Initial Medical Licensure
PERSONAL INFORMATION
11/2018 IML

MARYLAND BOARD OF PHYSICIANS
P.O. Box 37217 • Baltimore, MD 21297
Telephone: 410-764-4777 or Toll Free: 800-492-6836

FOR BANK USE ONLY
Date
Check Number
Amount Paid
Name Code
App ID 17
Fees: AMG-$790.00 or FMG-$890.00

APPLICATION FOR INITIAL MEDICAL LICENSURE

Please print legibly or type the required information. Do not leave any item unanswered. If an item does not apply to you, write "N/A" (Not Applicable) for that item. An incomplete application form will delay the processing of your application.

1. Your Complete Current Legal Name: As listed on your U.S. birth/marriage certificate, U.S. passport, or most recent document issued by the INS.

Last name and generational indicator (Jr., Sr., II, III, etc.): Complete name you would like to appear on License.

DO

First name and middle name:

ANH-CHI DANG

(If applicable, please check a box and complete below) ☐ Complete Maiden Name OR ☐ Complete Former Name ☐ Completed legal name

Stop! If any credential you submit bears a name other than your current legal name as listed above, or if you have been licensed in another state under any name other than your current legal name, sign and date an attachment which includes each different name, an explanation of why the name differs from your current legal name, and a copy of the legal document to support the name change.

2. Public Address: Your public address of record. This address, usually your office, is available to the public and will be posted on the internet.

Street Address: If you change your address prior to being licensed, immediately notify the Board in writing.

10401 OLD GEORGETOWN ROAD

SUITE 104

City: BETHESDA State: MD Zip Code: 20814-1911

3. Non-Public Address: This address, usually your home, is for Board use only. However, if no public address is listed, this address will be made public.

Street Address: **(Do NOT use a P. O. Box) If you change your address prior to being licensed, immediately notify the Board in writing.**

City State Zip Code

4. Telephone(s): Home

Office: 888-684-3599

Cell/Pager:

E-mail address:

5. Date of Birth: Month Day Year

6. Gender: Male Female

7. Race: Multiracial applicants may select all applicable categories — American Indian or Alaska Native; Asian; Black or African American; Native Hawaiian or other Pacific Islander; White

Ethnicity: Hispanic or Latino; Not Hispanic or Latino

8. U.S. Social Security Number: ___-___-___

9. Check this box if you are using the FCVS. ☐

For Board Use Only

License Number: MBP School Code:

Date Issued:

Licensed By: Licensing Exam:

Initial Medical Licensure CHRONOLOGY 11/2018 IML	Print Your Name: ANH-CHI DO	Date: 6/3/19	Page 2 of 9

10. Chronology of Activities: DO NOT ATTACH RESUME OR CURRICULUM VITAE

Beginning with the date you completed medical school and continuing through the present, list chronologically all of your activities, including hospital privileges. Account for all periods of time including each post-graduate training program you attended, regardless of whether or not you completed the program; each job you held, regardless of whether or not it was medically related or you were compensated; and any period of unemployment.

Date Medical School was Completed:	month	year
	05	16

Activities after completing medical school: Please type or print.

From (month)	From (year)		To (month)	To (year)	Activity / Address
06	16	TO	06	19	Activity: FAMILY MEDICINE RESIDENCY at VALLEY FAMILY MEDICINE RESIDENCY PROGRAM
					Address: 3915 TALBOT ROAD SOUTH, SUITE 401 RENTON, WA 98055
		TO			Activity:
					Address:
		TO			Activity:
					Address:
		TO			Activity:
					Address:
		TO			Activity:
					Address:
		TO			Activity:
					Address:
		TO			Activity:
					Address:
		TO			Activity:
					Address:

If you will need more space than page 2 allows, please photocopy page 2 for your use or attach a separate sheet. Please sign and date each sheet that you attach.

