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15-006 \$ 10
\$450

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
DIVISION OF HEALTH LICENSURE AND REGULATION
665 Mainstream Drive
Nashville, TN 37243
www.Tennessee.gov/health

TENNESSEE BOARD OF PODIATRIC MEDICAL EXAMINERS

615-532-5088 or 800-778-4123 ext 25088

APPLICATION FOR A LOCUM TENENS LICENSES AS A PODIATRIST

LOCUM TENENS INSTRUCTIONS:

1. Submit completed application.
2. A check or money order for \$450.00, payable to the Tennessee Board of Podiatric Medical Examiners.
3. Complete **attachment 1** to any state or Canada in which you hold a current active podiatric license and whether it is in good standing, or held a podiatric license which is currently inactive and whether it was in good standing at the time it became inactive.
4. All applicants for licensure in Tennessee must obtain a criminal background check. Click [here](#) for instructions.
5. All applicants must complete the attached Declaration of Citizenship form.

NOTE: Each Locum Tenens practice must be no more than ninety (90) days in duration. An applicant may obtain a maximum of two Locum Tenens licenses per lifetime.

Applicant's Name: _____
(First) (Middle and/or Maiden) (Last)

Social Security Number: _____ - _____ - _____ Date of Birth: _____ / _____ / _____

U.S. CITIZEN: Yes _____ No _____

All applicants must complete the attached Declaration of Citizenship form

Present Home Mailing Address: _____

Home Phone: (_____) _____ - _____ Work Phone Number: (_____) _____ - _____

E-MAIL ADDRESS: _____

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

Name of Podiatric Medical School: _____ Graduation Date: _____/_____/_____

Intended location of initial work in Tennessee: _____

Intended duration of initial work in Tennessee: _____

INITIAL PRACTICE SETTING

Briefly describe the reason why this license is desired and the situation in which it will be used.

List below all states or provinces in which you have ever been or are currently licensed as a Podiatrist, Additional pages may be added if necessary.

STATE	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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, and/or agencies must be submitted along with this application.

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

- "Ability to practice medicine"** is to be construed to include all of the following:
 - The cognitive capacity to make appropriate clinical diagnosis and exercise reasoned medical judgments, to learn and keep abreast of medical developments;
 - 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
 - The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.
- "Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to; orthopedic, visual, speech and/or hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV, tuberculosis, drug addiction, and alcoholism.
- "Chemical substances" is to be construed to include alcohol, drugs, 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.
- "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.
- "Illegal use of controlled substances" means the use of controlled substances obtained illegally (e.g. heroin, or cocaine) as well as the use of controlled substances which 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. Are you now in good physical and mental health?	_____	_____
2. Are you currently taking any medications requiring a prescription?	_____	_____
3. Have you failed any podiatric licensure examination?	_____	_____
4. Has your certificate or license to practice podiatry in any state ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, voluntarily surrendered, under threat of investigation or disciplinary action?	_____	_____
5. Have your staff privileges at any hospital or health care facility ever been revoked, suspended, curtailed, restricted, limited, otherwise disciplined, voluntarily surrendered, under threat of restriction or disciplinary action?	_____	_____
6. Have you ever been denied a state or federal controlled substance certificate?	_____	_____
7. Has your state or federal controlled substance certificate ever been revoked, suspended, restricted, otherwise disciplined, voluntarily surrendered, under threat of investigation or disciplinary action?	_____	_____
8. Do you have a medical condition which in any way impairs or limits your ability to practice podiatric medicine with reasonable skill and safety? If yes, please explain.	_____	_____
9. If you use chemical substance(s) do they in any way impair or limit your ability to practice podiatric medicine with reasonable skill and safety? If yes, please explain.	_____	_____
10. If you have any limitations or impairments caused by an existing medical condition are they reduced or ameliorated because you receive ongoing treatment (with or without medication) or participate in a monitoring program? If yes, please explain.	_____	_____
11. If you have any limitations or impairments caused by an existing medical condition are they reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? If yes, please explain.	_____	_____
12. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, or voyeurism? If yes, please explain.	_____	_____
13. Are you currently engaged in the illegal use of controlled dangerous substance? If yes, are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled substance?	_____	_____
14. Have you ever been convicted of a felony or misdemeanor other than a minor traffic violation?	_____	_____
15. Have you ever been rejected or censured by a professional society?	_____	_____
16. Have you ever had a judgment rendered against you, or any legal action settled or pending, relating to the performance of your professional service?	_____	_____
17. Have you ever applied for a professional license in any health care profession and been denied or restricted for any reason?	_____	_____

Affirmative responses require final documents or orders from the issuing states, courts, and/or agencies.

