



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

**TENNESSEE BOARD OF MEDICAL EXAMINERS,
BOARD OF OSTEOPATHIC PHYSICIANS AND COMMITTEE ON PHYSICIAN ASSISTANTS
(800) 778-4123, ext. 532-4384 or (615) 532-3202, ext. 532-4384**

APPLICATION INSTRUCTIONS FOR SPECIAL VOLUNTEER 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 Special Volunteer License.

Information Required for Tennessee Licensees

- | | Done |
|--|-------------|
| 1. Complete, have notarized, and mail the application pages 1 through 5. | _____ |
| 2. Complete and mail attachment 1 to each state, country, or province in which you hold or have ever held a license to practice any profession. | _____ |
| 3. Request the site of the free health clinic in which you intend to practice submit directly to this office a letter informing us of the clinic's location you will be working and a notarized copy of the IRS ruling that provides proof of the clinic's private, not-for-profit status. | _____ |
| 4. Complete and mail the Mandatory Practitioner Profile Questionnaire. | _____ |
| 5. Declaration of Citizenship Form (Attachment 2) | _____ |

Information Required for Non-Tennessee Licensees

- | | |
|--|-------|
| 1. Complete items 1, 2, 3, 4 and 5 above. | _____ |
| 2. Submit a clear and recognizable, recently taken, bust photograph which shows the full head, face forward from at least the top of the shoulders up. | _____ |
| 3. Provide two (2) letters attesting to the applicant's character, from medical professionals on the signator's letterhead. The letters must be original and dated within the last year. | _____ |
| 4. Provide proof of citizenship or evidence of being legally entitled to live and work in the United States. Such evidence may include notarized copies of birth certificates, naturalization papers or current Visa status. | _____ |

UNDERSTANDING THE APPLICATION PROCESS

1. All documents 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)**

2. **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.
3. 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 by certified mail. 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.)**
4. 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.
5. **If an address change occurs at any time during the application process, you must notify the Board office, in writing, immediately.**

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



STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 Mainstream Drive
Nashville, Tennessee 37243

APPLICATION FOR SPECIAL VOLUNTEER LICENSE

READ INSTRUCTIONS PRIOR TO COMPLETING APPLICATION. APPLICANTS MUST COMPLY WITH ALL INSTRUCTIONS. FILL IN ALL BLANKS; IF NOT APPLICABLE, STATE N/A

PERSONAL INFORMATION

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

Special Volunteer Type. You must check one:

Medical Doctor
 Osteopathic Physician
 Physician Assistant

Have you been known by any other name? Yes _____ No _____ If yes, list names: _____

Date of Birth: Mo. _____ Day _____ Yr. _____ Place of Birth _____
(City) (State or Country)

Social Security Number: _____ - _____ - _____ U.S. Citizen: Yes _____ No _____
Sex: Male _____ Female _____

Entitled to Live and Work in U.S.: Yes No

Email address: _____

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

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

_____ Work Phone: (_____) _____ - _____

Type of intended primary specialty practice in Tennessee, if applicable _____

Name and address of not-for-profit organization.

COMPETENCY INFORMATION

PLEASE ANSWER THE FOLLOWING QUESTIONS. If any answers to the questions in this part are in the affirmative, attach an explanation on a separate sheet. ***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.***

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

1. **"Ability to practice medicine"** is to be construed to include all of the following:
 - a. The cognitive capacity to make appropriate clinical diagnosis, 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 medical tasks such as physical examination and surgical procedures, 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 or disorders, such as, but not limited to; orthopedic, visual, speech and/or hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV, tuberculosis, drug addiction, and alcoholism.
3. **"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.
4. **"Currently"** does not mean on the day of or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee or within the past two (2) years.
5. **"Illegal use of controlled substances"** means the use of controlled 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 a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? | ___ | ___ |
| a. | If yes, are they reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? | ___ | ___ |
| b. | If you have any limitations or impairments caused by an existing medical condition, are they reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? | ___ | ___ |

[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:	YES	NO
2. Do you currently use chemical substances? If yes, do they in any way impair or limit your ability to practice medicine with reasonable skill and safety?	_____	_____
3. Are you currently engaged in the illegal use of controlled substances? If yes, are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you in order to assure that you are not engaged in the illegal use of controlled substances?	_____	_____
4. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, or voyeurism?	_____	_____
5. If you have ever held or applied for a license or certificate to practice medicine in any state, country, or province, has or was it ever been denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	_____	_____
6. If you have ever had staff privileges at any hospital or health care facility have they ever been revoked, suspended, curtailed, restricted, limited, otherwise disciplined, or voluntarily surrendered under threat of restriction or disciplinary action?	_____	_____
7. Have you ever applied for and been denied a state or federal controlled substance certificate? If you have possessed such a certificate has it ever been revoked, suspended, restricted, otherwise disciplined, or voluntarily surrendered under threat of investigation or disciplinary action?	_____	_____
8. Have you ever been convicted of a felony or a misdemeanor other than a minor traffic offense?	_____	_____
9. Have you ever been rejected or censured by a medical society?	_____	_____
10. In relation to the performance of your professional services in any profession:		
a. Have you ever had a final judgment rendered <u>against</u> you;	_____	_____
b. Have you ever had settlement of any legal action rendered <u>against</u> you; or	_____	_____
c. Are there any legal actions pending <u>against</u> you or to which you are a party?	_____	_____
11. If you have ever held a license or certificate in any health care profession, has it ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	_____	_____

***Affirmative response requires final documents or orders from the issuing states, courts, and/or agencies.**

LICENSURE INFORMATION

List below and submit a copy of attachment #1 to **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
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List below **ALL** state, countries, or provinces in which you hold or have ever held a license as a health professional other than a Medical Doctor. Submit a copy of attachment #3 to all such state, country, or province regarding such licensure. Additional pages may be added if necessary.

STATE	PROFESSION	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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

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 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.

I, _____ hereby certify that I will limit my practice of medicine exclusively to the patients receiving service from _____ which is a not-for-profit organization and that such practice is without compensation.

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, 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 _____ <i>(Name of Applicant)</i> <i>(Profession)</i> with license number _____ on _____ in the State of _____ <i>(Date)</i>
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: <p style="text-align: center;">State of Tennessee Board of Medical Examiners 665 Mainstream Drive Nashville, TN 37243</p>
Date: _____ <div style="text-align: right; margin-top: 10px;"> _____ Applicant's Signature _____ Applicant's typed or printed name </div>

ADMINISTRATIVE OFFICE OF STATE LICENSURE BOARD, PLEASE COMPLETE:		
Name In Full As It Appears On License _____		
License Number _____	Profession _____	Date Issued _____
Basis of issuance: (Check One)	<input type="checkbox"/> Endorsement/Reciprocity with _____ <i>(State)</i>	
	<input type="checkbox"/> Written Examination _____ <i>(Name of Exam)</i>	
The License is currently active and registered? Yes <input type="checkbox"/> No <input type="checkbox"/> Is there any derogatory information on file? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, an explanation must be attached.		
_____	_____	_____
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__.

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.