11. **MEDICAL EDUCATION: List all medical schools you have attended.** From: MM/YY To MM/YY

NEW JERSEY MEDICAL SCHOOL 08/11 to 05/16

Medical School From Which You Received Your Medical Degree: NEW JERSEY MEDICAL SCHOOL

Name of University Affiliation (if applicable): * RUTGERS UNIVERSITY

Street Address: 185 S ORANGE AVE, MSB C594

City: Newark **State/Province:** NJ **Country of citizenship during medical education:** U.S.A.

Language(s) of Instruction: English

Type of Degree: [X] M.D. [ ] D.O. [ ] M.D./Ph.D [ ] M.B.B.S. [ ] M.B.B.Ch [ ] Other: _____ (specify)

***Date Degree Was Conferred:** The date you officially received your degree after all prerequisite obligations, required training, government service, etc. was satisfied.

Month 0 5 Day 1 6 Year 1 6

GRADUATES OF FOREIGN MEDICAL SCHOOLS (Schools not in the U.S., U.S. territories, Puerto Rico, or Canada)

Attach the following documents to this application:

1. A copy of your valid ECFMG certificate or Fifth Pathway Certificate;
2. A copy of your medical school diploma and a certified translation;
3. If you listed an affiliation above (see * in 11 above), the certificate must include your name, name of the medical school, name of the university, and a certified translation.

If your name is not written the same way on all documents, you must submit documentation to explain how and why your name differs and submit one of the following documents to support the name change: passport, ICE card, birth certificate, court document, marriage license, court decree.

12. **Oral and Written English Language Competency Requirements.** Applicants must demonstrate oral and written competency in English by at least one of the following: (Check one)

a. [X] Documentation of graduation from a recognized English-speaking high school (includes GED) or undergraduate college, or university where English was the *only* language of instruction, after at least three years of enrollment; **or**

b. [ ] Documentation of graduation from a recognized English-speaking medical school; **or**

c. [ ] Documentation of a passing score on the USMLE Step 2 Clinical Skills**; **or**

d. [ ] Documentation of receiving a score of at least 26 on the Speaking section of the Internet–Based TOEFL (IBT)*; or

e. [ ] Documentation of receiving a score of Advanced or higher on the Oral Proficiency Interview (OPI).*

Are you claiming speech impairment? NO YES If "YES," please write or call the Board for additional information.

****See item #11 in the Instructions and Important Information for TOEFL and OPI testing Instructions.***

****Clinical Skills:** The Board <u>will only</u> accept **USMLE Step 2 Clinical Skills** as demonstration of oral and written competency in English. The Board <u>will not</u> accept the **Clinical Skills Assessment** administered by the ECFMG or the <u>**USMLE Step 2 Clinical Knowledge**</u> as demonstration of oral and written competency in English.

13. **POSTGRADUATE TRAINING.** (DO NOT ATTACH RESUME OR CURRICULUM VITAE.) List in chronological order **ALL** postgraduate training undertaken in the U.S., its territories or possessions, Puerto Rico, or Canada regardless of whether you did or did not complete the program, and regardless of whether you were or were not compensated.

NOTE: On a case by case basis, the Board may consider **full time teaching in an LCME-accredited medical school in the U.S.** as an alternative to the accredited postgraduate clinical medical education required in the Code of Maryland Regulations 10.32.01.03D. Applicants who intend to request consideration of teaching experience as an alternative to accredited postgraduate clinical medical education should contact the Board's licensure division for further information.

Applicants who have graduated from a medical school NOT in the U.S., U.S. territories, Puerto Rico, or Canada are required to submit evidence acceptable to the Board of successful completion of 2 years of training in a U.S. postgraduate clinical medical education program accredited by an organization recognized by the Board (ACGME, AOA, or equivalent). If you have not met this requirement, DO NOT submit this application. Contact the Board if your postgraduate medical education is not ACGME or AOA-accredited and you are applying for equivalency.

