



STATE OF TENNESSEE
DEPARTMENT OF HEALTH
Bureau of Health Licensure and Regulation
Division of Health Related Boards
665 Mainstream Drive, 2nd Floor
Nashville, TN 37243
www.tennessee.gov

(800) 778-4123 or (615) 741-3218

**APPLICATION INSTRUCTIONS FOR THE REGISTRATION OF
A PAIN MANAGEMENT CLINIC**

ALL APPLICATION FEES ARE NON-REFUNDABLE

NOTE: AN APPLICANT SHALL SUBMIT A SEPARATE APPLICATION FOR CERTIFICATION FOR EACH CLINIC REGARDLESS OF WHETHER THE CLINIC IS OPERATED UNDER THE SAME BUSINESS NAME, OWNERSHIP, OR MANAGEMENT AS ANOTHER CLINIC.

Provided below is a list for your personal use and convenience outlining all the things you must do to receive consideration for issuance of a certification of a pain management clinic:

1. Complete and mail the application along with Attachments 1, 2 and 3 to the address below. All three Attachments **must** be completed **prior** to consideration of your application.
2. If you answered “yes” to any question on page two of Attachment 1, you **must** provide an explanation along with any supporting documentation such as final documents or orders from the issuing states, courts, and/or agencies. This Attachment will not be considered completed absent the required materials.
3. In support of Attachment 2, please provide a copy of each identified individual health care providers’ Drug Enforcement Agency Registration card. This Attachment will not be considered completed absent the required materials.
4. In support of Attachment 3, you must **CIRCLE** the number of the paragraph which accurately describes the training of your medical director and providing supporting documentation. This Attachment will not be considered completed absent the required materials.
5. For each owner (or partial owner) of the pain management clinic identified in Attachment 1, please provide the results of a criminal background check. **Click [here](#) for instructions.**

UNDERSTANDING THE APPLICATION PROCESS

1. All Application fees are **NON-REFUNDABLE**.
2. All documents and fees required to be submitted by you must be mailed directly to:

Department of Health, Health-Related Boards
ATTN: Pain Management Clinic Registration
665 Mainstream Drive, 2nd Floor
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 Health-Related Boards asks that you please give the office every consideration in this matter.
4. If necessary documentation has not been received when your application has been received by the office, an initial deficiency letter will be sent to you. **If an applicant does not complete the application process within sixty (60) days after the Department receives the application because the application lacks the required information or fails to meet the prerequisites for certification, then the application will be closed, the application fee will not be refunded, and the applicant shall reapply for certification.**
5. Any application that is submitted to the Department may be withdrawn at any time prior to the grant or denial of certification; provided, however, that the application fee will **not** be refunded.
6. Once the application is completed **and** all the Attachments and supporting documents are received, your file will be reviewed, a certification determination made, and you will be promptly notified.
7. If an address change occurs at any time during the application process, you must notify the office, in writing, immediately.
8. The applicant must be the owner of the pain management clinic. For certification purposes, the owner will become the certificate holder for the clinic.

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

ATTACHMENT 1

(PAGE 1 OF 2)

PLEASE ANSWER THE FOLLOWING QUESTIONS. If any answer to questions three and four on page two of this Attachment is 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.

Pain Clinic Management Ownership Information:

1. Check type of legal entity: INDIVIDUAL PARTNERSHIP CORPORATION LLC PLLC
 OTHER

2. List the name(s) and address(s) of the individual owners, partners, directors and officers of the corporation and the percentage of their ownership interest:

Name: _____ Phone Number: (____) _____

Address: _____

Percentage of Ownership Interest: _____ Title: _____

Name: _____ Phone Number: (____) _____

Address: _____

Percentage of Ownership Interest: _____ Title: _____

Name: _____ Phone Number: (____) _____

Address: _____

Percentage of Ownership Interest: _____ Title: _____

Name: _____ Phone Number: (____) _____

Address: _____

Percentage of Ownership Interest: _____ Title: _____

Name: _____ Phone Number: (____) _____

Address: _____

Percentage of Ownership Interest: _____ Title: _____

(If additional space is needed, please use a separate sheet)

