

**State of Tennessee
Department of Health**

BOARD OF VETERINARY MEDICAL EXAMINERS

**665 Mainstream Drive
Nashville, TN 37243**

(Toll Free In State) 1-800-778-4123 ext. 5325090

Local Nashville Area 615-532-5090

tn.gov/health



Procedures for Application and Licensure

Veterinarian



**STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243**

**TENNESSEE BOARD OF VETERINARY MEDICAL EXAMINERS
(Toll Free In State) 1-800-778-4123 ext. 5325090
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Application Procedures

(1) Veterinarian by Exam:

Each applicant must submit the following documents to the board prior to licensure:

1. Completed application, signed in the presence of a Notary.
2. Check or money order payable to the Tennessee Board of Veterinary Medical Examiners.
Fee: One Hundred Thirty-Five Dollars (\$135.00)
3. Two (2) recent passport-type photographs, both signed.
4. Proof of United States or Canada citizenship or evidence of being legally entitled to live in the United States. Such evidence may include copies of birth certificate, naturalization papers, or current visa status. **All applicants must complete and submit the Declaration of Citizenship.**
5. Certified transcripts submitted directly from the school or college of veterinary medicine reflecting graduation.
6. Verification of valid, unrestricted license in all states where licensure is held.
7. Official North American Veterinary Licensing Examination (NAVLE) score, or both an official National Board Examination score and an official Clinical Competency Test score submitted from American Association of Veterinary State Boards (AAVSB).
8. Mandatory Practitioner Profile.
9. Criminal Background Check. (Please [click here](#) for instructions to obtain a criminal background check.)

(2) Veterinarian by Reciprocity

Each applicant must submit the following documents to the board prior to licensure:

1. Submit all documentation listed in (1).
Fee: Two Hundred Eighty-Five Dollars (\$285.00)
2. Furnish an affidavit or other proof of active practice in veterinary medicine for three (3) of the previous five (5) years before application is made for an average of at least twenty-five (25) hours per week.
3. Provide proof of completion of a minimum of sixty (60) hours of continuing education in the previous five (5) years. Forty-five (45) hours must pertain to the medical and surgical care of animals. Fifteen (15) hours may pertain to a special interest in veterinary medicine in fields other than the medical and surgical care of animals, including but not limited to practice management and state and federal regulatory programs. A maximum of thirty (30) hours may be obtained in a multi-media format.

(3) Graduates of Foreign Veterinary Schools

Graduates of foreign veterinary medical schools must:

1. Submit all documentation listed in (1).
Fee: One Hundred Thirty-Five Dollars (\$135.00).
2. Meet the requirements set by the American Veterinary Medical Association (ECFVG Certification) or certification deemed by the Board to be equivalent (PAVE Certification).
3. Be a graduate of a veterinary school approved by the American Veterinary Medical Association or by the Board.
4. Submit official copy of grades and curriculum, translated into English when necessary.

Items to Note

Senior Veterinary Students: Please submit all available documentation as soon as possible. The only items the Board should expect to receive at a later date are as follows: transcripts (which will be sent directly from school), and test scores (which will be sent directly to the Board). The licensure application and licensure fee payment must be submitted to the Board's administrative office in accordance with the National Board of Veterinary Medical Examiners (NBVME) deadline.
Note: You will need to apply directly to the NBVME in order to take the NAVLE.

To All Applicants: Please allow six (6) weeks for all documents to be received in our office. After receipt of your application in this office, a letter will be sent to you noting any deficiencies.

Mail To: Tennessee Board of Veterinary Medical Examiners
665 Mainstream Drive
Nashville, TN 37243

For Office Use Only

2317-001 Application Fee \$125
2317-006 State Regulatory Fee (biennial) \$10
2317-001 Reciprocity License Fee \$150

(MUST BE TYPED OR PRINTED NEATLY)



STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243

TENNESSEE BOARD OF VETERINARY MEDICAL EXAMINERS
APPLICATION FOR LICENSE

INITIAL: _____ RECIPROCITY: _____

S.S.N. _____ - _____ - _____ Date of Birth _____
Month/Day/Year

ATTACH
PICTURE SO
THAT IT MAY BE
EASILY
REMOVED

SIGN FULL
NAME ON
BACK OF
PICTURE

Name _____
Last First Middle Maiden

Home Address _____
(Street)

