



STATE OF TENNESSEE
 DEPARTMENT OF HEALTH
 HEALTH RELATED BOARDS
 665 MAINSTREAM DRIVE
 NASHVILLE, TENNESSEE 37243
www.tn.gov/health

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

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. All applicants must complete, sign and have notarized the Declaration of Citizenship form and submit the documents required by the Declaration of Citizenship form, The Declaration of Citizenship is available online at <https://www.tn.gov/content/dam/tn/health/healthprofboards/PH-41833.pdf>.

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? <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 <u>requires</u> final documents or orders from the issuing states, courts, and/or agencies. | YES | NO |
|---|-------|-------|
| <p>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.</p> <p style="margin-left: 20px;">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.</p> | _____ | _____ |
| <p>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?</p> | _____ | _____ |
| <p>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.</p> | _____ | _____ |
| <p>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?</p> | _____ | _____ |
| <p>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?</p> | _____ | _____ |
| <p>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?</p> | _____ | _____ |
| <p>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?</p> | _____ | _____ |
| <p>10. Have you ever been rejected or censured by a medical society?</p> | _____ | _____ |
| <p>11. In relation to the performance of your professional services in any profession:</p> | | |
| <p style="margin-left: 20px;">a. Have you ever had a final judgment rendered against you;</p> | _____ | _____ |
| <p style="margin-left: 20px;">b. Have you ever entered into any settlement of any legal action; or</p> | _____ | _____ |
| <p style="margin-left: 20px;">c. Are there any legal actions pending against you or to which you are a party?</p> | _____ | _____ |
| <p>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?</p> | _____ | _____ |
| <p>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).</p> | _____ | _____ |

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

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

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

Authorized Signature Title Date

ATTACHMENT 2