



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

TENNESSEE BOARD OF MEDICAL EXAMINERS

APPLICATION INSTRUCTIONS FOR A GRADUATE PHYSICIAN LICENSE

Provided below is a checklist for your personal use and convenience containing required items that must 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 submit 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 that apply to you are not included in your FCVS Information Profile, they must be submitted to the Board directly from the source:
  - Medical school transcript
  - Postgraduate training verification (if applicable)
  - USMLE or COMLEX exam transcript
  - ECFMG Certification of Status Report (if applicable)For information regarding FCVS Information Profile, please visit the Federation of State Medical Boards website. \_\_\_\_\_
8. Submit a check or money order in U.S. funds in the amount of \$510, made payable to the Tennessee Board of Medical Examiners. Be sure the check includes your name and your profession (MD). \_\_\_\_\_
9. If you participated in any post-graduate training program, Attachment 1 must be completed and submitted directly from the program if verification is not included in the FCVS profile. \_\_\_\_\_

**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](mailto:medical.health@tn.gov)

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

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

\_\_\_\_\_  
Program Director's/Dean's Signature

\_\_\_\_\_  
Date

Subscribed and sworn before me this the \_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

\_\_\_\_\_  
Notary Public

(Affix Seal Here)

My Commission Expires: \_\_\_\_\_

**BOARD OF MEDICAL EXAMINERS**  
**NOTIFICATION OF INTENT TO PRACTICE**

This form is not required for licensure but must be submitted to the Board prior to practicing as a Graduate Physician and within six (6) months of initial licensure.

**1) Collaborating Physician**

**2) Graduate Physician**

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Practice Address

\_\_\_\_\_  
Practice Address

\_\_\_\_\_  
Email Address

\_\_\_\_\_  
Email Address

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Board Certification Specialty

\_\_\_\_\_  
Practice Specialty

\_\_\_\_\_  
Tennessee Medical License Number

\_\_\_\_\_  
Tennessee Medical License Number

**Collaborating Physician**

**By initialing and signing below I am attesting to the following:**

\_\_\_\_ I have entered into a collaborative agreement in accordance with T.C.A 63-20-101, et seq., and Rule 0880-02-.27(6) with the physician listed above and I have accepted the responsibilities of that arrangement.

\_\_\_\_ I have read and understand the rules and statutes that govern the practice of graduate physicians in Tennessee.

\_\_\_\_ I have completed a certification course meeting the requirements of 0880-02-.27(7)(e). A copy of the completion certificate must be attached to this form.

\_\_\_\_\_  
Collaborating Physician Signature

\_\_\_\_\_  
Date

**Graduate Physician**

**By initialing and signing below I am attesting to the following:**

\_\_\_\_ I have entered into a collaborative agreement in accordance with T.C.A 63-20-101, et seq., and Rule 0880-02-.27(6) with the physician listed above and I have accepted the responsibilities of that arrangement.

\_\_\_\_ I have read and understand the rules and statutes that govern the practice of graduate physicians in Tennessee.

\_\_\_\_\_  
Graduate Physician Signature

\_\_\_\_\_  
Date