AGREEMENT TO UPDATE APPLICATION INFORMATION:

By signing this section of the North Dakota Board of Medicine licensure application form, I agree that:

If any of the information supplied on this application form changes, or becomes inaccurate or incomplete before I am granted a license to practice medicine in North Dakota, I will immediately provide the corrected information to the North Dakota Board of Medicine.

Failure to provide such corrected information to the Board will constitute the use of a fraudulent, deceitful, dishonest, or immoral practice in connection with the North Dakota licensing requirements and will, therefore, be a violation of Sec. 42-17-31, NDCC, which will subject me to disciplinary action or denial of licensure.

_____ _____

Signature of Applicant Date

AFFIDAVIT:

I, _____, swear that I am the person described and identified;
(NAME OF APPLICANT)

that I have not engaged in any of the acts prohibited by the statutes of the State of North Dakota; that I am the person named in the copy of the diploma which accompanies this application; that I am the lawful holder of said diploma; and that said diploma was procured in the regular course of instruction and examination without fraud or misrepresentation.

I hereby authorize all hospitals, all medical institutions or organizations, all medical schools and postgraduate training program, my references, personal physicians, employers (past and present), business and professional associates (past and present), all governmental agencies and instrumentalities (local, state, federal or foreign) to release to this licensing board any information, files, or records required by the Board for its evaluation of my professional, ethical and physical qualifications for licensure in the State of North Dakota.

I further authorize the Board to communicate with and provide application materials to the designated contact, if one is noted, for facilitating the application.

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 denial, suspension or revocation of my license to practice medicine in the State of North Dakota.

_____ _____

Signature of Applicant Date