A Fifth Pathway Program graduate must have been a U.S. citizen during the time of medical education and must have successfully completed two years of ACGME accredited postgraduate clinical medical education *after* successfully completing a Board approved Fifth Pathway Program. If you have not met these two requirements, **DO NOT SUBMIT THIS APPLICATION.**

NOTE: Postgraduate training program cycles usually run 12 consecutive months. If the dates of your postgraduate training fall short of the complete cycle, or extend beyond the usual cycle, please attach a complete explanation of why your training was "off-cycle."

A. During your years of postgraduate training, did you have a break in training? If "Yes," please provide an explanation. **YES** **NO**

B. Did you have any condition or impairment that affected your ability to practice medicine during your training? If "Yes," please provide an explanation. **YES** **NO**

C. During your years of postgraduate training, was any action taken against you by any training program, hospital, medical board, licensing authority, or court? Such actions include but are not limited to investigations, limitations of privileges or special conditions, requirements imposed for academic incompetence, disciplinary actions, probationary action, etc. If "Yes," please provide an explanation. **YES** **NO**

PG Year #s	Place of Training	Specialty	month / year	TO	month / year
1-3	VALLEY FAMILY MEDICINE RESIDENCY PROGRAM		06 2016		06 2019
	Address: 3915 TALBOT RD S, SUITE 401 RENTON, WA 98055	FAMILY MEDICINE	Accredited by: ACGME ☒ AOA ☐ RCPSC ☐		
PG Year #s	Place of Training:		month / year	TO	month / year
	Address:	Specialty:	Accredited by: ACGME ☐ AOA ☐ RCPSC ☐		
PG Year #s	Place of Training:		month / year	TO	month / year
	Address:	Specialty:	Accredited by: ACGME ☐ AOA ☐ RCPSC ☐		
PG Year #s	Place of Training:		month / year	TO	month / year
	Address:	Specialty:	Accredited by: ACGME ☐ AOA ☐ RCPSC ☐		
PG Year #s	Place of Training:		month / year	TO	month / year
	Address:	Specialty:	Accredited by: ACGME ☐ AOA ☐ RCPSC ☐		

(ATTACH A SEPARATE SIGNED AND DATED PAGE IF ADDITIONAL SPACE IS NEEDED)

14. Medical Licensing Examinations. (USMLE, NBME, NBOME, FLEX, FLEX-Weighted Average, Medical Council of Canada, and licensing exams given by individual states prior to January 1, 1985) **DO NOT SUBMIT THIS APPLICATION until you have received written verification of having passed all parts, steps, or components of your medical licensing examinations.**

Identify below ALL the medical licensing examinations that you have ever taken. Written or electronic documentation of passing a medical licensing exam must be sent directly to the Board, by e-mail or mail, from the agency that administered the examination. Mail documentation of passage to: P. O. Box 2571 Baltimore, MD. 21215. (**Do Not** send your licensure application to this address.) Electronic verification of passage may be e-mailed to: *mdh.mbpcredentials@maryland.gov*

Failing the Exam three or more times—If you have failed any medical licensing exam (part, step, component, or level), you may qualify for a license only if you meet the requirements in numbers 1-3 or 4. If you meet the requirements in numbers 1-3, complete the attached **IML 4 Verification of Clinical Practice.** If you meet the requirements in number 4, the Board will verify your Board certification. Please check either 1-3 or 4.

1. No disciplinary action pending and no disciplinary action taken against the applicant that would be grounds for discipline under Health Occupations Article, §14-404, Annotated Code of Maryland; **and**
2. Successful completion of 2 or more years of an ACGME or AOA accredited residency or fellowship; **and**
3. A minimum of 5 years of clinical medicine experience in the United States or in Canada under a full unrestricted medical license, with at least 3 of the 5 years having occurred within 5 years of the date* of the application; **or**
4. Board-certification.

If you have not met this requirement, you are not eligible for licensure in Maryland at this time. DO NOT submit this application until you have fulfilled this requirement.

