TENNESSEE BOARD OF OSTEOPATHIC EXAMINATION
665 Mainstream Drive
Nashville, TN 37243
(800) 778-4123, ext. 532-4384 Or (615) 532-3202, ext. 532-4384
www.tn.gov/health

APPLICATION FOR A SPECIAL TRAINING LICENSE AS AN OSTEOPATHIC PHYSICIAN

APPLICANT: Provide the information required in the Personal and Competency Information portions of this application, sign, have the affidavit notarized, and then submit the entire application to the appropriate training program personnel. The sponsoring institution must submit this application simultaneously with all required documentation. It is vitally important that you provide the required documentation to the program personnel as early as possible. 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. A criminal background check is required. For instructions to obtain a criminal background check, go to http://tn.gov/health/article/CBC-instructions. A Declaration of Citizenship must be completed before licensure can be awarded.

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

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

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

Are you a U.S. Citizen? Y N Are you entitled to Live and Work in the 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 Home Mailing Address: _____
_____
_____

Home Phone: (_____) _____ - _____

Residency or Fellowship Institution's Address: _____
_____
_____

Work Phone: (_____) _____ - _____

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 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 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 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 directions, 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 which 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 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 failed a medical licensure examination?	____	____
8. 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?	____	____
9. Have you ever been convicted of a felony or a misdemeanor other than a minor traffic offense?	____	____
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 <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?	____	____
	____	____
12. 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?	____	____

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

AFFIDAVIT AND RELEASE

I, _____, D.O., of _____
(Applicant's Name) *(City)* *(State)*
being duly sworn and identified as the person referred to in this application, attest 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 that 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 that 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

THIS PORTION OF THE APPLICATION MUST BE COMPLETED BY THE DEAN OR PROGRAM DIRECTOR RESPONSIBLE FOR THE TRAINING PROGRAM

I, the undersigned, am submitting an application on behalf of _____
(Applicant's Name)

to practice medicine in Tennessee with a special training license. **I am enclosing the following documents concerning this applicant with this application:**

1. An original medical school transcript sent directly from the applicant's medical school to me. (Note: the school's curriculum must be A.O.A. approved. The transcript must show that the degree was conferred and it must bear the institution's official seal.)

2. A clear and recognizable, recently taken photograph of the applicant that shows the full head, face forward from at least the top of the shoulders up.

3. Two (2) original letters from medical professionals on the signatory's letterhead attesting to the applicant's good moral character.

4. Proof of the applicant's United States or Canadian citizenship or evidence of being legally entitled to live and work in the United States or evidence of citizenship and residency in a N.A.F.T.A participating country. (Notarized copies of birth certificates, naturalization papers, current H-1 visa status, or voter registration are acceptable.)

5. A check or money order in the amount of Sixty Dollars ($60), payable to the Tennessee Board of Osteopathic Examination.

Tennessee licensed physician(s) who will have primary supervisory responsibility for the applicant:

Name and License Number: _____

Name and License Number: _____

Sponsoring Medical School: _____

_____

_____

_____

DEAN'S OR PROGRAM DIRECTOR'S NAME AND TITLE:

_____
(Please type or print)

SIGNATURE _____ DATE _____

Please mail to:

Board of Osteopathic Examination
665 Mainstream Drive
Nashville, TN 37243

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.