ATTACHMENT 1 (CONTINUED)
(PAGE 2 OF 2)

3. Has any owner, in whole or in part, been convicted of, pled nolo contendere to, or received deferred adjudication for:

CHECK ONE

(1) An offense that constitutes a felony. Yes No

(2) An offense that constitutes a misdemeanor, the facts of which relate to the distribution of illegal prescription drugs or a controlled substance. Yes No

4. Has any person who owns, co-owns, operates or otherwise provides medical services in the clinic, or any person who is an employee of the clinic or with whom the clinic contracts for medical services:

(1) Ever been denied, by any jurisdiction, a license under which the person may prescribe, dispense, administer, supply, or sell a controlled substance? Yes No

(2) Ever held a license issued by any jurisdiction, under which the person may prescribe, dispense, administer, supply, or sell a controlled substance, that has been restricted? Yes No

(3) Ever been subjected to disciplinary action by any licensing entity for conduct that was the result of inappropriately prescribing, dispensing, administering, supplying, or selling a controlled substance? Yes No

I affirm that the statements given in this attachment are true and correct and that I have read **TENN. CODE ANN. SECT. 63-1-301**, et seq. and the rules and regulations promulgated thereto.

Applicant's Signature

License No.

Date

ATTACHMENT 2
(PAGE 1 OF 1)

For each individual health care provider providing pain management services at the clinic, please provide the following:

Name: _____ Profession: _____ Lic. No: _____

Address: _____

Phone Number: (_____) _____ Fax Number: (_____) _____

DEA Registration Number: _____ Date Issued: _____ Expiration Date: _____

Supervising Physician(if applicable): _____

Name: _____ Profession: _____ Lic. No: _____

Address: _____

Phone Number: (_____) _____ Fax Number: (_____) _____

DEA Registration Number: _____ Date Issued: _____ Expiration Date: _____

Supervising Physician(if applicable): _____

Name: _____ Profession: _____ Lic. No: _____

Address: _____

Phone Number: (_____) _____ Fax Number: (_____) _____

DEA Registration Number: _____ Date Issued: _____ Expiration Date: _____

Supervising Physician(if applicable): _____

Name: _____ Profession: _____ Lic. No: _____

Address: _____

Phone Number: (_____) _____ Fax Number: (_____) _____

DEA Registration Number: _____ Date Issued: _____ Expiration Date: _____

Supervising Physician(if applicable): _____

(If additional space is needed, please use a separate sheet)

ATTACHMENT 3
(PAGE 1 OF 1)

From the list below, CIRCLE either number 1, 2, or 3 as corresponds to the which of the three approved types of pain management specialist training is held by the clinic's medical director and provide supporting documentation:

_____ (Name of Medical Director)

has or is considered a Pain Management Specialist who:

1. Has a subspecialty certification in pain medicine as accredited by the Accreditation Council for Graduate Medical Education (ACGME) through either the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA), or is eligible to sit for the board examination offered by ABMS or AOA and;
 - (a) Holds an unencumbered Tennessee license and
 - (b) Maintains the minimum number of continuing medical education (CME) hours in pain management to satisfy retention of ABMS or AOA certification. Any exceptions to this requirement shall be approved by the respective regulatory board;

2. Attains American Board of Pain Medicine (ABPM) diplomate status and;
 - (a) Holds an unencumbered Tennessee license and
 - (b) Maintains the minimum number of CME hours in pain management to satisfy retention of ABPM diplomate status. Any exceptions to this requirement shall be approved by the respective regulatory board;

3. Is board certified by the American Board of Interventional Pain Physicians (ABIPP) by passing parts 1 and 2 of its examination, and;
 - (a) Holds an unencumbered Tennessee license and
 - (b) Maintains the minimum number of CME hours in pain management to satisfy retention of ABIPP diplomate status

An alternate medical director must also qualify as a Pain Specialist based on the credentials listed above and supporting documentation for that alternate medical director must be included with this application.

I affirm that the statements given in this attachment are true and correct and that I have read Rule 1200-34-.01-.09 of the Rules that Govern Pain Management Clinics.

Applicant's Signature

License No.

Date