



STATE OF TENNESSEE  
DEPARTMENT OF HEALTH  
HEALTH RELATED BOARDS  
665 MAINSTREAM DRIVE  
NASHVILLE, TENNESSEE 37243  
[www.tennessee.gov/health](http://www.tennessee.gov/health)

TENNESSEE BOARD OF MEDICAL EXAMINERS  
(800) 778-4123, ext. 532-4384 or (615) 532-3202, ext. 532-4384

APPLICATION INSTRUCTIONS FOR

ST. JUDE CHILDREN'S RESEARCH HOSPITAL GLOBAL COLLABORATION LICENSE

Provided below is a checklist for your personal use and convenience containing all the things you must do to receive consideration for issuance of a St. Jude Children's Research Hospital Global Collaboration License.

**ALL APPLICATION FEES ARE NON-REFUNDABLE.**

- |  | <b>Done</b> |
|--|-------------|
| 1. Complete and mail the application pages 1 through 6.  | _____       |
| 2. Complete and mail attachment 1 to your medical school for transcript of courses, grades, and degree. If you are an International Medical School graduate you must <b>also</b> ask that your medical school provide to this office documentation proving that they meet or exceed the accreditation requirements of the LCME (Liaison Committee on Medical Education). Documentation must be submitted in English. | _____       |
| 3. Complete and mail attachment 2 to each state, country, or province in which you hold or have ever held a license to practice any profession.  | _____       |
| 4. Submit a clear and recognizable recently taken bust photograph of yourself that shows the full head, face forward from at least the shoulders up.   | _____       |
| 5. Submit proof of the citizenship in the United States or Canada or evidence of being legally entitled to live and work in the United States. (Notarized copies of birth certificates, naturalization papers, H-1 visas, or current passports are acceptable). License will not be issued to holders of J-1 Training Visa. Visa must allow one to hold employment in the United States.                             | _____       |
| 6. Submit two (2) original letters of recommendation from licensed medical doctors on the signatory's letterhead attesting to your good moral character. The letters must contain original signatures.   | _____       |
| 7. You must have successfully completed a medical licensure examination or an approved combination of examinations. If you are submitting USMLE scores, <b>all three steps must be taken and passed within seven years</b> . Please refer to attachment 3 for information in obtaining scores.   | _____       |
| 8. If you are an international medical school graduate, you must submit one of the following:  |             |
| a. A notarized copy of your original permanent E.C.F.M.G. Certificate;   | _____       |
| b. If you graduated from a Mexican Medical School, a letter from the E.C.F.M.G. stating that all certificate requirements have been met; or  | _____       |

- c. If you cannot obtain an original certificate due to the phase out of the E.C.F.M.G., proof of successful completion of U.S.M.L.E. Steps 1 and 2 submitted directly from the testing agency to the Board Administrative Office. \_\_\_\_\_
- 9. Complete and submit along with your application the *Practitioner Profile Questionnaire* which is online at <http://tn.gov/assets/entities/health/attachments/PH-3585.pdf>. You are required by law update your profile within 30 days of any change as long as you have an active license. Failure to do so may subject you to disciplinary action. \_\_\_\_\_
- 10. **Attach to the application and submit a check or money order in U.S. funds in the amount of \$410, payable to the Tennessee Board of Medical Examiners.** \_\_\_\_\_
- 11. **A criminal background check is required.** For instructions to obtain a criminal background check, go to <http://tn.gov/health/article/CBC-instructions> \_\_\_\_\_
- 12. Complete Declaration of Citizenship. \_\_\_\_\_

**UNDERSTANDING THE APPLICATION PROCESS**

- 1. **All application fees are non-refundable.**
- 2. All documents and fees required to be submitted by you or which must be requested from the appropriate institutions in this application process, must be mailed directly to:  
  

