## Instructions for Licensure for Advanced Practice Registered Nurse

*The statutes governing registered nurses are in TCA, Section δ 63-7-123 and δ 63-7-126, http://www.lexisnexis.com/hottopics/tncode/*

**Prior to applying**:

- Obtain national certification
- Obtain current unencumbered Registered Nurse license in Tennessee or compact state
  *To view current compact states, go to*: https://www.ncsbn.org/nurse-licensure-compact.htm

**Allow six weeks for processing. It is not necessary to call the board to check on the status of your application go to**: https://apps.health.tn.gov/Licensure/default.aspx.

**Complete Application**

- Request an official graduate transcript from the educational institution of the nursing program to be mailed directly to the Board of Nursing. If submitting post-masters' certificate, include masters' transcript.
- Declaration of Citizenship form: complete, sign, have notarized and submit with required documentation.
  *The form is online at*: http://tn.gov/assets/entities/health/attachments/PH-4183.pdf.
- Request an official verification of current National Certification from the national certifying ody (e.g. ANCC, AANP, NBCRNA) to be forwarded directly to the Board of Nursing.
- Complete and submit the Mandatory Practitioner Profile Questionnaire.
  *The form is online at*: http://tn.gov/assets/entities/health/attachments/PH-3585.pdf

**Additional information**:

- You are required by law to update changes to the Mandatory Practitioner Profile Questionnaire within 30 days. Failure to do so may subject you to disciplinary action.
- If prescribing, submit Notice & Formulary.
  The form is online at: http://tn.gov/assets/entities/health/attachments/PH-3625.pdf
- If you change your mailing or practice address, you must notify the Board's Administrative Office within thirty (30) days. Failure to abide by this law could affect your license, since failure to receive the renewal application does not relieve you of the responsibility for timely renewal.

**If the application is not complete upon receipt by the Board, you will be notified of the deficiency.**

FEES ARE NON REFUNDABLE

1702 001 - $200.00
006 - $10.00
$210.00

Department of Health
Division of Health Licensure and Regulation
Tennessee Board of Nursing
665 Mainstream Drive, Second Floor
Nashville, Tennessee 37243

# Application for Licensure as an Advanced Practice Registered Nurse

*Submit application **AFTER** obtaining national certification*

Print Legal Name (*use ink*): _____
LAST FIRST MIDDLE MAIDEN

List any other names by which you have been known: _____

Social Security Number: _____ Telephone Number: (_____) _____
*Your social security number may be used to verify your identity and for any other purpose allowed by state or federal law.*

U.S. Citizen ❒ Yes ❒ No Entitled to Live and Work in the U.S. ❒ Yes ❒ No

Date of Birth: _____ Gender: ❒ Female ❒ Male

Ethnic Group: ❒ White ❒ Black ❒ Native American Indian ❒ Asian ❒ Hispanic ❒ Other, Specify _____

Do you wish to receive notifications, including renewal notification, from Department of Health via email? Please note, by opting in, all correspondence from the Department of Health will be delivered to the email address on file. You will no longer receive physical mail from our office. ❒ Yes ❒ No Email address: _____
(Print legibly)

Mailing Address: _____
(Street/PO Box/Route) (City/State/Zip)

Street Address: _____
*(Required if Mailing Address is a PO Box)* (Street) (City/State/Zip)

## PRIMARY STATE OF RESIDENCE

I declare that my primary state of residence is _____. This state is referred to as my home state under the Nurse Licensure Compact and means that it is my declared fixed permanent and principle home for legal purposes and is my domicile.

***The following items may be requested as proof of primary state of residence: driver's license, voter registration card, federal income tax return, military form DD2058, state of legal residence certificate or military form DFAS702, leave and earning statement (LES).***

RN License Number _____ Name on License _____ State _____

NPI Number _____ DEA Number _____

Are you a member of the U.S. armed forces who has, within the preceding 180 days, retired from the armed forces, received any discharge other than a dishonorable discharge from the armed forces, or been released from active duty to a reserve component of the armed forces? *(If yes, provide proof of status)* ❒ Yes ❒ No

Are you the spouse of a member of the armed forces who has been transferred by the military to Tennessee or who has, within the preceding 180 days, retired from the armed forces, received a discharge other than a dishonorable discharge from the armed forces or been released from active duty to a reserve component? *(If yes, provide proof of status)* ❒Yes ❒ No

Are you or have you ever been licensed as a registered nurse in another state? ❒ Yes ❒ No
If yes, identify name as licensed, state and license number: _____

Have you previously applied for an advanced practice registered nurse license in Tennessee? ❒ Yes ❒ No
Are you or have you ever been licensed as an advanced practice registered nurse in another state? ❒ Yes ❒ No
If yes, identify name as licensed, state and license number: _____

Are you or have you ever been licensed in any other profession in Tennessee or another state? ❒ Yes ❒ No
If yes, identify profession, name as licensed, state, license number and status: _____

