STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TENNESSEE 37243
www.tennessee.gov

TENNESSEE BOARD OF MEDICAL EXAMINERS
COMMITTEE ON PHYSICIAN ASSISTANTS

(800) 778-4123, ext. 532-4384 or (615) 532-3202, ext. 532-4384

APPLICATION INSTRUCTIONS FOR LICENSURE AS A PHYSICIAN ASSISTANT
LICENSURE APPLICATION CHECK SHEET

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 Tennessee license to practice. **NOTE: All submissions must be executed and dated less than one (1) year before receipt or they will be rejected by the Committee.**

ALL APPLICATION FEES ARE NON-REFUNDABLE.

		Done
1.	Complete, have notarized, and mail the application pages 1 through 6.	_____
2.	Attach to the application a clear, recognizable, recently taken, signed and notarized passport photograph of yourself.	_____
3.	Complete and mail Attachment 1 to the institution at which you completed your physician assistant program.	_____
4.	If you are or have ever been licensed, certified, registered, or permitted by any state to practice as a physician assistant or other health professional, you must complete and mail Attachment 2 to each and every state. Copies of Attachment 2 may be duplicated to accommodate each request.	_____
5.	If you are certified by the national Commission on Certification of Physician Assistants, you must complete and mail Attachment 3 to the NCCPA.	_____
6.	If you have a supervising physician, submit Attachment 4 along with your application. Attachment 4 must be signed by the supervising physician and must be submitted prior to beginning practice.	_____
7.	Submit two (2) original letters of recommendation on letterhead from medical professionals who can attest to your character as a physician assistant. These letters must identify the individuals as medical professionals and **must be originals** on signatory's letterhead.	_____
8.	Please complete the enclosed practitioner profile questionnaire and mail back with the application for licensure.	_____
9.	Attach to the application a check or money order in the amount of $335 made payable to the Committee on Physician Assistants. If requesting temporary certification or temporary authorization, attach to the application a check or money order in the amount of $385. All fees are non-refundable.	_____
10.	If your supervising physician authorizes you to prescribe controlled drugs you must have a Federal Drug Enforcement Administration (DEA) number. A DEA number may be obtained by calling (800) 882-9539.	_____
11.	Effective June 1, 2006 applicants for initial licensure in Tennessee must obtain a criminal background check. For instructions please visit our website at http://tennessee.gov/health/article/CBC-instructions	_____
12.	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.	_____
13.	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 in 8 U.S.C. 1621. Attachment 6 must be completed and submitted before this application can be processed.	_____

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 by certified mail. The supporting documentation requested in the letter must be received in the Board office sixty (60) days from the date of the initial deficiency letter. **(Files not completed within sixty (60) days will be closed.)**

5. Absent any complicating factors, the average application processing time is six (6) 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 strongly recommended that you do not make arrangements to accept employment as a physician assistant in Tennessee until you are granted a license, temporary certificate, or temporary authorization by the Committee on Physician Assistants.

8. All practicing PAs must have a written protocol outlining the range of services under which they practice in their respective medical communities.

9. 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 your licensing board of an address change within thirty (30) days of any such change.

10. All documents provided to this office in conjunction with your request for an orthopedic physician assistant 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 process your application in a timely manner.

For Office Use Only

3628-001	$325
3628-006	$ 10
	$335
3628-001	$375
3628-006	$ 10
	$385

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

BOARD OF MEDICAL EXAMINERS
COMMITTEE ON PHYSICIAN ASSISTANTS
(800) 778-4123, ext. 532-4384 or (615) 532-3202, ext. 532-4384

APPLICATION FOR LICENSURE

Choose the appropriate licensure category for which you are applying. Check the appropriate subcategory which applies to your application. See the Practice Act and the rules and regulations to determine the requirements for each category of practitioner and temporary certification. **READ INSTRUCTIONS PRIOR TO COMPLETING APPLICATION. APPLICANTS MUST COMPLY WITH ALL INSTRUCTIONS. FILL IN ALL BLANKS; IF NOT APPLICABLE, STATE N/A**

_____ Physician Assistant Licensure by Exam or Reciprocity (attach $335 payment) (NCCPA Certified)
_____ Apply with request for temporary certificate (attach $385 payment) (Graduate/Not NCCPA Certified)

PERSONAL INFORMATION

PLEASE PRINT IN INK

Name as it will appear on license: _____
(First) *(Middle)* *(Last)*

Have you been known by any other name? Y N If yes, list names: _____

_____

Gender: M F Race: _____

Date of Birth: Mo. _____ Day _____ Yr. _____ Social Security Number: _____ - _____ - _____

U.S. Citizen: Y N Are you entitled to Live and Work in U.S.? Y N

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? Y N (If yes, please provide proof of status.)

