APPLICATION INSTRUCTIONS FOR THE LICENSURE OF A PAIN MANAGEMENT CLINIC

NOTE: AN APPLICANT SHALL SUBMIT A SEPARATE APPLICATION FOR LICENSURE 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 license of a pain management clinic:

1. Complete and mail the application including supporting documentation for the application and Attachments 1, 2 and 3 to the address below. All three Attachments must be completed prior to consideration of your application.

2. If you cannot answer “Yes” to questions 1-5 on the first page of the application, then you may not proceed. You are not eligible to obtain a license as a pain management clinic.

3. If you answered “Yes” to any questions on the Fitness and Competency pages, you must provide a detailed explanation along with supporting documentation such as final documents or orders from the issuing states, courts, and/or agencies. The application will not be considered completed absent the required materials.

4. All licensed employee(s) who prescribe controlled substances must submit a criminal background check; please provide the results of a criminal background check. Follow the link http://tn.gov/health/article/CBC-instructions for instructions.

5. If you answered “Yes” to any questions on Attachment 1 page 2, you must provide a detailed explanation along with supporting documentation such as final documents or orders from the issuing states, courts, and/or agencies. The application will not be considered completed absent the required materials.

6. 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.
UNDERSTANDING THE APPLICATION PROCESS

1. All documents and fees to be submitted by you must be mailed directly to:

   Department of Health, Health-Related Boards  
   ATTN: Pain Management Clinic Licensure  
   665 Mainstream Drive, 2nd Floor  
   Nashville, TN 37243 (37228 for courier service only)

2. All Application fees are NON-REFUNDABLE.

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, a 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 licensure, then the application will be closed, the application fee will not be refunded, and the applicant shall reapply for licensure.**

5. The entirety of the application process may take at a minimum 90 days. Please prepare your materials accordingly.

6. Any application that is submitted to the Department may be withdrawn at any time prior to the grant or denial of licensure; provided, however, that the application fee will not be refunded.

7. Once the application and all the Attachments and supporting documents are received and deemed complete, an inspection will be conducted. After the inspection, your application will be reviewed for approval 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 medical director of the pain management clinic. For licensing purposes, the medical director will become the license holder for the clinic.

9. The entirety of the application must be completed before being considered. If there is any missing information from the form, it will not be accepted until the missing information has been added. If there is information to which is not applicable, simply write N/A.

Thank you for your cooperation. We will make every effort to expedite your application in an efficient manner.
APPLICATION FOR LICENSURE OF PAIN MANAGEMENT CLINIC

Please Print In Ink

The first 3 pages of this application are questions regarding the fitness and competency of the medical director. As written in TCA 63-1-3(a), on or after July 1, 2017, no person shall own or operate a pain management clinic unless the medical director obtains a license from the department. No license shall be issued unless the pain management clinic has been inspected and found to be in compliance with this part by the department.

Please answer the following questions before proceeding:

1. Are you a Medical Doctor or Osteopathic Physician who holds an unencumbered license in Tennessee?
   - Yes
   - No

2. Do you hold a subspecialty certification in pain medicine through either the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA), or are you eligible to sit for the board examination offered by AMBS or AOA?
   - Yes
   - No

3. Have you attained American Board of Pain Medicine (ABPM) diplomate status?
   - Yes
   - No

4. Are you board certified by the American Board of Interventional Pain Physicians (ABIPP) by passing parts 1 and 2 of its examination?
   - Yes
   - No

5. Do you have an active pain management practice in a clinic accredited in outpatient interdisciplinary pain rehabilitation by the Commission on Accreditation of Rehabilitation Facilities?
   - Yes
   - No

Note: If you answered no to all of the questions from 2-5 then you do not qualify as the medical director of a pain management clinic. Please do not proceed. If you answered yes to any between 2-5 then you must provide supporting documentation for the pathway you qualify for as written in TCA §63-1-301.

List the names of all the pain management clinics for which you are currently the Medical Director.

1. Name: ____________________________ Lic #: ____________________________
2. Name: ____________________________ Lic #: ____________________________
3. Name: ____________________________ Lic #: ____________________________
4. Name: ____________________________ Lic #: ____________________________

Please list the identifying information for any other license, certificate, or application, either pending or denied, for a pain management clinic that you have worked at, had an ownership interest in, or for which you have served in the capacity of a supervising physician or Medical Director. If you require more slots than available, please add additional information on another sheet.

