Colorado Division of Professions and Occupations

Office of Licensing—Medical

1560 Broadway, Suite 1350 Denver, CO 80202

Phone: (303) 894-7800 / Fax: (303) 894-7693 www.dora.colorado.gov/professions

APPLICATION FOR PHYSICIAN TRAINING LICENSE

APPLICANT INSTRUCTIONS

Basic Requirements. Requirements for physician training licensure are outlined in the Medical Practice Act, specifically C.R.S. 12-36-122, and the Board's Rules and Policies. The Medical Practice Act, complete rules and policies, and more information about physician training licensure can be found on our website at www.dora.colorado.gov/professions/physicians. Please also refer to the Frequently Asked Questions located at the end of this application.

- ▶ All physicians participating in an internship, residency or fellowship are required to hold a physician training license or an active Colorado medical license. Upon notification to the Colorado Medical Board from the training program of acceptance into the training program, the applicant will have 60 days to complete and submit a training application.
- ▶ You are not required to complete a training license application if:
 - 1. You currently hold a full, active Colorado medical license.
 - 2. You are completing a Colorado training rotation in an approved internship, residency, or fellowship (as defined in Colorado law) that will last for no more than an aggregate period of 60 days.
 - 3. You are doing a rural rotation in conjunction with a non-Colorado training program and will be in the rotation for less than 60 days.

In compliance with the Michael Skolnik Medical Transparency Act of 2010, all applicants are required to complete and maintain an online Healthcare Professions Profile on our website at www.dora.colorado.gov/professions/hppp.

About the Application. This application is to be completed by you and returned to the Office of Licensing. All questions on the application are mandatory, and all supporting documents must be submitted with the application. You may copy as many forms as needed; however, each form submitted must be completed in original ink or typed. Keep a copy of the completed application for your records.

Social Security Number is Required. Effective January 1, 2009, a Social Security Number is required for all licensees. The Division will consider an application to be incomplete when the applicant fails to submit his/her Social Security Number. Exceptions are made for foreign nationals not physically present in the United States and for non-immigrants in the United States on student visas who do not have a Social Security Number. These applicants must submit a signed Social Security Number Affidavit in lieu of a Social Security Number. The affidavit is available on our website at www.dora.colorado.gov/professions/physicians, or you may call (303) 894-7800 to request that one be mailed to you.

Disclosure of Addresses. Consistent with Colorado law, all addresses and phone numbers on record with the Division are public record and must be provided to the public when requested. It is your responsibility to keep your address and contact information up-to-date in our database. All letters, renewal notices, and licenses are mailed to the last known address of record. **If your address is not current, it is possible you will not receive important documents.** You can change your address online by using Online Services at www.dora.colorado.gov/professions/onlineservices.

License Expiration and Renewal. Regardless of the date issued, all training licenses expire on August 31, three years from the year of issue, and may be renewed for three years thereafter. A training license can be granted for a total aggregate period of six (6) years, at which time you would need to apply for full licensure.

► Renewal notices are mailed to the address of record approximately six (6) weeks prior to the expiration date. Physician training licenses must be renewed to continue practicing.

APPLICANT INSTRUCTIONS (Continued)

Checking Your Application Status. Visit Online Services at www.dora.colorado.gov/professions/onlineservices to track your application from the date we log it in our database to the date your license is printed. Please allow us enough time to receive the application through the mail and enter your application into our database before you check the website. We recommend waiting at least 10 business days from date of mailing before checking the status of your application.

