STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TENNESSEE 37243

TENNESSEE BOARD OF MEDICAL EXAMINERS

APPLICATION INSTRUCTIONS FOR A FOREIGN TRAINING LICENSE

Provided below is a checklist for your personal use and convenience containing the items that are required to be completed and submitted before your application for a Tennessee medical license will be considered. **ALL DOCUMENTS MUST BE TRANSLATED INTO ENGLISH AND SUCH TRANSLATION SHALL BE CERTIFIED.**

ALL APPLICATION FEES ARE NON-REFUNDABLE

1. Complete and mail application pages 1 through 6, or complete the online application at https://lars.tn.gov _____

2. Submit a clear and recognizable recently taken bust photograph of yourself that shows the full head, face forward from at least the shoulders up. _____

3. All applicants must complete, sign and have notarized the Declaration of Citizenship form and submit the documents required by the Declaration of Citizenship form. _____

4. Submit proof of citizenship in the United States or evidence of being lawfully present in the United States. For US citizens - a copy of a birth certificate, current US Passport, or naturalization certificate. For non-US citizens - H1B visa, O visa, J-1, permanent resident card, or proof of visa application in process. _____

5. Complete and submit with your application the **Mandatory Practitioner Profile Questionnaire**. The paper version can be found online at https://www.tn.gov/content/dam/tn/health/healthprofboards/PH-3585.pdf. If you submitted your application online, you will complete the Profile in your LARS account at https://lars.tn.gov. From the Quick Start menu, select Mandatory Practitioner Profile Questionnaire from the dropdown under Applicant Activities. _____

6. A criminal background check is required and must be completed by the authorized vendor. **The OCA code for Medical Doctor is 1606**. For instructions to obtain a criminal background check, go to http://tn.gov/health/article/CBC-instructions _____

7. Cause to be submitted your FCVS Information Profile. If any of the following documents are not included in your FCVS Information Profile, they must be submitted to the Board directly from the source:
   - Medical school transcript
   - ECFMG Status of Certification Report
   - USMLE exam transcript

   For information regarding FCVS Information Profile, please visit the Federation of State Medical Boards website. _____

8. Complete the top section of Attachment 1, Verification of Postgraduate Medical Training, and send to each institution in which you received post-graduate medical training (internship, residency, fellowship). Once completed the program should submit the completed form directly to the Board. _____

9. Complete the top section of Attachment 2, Verification of Employment, and send it to all facilities in which you have been employed for the last three (3) years. Once completed the employer should submit the completed form directly to the Board.

10. Send Attachment 3, Employment Offer, to the healthcare provider/facility where you have received an offer of employment. Once completed the healthcare provider/facility should submit the completed form directly to the Board. _____

11. Submit Attachment 4, Foreign Training License Applicant Attestation. This form must be notarized. _____

12. Submit a check or money order in U.S. funds in the amount of $1,015, made payable to the Tennessee Board of Medical Examiners. Be sure the check includes your name and your profession (MD). _____

ATTACHMENT 1

TENNESSEE BOARD OF MEDICAL EXAMINERS
VERIFICATION OF POSTGRADUATE MEDICAL TRAINING

APPLICANT: Provide the information requested in the top box and then mail this form to each institution in which you received any postgraduate medical training. If additional forms are required, copy this one.

Institution Administration: I am applying for a Tennessee medical license and hereby authorize you to release any and all information in your files concerning my medical training. I was in training at your institution as follows:

Applicant's name: _____
(Last) (First) (Middle/Maiden)

Name of Institution: _____ **Program Title:** _____

_____ _____
Applicant's Signature **Dates of Training**

THIS PORTION IS TO BE COMPLETED BY THE TRAINING PROGRAM'S ADMINISTRATIVE OFFICE

Please complete (including all questions) and return to: **medical.health@tn.gov**

I attest that the information on this form is true and correct.

_____Internship **_____Residency** **_____Fellowship** **_____Research**	**Specialty/Subspecialty:** _____ **Successfully Completed? _____Yes _____No* _____In Progress** *If no, how many months of partial credit was received?_____ **From:_____/_____/_____ To:_____/_____/_____ (I**n progress, provide expected completion date.) **Accredited By: _____**ACGME **_____**ACGME-I **_____**AOA **_____**RCSPC **_____**None of These
Please attach an explanation for any "yes" response.	
____Yes ____No	1. Did this individual take a leave of absence or break during training?
____Yes ____No	2. Did this individual resign from training?
____Yes ____No	3. Was this individual ever placed on probation for any reason?
____Yes ____No	4. Did this individual receive a written warning or documented counseling about their behavior?
____Yes ____No	5. Was this individual ever disciplined or placed under investigation?
____Yes ____No	6. Were this individual's privileges or duties ever reduced, suspended, or revoked?
____Yes ____No	7. Did this individual experience delayed promotion or advancement to the next level?
____Yes ____No	8. Was this individual informed that their contract would not be renewed?
____Yes ____No	9. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems, or any other reason?
____Yes ____No	10. Was this individual suspended, terminated, or dismissed from training?

_____ _____
Program Director's/Dean's Signature Date

Subscribed and sworn before me this the ____ day of _____, _____.