(City) (State) (Zip) (County)

Work Address _____
Name of Facility

(Street)

(City) (State) (Zip) (County)

Home Phone _____ Office Phone _____

E-Mail Address _____ Do you wish to receive notification, including renewal notification, from the Department of Health via email? ___ Yes ___ No

Have you ever been licensed in Tennessee? _____ When? _____

Have you ever had a license in another name? ___ / ___. If so, what name? _____
Yes No Last First Middle

Have you passed the National Board Exam? _____ / _____; _____ / _____;
Yes No Date Score

Have you passed the Clinical Competency Test? _____ / _____; _____ / _____;
Yes No Date Score

Have you passed the NAVLE? _____ / _____; _____ / _____;
Yes No Date Score

Are you a U.S. Citizen?* ___ Yes ___ No *All applicants must complete the Declaration of Citizenship

Professional School _____
(Give Name)

Address _____

Year attended _____ - _____ Degree _____ Date Received _____
Month/ Day / Year

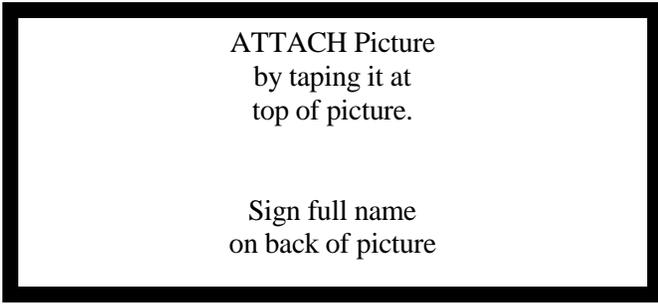
Have you ever been licensed to practice as a veterinarian in another state? _____
If so, give particulars:

State	Name	License Number

In what occupations or employments have you been engaged for the past five (5) years? Give names of employers, addresses, and dates:

1. _____
2. _____
3. _____
4. _____

USE ADDITIONAL SHEET OF PAPER IF NEEDED



COMPETENCY INFORMATION

PLEASE ANSWER THE FOLLOWING QUESTIONS. If any answers to questions in this part are in the affirmative, attach an explanation on a separate sheet. In support of your explanation, the final documents or orders from the issuing states, courts, and/or agencies must be submitted along with this application.

For the purposes of these questions, the following phrases or words have the following meanings:

1. **“Ability to practice veterinary medicine”** is to be construed to include all of the following:
 - a. The cognitive capacity to make appropriate clinical diagnosis, and exercise reasoned medical judgments, to learn, and keep abreast of medical developments,
 - b. The ability to communicate those judgments and medical information to clients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and

The physical capability to perform veterinary medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.
2. **“Medical Condition”** includes physiological, mental or psychological conditions or disorders, such as, but not limited to; orthopedic, visual, speech and/or hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.
3. **“Chemical substances”** is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber’s direction, as well as those used illegally.
4. **“Currently”** does not mean on the day of or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one’s functioning as a licensee or within the past two (2) years.
5. **“Illegal use of controlled substances”** means the use of controlled substances obtained illegally (e.g., heroin, or cocaine) as well as the use of controlled substances that are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

QUESTIONS:

YES NO

- | | | | |
|----|---|-------|-------|
| 1. | Do you currently have a medical condition which in any way impairs or limits your ability to practice veterinary medicine with reasonable skill and safety? | _____ | _____ |
| | a. If yes, are they reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? | _____ | _____ |
| | b. If you have any limitations or impairments caused by an existing medical condition, are they reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? | _____ | _____ |

[If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individual assessment of the nature, the severity, and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure.]

QUESTIONS:

YES NO

- | | | | |
|----|---|-------|-------|
| 2. | Do you currently use chemical substances? | _____ | _____ |
| | a. If yes, do they in any way impair or limit your ability to practice veterinary medicine with reasonable skill and safety? | _____ | _____ |
| 3. | Are you currently engaged in the illegal use of controlled substances? | _____ | _____ |
| | a. If yes, are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you in order to assure that you are not engaged in the illegal use of controlled substances? | _____ | _____ |
| 4. | Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, or voyeurism? | _____ | _____ |
| 5. | If you have ever held or applied for a license or certificate to practice veterinary medicine in any state, country, or province, has or was it ever been denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action? | _____ | _____ |
| 6. | If you have ever had staff privileges at any hospital or health care facility have they ever been revoked, suspended, curtailed, restricted, limited, otherwise disciplined, or voluntarily surrendered under threat of restriction or disciplinary action? | _____ | _____ |
| 7. | Have you ever applied for and been denied a state or federal controlled substance certificate? | _____ | _____ |
| | a. If you have possessed such a certificate has it ever been revoked, suspended, restricted, otherwise disciplined, or voluntarily under threat of investigation or disciplinary action? | _____ | _____ |
| 8. | Have you ever been convicted of a felony or a misdemeanor? | _____ | _____ |



