
4. HAVE YOU EVER HAD ANY ACTIN TAKEN AGAINST YOU FOR MEDICAID, MEDICARE, OR INSURANCE FRAUD?
5. HAVE YOU EVER SURRENDERED YOUR PROVIDER NUMBER OR THE STATUS OF A PROVIDER FOR THE MEDICARE OR MEDICAID PROGRAM BY ANY DIVISION OR AGENCY OF ANY STATE OR FEDERAL GOVERNMENT?
6. HAVE YOU EVER HAD A MEDICAL LICENSE DENIED, REVOKED, SUSPENDED OR LIMITED BY ANY STATE LICENSING BOARD OR PROVINCE?
7. HAVE YOU EVER FAILED TO PASS ANY EXAMINATION OR PART THEREOF, REQUIRED BY ANY STATE BOARD OR PROVINCE FOR LICENSURE? (FLEX, NATIONAL BOARD, STATE EXAM, COMLEX, USMLE)
8. HAVE YOU EVER RESIGNED OR WITHDRAWN YOUR APPLICATION FROM A HOSPITAL STAFF OR PROFESSIONAL MEDICAL GROUP?
9. HAVE YOUR HOSPITAL PRIVILEGES EVER BEEN REVOKED OR WITHDRAWN FOR ANY REASON?
10. HAVE YOU SURRENDERED HOSPITAL PRIVILEGES, STATE LICENSES, CONTROLLED SUBSTANCES REGISTRATION, OR DEA REGISTRATION AFTER DISCIPLINARY CASES OR INVESTIGATIONS WERE STARTED?
11. HAVE YOU EVER OR DO YOU HAVE ANY MALPRACTICE CLAIMS, SETTLEMENTS, JUDGMENTS OR MEDICALLY RELATED LAWSUITS AGAINST YOU OR PENDING?
12. HAVE YOU PREVIOUSLY APPLIED FOR A NEW MEXICO OSTEOPATHIC MEDICAL LICENSE OR PERMIT?
13. ARE YOU CURRENTLY MORE THAN THIRTY DAYS IN ARREARS IN PAYMENTS OF AMOUNTS REQUIRED TO BE PAID PURSUANT TO AN OUTSTANDING JUDGMENT AND ORDER FOR CHILD SUPPORT IN NEW MEXICO OR ANY OTHER STATE?

IF YOU HAVE ANSWERED "YES" TO ANY OF THE ABOVE QUESTIONS, GIVE A DETAILED EXPLANATION IN A NOTARIZED AFFIDAVIT ATTACHED TO THIS APPLICATION AND OFFICIAL DOCUMENTATION FROM HOSPITALS, INSURANCE COMPANY, ETC.

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IX. AFFIDAVIT

_____, being duly sworn, deposes and states that the foregoing statements are true and correct. I
(APPLICANT)
further solemnly swear that if granted a license to practice osteopathic medicine in the State of New Mexico, that I shall abide by the
laws of the State.

Dated _____ Signed _____

State of _____ County of _____

SUBSCRIBED AND SWORN TO before me this _____ day of _____, 20____.

My commission expires: _____
(DATE) (NOTARY PUBLIC SIGNATURE & SEAL)

**ATTACH A PASSPORT QUALITY PHOTO TO THE SPACE
PROVIDED AT THE RIGHT. (NO POLAROID)**