APPLICANT CHECKLIST

То арр	ly for a Colorado Physician Training license:		
	Complete the attached application. Return the completed application and all supporting documentation to the Office of Licensing.		
	Enclose the non-refundable application processing fee. See page 1 of the application form for current fees. Fees may be paid by a check or money order drawn in U.S. dollars on a U.S. bank and made payable to <i>State of Colorado</i> . All fees are non-refundable and subject to change every July 1.		
	Complete and return the attached Affidavit of Eligibility form. Pursuant to C.R.S .24-34-107, all applicants for licensure are required to complete and sign an Affidavit of Eligibility, and may also be required to provide a copy of a secure and verifiable document.		
	Provide documentation of any name change. If your name has changed since you obtained a previously-issued license, or if your name is different on any of your supporting documentation, you must provide a copy of the legal document verifying the name change (i.e., marriage license, divorce decree, or court order).		
	Request to have the attached Training Program Statement completed by the Program Director, Clinical Director, or Training Supervisor of your training program.		
	▶ NOTE: If a separate statement has already been submitted to the Board, this section does not need to be completed. Please check with your training program to see if this information has been submitted to the Colorado Medical Board.		
	Complete an online Healthcare Professions Profile. Once your application is received and entered into the Division of Professions and Occupations database, you must create a Healthcare Professions Profile on our website at www.dora.colorado.gov/professions/hppp . You may begin checking the Healthcare Professions Profiling Program (HPPP) website within a few days of submitting your application. If you cannot create your profile within 14 days of submitting your application, or if you have questions or technical issues regarding your online profile, contact the Healthcare Professions Profiling Program at (303) 894-5942. Your application is not considered complete , and a license will not be issued until you have submitted the online profile.		

Return your completed application packet and all supporting documentation to:

Division of Professions and Occupations
Office of Licensing—Medical
1560 Broadway, Suite 1350
Denver, CO 80202



IMPORTANT NOTICE

TO: All Applicants

FROM: Director of the Division of Professions and Occupations

SUBJECT: Licensure and Criminal History

Thank you for your interest in becoming a licensed* professional within the Division of Professions and Occupations. Before you submit your application, please be aware of a few facts regarding criminal conduct, convictions, and disciplinary actions in other states.

The mission of the Division of Professions and Occupations is "public protection through effective licensure and enforcement." One way the Division safeguards consumers is by issuing licenses to fully qualified, competent, and ethical applicants.

During the licensing process – and depending on the specific application – the Division will ask whether you have ever been disciplined in any state, arrested, charged, convicted, or pled guilty to a crime. An arrest, subsequent criminal conviction, or disciplinary action is not an automatic disqualification from licensure. Instead, the appropriate board or program will look at the facts surrounding the criminal conduct and disciplinary action to determine whether you are fit for licensure. You should know that licensure is a privilege, not a right. One thing you must do to obtain the privilege is to be completely honest on your application.

Be sure to list all relevant complaints, disciplinary actions, arrests, charges, or convictions in response to the licensure questions. Failure to fully disclose could constitute grounds alone for denial of your application or revocation of your license. More important, avoid some of the common excuses we have heard from people who failed to disclose, such as:

- My attorney told me I didn't have to disclose the criminal conduct or disciplinary actions.
- I didn't think the prior conduct had anything to do with the profession.
- I didn't think the disciplinary action, arrest, charges, or conviction was still on my record.
- I didn't think it was subject to disclosure because I received a deferred sentence/judgment.

Remember, there is no excuse not to disclose disciplinary actions and criminal conduct. Even after licensure, you are still required to notify your professional licensing board or program about subsequent convictions and disciplinary actions in other states.

The Division conducts audits of its licensing database against several criminal and national disciplinary databases. This allows the Division to verify the truthfulness of your application and track subsequent criminal and disciplinary conduct after initial licensure. Keep in mind, you will not necessarily be revoked or denied a license if you have been disciplined, arrested, charged or convicted, but you will most likely be denied or revoked if you fail to disclose it.

*The word "license" is used as a general term. While most of the professions and occupations are licensed, others may be registered, certified, or listed. For precise terminology and requirements related to a profession or occupation, please consult the website of the appropriate board or program.



