

06-001	\$500
06-006	\$ 5
TOTAL	\$505



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

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

**APPLICATION FOR A SINGLE PURPOSE LICENSE AS A MEDICAL DOCTOR**

Applicant: Provide the information required in the personal and competency information portions of this application, sign, and have the affidavit notarized and then submit the entire application to the sponsoring hospital and/or physician for completion of the sponsorship portion and submission to the Board. A profile questionnaire must also be completed and submitted to the Board before licensure is awarded. Effective June 1, 2006 applicants for initial licensure in Tennessee must obtain a criminal background check. For instructions to obtain a criminal background check, go to <http://tn.gov/health/article/CBC-instructions>. 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.

**ATTACH TO THIS APPLICATION a check or money order for \$505, payable to the Tennessee Board of Medical Examiners.**

**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: (\_\_\_\_) \_\_\_\_\_ Medical School \_\_\_\_\_ Year Graduated \_\_\_\_\_

Email address: \_\_\_\_\_

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

## 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? <i>(You may answer no if you are being appropriately treated and are not impaired.)</i> | _____ | _____ |
| 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).   | _____ | _____ |

**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, 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 \_\_\_\_\_, \_\_\_\_\_.

Affix Seal Here

\_\_\_\_\_  
**NOTARY PUBLIC**

My Commission expires: \_\_\_\_\_

## SPONSORSHIP INFORMATION

I, the undersigned am submitting this application for \_\_\_\_\_ to  
*(Applicant's Full Name )*

practice medicine in Tennessee with a single purpose license.

**I am enclosing the following documents with this application:**

1. Verification that the applicant has a license in good standing in another state or country. That verification must have been received by you directly from the applicable state or country and not the applicant.
2. A letter from the sponsoring hospital and/or physician stating that the applicant is engaged in advanced study in a particular field of medicine or is demonstrating a new medical technique to medical professionals in Tennessee.
3. Verification of the applicant's credentials from the appropriate United States specialty organization, or the American Medical Association, or a similar organization acceptable to the Tennessee Board of Medical Examiners.
4. **A check or money order for \$405, payable to the Tennessee Board of Medical Examiners.**

Name and Address of Sponsoring Hospital:

---

---

---

---

Name, Title and Address of Sponsoring Physician:

*(Please type or Print)*

---

---

---

---

Sponsoring Physician's License Number:

---

\_\_\_\_\_  
**Sponsoring Physician's Signature**

\_\_\_\_\_  
**Date**

Submit this form and all necessary documentation to :

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

**THIS LICENSE IS VALID FOR A PERIOD OF NO MORE THAN ONE (1) YEAR AND IS NOT RENEWABLE**



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\_\_.

\_\_\_\_\_  
NOTARY PUBLIC

AFFIX SEAL HERE

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.**