**STATE OF TENNESSEE**
**DEPARTMENT OF HEALTH**
**HEALTH RELATED BOARDS**
**665 MAINSTREAM DRIVE**
**NASHVILLE, TENNESSEE 37243**
**www.tennessee.gov/health**

# TENNESSEE BOARD OF MEDICAL EXAMINERS
## (800) 778-4123, ext. 532-4384 or (615) 532-3202, ext. 532-4384

### APPLICATION INSTRUCTIONS FOR

### ST. JUDE CHILDREN'S RESEARCH HOSPITAL GLOBAL COLLABORATION LICENSE

Provided below is a checklist for your personal use and convenience containing all the things you must do to receive consideration for issuance of a St. Jude Children's Research Hospital Global Collaboration License.

**ALL APPLICATION FEES ARE NON-REFUNDABLE.**

| | | Done |
|---|---|---|
| 1. | Complete and mail the application pages 1 through 6. | _____ |
| 2. | Complete and mail attachment 1 to your medical school for transcript of courses, grades, and degree. If you are an International Medical School graduate you must **also** ask that your medical school provide to this office documentation proving that they meet or exceed the accreditation requirements of the LCME (Liaison Committee on Medical Education). Documentation must be submitted in English. | _____ |
| 3. | Complete and mail attachment 2 to each state, country, or province in which you hold or have ever held a license to practice any profession. | _____ |
| 4. | Submit a clear and recognizable recently taken bust photograph of yourself that shows the full head, face forward from at least the shoulders up. | _____ |
| 5. | Submit proof of the citizenship in the United States or Canada or evidence of being legally entitled to live and work in the United States. (Notarized copies of birth certificates, naturalization papers, H-1 visas, or current passports are acceptable). License will not be issued to holders of J-1 Training Visa. Visa must allow one to hold employment in the United States. | _____ |
| 6. | Submit two (2) original letters of recommendation from licensed medical doctors on the signatory's letterhead attesting to your good moral character. The letters must contain original signatures. | _____ |
| **7.** | You must have successfully completed a medical licensure examination or an approved combination of examinations. If you are submitting USMLE scores, **all three steps must be taken and passed within seven years**. Please refer to attachment 3 for information in obtaining scores. | _____ |
| **8.** | If you are an international medical school graduate, you must submit one of the following**:** | |
| | a. A notarized copy of your original permanent E.C.F.M.G. Certificate; | _____ |
| | b. If you graduated from a Mexican Medical School, a letter from the E.C.F.M.G. stating that all certificate requirements have been met; or | _____ |

c. If you cannot obtain an original certificate due to the phase out of the E.C.F.M.G., proof of successful completion of U.S.M.L.E. Steps 1 and 2 submitted directly from the testing agency to the Board Administrative Office. _____

9. Complete and submit along with your application the *Practitioner Profile Questionnaire* which is online at http://tn.gov/assets/entities/health/attachments/PH-3585.pdf. You are required by law update your profile within 30 days of any change as long as you have an active license. Failure to do so may subject you to disciplinary action. _____

10. **Attach to the application and submit a check or money order in U.S. funds in the amount of $510, payable to the Tennessee Board of Medical Examiners.** _____

11. **A criminal background check is required.** For instructions to obtain a criminal background check, go to http://tn.gov/health/article/CBC-instructions _____

12. All applicants must complete, sign and have notarized the Declaration of Citizenship form and submit the documents required by the Declaration of Citizenship form, The Declaration of Citizenship is available online at https://www.tn.gov/content/dam/tn/health/healthprofboards/PH-41833.pdf. _____

## UNDERSTANDING THE APPLICATION PROCESS

**1. All application fees are non-refundable.**

2. All documents and fees required to be submitted by you or which must be requested from the appropriate institutions in this application process, must be mailed directly to:

**Tennessee Board of Medical Examiners**
**665 Mainstream Drive**
**Nashville, TN 37243 (37228 for courier service only)**

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 Board asks that you please give the Board office every consideration in this matter.