Colorado Department of Regulatory Agencies Division of Professions and Occupations 1560 Broadway, Suite 1350 Denver, CO 80202

Licensee/Applicant Full Legal Name

	Last	<u>-</u>		First	Middle	Suffix
	Colorado Professional or Occupational License/Certification/Registration Number: (if already licensed) Professional or Occupational License/Certification/Registration type applying for:					
			AFF	IDAVIT OF ELIGIBILIT	Y	
				LL applicants for original licer required to complete and sign		ng or reinstating a
				of the professions and occupations a profession or occupation, please co		
		Sect	ion A: LA\	WFUL PRESENCE in the Un	ited States	
1.				cceptable secure and verifiab d. Complete documentation r		
2.	to be employed	d in the U.S. Ch	neck <u>one</u> o	oresent in the U.S. and <u>authorize</u> f the acceptable secure and vicin requested. Complete doc	verifiable documents in S	ection B that
3.	sec. 1621 (c)(2 a.	2)(a). Check one a U.S. citizen, r	e option, a one option of physica	der 8 U.S.C. sec. 1621 (c)(2)(cor b below, then skip to Section Ily present or employed in the l	C. (Do not complete Secti United States.	
	b. 📙 lam	a Foreign Nation	onal, not p	hysically present or employed	I in the United States.	
		Coot	D. CE	CUDE AND VEDICIADI E DO	CLIMENTO	
	9			CURE AND VERIFIABLE DO		
		Name of state				Expiration
Go	vernment Issued	or federal ag	ency that	Full name as shown on o		Date
П	Identification Driver's license or	issued the d	ocument	license or state/federal is	sued ID Number	(mm/dd/yyyy)
	permit					
	Government issued ID card					
	Valid U.S. military ID/common access card					
	Colorado Department of Corrections inmate ID					
	Tribal ID card					
	U.S. passport					
	Certificate of					

	Section B: SECURE	AND VENILIABLE D	OCCIVILIA 13 (COI)	itiriueu <i>j</i>	
	Name of state agency				Expiration
Government Issued	or federal agency that	Full name as shown on driver's		License/ID	Date
Identification	issued the document	license or state/fe	deral issued ID	Number	(mm/dd/yyyy)
Certificate of (U.S.) Citizenship					
☐ Valid Temporary Resident card					
Valid I-94 issued by Canadian government					
Valid I-94 with refugee/asylum stamp					
☐ Valid I-766 (Employ	ment Authorization Card)		Issuing federal a	agency:	
Name	on card	Alien Number (A#)	Card Number	Valid from (mm/dd/yyyy)	Expires (mm/dd/yyyy)
☐ Valid I-551 (Reside	nt Alien or Permanent Resid	dent Card)	Issuing federal a	agency:	
Name	on card	Alien Number (A#)	Country of birth	Card expires (mm/dd/yyyy)	Resident since (mm/dd/yyyy)
		,		((**************************************
☐ Valid foreign passp	ort with an unexpired visa w	vith proper classification	n for work authoriza	ation, and an unex	pired I-94
			Visa Class		1
Issuing foreign country	Passport Number	Visa Number	(ex.: J-1, P-1, H-1B, etc.)	Date of entry (mm/dd/yyyy)	Until date (mm/dd/yyyy)
			,,	(**************************************	(**************************************
☐ Valid foreign passport	ort bearing an unexpired "P	rocessed for I-551" sta	mp or with an attac	ched unexpired "Te	mporary I-551"
Issuing foreign countr	y:		Passport Number	er:	
	5	Section C: ATTESTA	TION		
 I understand that this sworn statement is required by law because I have applied for or hold a professional or commercial license regulated by 8 U.S.C. sec. 1621. I understand that state law requires me to provide proof that I am lawfully present in the United States when asked as well as submission of a secure and verifiable document. I may also be required to provide proof of lawful presence. 					
are punishable	• I understand that in accordance with sections 18-8-503 and 18-8-501(2)(a)(I), C.R.S., false statements made herein are punishable by law. I state under penalty of perjury in the second degree, as defined in 18-8-503, C.R.S. that the above statements are true and correct.				
• I am the person identified above and the information contained herein is true and correct to the best of my knowledge. I understand that under Colorado law, providing false information is grounds for denial, suspension or revocation of a license, certificate, registration or permit.					
	 I understand that the above information must be disclosed to the Department of Regulatory Agencies upon request and is subject to verification. 				
Print Full Legal Name					
Signature (Full Name)			Date		