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, please provide proof of same.) Y N

Present Mailing Address: _____ Home Phone: (_____) _____

_____ Work Phone: (_____) _____

Email address: _____

Do you wish to receive notification, including renewal notification, from the Department of Health via email? Y N

Please note, by opting in, all correspondence from the Department of Health will be delivered to the email address on file for you. You will no longer receive physical mail from our office.

EDUCATIONAL AND EMPLOYMENT INFORMATION

Please provide the following information for all educational institutions you have attended beyond high school. Use the back of this page if you need additional space. (SEND **ATTACHMENT #1** TO THE EDUCATIONAL INSTITUTION WHERE YOU COMPLETED YOUR PROGRAM)

From: _____ To: _____ _____ _____
MM/YY MM/YY Educational Inst./Phys. Asst. Program Location

From: _____ To: _____ _____ _____
MM/YY MM/YY Educational Inst./Phys. Asst. Program Location

From: _____ To: _____ _____ _____
MM/YY MM/YY Educational Inst./Phys. Asst. Program Location

From: _____ To: _____ _____ _____
MM/YY MM/YY Educational Inst./Phys. Asst. Program Location

Please complete your entire employment history starting with the most current position first. Use the back of this page if you need additional space.

DATES **LOCATION**

From: _____ To: _____ _____ _____
MM/YY MM/YY City/State Position/Duties

From: _____ To: _____ _____ _____
MM/YY MM/YY City/State Position/Duties

From: _____ To: _____ _____ _____
MM/YY MM/YY City/State Position/Duties

From: _____ To: _____ _____ _____
MM/YY MM/YY City/State Position/Duties

From: _____ To: _____ _____ _____
MM/YY MM/YY City/State Position/Duties

From: _____ To: _____ _____ _____
MM/YY MM/YY City/State Position/Duties

From: _____ To: _____ _____ _____
MM/YY MM/YY City/State Position/Duties

LICENSURE INFORMATION

	YES	NO
Are you or have you ever been licensed in this profession 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 2** to all such states, countries, or provinces regarding such licensure, certification or permit. Use the back of this page if you need additional space.

STATE	PROFESSION	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS

	Yes	No
1. Are you certified by the National Commission on the Certification of Physician Assistants (NCCPA)? If so, complete **Attachment 3** and send it to the NCCPA.	____	____
2. Have you ever applied for a physician assistant license in Tennessee?	____	____
3. Have you ever received a temporary permit or license to practice as a physician assistant in Tennessee?	____	____
4. Do you have a DEA number?	____	____

If yes, what is your DEA number _____

5. If you have an NPI number, please provide: _____

COMPETENCY INFORMATION

PLEASE ANSWER THE FOLLOWING QUESTIONS. If any answers to the 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, 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 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 your profession 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.]

QUESTIONS: Please respond to ALL questions. If you answer "YES" to any question, please attach a written explanation.	**YES**	**NO**
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, privilege, registration or certificate to practice as a physician assistant 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 professional association or 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, 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?	___	___
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)	___	___
14. Have you ever failed a licensure or certification examination?	___	___
If yes, which exam and how many times have you failed? _____		

AFFIDAVIT AND RELEASE

I, _____, PA, 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 my profession 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 Committee, 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 my profession.

AUTHORIZE the Committee, 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 Committee, 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.

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

COMMITTEE ON PHYSICIAN ASSISTANTS
(800) 778-4123, ext. 532-4384 or (615) 532-3202, ext. 532-4384

EDUCATION VERIFICATION

APPLICANT: Supply the information requested in this box and then mail this entire form to the school at which you completed your physician assistant program. **NOTE:** Most schools require a fee, so you may want to contact the institution before mailing this form so that you can attach their fee..

Full Name: _____
(Last) (First) (Middle/Maiden)

Address: _____ Social Security Number: ___ - ___ - ___

_____

_____

_____

Student Identification Number: _____

Year of Graduation: _____

Degree Obtained: _____ Date Degree Conferred: _____

TO WHOM IT MAY CONCERN:

I am applying for a license to practice as a physician assistant in the State of Tennessee. Please forward an original graduate transcript of courses, grades, and degree bearing the institution's official seal to:

Board of Medical Examiners
Committee on Physician Assistants
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

COMMITTEE ON PHYSICIAN ASSISTANTS
(800) 778-4123, ext. 532-4384 or (615) 532-3202, ext. 532-4384
www.tennessee.gov/heath

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 Committee on Physician Assistants 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:

Committee on Physician Assistants
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.

_____ _____ _____
Authorized Signature Title Date

ATTACHMENT 3

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

COMMITTEE ON PHYSICIAN ASSISTANTS
(800) 778-4123, ext. 532-4384 or (615) 532-3202, ext. 532-4384
www.tennessee.gov/heath

NCCPA VERIFICATION

Only if or when you are credentialed with the NCCPA, please complete this form and mail it to the address below:

NATIONAL COMMISSION ON CERTIFICATION OF PHYSICIAN ASSISTANTS
12000 Findley Road, Suite 100
Johns Creek, GA 30097

To Be Completed By Applicant (Please Print In Ink)

Dear NCCPA Official:

I am applying for a license to practice as a Physician Assistant in the State of Tennessee. The State Board of Medical Examiners' Committee on Physician Assistants requires that a credential letter by **forwarded directly to their** office by the NCCPA.