1. Name: ____________________________ Lic #: ____________________________
   Relation to clinic: ____________________________________________________
2. Name: ____________________________ Lic #: ____________________________
   Relation to clinic: ____________________________________________________
3. Name: ___________________________________________ Lic #: __________________
   Relation to clinic: ________________________________________________________________

4. Name: ___________________________________________ Lic #: __________________
   Relation to clinic: ________________________________________________________________

Please list the name of the pain management clinics in Tennessee for which you hold ownership interest and include that percentage of interest. If you require more slots than available, please add additional information on another sheet.

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<thead>
<tr>
<th>Name:</th>
<th>Lic #</th>
<th>Interest %:</th>
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<td>1. Name:__________________</td>
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<td>3. Name:__________________</td>
<td>Lic #</td>
<td>Interest %:</td>
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<tr>
<td>4. Name:__________________</td>
<td>Lic #</td>
<td>Interest %:</td>
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</tbody>
</table>

Please list the name of the pharmacies in Tennessee for which you hold ownership interest and include that percentage of interest. If you require more slots than available, please add additional information on another sheet.

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<th>Name:</th>
<th>Lic #</th>
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<td>2. Name:__________________</td>
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<td>3. Name:__________________</td>
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<tr>
<td>4. Name:__________________</td>
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Please list the name and address of all other clinics, hospitals, or other facilities at which you provide medical or supervisory services. If you require more slots than available, please add additional information on another sheet.

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<th>Name:</th>
<th>Street Address:</th>
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If applicable, please list all pain management clinics at which you are the owner or the medical director outside of Tennessee. If you require more slots than available, please add additional information on another sheet.

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<th>Name:</th>
<th>Street Address:</th>
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<td>3. Name:__________________</td>
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Please answer the following questions before proceeding:

1. Have you read and do you understand the statutes and rules governing pain management clinics?
   - [ ] Yes  [ ] No

2. Have you read and do you understand the Pain Management Clinic Guidelines?
   - [ ] Yes  [ ] No

3. Have you read and do you understand the Tennessee Chronic Pain Guidelines?
   - [ ] Yes  [ ] No
Fitness and Competency

PLEASE ANSWER THE FOLLOWING QUESTIONS.

If you answer “yes” to any of the questions in this part, you must supplement your affirmative response with a thorough explanation on a separate page. 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. Additional information may be requested and/or required before a licensure decision may be made.

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

1. “Minor Traffic Offense” generally means moving and non-moving violations punishable by fines only and does not include offenses such as driving under intoxication or reckless driving.

1. Have you ever held or applied for a license, privilege, registration, or certificate to practice any profession 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?
   - Yes
   - No

2. Have you ever applied for or held a state or federal controlled substance registration certificate that was ever denied, revoked, suspended, restricted, surrendered for cause, or voluntarily surrendered or otherwise disciplined under threat of restriction or disciplinary action?
   - Yes
   - No

3. Are you under indictment for any offense involving the sale, diversion, or dispensing of controlled substances under any state or federal law?
   - Yes
   - No

4. 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 the sentence was imposed or suspended?
   - Yes
   - No

5. Have you ever worked at or held an ownership interest in a pain management clinic that has been disciplined or for which the application was denied?
   - Yes
   - No

6. 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?
   - Yes
   - No

7. Has anyone with an ownership interest in this clinic ever held or applied for a license, privilege, registration or certificate to practice any profession 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?
   - Yes
   - No

8. Has anyone with an ownership interest in this clinic ever applied for or held a state or federal controlled substance registration certificate that was ever denied, revoked, suspended, restricted, surrendered for cause, or voluntarily surrendered or otherwise disciplined under threat of restriction or disciplinary action?
   - Yes
   - No

9. Is anyone with an ownership interest in this clinic under indictment for any offense involving the sale, diversion, or dispensing of controlled substances under any state or federal law?
   - Yes
   - No
10. Have anyone with an ownership interest in this clinic 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 the sentence was imposed or suspended?
   ☐ Yes ☐ No

11. Has any employee of this clinic ever held or applied for a license, privilege, registration or certificate to practice any profession 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?
   ☐ Yes ☐ No

12. Has any employee of this clinic ever applied for or held a state or federal controlled substance registration certificate that was ever denied, revoked, suspended, restricted, surrendered for cause, or voluntarily surrendered or otherwise disciplined under threat of restriction or disciplinary action?
   ☐ Yes ☐ No

13. Is any employee of this clinic under indictment for any offense involving the sale, diversion, or dispensing of controlled substances under any state or federal law?
   ☐ Yes ☐ No

14. Has any employee of this clinic 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 the sentence was imposed or suspended?
   ☐ Yes ☐ No

15. Has any individual or company with whom this clinic contracts ever held or applied for a license, privilege, registration or certificate to practice any profession 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?
   ☐ Yes ☐ No