Application PHYSICIAN TRAINING LICENSE

Fee: \$10

The content of this application must not be changed. If the content is changed, the applicant may be referred to the Colorado State Attorney General's Office for violation of Colorado law.

Fees may be paid by a check or money order drawn in U.S. dollars on a U.S. bank and made payable to State of Colorado.

PART 1-	-APPLIC	ANT INFORMATION		
Name: Last:	☐ MD ☐ DO	First:	Middle:	Suffix:
Previous Name(s):				
Social Security Number: *	Date of	Birth (mm/dd/yyyy):	Gender: Male	e 🗌 Female
Place of Birth (city and state, or foreign country):				
Mailing Address: PO Box, Street: This is a ☐ Home ☐ Business City, State, Zip:				
Daytime Telephone Number: ()		E-mail Address: Preferred method for communicat	ion: 🗌 Mail 🗌 E-ma	nil
PART 2—ED	UCATION	I / TRAINING PROGRAM		
List the name and address of the school where y	our med	ical degree was received:		
Name of School Loc	cation (city a	nd state)	Years Attended	I (from / to)
List information about the specialty program into	which y	ou have been accepted:		
Name of School Address		Telepho	one Number Start Date	in Program
Is the training position you are filling a: CATEGORICAL – a permanent position for the duration of your program? PRELIMINARY NON-DESIGNATED – you have not yet matched into a permanent program? PRELIMINARY DESIGNATED – from which you will transfer to upon completion? (name/location of subsequent program)				
Have you received and/or completed additional postgraduate training approved by the ACGME/AOA in U.S. or Canadian programs in addition to the program listed above?				
► If YES, provide information below:				
Name of Facility Specialty Years Attended (from / to)			om / to)	

*Social Security Number Disclosure: Section 24-34-107(1) of the Colorado Revised Statutes requires that every application by an individual for a license issued pursuant to the authority set forth in title 12, C.R.S., by the Department of Regulatory Agencies, shall require the applicant's social security number. Disclosure of your social security number is mandatory for purposes of establishing, modifying, or enforcing child support under § 14-14-113 and § 26-13-126, C.R.S.; locating an individual who is under an obligation to pay child support as required by § 26-13-107(3)(a)(I)(A), C.R.S.; and reporting to the National Practitioner Data Bank pursuant to 45 CFR §§ 61.1 et seq., and the Health Integrity and Protection Data Bank as required by 45 CFR §§ 61.1 et seq. Failure to provide your social security number for these mandatory purposes will result in the denial of your licensure application. Disclosure of your social security number is voluntary for disclosure to other state regulatory agencies, testing and examination vendors, law enforcement agencies, and other private federations and associations involved in professional regulation. Your social security number will not be released for any other purpose not provided for by law.

OFFICE USE ONLY	LICENSE NUMBER:	DATE ISSUED:

