Hello!

Thank you for signing up for our licensing services. We are looking forward to working with you!

In this packet you will find:

- Authorization Form
- Plan Contract
- Credit Card Authorization Form
- Questionnaire

Please fill these out and return them to by email to ashley@adrmedicallicensing.com.

Along with these forms, we will also need the following documents to complete your file. These can be emailed as well.

- Current CV/Resume
- Driver's License
- Birth Certificate or Passport
- Board Certification (Certificate or Verification)
- Name Change Document, if applicable (Marriage license, divorce decree, etc.)
- Passport-Style photo (This can be taken yourself. It just has to be from the shoulders up against a white/light background)
- Any current login information to:
    - State board licensing portals
    - Parchment account (for transcript ordering)
    - CE tracking accounts (CEBroker, NetCE, AANP, UpToDate, etc.) if you'd like us to have access to those.

Please feel free to reach out with any questions you may have. Again, we look forward to working with you and we appreciate your trust in our team!

Thank you,

The ADR Medical Licensing Team

Licensure Authorization Form

ADR Medical Licensing's team will facilitate the process for obtaining a new state license and appropriate renewals in the following state(s): _____.

With your authorization, the Licensure team will work to submit the aforementioned provider's application, including but not limited to:

- Obtaining information from the provider to allow the ADR Medical Licensing team to electronically sign, and attest on their behalf for new state applications and renewals
- Requesting education, state, and board certification verifications, NPDB reports, and background checks
- Coordinating fingerprinting
- Enrolling for prescriptive authority, where required by state
- Applying and obtaining Controlled Substance permits and DEA registrations in the states above

All licensure fees outside of printing, postage, and fingerprint card ordering will be paid for by the applicant. A credit card must be held on file for such fees.

If you decline, we will not assist with any of the aforementioned steps.

If you have additional questions, you may contact us directly ashley@adrmedicallicensing.com.

Thank you for your cooperation and partnership.

Sincerely,

The Licensure Team

_____

☐ I **authorize** ADR Medical Licensing to submit my state license application or renewals and make necessary changes as outlined above.

☐ I **do not authorize** ADR Medical Licensing to submit my state license or renewal.

Signature: _____ **Date:** _____

Name: _____

Licensing Plan Contract

☐ Full-Service Plan - $300 per month

This plan will keep ADR Medical Licensing on retainer for the following services:

- Applying for new licenses
- Managing pending license applications and submitting all required documentation for those applications
- Applying for and managing Prescriptive Authority, Controlled Substance, and DEA registrations
- Managing CEs through each renewal cycle
- Renewing existing license when they are due
- Assisting in renewal of board certifications
- Being available for all updates that boards will need throughout the year
- Any other miscellaneous licensing need that comes up

☐ Maintenance Plan - $150 per month

This plan will keep ADR Medical Licensing on retainer for the following services:

- Managing CEs through each renewal cycle
- Renewing existing license when they are due

All plans automatically renew each month from your sign-up date. You may switch plans or cancel this subscription at any time with 30 days' written notice.

If you have additional questions, you may contact us directly at ashley@adrmedicallicensing.com.

By signing below, you agree to the terms and conditions listed herein this document.

Signature: _____ **Date:** _____

Name: _____

Credit Card Authorization Form

Your completion of this authorization form helps us protect you, our valued client, from credit card fraud. All information on this form will be kept strictly confidential by our company.

CARD HOLDER NAME: _____

CARD NUMBER: _____ _____ _____ _____

EXPIRATION DATE: _____ / _____

SECURITY CODE: _____

CARD BILLING ADDRESS: _____

CARD TYPE: ☐ VISA ☐ MASTERCARD

(AMEX and DISCOVER cards are not accepted by all boards of nursing/medicine and therefore are not ideal to hold on file for fees. Please supply either a VISA or MASTERCARD.)

I (We) herby authorize ADR Medical Licensing & Notary LLC to charge the credit card listed above for fees related to licensing. I understand that receipts will be provided to me for each transaction made, and I can request to have this card removed from my file at any time.

I guarantee that I am the legal cardholder for this credit card and that I am legally authorized to enter into this billing agreement with ADR Medical Licensing & Notary LLC.

Signed: _____

Dated: _____

☐ I understand that payments will be automatically processed each month and that I can switch plans or cancel my subscription with 30 days' written notice.

