STATE OF TENNESSEE
DEPARTMENT OF HEALTH
DIVISION OF HEALTH LICENSURE AND REGULATION
OFFICE OF HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE, 2ND FLOOR
NASHVILLE, TENNESSEE 37243

1-800-778-4123 or 615-532-3202

HEALTH RELATED BOARDS REINSTATEMENT APPLICATION

Profession: _____ License Number: _____

Date License Last Renewed: _____ Issue Date: _____

Legal Name: _____

Name when Originally Licensed: _____

(If your name has changed, a copy of the legal document that changed your name is required.)

Complete Mailing Address: _____

_____

Home Phone Number: _____ Work Phone Number: _____

All applicants must complete the Declaration of Citizenship form.

U.S. Citizen: Yes _____ No _____

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

If "Yes", please provide an email address: _____

Reason(s) for requesting reinstatement of your license _____

_____

Employment history during last five (5) years (use the back of this page if you need addition space):

Name of Employer	Complete Address of Employer	Position Held	Employment Date Beginning mm/dd/yy	Ending mm/dd/yy

If you answer YES to any of the questions below, attach an explanation and request any documentation from the states, courts, or agencies be submitted to the board's administrative office.

1. Have you been convicted of a crime other than a minor traffic violation? Yes ☐ No ☐
2. Have you ever held a health professional license that was disciplined? Yes ☐ No ☐
3. Are you currently in poor physical and mental health? Yes ☐ No ☐

List below ALL states in which you have ever been or are currently licensed, permitted, certified, or registered. Please have those states submit verification of your licensure status directly to the Board's Administrative Office. **If this section does not apply, mark N/A**.

STATE LICENSED	LICENSE NUMBER	STATUS OF LICENSE	DATE ISSUED

PLEASE RETURN LAST TENNESSEE RENEWAL CERTIFICATE (wallet-size card) ISSUED TO YOU.

PLEASE COMPLETE THE AFFIDAVIT AND SIGN IN THE PRESENCE OF A NOTARY.

This certifies that the information submitted by me in this application is true, correct and complete to the best of my knowledge and belief. I understand that if any information provided in this application is found to be untrue, the application may be denied or my license may be subject to suspension, revocation, or other restrictions or conditions, and/or I may be assessed a civil penalty for each separate violation.

_____ _____

Signature Date

State of: _____ County of: _____

Sworn to and subscribed before me, this _____ day of _____, _____.

_____

Notary Public

My commission expires _____ *SEAL*

INSTRUCTIONS

1. Please allow 10 working days for information submitted to be received and placed in the file. Additionally, if you use Federal Express or another special courier service, you will be responsible for any charges incurred.
2. All documents and fees required to be submitted by you, and any documents you request to be submitted, including any Employment Verification form, must be mailed directly to:

   Tennessee Department of Health
   Health Related Boards
   665 Mainstream Drive, 2nd Floor
   Nashville, TN 37243

3. Only the applicant may request a status of the application.
4. If the application is not complete upon receipt by the Board's administrative office, a deficiency letter will be sent to you by certified mail. The supporting documentation requested in the letter must be received in the Board's administrative office sixty (60) days from the date of the deficiency letter. Applications not completed within sixty (60) days will be closed. Once an incomplete file has been closed, all applicants must file a new application and submit, or cause to be submitted, all supporting documentation.
5. It is unlawful to practice your profession in Tennessee until your license is reinstated.
6. The Declaration of Citizenship form is available online at http://tn.gov/assets/entities/health/attachments/PH-4183.pdf.

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HEALTH RELATED BOARDS REINSTATEMENT APPLICATION
EMPLOYMENT VERIFICATION

Applicant: Please complete section one of this form. Have your employer sign and complete sections 2 and 3 and have the signature notarized. Please return to the Division of Health Related Boards.

SECTION 1.

Name of Employee _____

Street Address of Employee _____

City _____ State_____ Zip Code _____

SECTION 2.

Employer: The above employee has applied for the renewal and reinstatement of license. Please provide information as to current employment:

Facility Name _____

Street _____

City _____ State _____ Zip Code _____

SECTION 3.

Employer: Please list dates of employment during which the employee was required to hold a current Tennessee license.

Beginning Date: _____ Ending Date: _____

Please indicate if there has been any significant break in service (sick, personal, etc.)

Beginning Date: _____ Ending Date: _____

Name of Administrator/Employer completing Sections 2 & 3: _____

AFFIDAVIT

State of: _____ County of: _____

_____ personally appeared before me and being duly sworn states that the above statements are true and correct.

Administrator/Employer's Signature _____ Title _____

Sworn to and subscribed before me this _____ day of _____, _____

Notary Public _____

Commission Expires _____ **Seal**