	APPLICANT NAME:						
		PAR	T 3—LICENSE INF	ORMATION			
	_	icensed to practice me		e, territory, distr	ict, or	YES	□NO
	► If YES, provide a co	emplete list of all medica	al licenses (if needed	d, attach an addit	ional sheet in the s	ame forma	t):
	Type of license	State/Country	License Number	Year license issued	Disciplinary action against license?		license d/active?
					☐ YES ☐ NO	☐ YES	□ NO
					☐ YES ☐ NO	☐ YES	□ NO
					☐ YES ☐ NO	☐ YES	□ NO
В.	Have you ever filed a	n application in Colora	ado?			☐ YES	□NO
	► If YES, give date	e of previous application	າ:			<u> </u>	
		PAR	T 4—SCREENING	QUESTIONS			
1.		d by any state, territory, distri plaint, investigation, or inquiry			ate medical/osteopathic	☐ YES	□NO
		elow AND request official com well as personally submit a r			tly to the Board from		
	Agency	Date	Charge		Disposi	<u>tion</u>	
2.	2. Has any healing arts license which you now hold or have ever held been admonished, reprimanded, censured and/or disciplined in any way by any licensing agency in another state or country, by any peer review committee or body, by any healthcare facility or committee thereof, by any professional or medical society or association or committee thereof, or by any governmental agency, law enforcement agency or court of law? (Disciplinary actions include, but are not limited to, any allegations currently pending.) Washington licensees must disclose any Stipulation to Informal Disposition in response to this question. ▶ If YES, give details below AND request all official disciplinary documents including initial complaint, stipulations, orders or reprimands be sent directly to the Board, as well as a narrative regarding the action taken.					□NO	
	Agency	Date	Charge		Disposi	tion	
3.		any agreement with any stat		ry, U.S. government	agency, and state	☐ YES	□NO
		elow AND request all official d directly to the Board. Also su					
	Agency	Date	Reas	son			
4.		d a license, permission to pra ountry, or U.S. federal jurisdio		er healing art, or peri	mission to take an	YES	□NO
	► If YES, give details be	elow AND request all official d ands be sent directly to the B	isciplinary documents inc				

Reason for Denial

Date

Agency

		APPLICANT NAME:				
	PART 4—SCREEN	IING QUESTIONS (Continued)				
5.	Have you ever voluntarily surrendered a license to practice medic U.S. federal jurisdiction? This does not include allowing your licen If YES, summarize below AND request all official disciplinary agreements or reprimands be sent directly to the Board. Also	ine or any other healing arts in any other state, country, or use to expire solely due to non-payment of the renewal fee.	☐ YES	□NO		
	Agency Date	Reason				
6.	Have either your medical staff membership or clinical privileges at been voluntarily or involuntarily reduced, limited, placed on probat denied, revoked or suspended? You must answer YES if any of the you have withdrawn or failed to proceed with an application for the	tion, not renewed or relinquished or have either been nese actions are currently pending. You must answer YES if ese items.	YES	□NO		
	If YES, summarize below AND request hospital or DEA to su submit your narrative regarding the action taken.	ıbmit a report directly to the Board regarding the action. Also				
	Name of Facility Date	Reason for Action				
7.	Have you ever been charged, indicted, convicted, received a defe sentence, entered a plea of guilty, entered a plea of nolo contende any law? Note: It is unnecessary to report traffic offenses that do go	ere, or been placed on adult diversion for any violation of	☐ YES	□NO		
	If YES, summarize below AND submit your narrative regarding information regarding final disposition of the case.	ng the incident as well as court and police records and				
	Date Court	Violation Penalty or Dis	position			
8.	Do you now abuse or excessively use, or have you in the last five including alcohol, or any controlled substance that has a) resulted neglect of work, or failure to meet professional responsibilities; or competently?	I in any accusation or discipline for misconduct, unreliability,	YES	□NO		
9.	In the last five years, have you been diagnosed with or treated for behavior, or motor function, and that may impair your ability to pra not limited to bipolar disorder, severe major depression, schizophiillness, or sleep disorder?	actice as a physician safely and competently, including but	YES	□NO		
mea	You may answer NO to Question 8 or 9 if the behavior or condition is already known to the Colorado Physician Health Program (CPHP). "Known to CPHP" means that you have informed CPHP of your behavior or condition and you are complying with all of CPHP's requirements for evaluation, treatment, and/or monitoring.					
con	If you answer YES to Question 8 or 9, submit detailed information to the Board that will allow the Board to assess your ability to practice safely, competently, and without impairment to your professional judgment, skill, or knowledge. In addition to that information, you are required to provide copies of any related records, reports, evaluations, police reports, probation reports, and court records directly to the Board.					