STATE OF TENNESSEE
BOARD OF VETERINARY MEDICAL EXAMINERS
665 Mainstream Drive
Nashville, Tennessee 37243

Name of State where form is to be mailed (Toll Free In State) 1-800-778-4123 ext. 5325090
Local Nashville Area 615-532-5090
tn.gov/health

CERTIFICATE OF LICENSURE IN ANOTHER STATE
APPLICANT SECTION

Complete this section of this form. Mail to each state where you now hold or have ever held a license (make copies as needed). Print or type this information.

Name _____
(Last First Middle)

Address _____
(Street City State Zip Code)

License Number _____ Date Issued _____

I hereby authorize the _____
to furnish the Tennessee Veterinary Board any information in your files concerning me, favorable or otherwise.

Signature _____ Date _____

THIS SECTION TO BE COMPLETED BY AN OFFICIAL OF THE BOARD

This is to certify that the above-named individual was issued License # _____,
to practice as a _____.

Date Issued: _____

Licensed by: () Examination Status: () Active
() Endorsement/Reciprocity () Inactive
() Lapsed

Date License Expires: _____

Has this license ever been encumbered in any way? (revoked, suspended, limited, surrendered, restricted, placed on probation, or denied). () Yes () No If yes, explain on reverse side.

Signature _____ Date _____

Title _____ State _____

SEAL

ATTACHMENT 2



**STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243**

**TENNESSEE BOARD OF VETERINARY MEDICAL EXAMINERS
(Toll Free Instate) 1-800-778-4123 ext. 5325090
(615) 532-5090
tn.gov/health**

TRANSCRIPT REQUEST

APPLICANT: Supply the information requested in this box and then mail this entire form to your medical school. (To expedite call your school to check for fee requirements.)

Full Name: _____		
(Last)	(First)	(Middle/Maiden)
Address: _____	Social Security Number: _____ - _____ - _____	

Student Identification Number: _____		
Year of Graduation: _____		
Degree Obtained: _____		

TO WHOM IT MAY CONCERN:

I am applying for a license to practice Veterinary Medicine in the State of Tennessee. Please forward an original graduate transcript bearing the institution's official seal to:

**Board of Veterinary Medical Examiners
665 Mainstream Drive
Nashville, TN 37243**

Thank you for your cooperation and prompt response.

Applicant's Signature

Date

EB/G6057224/VME



TENNESSEE DEPARTMENT OF HEALTH

MANDATORY PRACTITIONER PROFILE QUESTIONNAIRE FOR LICENSED HEALTH CARE PROVIDERS

The Health Care Consumer Right-to-Know Act of 1998, T.C.A. §§ 63-51-101, *et seq.*, requires designated licensed health professionals to furnish certain information to the Tennessee Department of Health, and is requested in this questionnaire. From the information submitted, the Department compiles practitioner profiles which the law requires to be made available to the public via the World Wide Web and our toll-free telephone line. Each practitioner who has submitted information must update that information in writing by notifying the Department of Health, within 30 days after the occurrence of an event or an attainment of a status that is required to be reported by the law. A copy of your initial or updated profile will be furnished to you for your review prior to publication. That opportunity will allow you to make corrections, additions and helpful explanatory comments. Failure to comply with the requirement to submit and update profiling information may result in a delay or denial of your licensure application and/or may result in disciplinary action against your license. The professions required to submit a profile questionnaire are:

Advanced Practice Nurses	Nursing Home Administrators
Alcohol and Drug Counselors	Occupational Therapists
Audiologists	Optometrists
Chiropractic Physicians	Orthopedic Physician Assistants
Clinical Pastoral Therapists	Osteopathic Physicians
Dentists	Pharmacists
Dietitian/Nutritionists	Physician Assistants
Dispensing Opticians	Physical Therapists
Electrologists	Podiatrists
Licensed Registered Respiratory Therapists	Professional Counselors
Licensed Certified Respiratory Therapists	Psychologists
Licensed Laboratory Personnel	Respiratory Care Assistants
Marital & Family Therapists	Social Workers
Massage Therapists	Speech Language Pathologists
Medical Doctors	Veterinarians

A blank copy of the profile questionnaire may be obtained from the following web site address:
<http://health.state.tn.us/Downloads/g6019027.pdf>.