_____
Notary Public (Affix Seal Here)

My Commission Expires: _____

ATTACHMENT 2

TENNESSEE BOARD OF MEDICAL EXAMINERS
Verification of Employment

Applicant: Complete this section and submit this form to all hospitals, facilities, and employers where you have had privileges, employment, or appointments during the last three (3) calendar years. The form must be returned directly from the hospital, facility, or employer to the Board by email at medical.health@tn.gov

Facility/Hospital/Employer: I am applying for a Tennessee medical license and hereby authorize you to release any and all information in your files concerning my employment.

Applicant's name: _____
(Last) (First) (Middle/Maiden)

Applicant's Date of Birth: _____

Applicant's Signature: _____

HOSPITAL/FACILITY/EMPLOYER: You must answer all the following questions and provide any additional information in order for this form to be considered complete. Complete the section below for the above-named applicant and return directly to the Board by email at medical.health@tn.gov

Name of Hospital/Facility/Employer			
Hospital/Facility/Employer's Address (number/street)	(city)	(state)	(country)

1.	What position did this physician hold at your facility or under your employment?		
2.	What were this physician's dates of employment or privileges at your facility? (Note: If physician is still employed/privileged, end date should indicate "to present.") _____/_____/_____ to _____/_____/_____ ___ To Present		
3.	Did this physician either leave your employment in good standing or is physician currently employed and in good standing? If no, please attach explanation on a separate sheet.	Yes	No
4.	Was the physician placed on probation, suspended, or in any way sanctioned or disciplined while at your facility or under your employment? **If yes, attach an explanation on a separate sheet.**	Yes	No
5.	Was this physician granted a leave of absence while employed by you or at your facility? **If yes, attach an explanation on a separate sheet.**	Yes	No
6.	Did this physician have a record of unexcused absences during his or her attendance at this facility or under your employment? **If yes, attach an explanation on a separate sheet.**	Yes	No
7.	Were any restrictions or special requirements placed on this physician's activities that were not placed on all other employees/staff holding similar positions? **If yes, attach an explanation on a separate sheet.**	Yes	No
8.	Were any restrictions placed on this physician's privileges? **If yes, attach an explanation on a separate sheet.**	Yes	No
9.	Were any formal patient or staff complaints filed against this physician? **If yes, attach an explanation on a separate sheet.**	Yes	No
10.	Was this physician denied hospital privileges while employed by you? **If yes, attach an explanation on a separate sheet.**	Yes	No
11.	Were any incident reports filed involving the professional conduct or behavior of this physician? **If yes, attach an explanation on a separate sheet.**	Yes	No
12.	Was this physician ever subject to non-routine monitoring while at your facility? **If yes, please attach an explanation on a separate sheet.**	Yes	No

13.	Was this physician involuntarily removed from a call schedule for cause? **If yes, attach an explanation on a separate sheet.**	Yes No
14.	Was this physician subject to non-routine quality assessment review? **If yes, attach an explanation on a separate sheet.**	Yes No
15.	Was this physician the subject of a negative review by a quality assurance or departmental committee? **If yes, attach an explanation on a separate sheet.**	Yes No

_____ _____/_____/_____

Signature of Hospital/Facility/Employer **Date**

_____ _____

Printed Name **Phone Number**

_____ _____

Title **Email**

ATTACHMENT 3

TENNESSEE BOARD OF MEDICAL EXAMINERS
Employment Offer

APPLICANT: This form must be completed and submitted by the healthcare provider.
HEALTHCARE PROVIDER/FACILITY: Please complete, sign, and have this form notarized. Once completed the form should be emailed directly to the Board at medical.health@tn.gov

ATTESTATION

I, _____, attest that _____
Representative of Healthcare Provider / Facility ***Applicant's Name***

Has an offer of employment performing the duties of a clinical physician at _____
Healthcare Provider / Facility

Located at _____, _____,_____.
City ***State*** ***Zip Code***

I further attest that the healthcare provider/facility listed above has a postgraduate training program accredited by the Accreditation Council for Graduate Medical Education (ACGME) in place.

Training Program Specialty_____

Training Program ACGME Accreditation Code_____

THIS CERTIFIES THAT THE INFORMATION SUBMITTED BY ME IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

_____ _____
Representative Signature Date

Subscribed and sworn before me this the ____ day of _____, _____.

_____ (Affix Seal Here)
Notary Public

My Commission Expires: _____

ATTACHMENT 4

TENNESSEE BOARD OF MEDICAL EXAMINERS
Foreign Training License Applicant Attestation

ATTESTATION

I, _____, attest to the truth of each statement below. I further consent to the
(*Applicant's Name)*

use of official verification from other countries, to include but not be limited to licensure verification and criminal background checks if such forms of official verification are available.

Please initial each statement below and sign the form in the presence of a notary.

I HEREBY ATTEST:

_____I have no criminal history in any country.

_____Any license I hold in any country or province is in good standing and has never been disciplined.

_____I have no open or pending investigations.

_____There were no adverse actions taken against me in medical school.

_____There were no adverse actions taken against me during any healthcare employment.

_____There were no adverse actions taken against me during post-graduate training.

_____I will notify the Board within thirty (30) days should I no longer be employed by the same healthcare provider listed in my initial application.

THIS CERTIFIES THAT THE INFORMATION SUBMITTED BY ME IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

_____ _____
Applicant's Signature Date

Subscribed and sworn before me this the ____ day of _____, _____.

_____
Notary Public (Affix Seal Here)

My Commission Expires: _____