## Education History

| Educational Institution City, State | Graduation Date mm/dd/yyyy | Program | Population Foci | Setting | Degree Awarded |
|---|---|---|---|---|---|
| | | ___ Nurse Practitioner<br>___ Nurse Anesthetist<br>___ Nurse Midwife<br>___ Clinical Nurse Specialist | ___ Family<br>___ Adult/Gerontology<br>___ Pediatric<br>___ Neonatal<br>___ Women's Health<br>___ Psych/Mental Health | ___ Acute<br>___ Primary | ___ Masters/Nursing<br>___ Post Masters<br>___ DNP<br>___ Certificate |
| | | ___ Nurse Practitioner<br>___ Nurse Anesthetist<br>___ Nurse Midwife<br>___ Clinical Nurse Specialist | ___ Family<br>___ Adult/Gerontology<br>___ Pediatric<br>___ Neonatal<br>___ Women's Health<br>___ Psych/Mental Health | ___ Acute<br>___ Primary | ___ Masters/Nursing<br>___ Post Masters<br>___ DNP<br>___ Certificate |

## National Certification

| Name of Certifying Body | Examination Date | Certification Number | Certification Expiration Date | Status |
|---|---|---|---|---|
| | | | | ___ Current<br>___ Provisional/ Conditional |
| | | | | ___ Current<br>___ Provisional/ Conditional |
| | | | | ___ Current<br>___ Provisional/ Conditional |

## Work/Practice History

| Company/Employer | City & State of practice | Position | Duties | From Date mm/dd/yyyy | To Date mm/dd/yyyy |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**Definitions for Fitness and Competency Questions**

1. "Ability to practice your profession" is to be construed to include all of the following:

a. The cognitive capacity to make appropriate clinical diagnoses, exercise reasoned medical judgments, to learn, and keep abreast of medical developments;

b. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and

c. The physical capability to perform professional tasks and procedures required of your profession 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 including, but not limited to; orthopedic, visual, speech and/or hearing impairments, emotional or mental illness, specific learning disabilities, drug addiction, and alcoholism.

3."Minor Traffic Offense" generally means moving and non-moving violations punishable by fines only and does not include offenses such as driving under the influence or while intoxicated or reckless driving.

4. "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.

5. "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.

6. "Illegal use of illicit or controlled substances" means the use of 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.

**Fitness and Competency Questions**

1. Do you currently have any physical or psychological limitations or impairments caused by an existing medical condition which are reduced or ameliorated by ongoing treatment or monitoring, or the field of practice, the setting or the manner in which you have chosen to practice? ❒ Yes ❒ No

***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 to determine whether an unrestricted license should be issued, conditions should be imposed, or you are not eligible for licensure.***

2.Do you currently use any chemical substances which in any way impair or limit your ability to practice your profession with reasonable skill and safety? ❒ Yes ❒ No If yes, please list: _____

3. At any time within the past two years, have you engaged in the illegal use of illicit or controlled substances?
❒ Yes ❒ No

4. Are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you to assure that you do not consume alcohol and/or do not engage in the illegal use of illicit or controlled substances?
❒ Yes ❒ No

5. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or other diagnosis of a predatory nature? ❒ Yes ❒ No

6. Have you ever held or applied for a license, privilege, registration or certificate to practice as an advanced practice registered nurse in any state, country, or province, that has been or was ever denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?
❒ Yes ❒ No

7. Have you ever had staff privileges at any hospital or health care facility that were ever revoked, suspended, curtailed, restricted, limited, otherwise disciplined, or voluntarily surrendered under threat of restriction or disciplinary action?
❒ Yes ❒ No

8. Have you ever applied for or held a state or federal controlled substance certificate that was ever denied, revoked, suspended, restricted, voluntarily surrendered or otherwise disciplined or surrendered under threat of restriction or disciplinary action? ❒ Yes ❒ No

9. Have you ever been convicted (including a nolo contendere plea or guilty plea) of a felony or misdemeanor (other than a minor traffic offense) whether or not sentence was imposed or suspended? ❒ Yes ❒ No

10. Have you ever been rejected or censured by a professional association or society? ❒ Yes ❒ No

11. In relation to the performance of your professional services in any profession:
    a. Have you ever had a final judgment rendered against you;
    b. Have you ever entered into any settlement of any legal action; or
    c. Are there any legal actions pending against you or to which you are a party? ❒ Yes ❒ No

12. Have you ever held a license, registration, privilege or certificate in any profession that has ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action in any jurisdiction? ❒ Yes ❒ No

13. My name has been placed on the registry of persons who have abused, neglected or misappropriated the property of vulnerable individuals (Tennessee abuse registry or an abuse registry in another state). ❒ Yes ❒ No

***If you answered "yes" to any of the questions in this part, you must supplement your affirmative response with a thorough explanation on a separate page. In support of your explanation, the board orders from the issuing states, the certified arresting document (warrant), judgment (disposition), and release from judgment (receipt of payment of fines, letter of release from probation, etc.) from the court (clerk's office), and/or agencies must be submitted along with this application. Additional information may be requested and/or required before a licensure decision may be made.***

I, being duly sworn and identified as the person referred to in this application, attest to the truth of each statement made in said application. I further swear that I have read and understand the law and the Rules and Regulations regarding the practice of my profession, which are posted on the Board's Internet site and/or were provided to me by the Board office, and agree to abide by them in the practice as an Advanced Practice Registered Nurse in the State of Tennessee.

