



STATE OF TENNESSEE  
DEPARTMENT OF HEALTH  
HEALTH RELATED BOARDS  
665 MAINSTREAM DRIVE  
NASHVILLE, TENNESSEE 37243

TENNESSEE BOARD OF MEDICAL EXAMINERS

APPLICATION INSTRUCTIONS FOR A FOREIGN TRAINING LICENSE

Provided below is a checklist for your personal use and convenience containing the items that are required to be completed and submitted before your application for a Tennessee medical license will be considered. **ALL DOCUMENTS MUST BE TRANSLATED INTO ENGLISH AND SUCH TRANSLATION SHALL BE CERTIFIED.**

ALL APPLICATION FEES ARE NON-REFUNDABLE

1. Complete and mail application pages 1 through 6, or complete the online application at <https://lars.tn.gov> \_\_\_\_\_
  2. Submit a clear and recognizable recently taken bust photograph of yourself that shows the full head, face forward from at least the shoulders up. \_\_\_\_\_
  3. All applicants must complete, sign and have notarized the Declaration of Citizenship form and submit the documents required by the Declaration of Citizenship form. \_\_\_\_\_
  4. Submit proof of citizenship in the United States or evidence of being lawfully present in the United States. For US citizens - a copy of a birth certificate, current US Passport, or naturalization certificate. For non-US citizens - H1B visa, O visa, J-1, permanent resident card, or proof of visa application in process. \_\_\_\_\_
  5. Complete and submit with your application the **Mandatory Practitioner Profile Questionnaire**. The paper version can be found online at <https://www.tn.gov/content/dam/tn/health/healthprofboards/PH-3585.pdf>. If you submitted your application online, you will complete the Profile in your LARS account at <https://lars.tn.gov>. From the Quick Start menu, select Mandatory Practitioner Profile Questionnaire from the dropdown under Applicant Activities. \_\_\_\_\_
  6. A criminal background check is required and must be completed by the authorized vendor. **The OCA code for Medical Doctor is 1606**. For instructions to obtain a criminal background check, go to <http://tn.gov/health/article/CBC-instructions> \_\_\_\_\_
  7. Cause to be submitted your FCVS Information Profile. If any of the following documents are not included in your FCVS Information Profile, they must be submitted to the Board directly from the source: \_\_\_\_\_
    - Medical school transcript
    - ECFMG Status of Certification Report
    - USMLE exam transcript
- For information regarding FCVS Information Profile, please visit the Federation of State Medical Boards website.
8. Complete the top section of Attachment 1, Verification of Postgraduate Medical Training, and send to each institution in which you received post-graduate medical training (internship, residency, fellowship). Once completed the program should submit the completed form directly to the Board. \_\_\_\_\_
  9. Complete the top section of Attachment 2, Verification of Employment, and send it to all facilities in which you have been employed for the last three (3) years. Once completed the employer should submit the completed form directly to the Board. \_\_\_\_\_

10. Send Attachment 3, Employment Offer, to the healthcare provider/facility where you have received an offer of employment. Once completed the healthcare provider/facility should submit the completed form directly to the Board. \_\_\_\_\_
11. Submit Attachment 4, Foreign Training License Applicant Attestation. This form must be notarized. \_\_\_\_\_
12. Submit a check or money order in U.S. funds in the amount of \$1,015, made payable to the Tennessee Board of Medical Examiners. Be sure the check includes your name and your profession (MD). \_\_\_\_\_

**ATTACHMENT 1**

**TENNESSEE BOARD OF MEDICAL EXAMINERS  
VERIFICATION OF POSTGRADUATE MEDICAL TRAINING**

**APPLICANT:** Provide the information requested in the top box and then mail this form to each institution in which you received any postgraduate medical training. If additional forms are required, copy this one.

**Institution Administration:** I am applying for a Tennessee medical license and hereby authorize you to release any and all information in your files concerning my medical training. I was in training at your institution as follows:

**Applicant's name:** \_\_\_\_\_  
(Last) (First) (Middle/Maiden)

**Name of Institution:** \_\_\_\_\_ **Program Title:** \_\_\_\_\_

\_\_\_\_\_  
**Applicant's Signature** **Dates of Training**

**THIS PORTION IS TO BE COMPLETED BY THE TRAINING PROGRAM'S ADMINISTRATIVE OFFICE**

Please complete (including all questions) and return to: [medical.health@tn.gov](mailto:medical.health@tn.gov)

I attest that the information on this form is true and correct.