**Tennessee Board of Medical Examiners  
665 Mainstream Drive  
Nashville, TN 37243 (37228 for courier service only)**
- 3. **Allow fourteen (14) working days** for information mailed to our office to be received and placed in your file. Federal Express or special courier services will not appreciably reduce the processing time. Additionally, if Federal Express or special courier services are used, you will be responsible for charges incurred. The Board asks that you please give the Board office every consideration in this matter.
- 4. If necessary documentation has not been received when your application has been received by the Board office, an initial deficiency letter will be sent to you. The supporting documentation requested in the letter must be received in the Board office ninety (90) days from the date of the initial deficiency letter. **(Files not completed within ninety (90) days will be closed.)**
- 5. Absent any complicating factors, the average application processing time is eight (8) weeks. Once the application is completed, your file will be reviewed and an initial licensure determination made. You will be promptly notified by letter of the initial determination.
- 6. **If an address change occurs at any time during the application process, you must notify the Board office, in writing, immediately.**
- 7. It is recommended that you do not make arrangements to accept employment as a physician at St. Jude Children's Research Hospital until you are granted a license number by the Board of Medical Examiners.
- 8. You have the option to receive all correspondence from the Department of Health electronically. Should you "opt in," you will no longer receive physical mail from this office. Opting in does not discharge your obligation to provide the Department with a current physical address and email address. You are required by statute and rule to notify the Department of an address change within thirty (30) days of any such change.
- 9. All documents which are provided to this office in conjunction with your request for a medical license becomes part of the public record and must be released pursuant to a public records request.

Thank you for your cooperation. We will make every effort to expedite your application in an efficient manner.



**EDUCATIONAL AND EXAMINATION INFORMATION**

**PRE-MEDICAL EDUCATION**

From: \_\_\_\_\_ To: \_\_\_\_\_  
MM/YY MM/YY Educational Institution Location

From: \_\_\_\_\_ To: \_\_\_\_\_  
MM/YY MM/YY Educational Institution Location

From: \_\_\_\_\_ To: \_\_\_\_\_  
MM/YY MM/YY Educational Institution Location

**MEDICAL EDUCATION**

I have spent \_\_\_\_\_ years in the study of medicine in the medical educational institutions below:

From: \_\_\_\_\_ To: \_\_\_\_\_  
MM/YY MM/YY Educational Institution Location

From: \_\_\_\_\_ To: \_\_\_\_\_  
MM/YY MM/YY Educational Institution Location

Complete Attachment 1 and mail to the school which granted your medical degree

**EXAMS**

I have taken the following medical licensure examinations: (Check all applicable)

- 1. \_\_\_ National Boards (NBME) Certificate Number
- 2. \_\_\_ FLEX examination administered by the State of \_\_\_\_\_ on \_\_\_\_\_  
(Date(s))
- 3. \_\_\_ Licensure by the Medical Council of Canada (LMCC)
- 4. \_\_\_ USMLE
- 5. \_\_\_ State Board administered by \_\_\_\_\_ prior to 1972.  
(State)

Have you previously applied for a medical license in Tennessee?    Y    N

**PRACTICE AND LICENSURE INFORMATION**

**YES NO**

Are you or have you ever been licensed to practice medicine in another state? \_\_\_ \_\_\_

Are you or have you ever been licensed in any other profession in Tennessee or another state? \_\_\_ \_\_\_

List below all states, countries or provinces in which you have ever been or currently are licensed, permitted or certified. Submit a copy of **Attachment 1** to all such states, countries, or provinces regarding such licensure, certification or permit. Use the back of this page if you need additional space.

<b>STATE</b>	<b>PROFESSION</b>	<b>LICENSE NUMBER</b>	<b>DATE ISSUED</b>	<b>CURRENT STATUS</b>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Do you have a DEA Registration?    Y    N

If yes, please provide: \_\_\_\_\_  
 \_\_\_\_\_

Please complete your employment history starting with the most current position first. You may use a separate sheet of paper if you need additional space.

