TN Department of Health

Pain Management Clinic Medical Director 60-Day Waiver Request

Instructions: This form should be completed by a pain management clinic to request an extension of up to sixty (60) calendar days to continue to operate if, the pain management clinic has: 1) properly notified the Tennessee Department of Health of the departure or ineligibility of its Medical Director; 2) continued operation under the authority of an Interim Medical Director during a thirty (30) day grace period; and 3) had difficulty employing a new medical director.

Pursuant to Tennessee Department of Health Rule 1200-34-01-.09(1)(d), a pain management clinic having difficulty obtaining a new medical director may apply for a waiver of up to sixty (60) calendar days in addition to the thirty (30) day grace period. A waiver will only be granted upon good cause shown by demonstrating reasonable efforts to retain a new medical director and a reasonable belief that public health will be harmed if the waiver is not granted. The determination whether to grant this waiver request rests solely with the Tennessee Department of Health. Should the waiver be granted, the Interim Medical Director shall remain responsible for the clinic during the extension. Please answer the following questions completely. Failure to answer completely and specifically may result in denial of the waiver request.

Please Print Legibly

Name of Clinic: _____ License Number of Clinic: _____

Address: _____

City: _____ State: _____ Zip: _____

Name of Previous Medical Director: _____

Tennessee License Number: _____ Dates of employment: From _____ To _____

Name of Interim Medical Director: _____

Tennessee License Number: _____ Date upon which interim status began: _____

1. Please describe in detail all recruitment activity to locate and hire a new medical director, including the names and contact information for any recruiting agencies or resources.

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TN Department of Health

2. Please provide an impact statement describing any potential threat to public health should this waiver be denied.

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I certify that, to the best of my knowledge, the information I have provided on this form, and any additional information I have provided in an attachment, is accurate and complete.

_____ _____

Interim Medical Director Print Name Date

_____ _____

Interim Medical Director Signature Interim Effective Date

Please submit this Pain Management Clinic Medical Director 60-Day Waiver Request to:
PainManagementClinic@tn.gov