INSTRUCTIONS

QUESTIONNAIRE DEADLINE The provider must complete and submit the questionnaire before a license will be granted. Providers who have completed a similar questionnaire for another state's licensing board are, nevertheless, required to complete and submit this form. Changes to the questionnaire must be submitted within 30 days of the change.

COMPLETING THE QUESTIONNAIRE Complete the questionnaire by typing the information or by printing neatly in block letters in ball point pen. If a question does not apply to you, indicate so by checking the "Does not apply" box. **Illegible questionnaires will be returned.** If you need further instruction, contact your profession's licensing board by calling (615) 532-3202 or by calling toll free at (800) 778-4123.

SUBMITTING THE QUESTIONNAIRE Mail the completed profile questionnaire to:

Tennessee Board of (*board for your profession*)
Healthcare Provider Information
665 Mainstream Drive
Nashville, TN 37243

- ▶ Do not return pages 1 through 4 with the questionnaire to the department.
- ▶ Keep a copy of the questionnaire for your records.

The following numbered parts correspond to the matching number on the questionnaire form.

I. PRACTITIONER DATA

Complete Part I, noting the following:

- **License number:** Fill in your Tennessee license number and indicate your profession in the space provided. **If you have not been issued a license number, please leave this blank.**
- **Social security number:** **Your social security number will not be published or in any way given out to the public. It is required for in-house tracking purposes only.**
- **Primary Practice Address:** Complete the practice address (if applicable). If your practice address is also your home address, you should know the Department is prohibited from placing your home address on the Internet without your request to do so. There is a box to check in Part I to request this. Retirees: Write in "N/A" for practice address. If you do not have a practice address at the time of completing this questionnaire, you must report your practice address within 30 days of obtaining a practice address.
- **Supervising Physician:** Physician assistants and advanced practice nurses must list all supervising physicians. In addition, advanced practice nurses must also complete the Notice and Formulary if you are prescribing. The Notice and Formulary is available online at <http://health.state.tn.us/boards/Nursing/applications.htm>.

II. GRADUATE/POSTGRADUATE MEDICAL/PROFESSIONAL EDUCATION AND TRAINING

List chronologically medical/health professional related graduate/postgraduate education and training completed. Exclude any program or courses taken to satisfy continuing education requirements for licensure renewal. Provide information about health related degrees you have received including your licensure degree.

III. SPECIALTY BOARD CERTIFICATIONS

Provide information on any certification, specialty or subspecialty from any specialty board recognized by the American Medical Association, American Osteopathic Medical Association, American Podiatry Association, American Chiropractic Association, American Dental Association or any other specialty certifying body as determined by your Tennessee licensing board.

IV. FACULTY APPOINTMENTS

Answer ALL yes/no questions with a "yes" or "no" response. A brief statement in the space provided should follow a "yes" answer. If the space is insufficient for your response, attach an additional page, being sure to number the response to match the appropriate question.

V. STAFF PRIVILEGES

A. List all hospitals at which you hold staff privileges. The definition for "hospital" can be found at T.C.A. § 68-11-201.

VI. MANAGED CARE AND TENNCARE PLANS

A. In the spaces provided, answer information about the Managed Care plans in which you participate and accept as a provider, if any. If the space is insufficient for your response, attach an additional page, being sure to number the response to match the appropriate question.

B. In the spaces provided, answer information about the TennCare plans in which you participate and accept as a provider, if any. If the space is insufficient for your response, attach an additional page, being sure to number the response to match the appropriate question.

VII. FINAL DISCIPLINARY ACTION

These questions refer to final disciplinary or adverse actions taken within the previous **ten (10) years**, whether in this state or any other jurisdiction. The term **final** means the matter was fully adjudicated at a hearing and the appeal's period expired, or that the applicable board issued an agreed order or consent decree.