Please be advised that an affirmative response to Question 8 or 9 may result in a request from the Board for evaluation by the Colorado Physician Health Program (CPHP). The CPHP evaluation process could potentially delay consideration of an application. Therefore, the Board is providing advance notice of this possibility so that applicants may contact CPHP to schedule an evaluation at the beginning of the application process. By doing so, the application for licensure should not be unduly delayed. An applicant is not required to contact CPHP in advance of Board consideration of the application. The applicant may choose to wait for a specific decision by the Board that a CPHP evaluation is necessary. This information is being provided to put applicants on notice with respect to this potential requirement and affort the opportunity to expedite the process if he or she so desires.

(Colorado Physicians Health Program – CPHP, 899 Logan Street, #410, Denver, CO 80203; (303) 860-0122.)

APPLICANT NAME:
PART 4—SCREENING QUESTIONS (Continued)
10. Within the last five years, has any final judgment, settlement or arbitration award for medical malpractice been paid on your behalf or has any claim been filed which is still pending? ► If YES, list below and complete the attached Claims Information Form.
Date Name and Address of Insurance Company Reason for Action
11. Have you ever been refused malpractice insurance, or has your malpractice insurance ever been canceled or rated at a higher premium due to past claims experience? ▶ If YES, submit to the Board an explanation regarding the cancellation or increase in premiums of the insurance and
verification directly from the insurance company to the Board.
PART 5—SECURITY OF PATIENT MEDICAL RECORDS
By checking this box, I attest that I have developed a written plan to ensure the security of patient medical records in compliance with C.R.S. 12-36-140.
ATTESTATION
I hereby make application for a license to practice medicine in the state of Colorado. In so doing, I authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), business and professional associations (past and present), and all government agencies (local, state, federal and foreign), which includes state medical licensing boards and the Federation of State Medical Boards, to release to the licensing Board any information, files or records requested by the Board in connection with the processing of this application. I further authorize this Board to release to the organizations, individuals and groups listed above any information which is material to my application or pertinent to my practice of medicine during the processing of this application and the time that I am a licensee of this Board.
I understand that this license will apply only to the training program I am currently entering, and will only be transferable to a subsequent program if I am currently matched into that subsequent program as a requirement of my training program. I will not practice in any other subsequent training program until a new valid training license has been issued to me.
I understand that this license will only be valid for the training program listed within this application, and should I wish to practice medicine in Colorado outside the training environment, I would need to apply for a license to practice medicine in the state of Colorado.
I further understand that the issuance of this training license is not a guarantee of issuance of a license to practice medicine in the state of Colorado.
I state under penalty of perjury in the second degree, as defined in C.R.S. 18-8-503, that the information contained in this application is true and correct to the best of my knowledge. In accordance with C.R.S. 18-8-501(2)(a)(I), false statements made herein are punishable by law and may constitute violation of the practice act.

Date

Applicant Signature

TRAINING PROGRAM STATEMENT

This statement to be completed by Program Director, Clinical Director, or Training Supervisor.

NOTE: If a separate statement has already been submitted to the Board, this section does not need to be completed. Please check with your training program to see if this information has been submitted to the Colorado Medical Board.

Name of Colorado Training Program / Specialty:			
Address of Training Program:			
I certify that this applicant meets the criteria set forth in indicated above will accept responsibility for the applicant	a C.R.S. 12-36-122 (2)(a), and that the training program ant's medical training while in the program.		
This applicant is filling a			
□ CATEGORICAL – a permanent position for the	duration of their program.		
□ PRELIMINARY NON-DESIGNATED – they have	ve not yet matched into a permanent program.		
□ PRELIMINARY DESIGNATED – from which the	ey will transfer to the following upon completion:		
(Name / location of subsequent program)			
that a signed attestation from the Program Director of t	ng in my program and will also advise the Board if the		
Signature of Program Director, Clinical Director, or Sup of Colorado Training Program (must be a Colorado li	- -		
Print name	Colorado license number		
Name of contact for program	Program contact phone number		

COLORADO MEDICAL BOARD CLAIMS INFORMATION FORM

Applicant: Complete this form for each liability or malpractice claim identified in the application Screening Question regarding malpractice.