Before signing this application, please read it again to make sure you have answered all questions accurately, completely, and clearly. Use additional sheets whenever necessary.

I, _____ of _____

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, which were enclosed in the application packet, and agree to abide by them in practice of podiatry in the State of Tennessee, I HEREBY:

SIGNIFY MY WILLINGMESS to appear to answer such questions as the Board may find necessary, which may include a full Board interview.

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.

CONSENT TO THE RELEASE of such information.

RELEASE FROM LIABILITY the Board, its staff, and all their representatives for their acts performed and statements made good faith and without malice in connection with evaluating my application, my credentials, and my qualification.

RELEASE FROM LIABILITY any and all organizations which provide information in good faith and without malice concerning my professional competence, ethics, character, and other qualifications for licensure.

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

Signature of applicant



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LOCUM TENENS

NOTIFICATION OF PRACTICE SETTING

Next Practice Setting Date: _____

Next Practice Setting Location: _____

Please describe the reason for this practice:
(If the reason is to substitute or provide coverage, include the doctor's name and specialty)

Name: _____

Date: ____ / ____ / ____

Signature: _____

License Number: _____



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VERIFICATION OF LICENSURE

Applicant: Please complete the top portion and forward one (1) form to the Board of Podiatry in each state where you hold or have held a license to practice, (If you need more forms, make copies of this form)

Note: Some states require a fee to be paid for providing clearance information. In order to expedite your application, you may wish to contact the applicable state or states.

_____ was granted _____ on _____ by the
(Name of applicant) (License number) (Date)

State of _____. The Tennessee Board of Podiatric Medical Examiners request that I submit evidence that my license in your state is in good standing. You are hereby authorized to release any information in your files, favorable or otherwise, directly to the address listed above.

Your early attention is appreciated.

Date: ____ / ____ / ____

(Signature)

(Typed or print name)

**ADMINISTRATIVE OFFICE OF STATE PODIATRY BOARD
PLEASE COMPLETE:**

Name as it appears on license: _____

License Number: _____ Profession: _____ Date Issued: ____ / ____ / ____

Basis of Issuance: _____ Endorsement/Reciprocity with: _____
(Check One) (State)

_____ Written Examination: _____
(Name of examination)

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: ____ / ____ / ____



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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
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Please Print Legibly

- Name: _____
Last First Middle Maiden_
- Mailing Address: _____
- Phone Number: Home: (____)____-____ Office: (____)____-____ Fax: (____)____-____
- I am a United States Citizen: ___Yes ___No
- 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.
- Applicants Claiming United States Citizenship **MUST** provide one of the following:
 - Tennessee Driver's License, or photo ID issued by Department of Safety.
 - A valid driver license or ID issued by another state, provided its issuance requirements meet Department of Safety criteria.
 - An official birth certificate issued by a U.S. state, territory, or other jurisdiction. Puerto Rican birth certificates issued before July 1, 2010 do not count.
 - A federally issued birth certificate.
 - A valid, unexpired U.S. passport.
 - A report of birth abroad of a U.S. citizen.
 - A certificate of citizenship.
 - A certificate of naturalization.
 - A U.S. citizen ID card.
 - Any successor document to #'s a-i above.
 - SSN that the entity or local health department may verify with the Social Security Administration in accordance with federal law.
- If you checked "No" in question 4 please indicate from the list below which category applies to you: (circle one)
 - Permanent Residents

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

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

I-327 (Reentry Permit)

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

I-571 (Refugee Travel Document)

I-766 (Employment Authorization Card)

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

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

I-94 (Arrival/Departure record)

Unexpired foreign passport

WT/WB Admission Stamp in unexpired foreign passport

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

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

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

Signed this ____ day of _____, 20__.

Signature

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

NOTARY PUBLIC

AFFIX SEAL HERE

My Commission Expires: _____

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