In the "Description of Violation" spaces, indicate the nature of the conduct in question such as malpractice, unethical conduct, drug-related, sex related, impairment, fraud, etc.

In the "Description of Action" spaces, indicate the type of disciplinary action imposed against your professional license such as censure, reprimand, probation, etc.

The term **disciplinary action** includes, but is not limited to:

- Probation
- Limitation/Restriction
- Suspension
- Revocation
- Voluntary relinquishment in lieu of disciplinary action
- Any other adverse action taken against a license or privilege by a medical/health related institution
- Compulsory surrender of license or privilege
- Civil or other monetary fine or penalty
- Resignation from or non-renewal of medical staff membership at a hospital in lieu of, or in settlement of, a pending disciplinary case related to competence or character
- Restriction of privileges in lieu of, or in settlement of, a pending disciplinary case related to competence or character

If you answer "yes" to any of the questions regarding Final Disciplinary Actions and/or Criminal Offenses and if the action is under appeal, you must attach a copy of the notice of appeal. Note: You must submit a copy of the final written order of disposition immediately after the appeal is disposed of by the adjudicating authority. Please read questions B and C in Part VII in their entirety before answering those questions.

VIII. CRIMINAL OFFENSES

This part requires you to report any state or federal felony criminal offense convictions. It also requires the reporting of misdemeanor offenses, regardless of classification, in which any element of the offense involves sex; alcohol or drugs; physical injury or threat of injury to any person; abuse or neglect of any minor, spouse or the elderly; fraud or theft in Tennessee or another jurisdiction; or unlicensed practice within the most recent ten (10) years. If you answer "yes" to this question and the offense is under appeal, you must submit a copy of the notice of appeal of that criminal offense. Immediately upon disposition of the appeal, you must submit a copy of the final written order of disposition. If any misdemeanor conviction reported is expunged, a copy of the order of expungement signed by the judge must be submitted to the Department before the conviction will be removed from any profile.

IX. LIABILITY CLAIMS

This section requires you to indicate all medical malpractice court judgments, arbitration awards, or settlements in which a payment was awarded to a complaining party beginning with judgments or settlements entered or executed after May 19, 1998. That means if the act or event leading to the claim occurred in, for instance, 1995, but was finally adjudicated against you after May 19, 1998, you must indicate that claim in the space provided. JUDGMENTS OR SETTLEMENTS BELOW THE FOLLOWING AMOUNTS ARE NOT REQUIRED TO BE SUBMITTED.

- A) For Medical Doctors and Osteopathic Physicians, judgments or settlements below \$75,000 are not required to be submitted.
- B) For Chiropractors, judgments or settlements below \$50,000 are not required to be submitted.
- C) For Dentists, judgments or settlements below \$25,000 are not required to be submitted.
- D) For all other professions, judgments or settlements below \$10,000 are not required to be submitted.

Pending malpractice claims are not required to be reported unless/until final adjudication against you.

X. OPTIONAL INFORMATION

This section is voluntary. You may list, briefly describe, and submit any information/documentation regarding your professional practice in the spaces provided. Attach an additional sheet labeled with the question number if additional space is required.

Practitioner's Name _____ License # _____

Profession _____

TENNESSEE BOARD OF *(board for your profession)*
HEALTHCARE PROVIDER INFORMATION
TENNESSEE DEPARTMENT OF HEALTH
OFFICE OF HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TENNESSEE 37243

I. PRACTITIONER DATA

A. PROFESSION: _____ LICENSE NUMBER: _____

B. SOCIAL SECURITY NUMBER: _____ (This will not be published).

C. NAME (INCLUDE MAIDEN AND ON 2ND/3RD LINES ANY ALIASES, IF APPLICABLE):

CURRENT NAME:

(LAST) (FIRST) (MIDDLE AND MAIDEN NAME)
(IF APPLICABLE)

FORMER NAME(S):

(LAST) (FIRST) (MIDDLE)

(LAST) (FIRST) (MIDDLE)

D. PRIMARY PRACTICE ADDRESS (attach additional sheets if necessary):

(PRACTICE NAME)

(STREET NUMBER AND NAME)

(CITY) (STATE) (ZIP CODE)

Check here if your primary practice address is your home address and you want it to be published as part of the profile and on the web site.