PA Information

Full Name: _____
Last *First* *Middle*

Address: _____
Street Address *Apt/Unit*

_____
City *State* *Zip Code*

Phone: _____ Email: _____

Birthday: _____ Social Security Number: _____

Race/Ethnic Group:

- Caucasian (White)
- African American (Black)
- Hispanic
- Asian/Pacific Islander
- American Indian/Alaskan Native
- Other: _____

Gender: _____ Birth Name: _____

Any other names you've gone by: _____

_____

Birthplace (City/State/Country): _____

Mother's Maiden Name: _____

Height: _____ Weight: _____

Eye Color: _____ Hair Color: _____

Marital Status: _____

Fluent Languages (Besides English): _____

Education & Training

Have you ever served in the military? _____

If so, what branch? _____ Was it an honorable discharge? _____

Are you the spouse or registered domestic partner or military personnel? _____

Professional Exam:
Did you take the NCCPA exam? _____ Date Taken: _____

City/State where you took exam: _____ # of Attempts: _____

List all schools you have attended since high school:

College Name: _____

Address: _____
Street Address

_____
City *State* *Zip Code*

Dates Attended: _____ to _____ (MM/DD/YYYY)

Degree Obtained: _____

College Name: _____

Address: _____
Street Address

_____
City *State* *Zip Code*

Dates Attended: _____ to _____ (MM/DD/YYYY)

Degree Obtained: _____

College Name: _____

Address: _____
Street Address

_____
City *State* *Zip Code*

Dates Attended: _____ to _____ (MM/DD/YYYY)

Degree Obtained: _____

License Information

Have you ever been licensed in a country outside the United States? _____

If yes:

Country: _____ License #: _____

Do you have an FCVS profile? _____

If so, please provide your login information:

Username: _____

Password: _____

**You may be requested to create an FCVS profile to expedite licensing in certain states.*

Please list ALL licenses you have ever held in any state or jurisdiction (Email any that you cannot fit on this form to ashley@adrmedicallicensing.com:

License State: _____ License #: _____

Type of License: _____ Status: _____

License State: _____ License #: _____

Type of License: _____ Status: _____

License State: _____ License #: _____

Type of License: _____ Status: _____

License State: _____ License #: _____

Type of License: _____ Status: _____

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Type of License: _____ Status: _____

License State: _____ License #: _____

Type of License: _____ Status: _____

License State: _____ License #: _____

Type of License: _____ Status: _____

License State: _____ License #: _____

Type of License: _____ Status: _____

License State: _____ License #: _____

Type of License: _____ Status: _____

Have you ever held a DEA license? _____

If yes, please list those below:

State: _____ DEA License #: _____

Date of Issuance: _____ Expiration Date: _____

State: _____ DEA License #: _____

Date of Issuance: _____ Expiration Date: _____

**Email any others that do not fit on this form*

Board Certification

Are you board certified? _____

Certifying Board: _____

Specialty: _____ Certification #: _____

Issued: _____ Expires: _____

Certifying Board: _____

Specialty: _____ Certification #: _____

Issued: _____ Expires: _____

Medical Malpractice

Do you hold current medical malpractice insurance? _____

Has a suit ever been filed against you for medical malpractice? _____

If yes, please attach a letter of explanation and any court documents that you have regarding the case.

Attestation Questions

- Have you ever filed an application for any type of medical license in any state that has been withdrawn, abandoned, or denied? _____
- Have you ever, for any reason been denied licensure or relicensure, application for licensure or relicensure, or the privilege of takin an examination in any state, territory, province, or country? _____
- Have you ever been requested to appear before any board, bureau, department, agency, or other body? _____
- Have you ever been denied professional liability insurance or coverage, or had such insurance or coverage canceled, limited, or restricted in any way? _____

- Have you ever been diagnosed as having, or have you been treated for, pedophilia, exhibitionism, or voyeurism? _____

- Are you under an obligation to pay child support? _____

- In the past five years, have you been diagnosed as having, or been hospitalized for a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? _____
  If yes, are the limitations or impairment cause by your medical condition reduced or ameliorated because you receive ongoing treatment of received treatment in the past (with or without medication) or participate in a monitoring program?

- Are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not using illegal controlled substance?
  _____

- Have you engaged in conduct prohibited by any Board of Nursing's rules regarding sexual misconduct and impropriety? _____

- Are you in default on any student loans? _____

- Have you ever been arrested? _____

- Have you ever been convicted of a crime? (This excludes traffic violations, but includes DUI/DWI)
  _____
  If yes, please attach a letter of explanation and any court documents that you have regarding the case.

Signature

By signing below, I certify that the above information is a true, accurate, and complete statement of record to the best of my knowledge and belief.

Applicant Signature:_____Date: _____