**4.** If necessary documentation has not been received when your application has been received by the Board office, an initial deficiency letter will be sent to you. The supporting documentation requested in the letter must be received in the Board office ninety (90) days from the date of the initial deficiency letter. **(Files not completed within ninety (90) days will be closed.)**

5. Absent any complicating factors, the average application processing time is eight (8) weeks. Once the application is completed, your file will be reviewed and an initial licensure determination made. You will be promptly notified by letter of the initial determination.

**6. If an address change occurs at any time during the application process, you must notify the Board office, in writing, immediately.**

7. It is recommended that you do not make arrangements to accept employment as a physician at St. Jude Children's Research Hospital until you are granted a license number by the Board of Medical Examiners.

8. You have the option to receive all correspondence from the Department of Health electronically. Should you "opt in," you will no longer receive physical mail from this office. Opting in does not discharge your obligation to provide the Department with a current physical address and email address. You are required by statute and rule to notify the Department of an address change within thirty (30) days of any such change.

9. All documents which are provided to this office in conjunction with your request for a medical license becomes part of the public record and must be released pursuant to a public records request.

Thank you for your cooperation. We will make every effort to expedite your application in an efficient manner.

**For Office Use Only**

| |
|---|
| 06-001 $500 |
| 06-006 $ 10 |

**STATE OF TENNESSEE**
**DEPARTMENT OF HEALTH**
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**TENNESSEE BOARD OF MEDICAL EXAMINERS**
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# APPLICATION FOR ST. JUDE CHILDREN'S RESEARCH HOSPITAL GLOBAL COLLABORATION LICENSE

**READ INSTRUCTIONS PRIOR TO COMPLETING APPLICATION. APPLICANTS MUST COMPLY WITH ALL INSTRUCTIONS.**

**Attach to this application a check or money order in the amount of $510, payable in U.S. funds to the Tennessee Board of Medical Examiners.**

## PERSONAL INFORMATION

Name as it will appear on license: _____
(*First*) *(Middle)* *(Last)*

Have you been known by any other name? Y N If yes, list names: _____
_____

Date of Birth: Mo._____Day_____Yr._____ Social Security Number: ----------_____

Are you a U.S. Citizen? Y N Gender: M F Race: _____

Are you entitled to Live and Work in U.S.? Y N

Are you a member of the U.S. armed forces who has, within the preceding 180 days, retired from the armed forces, received any discharge other than a dishonorable discharge from the armed forces, or been released from active duty to a reserve component of the armed forces? Y N (If yes, please provide proof of status.)

Are you the spouse of a member of the armed forces who has been transferred by the military to Tennessee or who has, within the preceding 180 days, retired from the armed forces, received a discharge other than a dishonorable discharge from the armed forces or been released from active duty to a reserve component? Y N (If yes, please provide proof of same.)

Present Mailing Address: _____ Home Phone: (_____) _____-_____
_____
_____ Work Phone: (_____) _____-_____

Email address: _____

Do you wish to receive notification, including renewal notification, from the Department of Health via email? Y N
**Please note, by opting in, all correspondence from the Department of Health will be delivered to the email address on file for you. You will no longer receive physical mail from our office.**

Type of intended primary specialty practice in Tennessee _____

## EDUCATIONAL AND EXAMINATION INFORMATION

### PRE-MEDICAL EDUCATION

From:_____To: _____ _____ _____
*MM/YY* *MM/YY* *Educational Institution* *Location*

From:_____To: _____ _____ _____
*MM/YY* *MM/YY* *Educational Institution* *Location*

From:_____To: _____ _____ _____
*MM/YY* *MM/YY* *Educational Institution* *Location*

### MEDICAL EDUCATION

I have spent_____years in the study of medicine in the medical educational institutions below:

From:_____To: _____ _____ _____
*MM/YY* *MM/YY* *Educational Institution* *Location*

From:_____To: _____ _____ _____
*MM/YY* *MM/YY* *Educational Institution* *Location*

Complete Attachment 1 and mail to the school which granted your medical degree

### EXAMS

I have taken the following medical licensure examinations: (Check all applicable)

1. ____National Boards (NBME) Certificate Number
2. ____FLEX examination administered by the State of_____on_____.
*(Date(s))*
3. ____Licensure by the Medical Council of Canada (LMCC)
4. ____USMLE
5. _____State Board administered by_____prior to 1972.
*(State)*