E. E-MAIL ADDRESS: _____
Your e-mail address will be published unless you elect not to by checking here.

F. WEB PAGE ADDRESS: _____
Your web page address will be published unless you elect not to by checking here.

G. PRACTICE TELEPHONE: (_____) _____
Your telephone number will be published unless you elect not to by checking here.

H. LANGUAGES, OTHER THAN ENGLISH: Indicate languages other than English or translation services that may be available at your primary practice location.

1. _____ 2. _____

I. SUPERVISING PHYSICIAN: If you are required by law to be supervised by a physician (physician assistant or advanced practice nurse) indicate the name(s) and address(es) of each supervising physician. If you need more space, attach additional sheets:

1. _____

2. _____

Practitioner's Name _____ License # _____

Profession _____

II. GRADUATE/ POSTGRADUATE MEDICAL EDUCATION AND TRAINING

A. What school(s)/educational programs have you attended? And, what type(s) of degree(s) do you hold? Do not include coursework taken to meet the continuing education requirement for licensure renewal. (Authority: T.C.A. §63-51-105(a)(6) and (7))

PROGRAM/INSTITUTION	CITY/STATE/COUNTRY	DATE OF GRADUATION MM/DD/YYYY	TYPE OF DEGREE
1.			
2.			
3.			

B. List in chronological order from date of graduation to the present, all completed medical/professional graduate and/or post-graduate training (internship, residency, fellowship or other program). Do not include coursework taken to meet continuing education requirements for licensure renewal. (Authority: T.C.A. § 63-51-105(a)(6))

PROGRAM AND SPECIALTY AREA (INTERNSHIP, RESIDENCY, FELLOWSHIP, ETC.)	LOCATION OF TRAINING (CITY, STATE, COUNTRY)	FROM MM/DD/YYYY	TO MM/DD/YYYY
1.			
2.			

III. SPECIALTY BOARD CERTIFICATIONS:

Do you hold a certification, specialty or subspecialty from any specialty board recognized by the board regulating the profession for which you are licensed? (see instructions) YES NO

(Authority: T.C.A. § 63-51-105(a)(8)) If "Yes", complete section below

CERTIFYING BODY/BOARD INSTITUTION	CERTIFICATION/SPECIALTY/SUBSPECIALTY
1.	
2.	
3.	
4.	
5.	

Practitioner's Name _____ License # _____

Profession _____

IV. FACULTY APPOINTMENTS

- A. Have you had the responsibility for graduate medical education within the last ten (10) years? (Authority: T.C.A. § 63-51-105(a)(10)) YES NO
- B. Do you currently hold a faculty appointment at a medical/health related institution of higher learning? (Authority: T.C.A. § 63-51-105(a)(10)) YES NO

If "YES", list the title of the appointment, name(s) and city/state of institution(s). (Attach additional sheets, clearly labeled with this question number, if necessary.)

	TITLE	INSTITUTION	CITY/STATE
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

V. STAFF PRIVILEGES

- A. Do you currently hold staff privileges at a hospital? (Authority: T.C.A. §63-51-105(a)(9)) YES NO
- If "YES", list each hospital at which you currently have staff privileges: (Attach additional sheets, clearly labeled with this question number, if necessary)

	NAME OF HOSPITAL	CITY/STATE
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

VI. MANAGED CARE PLANS

- A. Do you participate in any managed care plans? (Authority: T.C.A. §63-51-105(a)(15)) YES NO
- If "YES", list each: (Attach additional sheets, clearly labeled with this question number, if necessary)

	NAME OF MANAGED CARE PLAN
1.	_____
2.	_____
3.	_____
4.	_____
5.	_____

Practitioner's Name _____ License # _____

Profession _____

B. Do you currently participate in and accept any TennCare plan(s) as a provider? YES NO

If "YES", list each plan in which you currently participate or accept as a provider: (Authority: T.C.A. § 63-51-105(a)(16))

NAME OF TENNCARE PLAN

1. _____
2. _____
3. _____
4. _____
5. _____

VII. FINAL DISCIPLINARY ACTION (See Instructions):

A. Within the previous ten (10) years, have you ever had any final disciplinary action taken against you by the agency regulating your license, in this state or any other jurisdiction? (Authority: T.C.A. § 63-51-105(a)(8)) YES NO

If "YES", list name(s) and address(es) of agency(s) and a brief description of the final disciplinary action(s) and stated reason(s) for taking the action. (Attach additional sheets, clearly labeled with this question number, if necessary.)