** This is the date the Applicant signs this application.*

a. **State Board Examination List state(s):** _____

State Board Exams were licensing exams given by individual states and do not include USMLE Step 3, oral exams, interviews or jurisprudence exams. State Board Exams taken after December 31, 1984 are not accepted for licensure in Maryland. Send a copy of the **IML 7 State Board Licensure and Examination Certification** form to the state(s) that administered your licensing exam and ask the state(s) to send your exam results directly to the Board of Physicians. **NOTE: This section does not relate to National Board Certification.**

USMLE, FLEX-Weighted Average, and FLEX Components 1 & 2 Exams. (See Page 6 if you took a combination of these exams or combined either with the NBME exams) **If you took any of the exams below, contact the Federation of State Medical Boards at** *www.fsmb.org.*

b. USMLE Steps 1, 2 and 3

c. FLEX-Weighted Average: All FLEX-Weighted exams must have been taken prior to 1985 and in one sitting with a passing score of 75; or if taken in more than one sitting, must have a passing score of 75 and be currently certified by a member board of the American Board of Medical Specialties.

d. FLEX Components 1 and 2: **Passing score is 75 on each component.**

e. **National Board of Medical Examiners (NBME)** (See Page 6 if you combined this examination with FLEX or USMLE exams)
Ask the NBME to send to the Board both the Endorsement of Certification ***and*** the Record of Scores. If you took NBME exams but were not certified, or you took NBME as part of hybrid exams, ask NBME to send only your Record of Scores. Contact the NBME at *www.nbme.org*

f. **National Board of Osteopathic Medical Examiners Certifications issued before January 1, 1971 are not accepted for licensure in Maryland.**
Contact the NBOME at *www.nbome.org*

g. **Medical Council of Canada (MCC)**—Licentiate of the Medical Council of Canada. Contact the MCC at *http://mcc.ca/about/lmcc/*

CONTINUED ON PAGE 6

HYBRID EXAMINATIONS

The following combinations are the only hybrid examinations accepted by the Maryland Board of Physicians. **ALL HYBRID EXAMINATIONS MUST HAVE BEEN COMPLETED BEFORE JANUARY 1, 2000.**

h. ☐	USMLE 1 + NBME II + NBME III	n. ☐	FLEX 1 + USMLE 3
i. ☐	USMLE 1 + USMLE 2 + NBME III	o. ☐	FLEX 2 + USMLE 1 + NBME II
j. ☐	USMLE 1 + NBME II + USMLE 3	p. ☐	FLEX 2 + USMLE 1 + USMLE 2
k. ☐	NBME I + USMLE 2 + USMLE 3	q. ☐	FLEX 2 + NBME I + USMLE 2
l. ☐	NBME I + USMLE 2 + NBME III	r. ☐	FLEX 2 + NBME I + NBME II
m. ☐	NBME I + NBME II + USMLE 3	s. ☐	NBOME + USMLE

- If your hybrid exams included any part of the NBME examination, contact the NBME at www.nbme.org and request to have your Endorsement of Certification and your Record of Scores sent directly to the Board of Physicians.
- If your hybrid exams included only FLEX and USMLE examinations, request your transcript from the Federation of State Medical Boards at www.fsmb.org.
- If your hybrid exams included any part of the NBOME, ask NBOME to send the verification of certification and the complete history of your medical examinations to the Board. Contact the NBOME at www.nbome.org.

15. Licensing History: Please complete all that apply.

a. ☐ I have never been licensed (including training licenses) in the U.S., its territories, Puerto Rico, or Canada.

b. ☐ I have an application for license (including a training license) pending in the following states: _____, _____, _____, _____, _____.

c. Including training licenses, please list below all licenses ever issued to you by a U.S. state/territory, Puerto Rico, or Canada.

d. Has any disciplinary action ever been taken against your license? Yes No If "Yes," please enclose an explanation.

STATE (Or Puerto Rico or Canadian Province)	LICENSE NUMBER or Registration Number	CURRENT STATUS					
		Active	Inactive	Expired / Lapsed	Surrendered in good standing	Surrendered / Suspended	Revoked
WA	MD 60865937	X					

(If more space is needed, please attach an additional signed and dated sheet.)