Have you previously applied for a medical license in Tennessee? Y N

## PRACTICE AND LICENSURE INFORMATION

| | YES | NO |
|---|---|---|
| Are you or have you ever been licensed to practice medicine in another state? | ___ | ___ |
| Are you or have you ever been licensed in any other profession in Tennessee or another state? | ___ | ___ |

List below all states, countries or provinces in which you have ever been or currently are licensed, permitted or certified. Submit a copy of **Attachment 1** to all such states, countries, or provinces regarding such licensure, certification or permit. Use the back of this page if you need additional space.

| STATE | PROFESSION | LICENSE NUMBER | DATE ISSUED | CURRENT STATUS |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Do you have a DEA Registration? Y N

If yes, please provide:

_____

Please complete your employment history starting with the most current position first. You may use a separate sheet of paper if you need additional space.

| DATES | LOCATION | POSITION AND DUTIES |
|---|---|---|
| From: _____ (MM/YY) To: _____ (MM/YY) | _____ (City) _____ (State) | _____ |
| From: _____ (MM/YY) To: _____ (MM/YY) | _____ (City) _____ (State) | _____ |
| From: _____ (MM/YY) To: _____ (MM/YY) | _____ (City) _____ (State) | _____ |
| From: _____ (MM/YY) To: _____ (MM/YY) | _____ (City) _____ (State) | _____ |
| From: _____ (MM/YY) To: _____ (MM/YY) | _____ (City) _____ (State) | _____ |
| From: _____ (MM/YY) To: _____ (MM/YY) | _____ (City) _____ (State) | _____ |

## COMPETENCY INFORMATION

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

1. "**Ability to practice your profession**" is to be construed to include all of the following:

   a. The cognitive capacity to make appropriate clinical diagnoses, exercise reasoned medical judgments, to learn, and keep abreast of medical developments;
   b. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
   c. The physical capability to perform professional tasks and procedures required of your profession, with or without the use of aids or devices, such as corrective lenses or hearing aids.

2. "**Medical Condition**" includes physiological, mental or psychological conditions including, but not limited to: orthopedic, visual, speech and/or hearing impairments, emotional or mental illness, specific learning disabilities, drug addiction, and alcoholism.

3. "**Minor Traffic Offense**" generally means moving and non-moving violations punishable by fines only and does not include offenses such as driving under the influence or while intoxicated or reckless driving.

4. "**Chemical substances**" is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

5. "Currently" does not mean on the day of or even in the weeks or months preceding the completion of the application; rather, it means within the past two years or recently enough so that the use of drugs or alcohol or other medical conditions may have an ongoing impact on one's functioning as a physician.

6. "**Illegal use of illicit or controlled substances**" means the use of substances obtained illegally (e.g., heroin or cocaine) as well as the use of controlled substances that are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

**Please respond to ALL questions. If you answer "YES" to any question, please attach a written explanation. Affirmative response requires final documents or orders from the issuing states, courts and/or agencies.**

| **QUESTIONS:** | **YES** | **NO** |
|---|---|---|
| 1. The Board recognizes that licensees may suffer from potentially impairing health conditions, just like their patients, including psychiatric illnesses, physical illnesses which may impact cognition, and substance use disorders. The Board expects its licensees to properly address their health concerns, in order to ensure patient safety. Licensees should seek appropriate medical care and should limit their medical practice, when appropriate. The Board encourages licensees to utilize the services of the Tennessee Medical Foundation, a confidential resource which provides advocacy for licensees who may suffer from potentially impairing illnesses. (www.e-tmf.org)The failure of a licensee to adequately address any health condition which may impair their ability to practice medicine with reasonable skill and safety to patients, may result in the board taking action against the license to practice medicine. I have read and understand this statement. | ____ | ____ |
| 2. Do you currently have any condition that is causing impairment that affects your ability to practice medicine with reasonable skill and safety in a competent, ethical and professional manner? *(You may answer no if you are being appropriately treated and are not impaired.)* | ____ | ____ |