16. Has any individual or company with whom this clinic contracts ever applied for or held a state or federal controlled substance registration certificate that was ever denied, revoked, suspended, restricted, surrendered for cause, or voluntarily surrendered or otherwise disciplined under threat of restriction or disciplinary action?
   ☐ Yes ☐ No

17. Is any individual or company with whom this clinic contracts under indictment for any offense involving the sale, diversion, or dispensing of controlled substances under any state or federal law?
   ☐ Yes ☐ No

18. Has any individual or company with whom this clinic contracts 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 the sentence was imposed or suspended?
   ☐ Yes ☐ No

19. Are you or any owners, employees, or contractors of this clinic required by any form of board order (including a requirement in lieu of public discipline) to have advocacy from a professional assistance program that monitors for substance abuse?
   ☐ Yes ☐ No

I hereby certify that the above information completed is complete and true,

__________________________________________________                  _________________
Licensee                                                Date
Facility Information

Name of Pain Management Clinic: 

Address of Pain Management Clinic: 

Phone Number: (____) _______ Fax Number: (____) _______

Clinic Operations

Email Address: __________________________

Please indicate the operating hours of the clinic:

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Has the clinic been open for business prior to the date of your application being submitted?

☐ Yes    ☐ No

If Yes, what type of practice has been operating at the clinic?

The Medical Director named below is a Pain Specialist as described in Public Chapter 475, holds an unrestricted and unencumbered Tennessee medical license and shall serve as medical director for no more than four (4) pain management clinics:

Medical Director

Name: __________________________________________

Last   First   Middle   Maiden

Mailing Address: __________________________________________

Phone Number: Home: (____) _______ Office: (____) _______ Fax: (____) _______

Medical Doctor’s License Number: ___________ Date Issued: ___________

DEA Registration Number: __________________________

Alternate Medical Director (To serve for no more than 10 business days if needed)

Name: __________________________________________

Last   First   Middle   Maiden

Mailing Address: __________________________________________

Phone Number: Home: (____) _______ Office: (____) _______ Fax: (____) _______

Medical Doctor’s License Number: ___________ Date Issued: ___________

DEA Registration Number: __________________________

Medical Director/Licensee Signature _______ License No. _______ Date

Alternate Medical Director’s Signature _______ License No. _______ Date

Owner’s Signature (If different from Medical Director) _______ License No. _______ Date
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: _______________________

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

3. Please list any pharmacy in which anyone with an ownership interest in this clinic also holds an ownership interest and list the percentage of pharmacy ownership.

   Name: ___________________________ Lic # _____ Interest %: _____

   Name: ___________________________ Lic # _____ Interest %: _____

(If additional space is needed, please use a separate sheet.)
4. Has any owner, in whole or in part, been convicted of, pled nolo contendere to, or received deferred adjudication for:

   (1) An offense that constitutes a felony.

     CHECK ONE

     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.

     CHECK ONE

     Yes☐  No☐

5. 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?

     CHECK ONE

     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?

     CHECK ONE

     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?

     CHECK ONE

     Yes☐  No☐

6. Are all supervising physicians supervising any APRN or PA providing services at this clinic, pain management specialists as defined by the statutes?

     CHECK ONE

     Yes☐  No☐

7. Have all Advanced Practice Registered Nurses practicing and prescribing in the clinic submitted to the Board of Nursing all required documents regarding their supervising physician(s)? (A copy of documents submitted to the Committee on Physician Assistants must be attached.)

     CHECK ONE

     Yes☐  No☐

8. Have all Physician Assistants practicing and prescribing in the clinic submitted to the Committee on Physician Assistants all required documents regarding their supervising physician(s)? (A copy of documents submitted to the Committee on Physician Assistants must be attached.)

     CHECK ONE

     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 thereeto.

Applicant’s Signature  License No.  Date
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)

Please list all of the non-prescribing employees or independent contractors who work in this clinic:

Name: ___________________________ Profession: ___________________________ Lic. No: __________
Address: ____________________________________________________________
Phone Number: (_____) ___________ Fax Number: (_____) ___________

Name: ___________________________ Profession: ___________________________ Lic. No: __________
Address: ____________________________________________________________
Phone Number: (_____) ___________ Fax Number: (_____) ___________

Name: ___________________________ Profession: ___________________________ Lic. No: __________
Address: ____________________________________________________________
Phone Number: (_____) ___________ Fax Number: (_____) ___________

Name: ___________________________ Profession: ___________________________ Lic. No: __________
Address: ____________________________________________________________
Phone Number: (_____) ___________ Fax Number: (_____) ___________

Name: ___________________________ Profession: ___________________________ Lic. No: __________
Address: ____________________________________________________________
Phone Number: (_____) ___________ Fax Number: (_____) ___________

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