16. Character and Fitness Questions (Check either **YES** or **NO**) **Please answer questions "a" through "q" on pages 7 and 8.**

	YES	NO	
a.			Has a state licensing or disciplinary board (including Maryland), a comparable body in the armed services, or the Veterans Administration, ever denied your application for licensure, reinstatement, or renewal?
b.			Has a state licensing or disciplinary board (including Maryland), a comparable body in the armed services, or the Veterans Administration, ever taken action against your license? Such actions include, but are not limited to, limitations of practice, required education admonishment or reprimand, suspension, probation or revocation.
c.			Has any licensing or disciplinary board in any jurisdiction (including Maryland), a comparable body in the armed services, or the Veterans Administration, ever filed any complaints or charges against you or investigated you for any reason?
d.			Have you ever withdrawn your application for a medical license or other health professional license?
e.			Has a hospital, related health care institution, HMO, or alternative health care system ever investigated you or ever brought charges against you?
f.			Has a hospital, related health care facility, HMO, or alternative health care system ever denied your application; failed to renew your privileges, including your privileges as a resident; or limited, restricted, suspended, or revoked your privileges in any way?
g.			Have you ever pleaded guilty or *nolo contendere* to any criminal charge, been convicted of a crime, or received probation before judgment because of a criminal charge?
h.			Have you ever committed an offense involving alcohol or controlled dangerous substances to which you pled guilty or *nolo contendere*, or for which you were convicted or received probation before judgment? Such offenses include, but are not limited to, driving while under the influence of alcohol or controlled dangerous substances.
i.			Are there any charges pending against you in any court of law, are you currently under arrest, released pending trial with or without bond, or is there an outstanding warrant for your arrest?
j.			Do you currently have any condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or a physical, mental, emotional, or nervous disorder or condition) that in any way affects your ability to practice your profession in a safe, competent, ethical, and professional manner?
k.			Have any malpractice claims or other claims for money damages ever been filed against you? Include past claims as well as any claim that is now pending, has been dismissed, has been settled, or which has resulted in a damages award against you or your medical practice.
l.			Are you in default of a service obligation that you incurred by receiving State or Federal funds for your medical education?

If you answered "YES" to any question, on a separate sheet of paper, please provide a signed and dated detailed explanation and attach appropriate supporting documents. Failure to provide documentation and a signed and dated explanation will delay the processing of your application.

16a. Character and Fitness Questions *(Continued)* (Check either **YES** or **NO**) **Please answer questions "m" through "q."**

	YES	NO	
m.			Have you ever failed to make arrangements to satisfy State or Federal loans that financed your medical education?
n.			Has your employment or contractual relationship with any hospital, HMO, other health care facility, health care provider, institution, armed services, or the Veterans Administration ever been terminated for disciplinary reasons?
o.			Have you ever voluntarily resigned or terminated a contract with any hospital, HMO, other health care facility, health care provider, institution, armed services, or the Veterans Administration while under investigation by that institution for disciplinary reasons?
p.			Have you ever surrendered your license or allowed it to lapse while you were under investigation by any licensing or disciplinary board of any jurisdiction, any entity of the armed services, or the Veterans Administration?
q.			Have you ever been dishonorably discharged from any military service of the U.S. Government? Attach a copy of your military discharge documentation that includes type of service, date of discharge, and type of discharge.

If you answered "YES" to any question, on a separate sheet of paper, please provide a signed and dated detailed explanation and attach appropriate supporting documents. Failure to provide documentation and a signed and dated explanation will delay the processing of your application.

