



CREDENTIALING LICENSES FORM

Please fill out this evaluation form to its' entirety and fax to **(404) 297-4048** or mail to the following address:

J&D Licensure Consultants
666 Collingwood Drive
Decatur, Georgia 30032.

The information that you provide will give us an idea of your interest and eligibility for state licensure. This information will not be shared with anyone outside of J&D Licensure Consultants and its' agents. Please be advised that filling out this form in no way obligates you to any of our services.

DEMOGRAPHICS:

Last Name: _____ First Name: _____ M.I.: _____

Degree Type: _____ Date (mm/yyyy): _____

SSN: _____ UPIN: _____

Personal TX ID: _____

Medicare #: _____ Medicaid #: _____

Practice Address: _____ City: _____ State: _____

Zip: _____ Time Zone: _____

Organization: _____

Address: _____

City: _____ State: _____

Zip: _____ Country (if outside US): _____

Time Zone: _____

Phone: (Day) _____ (Evening) _____

Email: _____

Fax: _____

LICENSES:

All Past and Present Licenses (both Active & Inactive)

State License

License Number (Please list the corresponding License Numbers respectively):

Issue Date (Please list the corresponding Issue Dates respectively):

Expiration Date (Please list the corresponding Expiration Dates respectively):

Status (Please list the corresponding License Status respectively):

State(s) you are interested in being licensed
State License:

Date License Needed:

Type Needed:

EDUCATION:

Medical School Attended:

Medical School Location:

Year of Graduation:

US or Foreign Graduate? United States Foreign Graduate

What is your highest level of Training?

Fifth Pathway

Internship

Residency

Fellowship

Other

Are you board certified?

Yes

No

No, but board eligible

If certified, which specialty?

EXAMINATIONS:

Which exam(s) did you take?

- COMPLEX Year Passed _____
- ECFMG Year Passed _____
- FLEX Year Passed _____
- FMGEMS Year Passed _____
- LMCC Year Passed _____
- NBME Year Passed _____
- NBOME Year Passed _____
- SPEX Year Passed _____
- STATE BOARD Year Passed _____
- USMLE Year Passed _____

MALPRACTICE and DISCIPLINARY HISTORY

Malpractice Claims:

#Pending _____

#Settled _____

#Dismissed _____

Have you ever been subject to any disciplinary actions taken against a state medical license, hospital, and/or Medicare/Medicaid privileges?

- Yes No

Preferred Method of Contact:

- Phone (Daytime) Phone (Evening) Email

How did you hear about us?

- Advertisement (Magazine, Classified, Newspaper) Referral Website Other

Category:

- Medical License
- Application Processing Individual/Small Group Credentialing
- Network Credentialing & Development
- LTC & Subacute Facility Credentialing
- Credentialing/MSS Staffing Medical Billing

Additional Comments:

Thank you for filling out this informational form. Please be advised that this information is confidential and will be used only for the purposes of assisting you with your licensure needs.