## COMPETENCY INFORMATION

**CONTINUED**

| | | YES | NO |
|---|---|---|---|
| 3. | Do you currently use any medications or substances (legal, OTC, prescribed or illicit) which in any way impairs or limits your ability to practice medicine with reasonable skill and safety in a competent, ethical and professional manner?<br><br>If so, please list:_____ | ____ | ____ |
| 4. | During the past two years, did you engage in any activity involving substances, either alcohol or controlled/illicit drugs, that impaired or limited your ability to practice medicine with reasonable skill and safety in a competent, ethical and professional manner? You may answer "NO" if you are being appropriately treated and are not impaired).<br><br>It should be noted, however, that if such activity is not revealed, but manifests at some later time in your career, the Board, in its role as the protector of the health, safety and welfare of people in the State of Tennessee, will be able to pursue a disciplinary action on your license. | ____ | ____ |
| 5. | Have you ever been diagnosed as having or have you ever been treated for a paraphilia or other type disease of a predatory nature such as, but not limited to pedophilia, exhibitionism, voyeurism, etc. | ____ | ____ |
| 6. | Have you ever held or applied for a license or certificate in any state, country, or province, in any health care profession, that has been or was ever denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action? | ____ | ____ |
| 7. | 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? | ____ | ____ |
| 8. | Have you ever applied for or held a state or federal controlled substance certificate that was ever denied, revoked, suspended, restricted, voluntarily surrendered or otherwise disciplined or surrendered under threat of restriction or disciplinary action? | ____ | ____ |
| 9. | 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 sentence was imposed or suspended? | ____ | ____ |
| 10. | Have you ever been rejected or censured by a medical society? | ____ | ____ |
| 11. | In relation to the performance of your professional services in any profession: | | |
| | a. Have you ever had a final judgment rendered against you; | ____ | ____ |
| | b. Have you ever entered into any settlement of any legal action; or | ____ | ____ |
| | c. Are there any legal actions pending against you or to which you are a party? | ____ | ____ |
| 12. | Are you currently under investigation by a licensing board? | ____ | ____ |
| 13. | My name has been placed on the registry of persons who have abused, neglected or misappropriated the property of vulnerable individuals (Tennessee abuse registry or an abuse registry in another state). | ____ | ____ |

## AFFIDAVIT AND RELEASE

I,_____, M.D., of _____
(*Applicant's Name)* *(City)* *(State)*
being duly sworn and identified as the person referred to in this application attests to the truth of each statement made in said application. I further swear that I have read and understand the law and the Rules and Regulations regarding the practice of my profession, which are posted on the Board's Internet site and/or were provided to me by the Board office, and agree to abide by them in the practice of medicine in the State of Tennessee.

**I HEREBY:**

**SIGNIFY** my willingness to appear to answer such questions as the Board may find necessary, which may include a full Board interview.

**RELEASE** to the Board, its staff, and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice medicine.

**AUTHORIZE** the Board, its staff, and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others, and other qualifications.

**RELEASE** from liability the Board, its staff, and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character, and/or other qualifications for licensure.

**ACKNOWLEDGE** that I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical, other qualifications, and for resolving any doubts about such qualifications.

**AGREE** not to practice medicine outside my duties and responsibilities as an employee of St. Jude Children's Research Hospital. Termination of employment with St. Jude Children's Research Hospital for any reason terminates this special license.

**AUTHORIZE** release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

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

_____ _____
**SIGNATURE** **DATE**

**ATTACHMENT 1**

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

## TENNESSEE BOARD OF MEDICAL EXAMINERS
## (800) 778-4123, ext. 532-4384 or (615) 532-3202, ext. 532-4384

**APPLICANT:** Supply the information requested in this box and then mail this entire form to your medical school.

Full Name: _____
(Last) (First) (Middle/Maiden)

Address: _____ Social Security Number: ___ - ___ - ___

_____

_____

_____

Student Identification Number: _____

Year of Graduation: _____

Degree Obtained: _____

**TO WHOM IT MAY CONCERN:**

I am applying for a St. Jude Children's Research Hospital Global Collaboration License in the State of Tennessee.

Please forward an original graduate transcript of courses, grades, and degree bearing the institution's official seal to:

**State of Tennessee**
**Board of Medical Examiners**
**665 Mainstream Drive**
**Nashville, TN 37243 (37228 for courier service only)**

Thank you for your cooperation and prompt response.

