



Commonwealth of the Northern Mariana Islands  
**HEALTH CARE PROFESSIONS LICENSING BOARD**

P.O. Box 502078, Bldg., 1242 Pohnpei Court  
Capitol Hill, Saipan, MP 96950  
Tel No: (670) 664-4809 Fax: (670) 664-4814  
Email: [cnmi@cnmibpl-hcplb.net](mailto:cnmi@cnmibpl-hcplb.net)  
Website: [cnmibpl-hcplb.net](http://cnmibpl-hcplb.net)



**General Information**

**Completion of the Application Forms**

Help us to do a good job processing your application. Type or print legibly all application documents. Please read the instructions and give careful thought before answering the questions in the application. Remember, you are certifying that the information is truthful and correct. Make sure all documents are originals or a certified or notarized true copy of original documents. Provide all documents requested in the application; incomplete applications will delay processing. Application fees must accompany applications before initial review can begin.

Each question in the application must be answered. Attach separate sheets of paper, labeled with your name and signed by you, for any question for which you provided a "yes" response.

Failure to answer all questions completely and accurately, or the omission or falsification of information may be cause for denial of your application or disciplinary action if the board subsequently issues you a license.

The application cannot be altered, changed, modified or added to unless approved by the Board.

**Confidentiality**

The contents of licensing files are generally considered public records. If you believe that the additional information you are attaching to explain a "yes" answer should be considered confidential, state that in the attachment. A request for confidentiality may or may not be granted.

**Documents sent by Fax or Email**

Fax copies or documents sent via email are not accepted for documentation or verification in our licensing process. If copy of document is sent via fax or email, the original must be sent via U.S. Postal Service to the Board's office.

**Foreign Language Documents**

All documents submitted in a foreign language shall be accompanied by an accurate translation in English. Each translated document shall bear the affidavit of the translator certifying that the translator is competent in both the language of the document and the English language and that the translation is a true and complete translation of the foreign language original, and sworn to before a notary public. Translation of any document relative to a person's application shall be at the expense of the applicant.

**National Practitioner Data Bank (NPDB)**

Attach the original report from the NPDB. To obtain the report, go to the NPDB-HIPDB website at [www.npdb-hrsa.gov](http://www.npdb-hrsa.gov) and click on Perform a Self-Query. If you are unable to go online, call NPDB at 1-800-767-6732 for assistance.

**Federation Credentials Verification Service (FCVS)**

The FCVS is operated by the Federation of State Medical Boards of the United States. The HCPLB provides this link to FCVS as a convenience to our applicants. You may learn more about FCVS at: <http://www.fsmb.org/fcvs.html>

The Board does not mandate that you use the FCVS. FCVS is NOT a requirement for filing a Physician's and Surgeon's Application. As part of your application, you may request FCVS to submit directly to the Board your Medical Professional Information Profile. You are required to complete the Board's application and provide all other necessary supporting documentation. We will review the information provided along with our application and determine on an individual basis the items that we will accept from FCVS.

### **Personal Interviews**

Applicants for medical licensure may be required to have a personal interview either with an individual board member or with the full board. Should an interview be required, you will be notified and an interview scheduled. An interview may be required if, during the processing of your application, a question arises for which the board determines it requires additional information from you.

### **Processing Time**

In general, average processing time for a permanent license is 4 - 6 weeks. Application processing time depends to a large extent on the response time from other organizations, our workload and the volume of applications being processed.

### **License Renewal**

All licenses issued by the Board expired every two years following its issuance or renewal and becomes invalid after that date. Notification for license renewal is mailed or emailed to licensees at least sixty (60) days before the expiration date. You are required by regulations to keep your current address on file with the Board. There is a late fee of \$25.00 charged for every 1st of the month after the expiration date. Licenses, which have expired for failure to renew on or before the date required may be reinstated within one year of the expiration date. Each licensee whose license has expired and lapsed for more than one year by failure to renew must file a new application, meet present day requirements for licensure, and receive board approval.

