06-001	$500
06-006	$ 10
TOTAL	$510

State of Tennessee
Department of Health
Health Related Boards
665 Mainstream Drive
Nashville, TN 37243
www.tennessee.gov/health

TENNESSEE BOARD OF MEDICAL EXAMINERS

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

APPLICATION FOR A LOCUM TENENS LICENSE AS A MEDICAL DOCTOR

ATTACH THE FOLLOWING TO THIS APPLICATION AND MAIL TO :

Board of Medical Examiners
665 Mainstream Drive
Nashville, TN 37243

1. A check or money order for $510, payable to the Tennessee Board of Medical Examiners.
2. A clear and recognizable, recently taken, bust photograph that shows the full head, face forward from at least the shoulders up.
3. A notarized copy of a specialty certification from a recognized specialty.
4. Proof of citizenship in the United States, Canada, a N.A.F.T.A. participation country, or evidence of being legally entitled to live and work in the United States (Notarized copies of birth certificates, naturalization papers, resident alien cards, green cards, or U.S. passport are acceptable.)
5. Complete and mail attachment 1 to each state in which you hold or ever held a license to practice medicine.
6. 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.
7. **A criminal background check is required.** For instructions to obtain a criminal background check, go to http://tn.gov/health/article/CBC-instructions
8. Attachment 2 must be completed – Declaration of Citizenship

PERSONAL INFORMATION

Applicant's Name: _____
(First) (Middle and/or Maiden) (Last)

Date of Birth : _____ Social Security Number: _____-_____-_____
(Month) (Day) (Year)

Present Home Mailing Address: _____

_____

Home Phone: (_____) _____ Work Phone: (_____) _____

Name of Medical School: _____

Year Graduated: _____

Intended location of initial work in Tennessee: _____

Intended duration of initial work in Tennessee _____

Email address: _____

Do you wish to receive notification, including renewal notification, from the Department of health via email? Y N

INITIAL PRACTICE SETTING

Briefly describe the reason why this license is desired and the situation in which it will be used.

LICENSURE INFORMATION

List below **ALL STATES, COUNTRIES, OR PROVINCES** in which you **HAVE EVER BEEN OR ARE CURRENTLY** licensed as a medical doctor. Additional pages may be added if necessary.

STATE	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS

COMPETENCY INFORMATION

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

   a. The cognitive capacity to make appropriate clinical diagnoses and treatment decisions, exercise reasonable medical judgment, and keep abreast of medical education.

   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.

QUESTIONS:	**YES**	**NO**
1. 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.)*	____	____
2. 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?	____	____

If so, please list: _____

[If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individual assessment of the nature, the severity, and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure.]

COMPETENCY INFORMATION
CONTINUED

QUESTIONS: 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.	**YES**	**NO**
3. During the past two years, did you engage in any activity involving substances, either alcohol or controlled/illicit drugs, that has created or might create a challenging pathway for you in your current or future professional career if continued? If so and you answer "yes" to this question, the Board is prepared to offer an evaluation by the Tennessee Medical Foundation's Physicians Health Program to determine the best pathway to licensure for you as you begin or continue your career in the State of Tennessee. 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.	_____	_____
4. Are you currently participating in a Professional Health Program (PHP) or similar type program that provides monitoring and advocacy for you for a physical, mental health or substance use disorder which has caused you impairment?	_____	_____
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 to practice medicine 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?	_____	_____
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. Have you ever held a license or certificate in any health care profession that has ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	_____	_____
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).	_____	_____

APPLICANT: FILL OUT THE FOLLOWING AFFIDAVIT IN THE PRESENCE OF A NOTARY PUBLIC

AFFIDAVIT AND RELEASE

I, _____, M.D., of _____
(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, which were enclosed in the application packet, 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 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.

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**

Sworn to before me this ____ day of _____, _____.

_____
NOTARY PUBLIC Affix Seal Here

My Commission expires:

State of Tennessee
Department of Health
Health Related Boards
665 Mainstream Drive
Nashville, TN 37243

BOARD OF MEDICAL EXAMINERS

LOCUM TENENS

NOTIFICATION OF PRACTICE SETTING

Next Practice Setting Dates _____

Next Practice Setting Location _____

_____

_____

Please describe the reason for this practice:
(If the reason is to substitute or provide coverage, include the doctor's name and specialty)

_____

_____

_____

_____

_____

Name _____ **Date** _____

Signature _____ **License # M.D.L.T.** _____

State of Tennessee
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TENNESSEE BOARD OF MEDICAL EXAMINERS

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CLEARANCE FROM OTHER STATE LICENSURE BOARDS

APPLICANT: Please provide the information requested in the top box and then mail one (1) form to the licensure board in EACH state where you hold OR HAVE EVER HELD a license to practice any profession. (Copies of this form can be used.) **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 (37228 for overnight or special courier services)

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? ____ ____ If yes, an explanation must be attached.
yes no

_____ _____ _____
Authorized Signature Title Date

ATTACHMENT 2

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

DECLARATION OF CITIZENSHIP
MUST ACCOMPANY ALL APPLICATIONS FOR INITIAL LICENSURE OR REINSTATEMENT OF LICENSURE

The "SAVE Act" requires Tennessee Department of Health (including all Boards, Commissions, and contractors), along with every local health department in the State, to verify that *every adult* applicant for a professional license is either a U.S. citizen, a "qualified alien," or a nonimmigrant who meets the requirements set out at 8 U.S.C. 1621.