AGENCY NAME/ADDRESS	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION
1. _____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES NO

2. _____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES NO

Practitioner's Name _____ License # _____

Profession _____

B. Within the previous ten (10) years, have you ever had your hospital privileges revoked or involuntarily restricted or reasons related to competence or character by the hospital's governing body? (Authority: T.C.A. § 63-51-105(a)(4)) YES NO

If "YES", list name(s) and address(es) medical institution(s) and a brief description of the final disciplinary action(s) and stated reason(s) for the action. (Attach additional sheets, clearly labeled with this question number, if necessary)

HOSPITAL NAME/ADDRESS	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION
1. _____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES NO

2. _____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES NO

C. Within the previous ten (10) years, have you ever been asked to or allowed to resign from or had any medical staff privileges restricted or not renewed by any hospital in lieu of or in settlement of a pending disciplinary action related to competence or character? (Authority: T.C.A.: § 63-51-105(a)(4))

YES NO

If "YES", list name(s) and address(es) of the hospital(s) and a brief description of the final disciplinary action(s) and stated reason(s) for the action. (Attach additional sheets, clearly labeled with this question number, if necessary)

HOSPITAL NAME/ADDRESS	DATE	DESCRIPTION OF ACTION
1. _____	_____	_____
_____	_____	_____
_____	_____	_____

If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES NO

2. _____	_____	_____
_____	_____	_____
_____	_____	_____

If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES NO

Practitioner's Name _____ License # _____

Profession _____

VIII. CRIMINAL OFFENSES (See Instructions)

Have you within the most recent ten (10) years, been found guilty, regardless of whether adjudication of guilt was withheld, or pled guilty or nolo contendere to a criminal misdemeanor or felony in any jurisdiction? (Authority: T.C.A. § 63-51-105(a)(1)) YES NO

If "YES" briefly describe the offense(s):

DESCRIPTION OF OFFENSE(S)	DATE	JURISDICTION
1. _____ _____	_____	_____

If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES NO

2. _____ _____	_____	_____
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If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES NO

3. _____ _____	_____	_____
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If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES NO

IX. LIABILITY CLAIMS

Have you had a medical malpractice court judgment, arbitration award, or settlement against you since May 19, 1998? (Authority: T.C.A. § 63-51-105(a)(5)) YES NO

If "YES", indicate a brief description of the nature(s) of the claim, the date(s) of the claim report(s), and the amount of the judgment(s), award or settlement(s):

ENTRY DATE OF DISPOSITION ORDER OR SETTLEMENT	AMOUNT
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Practitioner's Name _____ License # _____

Profession _____

X. OPTIONAL INFORMATION:

A. PUBLICATIONS: List any publications you have authored in peer-reviewed medical literature: (optional)
(Authority: T.C.A. § 63-51-105(a)(11))

	TITLE	PUBLICATION	DATE
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

B. PROFESSIONAL OR COMMUNITY SERVICE ACTIVITIES AWARDS: List any information regarding professional or community service associates, activities and awards: (optional) (Authority: T.C.A. § 63-51-105(a)(12))

	COMMUNITY SERVICE/AWARD/HONOR	ORGANIZATION
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

I affirm these statements are true and correct and recognize that providing false information may result in disciplinary action against my license pursuant to T.C.A. §§ 63-51-113 and/or 63-51-118.

(Signature of Provider) Date: _____

REMINDER: Each practitioner who has submitted information must update that information in writing by notifying the Department of Health, Healthcare Provider Information Unit, within 30 days after the occurrence of an event or an attainment of a status that is required to be reported by the law.



STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243

**DECLARATION OF CITIZENSHIP
MUST ACCOMPANY ALL APPLICATIONS FOR INITIAL LICENSURE OR REINSTATEMENT OF LICENSURE**

The "SAVE Act" requires Tennessee Department of Health (including all Boards, Commissions, and contractors), along with every local health department in the State, to verify that *every adult* applicant for a professional license is either a U.S. citizen, a "qualified alien," or a nonimmigrant who meets the requirements set out at 8 U.S.C. 1621.