17. SPEX/COMVEX Examinations: Please check all that apply. If none apply, please make **N/A** here. N/A

- ☐ a. The last time I passed a medical licensing exam was more than 15 years before *submitting this application for initial medical licensure.
- ☐ b. I have never had a specialty board certification.
- ☐ c. During the 10 years preceding the *submission of this application for initial medical licensure, I did not pass a specialty board certification or recertification examination give by the American Board of Medical Specialties or the American Osteopathic Association Bureau of Osteopathic Specialists.
- ☐ d. I have not had a full, unrestricted medical license in at least one state of the U.S. or Canada within the 10-year period before *submitting this application for initial medical licensure.
- ☐ e. I have not actively practiced clinical medicine in the U.S. or Canada for a least 7 of the 10 years before *submitting this application for initial medical licensure.

The date the application is signed will be used for date of submission.

If you checked all of the statements listed above, the Board will require you to pass the Special Purpose Examination (SPEX) or the Comprehensive Osteopathic Medical Variable-Purpose Examination (COMVEX). The SPEX is administered by the Federation of State Medical Boards (FSMB), and the COMVEX is administered by the National Board of Osteopathic Medical Examiners (NBOME). If you are required to take the SPEX, contact the FSMB at http://www.fsmb.org/licensure/spex_plas/. If you are required to take the COMVEX, contact the NBOME—Client Services Department at clientservices@nbome.org or (866) 479-6828. The Website address is http://www.nbome.org/comvex.asp.

RELEASE AND CERTIFICATION

18. Release: I agree that the Maryland Board of Physicians (the Board) may request any information necessary to process my application for medical licensure in Maryland from any person or agency, including but not limited to postgraduate program directors, individual physicians, government agencies, the National Practitioner Data Bank, the Federation of State Medical Boards, hospitals, and other licensing bodies. I also agree to sign any subsequent release for information that may be requested by the

ANH-CHI DANG DO — 6/3/19

Applicant's Name (Printed) — Applicant's Signature — Date

19. (OPTIONAL) Third Party Release: The Board encourages you to complete all aspects of your application on your own. If you plan to use an intermediary to receive information about the status of your application, please complete this release.

I agree that the Maryland Board of Physicians may release any information pertaining to the status of my application to the following person:

Name: _____ **Signature:** _____

Phone: _____ **Date:** _____

E-mail address: _____

20. Cooperation in an Investigation: I agree that I will cooperate fully with any request for information or with any investigation related to my medical practice as a licensed physician in Maryland, including the subpoena of documents or records or the inspection of my medical practice.

During the period in which my application is being processed, I shall inform the Board within 30 days of any change to any answer I originally gave in this application, any arrest or conviction, any change of address or any action that occurs based on accusations that would be grounds for disciplinary action under Md. Code Ann., Health Occ. § 14-404.

_____ _____ 6/3/19

Applicant's Signature — Date

21. Certification: To be completed by the applicant in the presence of a notary public after the applicant's picture has been attached below.

I certify that I have personally reviewed all the responses to items 1-20 of this application and that the information I have given is true and accurate to the best of my knowledge. I understand and agree that I may not practice, attempt to practice, or offer to practice medicine in Maryland unless licensed by the Board. I also certify that I am thoroughly familiar with the Statute (Title 14) and Code of Maryland Regulations (COMAR) 10.32.01 *et seq.* which govern the practice of medicine in Maryland.

_____ 6/3/2019

Applicant's Signature — Date

STATE OF _____, CITY/COUNTY OF _____, I HEREBY CERTIFY that on this 3rd day of JUNE, 2019, before me, a Notary Public of the State and City/County aforesaid, personally appeared the Applicant, ANH-CHI DO (print applicant's name), whose likeness is identifiable as that of the individual in the photograph attached to this application and who has made oath in due form of law to be the individual referenced in the above application for license to practice medicine and surgery in Maryland, and to have stated the truth in all statements made in this application.

AS WITNESS my hand and notorial seal. DESIRAE SEARING
Notary Public

My Commission expires: 02/29/2020

DESIRAE SEARING NOTARY PUBLIC STATE OF WASHINGTON COMMISSION EXPIRES 2-29-20 SEAL

The date the applicant and the notary sign the application must be the same.