<input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Research	<b>Specialty/Subspecialty:</b> _____ <b>Successfully Completed?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No* <input type="checkbox"/> In Progress *If no, how many months of partial credit was received? _____ <b>From:</b> ___/___/___ <b>To:</b> ___/___/___ (In progress, provide expected completion date.) <b>Accredited By:</b> ___ ACGME ___ ACGME-I ___ AOA ___ RCSPC ___ None of These
Please attach an explanation for any "yes" response. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	1. Did this individual take a leave of absence or break during training? 2. Did this individual resign from training? 3. Was this individual ever placed on probation for any reason? 4. Did this individual receive a written warning or documented counseling about their behavior? 5. Was this individual ever disciplined or placed under investigation? 6. Were this individual's privileges or duties ever reduced, suspended, or revoked? 7. Did this individual experience delayed promotion or advancement to the next level? 8. Was this individual informed that their contract would not be renewed? 9. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems, or any other reason? 10. Was this individual suspended, terminated, or dismissed from training?

\_\_\_\_\_  
Program Director's/Dean's Signature **Date**

Subscribed and sworn before me this the \_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

\_\_\_\_\_  
Notary Public (Affix Seal Here)

My Commission Expires: \_\_\_\_\_



13.	Was this physician involuntarily removed from a call schedule for cause? <b>If yes, attach an explanation on a separate sheet.</b>	Yes No
14.	Was this physician subject to non-routine quality assessment review? <b>If yes, attach an explanation on a separate sheet.</b>	Yes No
15.	Was this physician the subject of a negative review by a quality assurance or departmental committee? <b>If yes, attach an explanation on a separate sheet.</b>	Yes No

\_\_\_\_\_  
**Signature of Hospital/Facility/Employer**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Printed Name**

\_\_\_\_\_  
**Phone Number**

\_\_\_\_\_  
**Title**

\_\_\_\_\_  
**Email**

**ATTACHMENT 3**

**TENNESSEE BOARD OF MEDICAL EXAMINERS  
Employment Offer**

**APPLICANT:** This form must be completed and submitted by the healthcare provider.

**HEALTHCARE PROVIDER/FACILITY:** Please complete, sign, and have this form notarized. Once completed the form should be emailed directly to the Board at [medical.health@tn.gov](mailto:medical.health@tn.gov)

**ATTESTATION**

I, \_\_\_\_\_, attest that \_\_\_\_\_  
**Representative of Healthcare Provider / Facility** **Applicant's Name**

Has an offer of employment performing the duties of a clinical physician at \_\_\_\_\_  
**Healthcare Provider / Facility**

Located at \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_.  
**City State Zip Code**

I further attest that the healthcare provider/facility listed above has a postgraduate training program accredited by the Accreditation Council for Graduate Medical Education (ACGME) in place.

**Training Program Specialty** \_\_\_\_\_

**Training Program ACGME Accreditation Code** \_\_\_\_\_

**THIS CERTIFIES THAT THE INFORMATION SUBMITTED BY ME IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.**

\_\_\_\_\_  
Representative Signature

\_\_\_\_\_  
Date

Subscribed and sworn before me this the \_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

\_\_\_\_\_  
Notary Public

(Affix Seal Here)

My Commission Expires: \_\_\_\_\_

**ATTACHMENT 4**

**TENNESSEE BOARD OF MEDICAL EXAMINERS  
Foreign Training License Applicant Attestation**

**ATTESTATION**

I, \_\_\_\_\_, attest to the truth of each statement below. I further consent to the  
(Applicant's Name)  
use of official verification from other countries, to include but not be limited to licensure verification and criminal background  
checks if such forms of official verification are available.

**Please initial each statement below and sign the form in the presence of a notary.**

**I HEREBY ATTEST:**

\_\_\_\_\_ I have no criminal history in any country.

\_\_\_\_\_ Any license I hold in any country or province is in good standing and has never been disciplined.

\_\_\_\_\_ I have no open or pending investigations.

\_\_\_\_\_ There were no adverse actions taken against me in medical school.

\_\_\_\_\_ There were no adverse actions taken against me during any healthcare employment.

\_\_\_\_\_ There were no adverse actions taken against me during post-graduate training.

\_\_\_\_\_ I will notify the Board within thirty (30) days should I no longer be employed by the same healthcare  
provider listed in my initial application.

**THIS CERTIFIES THAT THE INFORMATION SUBMITTED BY ME IS TRUE TO THE BEST OF MY KNOWLEDGE  
AND BELIEF.**

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

Subscribed and sworn before me this the \_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

\_\_\_\_\_  
Notary Public

(Affix Seal Here)

My Commission Expires: \_\_\_\_\_