1907-001	$400.00
1907-006	$ 10.00
TOTAL	$410.00

State of Tennessee
Department of Health
Health Related Boards
665 Mainstream Drive
Nashville, TN 37243

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

APPLICATION FOR A LOCUM TENENS LICENSE AS AN OSTEOPATHIC DOCTOR

ATTACH THE FOLLOWING TO THIS APPLICATION AND MAIL TO:

Board of Osteopathic Examination
665 Mainstream Drive
Nashville, TN 37243

1. A check or money order for $410.00, payable to the Tennessee Board of Osteopathic Examination.
2. A clear and recognizable, recently taken, bust photograph.
3. Evidence of current licensure in good standing in another state (only need one). Use Attachment 2
4. A notarized copy of a specialty certification from a recognized specialty or a letter from your training program director which states that you are eligible to apply for the certification examination.
5. Proof of 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, resident alien cards, green cards, current H-1 Visa status, U.S. passport, or voter registration are acceptable.)
6. 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 such change as long as you have an active license.
7. Criminal Background Check. For instructions to obtain a criminal background check, go to http://tn.gov/health/article/CBC-instructions
8. Complete Attachment 3 – Declaration of Citizenship

UNDERSTANDING THE APPLICATION PROCESS

1. All application fees are non-refundable.
2. Absent any complicating factors, the application process may take up to eight (8) weeks.
3. 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 ninety (90) days from the date of the initial deficiency letter. Files not completed within ninety (90) days will be closed.
4. If an address change occurs at any time during the application process, you must notify the board office in writing immediately.
5. It is strongly encouraged that you do NOT make arrangements to accept employment as a physician in Tennessee until you are granted a license number by the board of osteopathic examination.
6. 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.
7. 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.

PERSONAL INFORMATION

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

Are you a U.S. Citizen? Y N Gender: M F Race: _____

Date of Birth : _____ Social Security Number: _____-_____-_____
(Month) (Day) (Year)

Present Home Mailing Address: _____

_____

Home Phone: (_____) _____ Work Phone: (_____) _____

Name of Medical School: _____

Year Graduated: _____

Type of intended primary specialty practice in Tennessee: _____

Intended location of initial work in Tennessee: _____

Intended duration of initial work in Tennessee: _____

Are you Board eligible? Y N Are you Board certified? Y N

Identify the specialty in which you are board eligible or board certified: _____

E-mail 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.

INITIAL PRACTICE SETTING

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

_____

_____

_____

	YES	NO
Have you previously applied for a license to practice osteopathic medicine in Tennessee?	_____	_____
I intend to perform Level II Office Based Surgery which is integral to a planned treatment regimen and not performed on an urgent or emergent basis.	_____	_____

If you intend to perform Level III Office Based Surgery, you must apply for and obtain a permit prior to engaging in such practice. You may access the application by visiting: https://tn.gov/assets/entities/health/attachments/PH-3963.pdf

Do you have a DEA Registration?	_____	_____

If yes, please provide: _____

If you have an NPI number, please _____

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.

STATE	PROFESSION	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS

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

Company/ Employer:	Address: (City, and State)	Position:	Duties:	Dates From: Mo./Yr.	Dates To: Mo./Yr.

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, 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:

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: _____		
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?	____	____

[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

		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?	____	____
6.	Have you ever held or applied for a license, privilege, registration 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 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).	____	____

AFFIDAVIT AND RELEASE

I, _____, D.O., of _____
(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 which were enclosed in the application packet 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/or 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 and/or 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, TN 37243

BOARD OF OSTEOPATHIC EXAMINATION
LOCUM TENENS PHYSICIAN

NOTIFICATION OF PRACTICE SETTING

Next Practice Setting Dates _____

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 # D.O.L.T.** _____

ATTACHMENT 2

State of Tennessee
Department of Health
Health Related Boards
665 Mainstream Drive
Nashville, TN 37243

TENNESSEE BOARD OF OSTEOPATHIC EXAMINATION
(615) 532-3202, ext. 532-4384 or (800) 778-4123, 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. (Copies of this form can be used.) **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 Osteopathic Examination 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:

State of Tennessee
Board of Osteopathic Examination
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, 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.