### **Continuing Medical Education (CME)**

All licensed physicians are required to complete fifty (50) Category I CME hours as a prerequisite to the renewal of their license **during** the 24 months prior to the expiration of his/her license. It shall be the responsibility of the licensee to obtain documentation, satisfactory to the Board, from the organization or institution, of his or her participation in the CME, and the number of credits earned. Licensure renewal shall be denied to any licensee who fails to provide satisfactory evidence of completion of CME requirements, or who falsely certifies attendance at and/or completion of the CME, as required herein.

### **License Denial**

If for any reason you are denied the license you are applying for, you are entitled to a hearing pursuant to the Commonwealth Administrative Procedures Act, 1 CMC § 9108-15.

### **Abandonment of Application**

Your application shall be considered abandoned and shall be destroyed if you fail to provide evidence of continued efforts to complete the licensing process for one (1) year. If the application is deemed abandoned the applicant shall be required to reapply for licensure and comply with the licensing requirements in effect at the time of the reapplication.

### **Schedule of Fees**

Application Fee	\$100.00	Replacement of License	\$75.00
License Fee	\$200.00	Replacement of Card	\$25.00
Temporary License Fee	\$100.00	Verification of License	\$25.00
Renewal License Fee	\$200.00	Letter of Good Standing	\$25.00
Delinquent Fee (each month)	\$25.00		

### **Applicants for Initial License - U.S. or Canada**

- MD Degree from an LCME-accredited medical school in the U.S. or from a CACMS-accredited medical school in Canada.
- One year of post-graduate training, internship, residency, or fellowship in an ACGME-accredited program in the U.S. or an accredited program in Canada.
- Satisfactory completion of the NBME, FLEX, USLME or the Qualifying Exam of LMCC.

Items/Documents required when applying:

- Application form
- Applicant's 2x2 photograph taken within 6 months from date of application
- Application non-refundable fee of \$100  
(Cashier's Check or Money Order made payable to "CNMI Treasurer")
- Evidence of MD degree
- Evidence of post-graduate training
- Evidence of current and active license from another jurisdiction
- Examination scores
- NPDB Report (within 60 days of application date) and/or
- FSMB Discipline Report

### **Foreign or International Medical Graduates**

- ECFMG Certificate ("valid indefinitely").
- Three (3) years of post-graduate training, internship, residency, or fellowship in an ACGME-accredited program in the U.S. or an accredited program in Canada, after earning a medical degree.
- Satisfactory completion of the NBME, FLEX, USLME or the Qualifying Exam of LMCC.

Items/Documents required when applying:

- Application form
- Application non-refundable fee of \$100  
(Cashier's Check or Money Order made payable to "CNMI Treasurer")
- Evidence of MD degree
- Evidence of ECFMG certificate
- Evidence of post-graduate training
- Evidence of current and active license from another jurisdiction
- Examination scores
- A certificate or Letter of Good Standing

### **Applicants for Osteopathic Physician**

- MD degree from an AOA-accredited osteopathic medical school in the U.S.
- One year of post-graduate training, internship, residency, or fellowship in an AOA-approved program in the U.S.
- Satisfactory completion of the NBOME.

Items/Documents required when applying:

- Application form
- Applicant's 2x2 photograph taken within 6 months from date of application
- Application non-refundable fee of \$100  
(Cashier's Check or Money Order made payable to "CNMI Treasurer")
- Evidence of MD degree
- Evidence of post-graduate training
- Evidence of current and active license from another jurisdiction
- Examination scores
- NPDB Report (within 60 days of application date) and/or
- FSMB Discipline Report

### **Applicants for Podiatry Medicine**

- Podiatric Medicine degree from a school/college accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association or a school/college approved by the Board
- One year of post-graduate training approved by the Council on Podiatric Medical Education of the American Podiatric Medical Association or a program approved by the Board
- Satisfactory completion of the APMLE

Items/Documents required when applying:

- Application form
- Applicant's 2x2 photograph taken within 6 months from date of application
- Application non-refundable fee of \$100  
(Cashier's Check or Money Order made payable to "CNMI Treasurer")
- Evidence of podiatry medicine degree
- Evidence of post-graduate training
- Evidence of current and active license from another jurisdiction
- Examination scores
- NPDB Report (within 60 days of application date) and/or
- FSMB Discipline Report

### **Applicants for Licensure by Endorsement**

HCPLB may issued a medical license to an applicant by endorsement if you hold an active, unrestricted medical license from another U. S. state, territory or Canada and the requirements in the other jurisdiction are at least as stringent as the requirements in the CNMI.