Applicants Name: _____
(First) (Middle) (Last)

Social Security Number: ___ Credential #_____

PLEASE MAIL CREDENTIAL VERIFICATION DIRECTLY TO:

Committee on Physician Assistants
665 Mainstream Drive
Nashville, Tennessee 37243

ATTACHMENT 4 **Applicant's Name** _____

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

COMMITTEE ON PHYSICIAN ASSISTANTS
(800) 778-4123, ext. 532-4384 or (615) 532-3202, ext. 532-4384

SUPERVISING PHYSICIANS

This section must be completed by the supervising physician(s).
(This page may be duplicated if necessary)

List all practice settings:

1) Setting:

_____
Supervising Physician Signature

_____
Printed Name

_____
Address

_____
Tennessee Medical License Number

2) Setting:

_____
Supervising Physician Signature

_____
Printed Name

_____
Address

_____
Tennessee Medical License Number

3) Setting:

_____
Supervising Physician Signature

_____
Printed Name

_____
Address

_____
Tennessee Medical License Number

4) Setting:

_____
Supervising Physician Signature

_____
Printed Name

_____
Address

_____
Tennessee Medical License Number

ATTACHMENT 5

TENNESSEE BOARD OF MEDICAL EXAMINERS' COMMITTEE ON PHYSICIAN ASSISTANTS

AUTHORIZATION FOR PRESCRIBING FOR PHYSICIAN ASSISTANTS

Supervising Physician _____

Address _____

_____

City State Zip Code

Phone Number _____

Field of Practice _____

Medical License Number _____

Physician Assistant _____

Field of Practice _____

Address _____

_____

City State Zip Code

Phone Number _____ TN License Number _____

Check the class of drugs you desire to delegate:

_____	Analgesics	_____	Enzymes
_____	Anesthetics	_____	Expectorants and Cough Preparations
_____	Antihistamines	_____	Eye, Ear, Nose, and Throat Preparations
_____	Anti-infective Agents	_____	Gastrointestinal Drugs
_____	Anti-inflammatory Agents	_____	Hormones and Synthetic Substitutes
_____	Anti-neoplastic Agents	_____	Hyperglycemic Agents
_____	Antispasmodics and Anticholinergics	_____	Migraine Preparations
_____	Antivirals	_____	Muscle Relaxant Preparations
_____	Arthritis Medications	_____	Narcotic Antagonists
_____	Autonomic Drugs	_____	Oxytocics
_____	Blood Derivatives	_____	Psychotropics
_____	Blood Formation and Coagulation	_____	Serum, Toxoids, and Vaccine
_____	Birth Control Drugs and Devices	_____	Skin and Mucous Membrane Preparations
_____	Bronchodilators/Anti-asthma Drugs	_____	Smoking Cessation Aids
_____	Cardiovascular Drugs	_____	Smooth Muscle Relaxants
_____	Central Nervous system Drugs	_____	Spasmolytic Agents
_____	Contraceptives	_____	Sympathomimetics and Combination
_____	Diabetic Agents	_____	Vitamins
_____	Diagnostic Agents	_____	Unclassified Therapeutic
_____	Decongestants	_____	Other _____
_____	Electrolytic, Caloric, and Water Balance		_____
			_____

Check the type **and** schedule of controlled drugs you desire to delegate:

Type		Schedule II	Schedule III	Schedule IV	Schedule V
_____	None	_____	_____	_____	_____
_____	Barbiturates	_____	_____	_____	_____
_____	Benzodiazepines	_____	_____	_____	_____
_____	Depressants	_____	_____	_____	_____
_____	Narcotics	_____	_____	_____	_____
_____	Stimulants	_____	_____	_____	_____
_____	Other (Please List)	_____			
		_____			
		_____			

I, _____ MD/DO, License Number _____
Please print

I, _____ MD/DO, License Number _____
Please print

I, _____ MD/DO, License Number _____
Please print

I, _____ MD/DO, License Number _____
Please print

do hereby delegate the above prescribing authority to _____ PA of whom I am the supervising physician and will assume the responsibility according to TCA §63-19-107.

I, _____ PA do hereby accept the delegated function of prescribing authorization and will utilize it as such according to TCA §63-19-107.

_____
Signature of Physician Assistant Date

_____
Signature of Supervising Physician Date

_____
Signature of Supervising Physician Date

_____
Signature of Supervising Physician Date

_____
Signature of Supervising Physician Date

ATTACHMENT 6

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 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__.

_____ 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 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.