**I HEREBY**:
**SIGNIFY** my willingness to appear to answer such questions as the Board may find necessary, which may include a full Board interview.
**RELEASE** to the Board, its staff, and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice as an Advanced Practice Registered Nurse.
**AUTHORIZE** the Board, its staff, and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others, and other qualifications.
**RELEASE** from liability the Board, its staff, and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character, and/or other qualifications, for certification.
**ACKNOWLEDGE** that I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical, and other qualifications, and for resolving any doubts about such qualifications.
**AUTHORIZE** release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

**This certifies that the information submitted by me in this application is true and complete to the best of my knowledge and belief.**

_____ _____
Signature Date

**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**

**Pursuant to T.C.A. § 4-58-101 et seq, the Eligibility Verification for Entitlements Act (also known as the "SAVE Act") requires the 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 the Tennessee Department of Safety.
   b) A valid driver license or ID issued by another state, provided its issuance requirements meet Tennessee 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 qualify.
   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 e-i above.
   k) An SSN that is verifiable 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 Resident
   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)

**ALL APPLICANTS MUST SIGN AND HAVE NOTARIZED**

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____.

_____ AFFIX SEAL HERE
NOTARY PUBLIC

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 or qualified alien status, state governmental entities and local health departments must also file a criminal complaint with the Office of the Attorney General and/ or the United State Attorney.**

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

***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.

**Each provider who has submitted information pursuant to this chapter must update that information in by notifying the department within thirty (30) days after the occurrence of an event or the attainment of a status that is required to be reported.**

***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 Nursing
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. Advanced practice nurses must also complete the **Notice and Formulary** if you are prescribing and physician assistants must also complete the **PA Supervising Physician form**. Completion of the Notice and Formulary or the PA Supervising Physician form is in addition to completing and/or updating the practitioner profile. The Notice and Formulary is online at http://tn.gov/assets/entities/health/attachments/PH-3625.pdf. The PA Supervising Physician form is online at http://tn.gov/assets/entities/health/attachments/PA_Supervising_Physician_Application.pdf.

## II. GRADUATE/POSTGRADUATE 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, APN certifications or any other specialty certifying body as determined by your Tennessee licensing board.

## IV. 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.

## V. 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.

## VI. 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.**

## VII. 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.

## VIII. 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.

## IX. 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** _____ **TN License #** _____ (if applicable)

**Profession** _____

**TENNESSEE BOARD OF NURSING**
**HEALTHCARE PROVIDER INFORMATION**
**TENNESSEE DEPARTMENT OF HEALTH**
**OFFICE OF HEALTH RELATED BOARDS**
**665 MAINSTREAM DRIVE**
**NASHVILLE, TENNESSEE 37243**

## I. PRACTITIONER DATA (Please read instructions before completing this form)

A. PROFESSION: _____ TN 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: (see page 2 of instructions)

1. _____
2. _____

**Practitioner's Name** _____ **TN License #** _____ (if applicable)

**Profession** _____

## II. GRADUATE/ POSTGRADUATE PROFESSIONAL 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 (if applicable):

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** _____ **TN License #** _____ (if applicable)

**Profession** _____

## IV. 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. | |

## V. MANAGED CARE AND TENNCARE 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. |

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. _____ |

**Practitioner's Name** _____ **TN License #** _____ (if applicable)

**Profession** _____

## VI. FINAL DISCIPLINARY ACTION AGAINST A PROFESSIONAL LICENSE (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)(2) and (3))

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 ___

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 ___

**Practitioner's Name** _____ **TN License #** _____ (if applicable)

**Profession** _____

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 ___

## VII. 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. | | | |
| | | | |

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

| | | | |
|---|---|---|---|
| 3. | | | |
| | | | |

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

**Practitioner's Name** _____ **TN License #** _____ (if applicable)

**Profession** _____

## VIII. 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. | | |

## IX. OPTIONAL INFORMATION: (limit of four)

A. PUBLICATIONS: List any publications you have authored in peer-reviewed medical literature: (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: (Authority: T.C.A. § 63-51-105(a)(12))

| | COMMUNITY SERVICE/AWARD/HONOR | ORGANIZATION |
|---|---|---|
| **1.** | | |
| **2.** | | |
| **3.** | | |
| **4.** | | |

**Practitioner's Name** _____ **TN License #** _____ **(if applicable)**

**Profession** _____

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.

C. RESPONSIBILITY FOR GRADUATE MEDICAL EDUCATION: 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 ___

D. FACULTY APPOINTMENTS: 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. | | | |

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.

_____ Date: _____

**(Signature of Provider)**

REMINDERS:

- 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.
- If you are a DEA registrant who prescribes controlled substances, independent of the obligation to make certain information available to your licensing board, you must also register in the **Controlled Substance Monitoring Database (CSMD)**. More information regarding this obligation is available online at http://tn.gov/health/article/CSMD-about.