I am a(n) _____
Healthcare Profession (Please Print) License number if applicable

Please Print Legibly

1. Name: _____
Last First Middle Maiden_
2. Mailing Address: _____
3. Phone Number: Home: (____)____-____ Office: (____)____-____ Fax: (____)____-____
4. I am a United States Citizen: ____Yes ____No
5. I am a foreign national not physically present in the United States ____Yes ____No. If you answered yes, to this question please sign this form in the presence of a notary and return it with your application. No further documentation is required.
6. Applicants Claiming United States Citizenship **MUST** provide one of the following:
 - a) Tennessee Driver's License, or photo ID issued by Department of Safety.
 - b) A valid driver license or ID issued by another state, provided its issuance requirements meet Department of Safety criteria.
 - c) An official birth certificate issued by a U.S. state, territory, or other jurisdiction. Puerto Rican birth certificates issued before July 1, 2010 do not count.
 - d) A federally issued birth certificate.
 - e) A valid, unexpired U.S. passport.
 - f) A report of birth abroad of a U.S. citizen.
 - g) A certificate of citizenship.
 - h) A certificate of naturalization.
 - i) A U.S. citizen ID card.
 - j) Any successor document to #'s a-i above.
 - k) SSN that the entity or local health department may verify with the Social Security Administration in accordance with federal law.
7. If you checked "No" in question 4 please indicate from the list below which category applies to you: (circle one)
 - a) Permanent Residents

- b) A nonimmigrant applicant for a professional or commercial license whose visa for entry into the United States is related to such employment, or a nonimmigrant under the Immigration and Nationality Act (8 U.S.C. 1101 *et seq.*).
- c) Asylees who meet the qualifications set out in 8 U.S.C. 1158
- d) Refugees who meet the qualifications set out in 8 U.S.C. 1157
- e) Persons who have been "paroled into the United States," under 8 U.S.C. 1182(d)(5) or whose deportation has been withheld under 8 U.S.C. 1253.
- f) Cuban or Haitian entrants as defined by section 501(e) of the Refugee Education Assistance Act of 1980
- g) Persons granted conditional entry into the U.S. under 8 U.S.C. 1153(a)(7) before April 1, 1980, because of persecution or fear of persecution on account of race, religion, or political opinion or because of being uprooted by catastrophic national calamity.
- h) An alien who has been "battered" or subjected to "extreme cruelty" by a parent or spouse as defined by 8 U.S.C. 1641(c), and also meets the qualifications set out 8 U.S.C. 1641(c)(1)(B). Under the circumstances set out in 8 U.S.C. 1641(c)(2) and (3), victims' children, or the parents of children who are victims, may also apply for benefits as qualified aliens.

Applicants claiming **qualified alien status** (question 7 above), please submit two of the following forms of "documentation of identity and immigration status" as determined by U.S. Homeland Security to be acceptable for verification through the SAVE program. Common types of documents used to verify immigration status are listed below. (Note: If you can provide only one document, your status will be verified through the U.S. Department of Homeland Security's SAVE program):

I-327 (Reentry Permit)

I-551 (Permanent Resident Card or "Green Card")

I-571 (Refugee Travel Document)

I-766 (Employment Authorization Card)

Machine Readable Immigrant Visa (with Temporary I-551 language)

Temporary I-551 stamp (on passport or I-94)

I-94 (Arrival/Departure record)

Unexpired foreign passport

WT/WB Admission Stamp in unexpired foreign passport

I-20 (Certificate of Eligibility for Nonimmigrant F(1) student status- "student visa")

DS2019 (Certificate of Eligibility for Exchange Visitor (J-1) Status)

I affirm under the penalty of perjury that the above is true and correct.

Signed this _____ day of _____, 20__.

Signature

Sworn to before me this _____ day of _____, 20__.

NOTARY PUBLIC

AFFIX SEAL HERE

My Commission Expires: _____

If an applicant is discovered to be an unqualified alien, or otherwise ineligible for benefits under the Act, all recurring benefits provided to that applicant must be immediately terminated. Anyone who purposefully makes a false, fictitious, or fraudulent claim of U.S. citizenship or qualified alien status will be liable under the Tennessee Medicaid False Claims Act, or Tennessee's False Claims Act. Any person who conspires to defraud the state or any local health department by securing a false claim allowed or paid to another person in violation of the Act may be liable under Tennessee's False Claims Act. Upon discovery of an applicant's false, fictitious, or fraudulent claim of U.S. citizenship, state governmental entities and local health departments must also file a criminal complaint with the United States Attorney.