<b><u>DATES</u></b>		<b><u>LOCATION</u></b>		<b><u>POSITION AND DUTIES</u></b>
From: _____	To: _____	_____	_____	_____
MM/YY	MM/YY	(City)	(State)	_____
From: _____	To: _____	_____	_____	_____
MM/YY	MM/YY	(City)	(State)	_____
From: _____	To: _____	_____	_____	_____
MM/YY	MM/YY	(City)	(State)	_____
From: _____	To: _____	_____	_____	_____
MM/YY	MM/YY	(City)	(State)	_____
From: _____	To: _____	_____	_____	_____
MM/YY	MM/YY	(City)	(State)	_____

**COMPETENCY INFORMATION**

**PLEASE ANSWER THE FOLLOWING QUESTIONS.** If you answer "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 FINAL DOCUMENTS OR ORDERS FROM THE ISSUING STATES, COURTS, 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.**

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

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.

**QUESTIONS:**

**YES NO**

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? \_\_\_\_\_ \_\_\_\_\_

2. Do you currently use any chemical substances which in any way impair or limit your ability to practice medicine with reasonable skill and safety? \_\_\_\_\_ \_\_\_\_\_

If so, please list: \_\_\_\_\_

*[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.]*

**COMPETENCY INFORMATION CONTINUED**

<b>QUESTIONS: Please respond to ALL questions. If you answer "YES" to any question, please attach a written explanation.</b>		<b>YES</b>	<b>NO</b>
3.	At any time within the past two years, have you engaged in the illegal use of illicit or controlled substances?	_____	_____
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?	_____	_____
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?	_____	_____
6.	Have you ever held or applied for a license or certificate to practice medicine 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?	_____	_____
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?	_____	_____
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?	_____	_____
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?	_____	_____
10.	Have you ever been rejected or censured by a medical society?	_____	_____
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?	_____	_____
12.	Have you ever held a license or certificate in any health care profession that has ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	_____	_____
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).	_____	_____

**Affirmative response requires final documents or orders from the issuing states, courts, and/or agencies.**

**AFFIDAVIT AND RELEASE**

I, \_\_\_\_\_, M.D., of \_\_\_\_\_  
(Applicant's Name) (City) (State)

being duly sworn and identified as the person referred to in this application attests 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 of medicine 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 medicine.

**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 licensure.

**ACKNOWLEDGE** that I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical, other qualifications, and for resolving any doubts about such qualifications.

**AGREE** not to practice medicine outside my duties and responsibilities as an employee of St. Jude Children's Research Hospital. Termination of employment with St. Jude Children's Research Hospital for any reason terminates this special license.

**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**

**ATTACHMENT 1**



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

**TENNESSEE BOARD OF MEDICAL EXAMINERS  
(800) 778-4123, ext. 532-4384 or (615) 532-3202, ext. 532-4384**

**APPLICANT:** Supply the information requested in this box and then mail this entire form to your medical school.

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 St. Jude Children's Research Hospital Global Collaboration License in the State of Tennessee.

Please forward an original graduate transcript of courses, grades, and degree bearing the institution's official seal to:

**State of Tennessee  
Board of Medical Examiners  
665 Mainstream Drive  
Nashville, TN 37243 (37228 for courier service only)**

Thank you for your cooperation and prompt response.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

ATTACHMENT 2



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

TENNESSEE BOARD OF MEDICAL EXAMINERS  
(800) 778-4123, ext. 532-4384 or (615) 532-3202, ext. 532-4384

CLEARANCE FROM OTHER STATE LICENSURE BOARDS

**APPLICANT:** Please provide the information requested in the top box and then mail one form to the licensure board in EACH state where you hold OR HAVE EVER HELD a license to practice any profession. (You may copy this form.) **NOTE:** Some states require a fee for providing clearance information. To expedite your application, you may wish to contact the applicable state(s).