Items/Documents required when applying:

- Application form
- Applicant's 2x2 photograph taken within 6 months from date of application
- Application non-refundable fee of \$100  
(Cashier's Check or Money Order made payable to "CNMI Treasurer")
- Evidence of medical license from another state or Canada
- Evidence of MD degree
- Evidence of post-graduate training
- NPDB Report (within 60 days of application date) and/or
- FSMB Discipline Report



Commonwealth of the Northern Mariana Islands  
**HEALTH CARE PROFESSIONS LICENSING BOARD**  
 P.O. Box 502078, Bldg., 1242 Pohnpei Court  
 Capitol Hill, Saipan, MP 96950  
 Tel No: (670) 664-4809 Fax: (670) 664-4814  
 Email: cnmi@cnmibpl-hcplb.net  
 Website: cnmibpl-hcplb.net

Attach a recent 2x2 ID photo here taken within 6 months of the application.

## APPLICATION FOR PHYSICIAN

<input type="checkbox"/> Initial	<input type="checkbox"/> Endorsement	<input type="checkbox"/> Temporary
----------------------------------	--------------------------------------	------------------------------------

**HCPLB STAFF USE ONLY**

Date Received: \_\_\_\_\_

**APPLICATION INFORMATION** – Please Type or Print

1. Last:		First:		Middle:		2. Social Security No:	
3. Birthdate: (Mo/Day/Yr)		4. Color of Eyes:		5. Height:		6. Sex:	
		Color of Hair:		Weight:			
7. Mailing Address:				8. Email Address:			
9. Residence Address:				10. Phone No: (W): (H):			
11. NPI # (if available):		12. Specialty:		13. Citizenship: ___ U.S. ___ Other      Specify:			

**14. EDUCATION** – (Provide an original, notarized or certified copy of your degree)  
 (From secondary school to all colleges. Provide an original, notarized or certified copy of your medical degree or valid ECFMG certificate)

Name of Schools	Location (City/State or Country)	Degree Earned	Dates (Mo/Yr)	
			From	To

**15. POSTGRADUATE TRAINING** – (List internship, residency or fellowship training programs chronologically)

Hospital	Location (City/State or Country)	Dates (Mo/Yr)	
		From	To

**16. EXAMINATION**– (List all examinations you have taken: USLME, FLEX, NBME, SPEX, APMLE, State Boards and/or QME in Canada)

Examination	Date	Result (Pass/Fail)

**17. LICENSES** – (List of all jurisdiction where you are licensed or applied for a license.)

Name of Jurisdiction	Date Issued	Expiration Date	License Number	Current Status

**18. HOSPITAL AFFILIATIONS** (if none state “None”)

Name of Hospital	Location (City/State or Country)	Dates (Mo/Yr)	
		From	To

**19. Name/Address of Intended Employment within the CNMI:**


*If you answer “yes” for any of items 20-37 you must attach a detailed explanation on a separate sheet, which includes state or country where action is pending or took place, relevant dates, action taken and reasons for such action. (Include Findings of Fact, Conclusion of Law, Final Order and whether you have been reinstated. If reinstated, date and conditions of license.)*

20. Have you ever been charged with, or been found to have committed dishonorable, unprofessional conduct, negligence, incompetence, misconduct, or repeated negligent acts or malpractice by any medical licensing board, other agency, or hospital?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
21. Has a claim or an action ever been filed against you for the practice of medicine which resulted in a malpractice settlement, judgment, or arbitration award of \$25,000 or more?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
22. Has any medical licensing board, other agency, or disciplinary authority refused to issue you a license, renew your license, suspended, revoked, accepted surrender of your license, placed on probation or conditioned your license, held by you now or previously, or ever fined or otherwise disciplined you?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
23. Is there any ongoing or pending investigation against you?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
24. Is there any disciplinary action pending against you?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

25. Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges or have you ever voluntarily or involuntarily resigned or withdrawn from such association to avoid imposition of such measures?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
26. Have your DEA or state-controlled substance registration ever been denied, suspended, restricted, or terminated?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
27. Have you ever entered into any arrangement or plea or agreement in lieu of a federal prosecution for a drug violation regulated by the DEA?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
28. Have you ever been terminated, sanctioned, and penalized, had to repay monies to or been denied provider participation in any Medicaid, Medicare or other publicly funded healthcare program?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
29. Has your ability to practice medicine in a competent and safe manner ever been impaired or limited by any condition, behavior, impairment, or limitation of a physical, mental, or emotional nature?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
30. Have you used or are you currently using any chemical substance(s), legal or illegal, that in any way impaired or limited, or is currently impairing or limiting, your ability to practice medicine in a safe and competent manner?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
31. Have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
32. Have you been treated for or had a recurrence or a diagnosed addictive disorder?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
33. Have you ever been diagnosed with a neurological or other physical condition that would impair your ability to practice medicine safely?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
34. Do you have any other condition in which in any way impairs or limits your ability to practice medicine safely?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
35. Have you ever been found guilty, pleaded guilty, no contest, or nolo contendere to a crime involving moral turpitude or crime related to the medical profession, or felony in any court?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
36. Is criminal action pending against you in any court?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
37. Are you required to register as a Sex Offender?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

**38. DECLARATION:**

I hereby certify that I am the person herein named subscribing to this application. I have read the complete application, and I know the full content hereof. I declare that all of the information contained herein and evidence or other credentials submitted herewith are true and correct. I understand that any falsification or misrepresentation of any item or response in this application, or any attachment hereto or falsification on misrepresentation of credentials to support this application, is sufficient grounds for denying, revoking, or otherwise disciplining a license to practice medicine in the Commonwealth of the Northern Mariana Islands. I further certify that I have read and will abide by P.L. 15-105 and the Regulations for Licensing of Physicians or Podiatrists.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

*Please complete the application form and attach all original, certified or notarized documents and a non-refundable application fee of \$100.00 (money order or cashier's check make payable to "CNMI Treasurer"). Do not send cash.*

2021

**AUTHORIZATION FOR RELEASE OF INFORMATION**

I, \_\_\_\_\_ (print name), do hereby authorize a disclosure of records concerning myself to the Health Care Professions Licensing Board (HCPLB). This release includes records of a public, private or confidential nature.

I acknowledge that the information released to the HCPLB may include material that is protected by federal and/or state laws applicable to substance abuse and mental health information. If applicable, I specifically authorize the release of confidential information to and from the HCPLB relating to substance abuse or dependence and/or mental health.

I further agree that the HCPLB may receive confidential information and records, including, but not limited to the following records:

- Medical Records
- Education Records
- Personnel or employment records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Post-graduate training (internship, residency, and fellowship) records, including records or any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Any information the HCPLB deems reasonably necessary for the purposes set forth in this release.

**Release of Liability:**

I do hereby irrevocably and unconditionally release, covenant not to sue, and forever discharge any person or entity, including but not limited to any medical school, residency or fellowship training program, hospital, health care provider, health care facility, licensing board, impaired practitioner program, agency, or organization, which releases information to the HCPLB pursuant to this release from any liability, claim, or cause of action arising out of the release of such information. I further irrevocably and unconditionally release, covenant not to sue, and forever discharge the HCPLB, the Commonwealth of the Northern Mariana Islands, and its employees and agents from any liability, claim, or cause of action arising out of the collection or release of information pursuant to this release.

A photocopy of this release form will be valid as an original thereof, even though the photocopy does not contain an original writing of my signature.

I have read and fully understand the contents of this "Authorization to Release Information".

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

---

**AFFIDAVIT**

I, the undersigned, being duly sworn, say that I am the person referred to in the foregoing application for license to practice \_\_\_\_\_ in the Commonwealth of the Northern Marianas, that the statements therein are true to the best of my knowledge and belief.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension or revocation of my license to practice as a \_\_\_\_\_ in the Commonwealth of the Northern Marianas.

\_\_\_\_\_  
Signature of Applicant