_____ _____
Applicant's Signature Date

**ATTACHMENT 2**

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

## TENNESSEE BOARD OF MEDICAL EXAMINERS

**(800) 778-4123, ext. 532-4384 or (615) 532-3202, ext. 532-4384**

## CLEARANCE FROM OTHER STATE LICENSURE BOARDS

**APPLICANT:** Please provide the information requested in the top box and then mail one form to the licensure board in EACH state where you hold OR HAVE EVER HELD a license to practice any profession. (You may copy this form.) **NOTE:** Some states require a fee for providing clearance information. To expedite your application, you may wish to contact the applicable state(s).

_____ was granted a license to practice _____
*(Name of Applicant)* *(Profession)*
with license number _____ on _____ in the State of _____.
*(Date)*

The Board of Medical Examiners of Tennessee requests that I submit evidence of the current status of that license in your state. You are hereby authorized to release any information in your files, favorable or otherwise, directly to:

**Board of Medical Examiners**
**665 Mainstream Drive**
**Nashville, TN 37243**

Date: _____ _____
Applicant's Signature

_____
Applicant's typed or printed name

**ADMINISTRATIVE OFFICE OF STATE LICENSURE BOARD, PLEASE COMPLETE:**

Name In Full As It Appears On License: _____

License Number _____ Profession _____ Date Issued _____

Basis of issuance: _____ Endorsement/Reciprocity with _____
(Check One) (State)
_____ Written Examination _____
(Name of Exam)

The License is currently active and registered? Yes_____ No _____
Is there any derogatory information on file? Yes_____ No_____ If yes, an explanation must be attached.

_____ _____ _____
Authorized Signature Title Date

**ATTACHMENT 3**

# Tennessee Requires Medical Examination Scores be Sent Directly to the Tennessee Board of Medical Examiners

In order to have medical examination scores reported to the Tennessee Board please read the following:

**For FLEX, SPEX and USMLE scores contact the Federation of State Medical Boards to obtain a score reporting form at:**

Federation of State Medical Boards of the U.S., Inc.
Federation Place
Suite 300
400 Fuller Wiser Road
Euless, TX 76039-3855
(800) 876-5396

or download the form from the web site at:

http://www.fsmb.org

For NBME Parts I, II, and III or any **COMBINATION** OF NBME Parts, the request form is now available on the NBME web site at:

http://www.nbme.org/programs/nbmecert.asp

National Board of Medical Examiners
P.O. Box 48014
Newark, NJ 07101-4814

For NBME Parts I, II, and III administered by ECFMG or for information concerning FMGEMS contact:

Educational Commission for Foreign Medical Graduates
3624 Market Street
Philadelphia, PA 19104
Phone (215) 386-5900

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**APPLICANT: USE THIS FORM ONLY IF YOU HAVE TAKEN A STATE EXAM PRIOR TO DECEMBER 1972. IF YOU HAVE, COMPLETE THE INFORMATION IN THE BOX AND THEN SEND IT TO THE STATE BOARD FOR WHICH YOU TOOK THE EXAMINATION:**

Full Name:_____
(Last) (First) (Middle/Maiden)

Social Security Number:_____-_____-_____ State License Number: _____

## CERTIFICATE OF SECRETARY OF STATE BOARD ISSUING ORIGINAL LICENSE

I,_____, Secretary of the _____
*(State)*

Board of Medical Examiners, certify that_____of
*(Applicant's Name)*

_____was granted License/Certificate number _____
*(City & State)*

to practice Medicine in this State on the_____day of_____,_____. I further certify that the aforesaid in the written examination before this Board, which was administered on_____,
*(Date)*

obtained a general average of_____percent and the following percentages on each subject:

| Subject | Percent | Subject | Percent |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Acting on behalf of the_____Board of Medical Examiners, I hereby certify that the Applicant successfully completed the state licensure examination.
*(State)*

Seal of the Board _____ Date: _____
Board Secretary's Signature

Please return to: **State of Tennessee**
**Board of Medical Examiners**
**665 Mainstream Drive**
**Nashville, TN 37243**