\_\_\_\_\_ was granted a license to practice \_\_\_\_\_  
 (Name of Applicant) (Profession)  
 with license number \_\_\_\_\_ on \_\_\_\_\_ in the State of \_\_\_\_\_.  
 (Date)

The Board of Medical Examiners of Tennessee requests that I submit evidence of the current status of that license in your state. You are hereby authorized to release any information in your files, favorable or otherwise, directly to:

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

Date: \_\_\_\_\_ Applicant's Signature \_\_\_\_\_  
 \_\_\_\_\_  
 Applicant's typed or printed name

**ADMINISTRATIVE OFFICE OF STATE LICENSURE BOARD, PLEASE COMPLETE:**

Name In Full As It Appears On License: \_\_\_\_\_

License Number \_\_\_\_\_ Profession \_\_\_\_\_ Date Issued \_\_\_\_\_

Basis of issuance: \_\_\_\_\_ Endorsement/Reciprocity with \_\_\_\_\_  
 (Check One) (State)

\_\_\_\_\_ Written Examination \_\_\_\_\_  
 (Name of Exam)

The License is currently active and registered? Yes \_\_\_\_\_ No \_\_\_\_\_  
 Is there any derogatory information on file? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, an explanation must be attached.

\_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_  
 Authorized Signature

ATTACHMENT 3



**Tennessee Requires Medical Examination  
Scores be Sent Directly to the  
Tennessee Board of Medical Examiners**

In order to have medical examination scores reported to the Tennessee Board please read the following:

**For FLEX, SPEX and USMLE scores contact the Federation of State Medical Boards to obtain a score reporting form at:**

Federation of State Medical Boards of the U.S., Inc.  
Federation Place  
Suite 300  
400 Fuller Wiser Road  
Eules, TX 76039-3855  
(800) 876-5396

or download the form from the web site at:

<http://www.fsmb.org>

For NBME Parts I, II, and III or any **COMBINATION** OF NBME Parts, the request form is now available on the NBME web site at:

<http://www.nbme.org/programs/nbmecert.asp>

National Board of Medical Examiners  
P.O. Box 48014  
Newark, NJ 07101-4814

For NBME Parts I, II, and III administered by ECFMG or for information concerning FMGEMS contact:

Educational Commission for Foreign Medical Graduates  
3624 Market Street  
Philadelphia, PA 19104  
Phone (215) 386-5900



**STATE OF TENNESSEE  
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**TENNESSEE BOARD OF MEDICAL EXAMINERS  
(800) 778-4123, ext. 532-4384 or (615) 532-3202, ext. 532-4384**

**APPLICANT: USE THIS FORM ONLY IF YOU HAVE TAKEN A STATE EXAM PRIOR TO DECEMBER 1972. IF YOU HAVE, COMPLETE THE INFORMATION IN THE BOX AND THEN SEND IT TO THE STATE BOARD FOR WHICH YOU TOOK THE EXAMINATION:**

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

**CERTIFICATE OF SECRETARY OF STATE BOARD ISSUING ORIGINAL LICENSE**

I, \_\_\_\_\_, Secretary of the \_\_\_\_\_  
(State)

Board of Medical Examiners, certify that \_\_\_\_\_ of  
(Applicant's Name)

\_\_\_\_\_ was granted License/Certificate number \_\_\_\_\_  
(City & State)

to practice Medicine in this State on the \_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_. I further certify that the  
aforesaid in the written examination before this Board, which was administered on \_\_\_\_\_,  
(Date)

obtained a general average of \_\_\_\_\_ percent and the following percentages on each subject:

Subject	Percent	Subject	Percent
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Acting on behalf of the \_\_\_\_\_ Board of Medical Examiners, I hereby  
(State)

certify that the Applicant successfully completed the state licensure examination.

Seal of the Board \_\_\_\_\_ Date: \_\_\_\_\_  
Board Secretary's Signature

Please return to: **State of Tennessee  
Board of Medical Examiners  
665 Mainstream Drive  
Nashville, TN 37243**



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)

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