I am a(n) _____ _____.
Healthcare Profession (Please Print) **License number if applicable**

Please Print Legibly

1. Name:_____
   Last First Middle Maiden_
2. Mailing Address: _____
_
3. Phone Number: Home: (____)_____-_____ Office: (____)_____-_____ Fax: (____)___-_____
4. I am a United States Citizen: ____Yes ____No
5. I am a foreign national not physically present in the United States _____Yes _____No. If you answered yes, to this question please sign this form in the presence of a notary and return it with your application. No further documentation is required.
6. Applicants Claiming United States Citizenship **MUST** provide one of the following:

   a) Tennessee Driver's License, or photo ID issued by Department of Safety.
   b) A valid driver license or ID issued by another state, provided its issuance requirements meet Department of Safety criteria.
   c) An official birth certificate issued by a U.S. state, territory, or other jurisdiction. Puerto Rican birth certificates issued before July 1, 2010 do not count.
   d) A federally issued birth certificate.
   e) A valid, unexpired U.S. passport.
   f) A report of birth abroad of a U.S. citizen.
   g) A certificate of citizenship.
   h) A certificate of naturalization.
   i) A U.S. citizen ID card.
   j) Any successor document to #'s a-i above.
   k) SSN that the entity or local health department may verify with the Social Security Administration in accordance with federal law.

7. If you checked "No" in question 4 please indicate from the list below which category applies to you: (circle one)

   a) Permanent Residents

b) A nonimmigrant applicant for a professional or commercial license whose visa for entry into the United States is related to such employment, or a nonimmigrant under the Immigration and Nationality Act (8 U.S.C. 1101 *et seq.*).
c) Asylees who meet the qualifications set out in 8 U.S.C. 1158
d) Refugees who meet the qualifications set out in 8 U.S.C. 1157
e) Persons who have been "paroled into the United States," under 8 U.S.C. 1182(d)(5) or whose deportation has been withheld under 8 U.S.C. 1253.
f) Cuban or Haitian entrants as defined by section 501(e) of the Refugee Education Assistance Act of 1980
g) Persons granted conditional entry into the U.S. under 8 U.S.C. 1153(a)(7) before April 1, 1980, because of persecution or fear of persecution on account of race, religion, or political opinion or because of being uprooted by catastrophic national calamity.
h) An alien who has been "battered" or subjected to "extreme cruelty" by a parent or spouse as defined by 8 U.S.C. 1641(c), and also meets the qualifications set out 8 U.S.C. 1641(c)(1)(B). Under the circumstances set out in 8 U.S.C. 1641(c)(2) and (3), victims' children, or the parents of children who are victims, may also apply for benefits as qualified aliens.

Applicants claiming **qualified alien status** (question 7 above), please submit two of the following forms of "documentation of identity and immigration status" as determined by U.S. Homeland Security to be acceptable for verification through the SAVE program. Common types of documents used to verify immigration status are listed below. (Note: If you can provide only one document, your status will be verified through the U.S. Department of Homeland Security's SAVE program):

I-327 (Reentry Permit)

I-551 (Permanent Resident Card or "Green Card")

I-571 (Refugee Travel Document)

I-766 (Employment Authorization Card)

Machine Readable Immigrant Visa (with Temporary I-551 language)

Temporary I-551 stamp (on passport or I-94)

I-94 (Arrival/Departure record)

Unexpired foreign passport

WT/WB Admission Stamp in unexpired foreign passport

I-20 (Certificate of Eligibility for Nonimmigrant F(1) student status– "student visa")

DS2019 (Certificate of Eligibility for Exchange Visitor (J-1) Status)

I affirm under the penalty of perjury that the above is true and correct.

Signed this _____ day of _____, 20__.

_____
Signature

Sworn to before me this _____day of _____, 20__.

_____ AFFIX SEAL HERE
NOTARY PUBLIC

My Commission Expires:_____

If an applicant is discovered to be an unqualified alien, or otherwise ineligible for benefits under the Act, all recurring benefits provided to that applicant must be immediately terminated. Anyone who purposefully makes a false, fictitious, or fraudulent claim of U.S. citizenship or qualified alien status will be liable under the Tennessee Medicaid False Claims Act, or Tennessee's False Claims Act. Any person who conspires to defraud the state or any local health department by securing a false claim allowed or paid to another person in violation of the Act may be liable under Tennessee's False Claims Act. Upon discovery of an applicant's false, fictitious, or fraudulent claim of U.S. citizenship, state governmental entities and local health departments must also file a criminal complaint with the United States Attorney.