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

TENNESSEE BOARD OF MEDICAL EXAMINERS

APPLICATION INSTRUCTIONS FOR A TEMPORARY LICENSE

Provided below is a checklist for your personal use and convenience containing the items that are required to 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. You must provide a complete history in the training and employment sections of the application from the time of graduation from medical school until the present day. _____

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 along with your application the *Practitioner Profile Questionnaire* which is online at https://www.tn.gov/content/dam/tn/health/healthprofboards/PH-3585.pdf. You are required by law to 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. _____

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 are not included in your FCVS Information Profile, they must be submitted to the Board directly from the source: _____
   - Medical school transcript
   - ECFMG Status of Certification Report
   - USMLE exam transcript
   - Verification of one (1) year ACGME accredited postgraduate training.

   For information regarding the FCVS Information Profile, please visit the Federation of State Medical Boards website.

8. If applicable, complete the top section of Attachment 1, Verification of Postgraduate Medical Training, and send to each institution in which you received any postgraduate medical training (internship, residency, fellowship) in another country or that was not included in the FCVS Profile. Once completed the program should submit the completed form directly to the Board. _____

9. Complete the top section of Attachment 2, Verification of Competency for Independent Practice, and send it to three (3) supervising physicians from your training program. One (1) must be the Program Director. Once completed the program should submit the completed form(s) directly to the Board. **This form will not be accepted if it is not completed in its entirety or if it is completed prior to a full twelve (12) months of training.** _____

10. Submit Attachment 3, Temporary License Applicant Attestation. This form must be notarized. _____

11. Submit a check or money order in U.S. funds in the amount of $715, made payable to the Tennessee Board of Medical Examiners. Be sure the check includes your name and your profession (MD). _____

ATTACHMENT 1

TENNESSEE BOARD OF MEDICAL EXAMINERS
Verification of Postgraduate Medical Education

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

_____**Internship**
_____**Residency**
_____**Fellowship**
_____**Research**

Specialty/Subspecialty:

_____

Successfully Completed? _____**Yes** _____**No*** _____**In Progress**
***If no, how many months of credit was received? _____

From:_____/_____/_____ **To:**_____/_____/_____ **(I**n progress, provide expected completion date.)

Please attach an explanation for any "yes" response

Accredited By: _____ACGME _____ACGME-I _____AOA _____RCSPC _____None of These

_____Yes	_____No	Did this individual take a leave of absence or break during training?
_____Yes	_____No	Did this individual resign from training?
_____Yes	_____No	Was this individual ever placed on probation for any reason?
_____Yes	_____No	Did this individual receive a written warning or documented counseling about their behavior?
_____Yes	_____No	Was this individual ever disciplined or placed under investigation?
_____Yes	_____No	Were this individual's privileges or duties ever reduced, suspended, or revoked?
_____Yes	_____No	Did this individual experience delayed promotion or advancement to the next level?
_____Yes	_____No	Was this individual informed that their contract would not be renewed?
_____Yes	_____No	Was this individual suspended, terminated, or dismissed from training?
_____Yes	_____No	Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems, or any other reason?

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

_____ _____
Program Director's/Dean's Signature Date

Subscribed and sworn before me this the ____ day of _____, _____.

_____
Notary Public (Affix Seal Here)

My Commission Expires: _____

ATTACHMENT 2

TENNESSEE BOARD OF MEDICAL EXAMINERS
Verification of Competency for Independent Practice

APPLICANT: Provide the information requested in the top box and send this form to three (3) physicians who supervised you during training. One (1) must be your Program Director.

Applicant: 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 PROGRAM DIRECTOR/SUPERVISING PHYSICIAN

Name:_____

I am the _____Program Director _____Supervising Physician

Which rotation did you supervise?_____

Dates of rotation _____/_____/_____ to _____/_____/_____

Are you aware of any adverse action taken during training? _____YES _____NO

Do you believe this individual is ready to independently practice medicine? _____YES _____NO

Please provide an explanation to support your answer. (An explanation is required for this form to be accepted) _____

_____

_____

_____

_____

_____

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

_____ _____
Program Director's/Supervising Physician's Signature Date

ATTACHMENT 3

TENNESSEE BOARD OF MEDICAL EXAMINERS
Temporary License Applicant Attestation

ATTESTATION

I, _____, attest to the truth of each statement below. I further consent to the
(*Applicant's Name)*

use of official verification from other countries, to include but not be limited to, licensure verification and criminal background checks if such forms of official verification are available.

Please initial each statement below and sign the form in the presence of a notary.

I HEREBY ATTEST:

_____I have no criminal history in any country.

_____Any license I hold in any country or province is in good standing and has never been disciplined.

_____I have no open or pending investigations.

_____There were no adverse actions taken against me in medical school.

_____There were no adverse actions taken against me during any postgraduate training.

_____There were no adverse actions taken against me during any healthcare employment.

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

_____ _____
Applicant's Signature Date

Subscribed and sworn before me this the ____ day of _____, _____.

_____ (Affix Seal Here)
Notary Public

My Commission Expires: _____