Name of Physician		Business Telephone Number			
Ad	ddress		City, State, ZIP		
1.	case(s) / allegations. Include name of patie not omit the answers to these questions or	ent, age, sex, date make reference on, which include	de a clinical narrative regarding each malpractice of occurrence, and location (include address). Do attached documents for answers. This section is all of the facts requested above. Simply stating must be provided.		
2.	Indicate your position in case, i.e., intern, re	esident, primary o	doctor, etc.		
3.	_	dual doctor	Group		
4.	Plaintiff's Attorney and Telephone:				
5.	Is the claim pending?	☐ YES	□NO		
6.	Was there a judgment or settlement?	☐ YES	□NO		
7.	What was the amount and date of the judg	ment or settleme	nt?		
8.	What amount was attributable to you, your	insurance compa	iny, or your employer?		
Ιc	ertify that the information I have provided	d is correct to th	e best of my knowledge.		
Siç	gnature		Date		

FREQUENTLY ASKED QUESTIONS

Why is a training license necessary?

Colorado law requires all physicians accepted into training programs in this state to have, at a minimum, a physician-training license. You may not work in a training program in Colorado without a training license.

Are there any exceptions to the training license?

Yes, there are exceptions. First, if you hold a full, active Colorado medical license, you do not need a training license. Second, if you are completing a Colorado training rotation in an approved internship, residency or fellowship (as defined in Colorado law) that will last for no more than an aggregate period of 60 days, you do not need to apply for a training license. Third, if you are doing a rural rotation in conjunction with a non-Colorado training program and will be in the rotation for less than 60 days.

Are there further requirements for an out-of-state resident to do a Colorado rotation?

Yes, the out-of-state residency program must be ACGME or AOA approved, the resident must be working under the responsible direction of a Colorado licensed physician, and the resident must meet the malpractice insurance requirements for Colorado.

Can an applicant still apply if the program is not ACGME/AOA approved?

Yes, but the program would need to also apply for and receive approval from the Board prior to the applicant's application being reviewed. Applications to request approval of a non-ACGME/AOA program are available from the Board.

Do I need to reapply if I change training programs?

Yes, this license will be issued based on your acceptance into a specific program documented in your application. The only exception is if you are in a Preliminary Designated position and have matched into your subsequent program at the time of initial application.

What is the deadline for submitting this application?

A temporary permit may be issued upon notification from your training program of acceptance into the training program. If a completed application package is not received and approved within 60 days of the date you begin work in your training program, your temporary permit will expire. When your application is approved, your permit will convert to a training license. It will be the responsibility of the applicant to provide the Medical Board with a completed application package and fee in sufficient time to allow a two-week processing time prior to the end of the 60-day temporary period.

Can I use this license to moonlight in a part time job?

No, this training license is only valid for the training program indicated on the application. You must apply for and be approved by the Board for a full medical license with the Board should you wish to practice outside the designated training program.

Do I need both a training license and a full medical license?

No, upon issuance of a full medical license, your training license will immediately expire.

Does the training permit or license allow me to write prescriptions?

No, you may not write prescriptions, which will be filled, outside of your training institution. That is, prescription orders that are given to a patient to be filled at a retail pharmacy must be co-signed by a fully licensed attending physician.

How do I know if I have been approved for a temporary permit to practice in a training program?

Contact your training program to see if your name and the required attestation have been submitted to the Medical Board. If so, your 60-day temporary permit to practice will be mailed to you in care of the training program. You may also verify a Colorado credential on our website at www.dora.colorado.gov/professions/onlineservices.