



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

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

APPLICATION INSTRUCTIONS FOR

ST. JUDE CHILDREN'S RESEARCH HOSPITAL GLOBAL COLLABORATION 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 St. Jude Children's Research Hospital Global Collaboration License.

ALL APPLICATION FEES ARE NON-REFUNDABLE.

- | | Done |
|--|-------|
| 1. Complete and mail the application pages 1 through 6. | _____ |
| 2. Complete and mail attachment 1 to your medical school for transcript of courses, grades, and degree. If you are an International Medical School graduate you must also ask that your medical school provide to this office documentation proving that they meet or exceed the accreditation requirements of the LCME (Liaison Committee on Medical Education). Documentation must be submitted in English. | _____ |
| 3. Complete and mail attachment 2 to each state, country, or province in which you hold or have ever held a license to practice any profession. | _____ |
| 4. Submit a clear and recognizable recently taken bust photograph of yourself that shows the full head, face forward from at least the shoulders up. | _____ |
| 5. Submit proof of the citizenship in the United States or Canada or evidence of being legally entitled to live and work in the United States. (Notarized copies of birth certificates, naturalization papers, H-1 visas, or current passports are acceptable). License will not be issued to holders of J-1 Training Visa. Visa must allow one to hold employment in the United States. | _____ |
| 6. Submit two (2) original letters of recommendation from licensed medical doctors on the signatory's letterhead attesting to your good moral character. The letters must contain original signatures. | _____ |
| 7. You must have successfully completed a medical licensure examination or an approved combination of examinations. If you are submitting USMLE scores, all three steps must be taken and passed within seven years . Please refer to attachment 3 for information in obtaining scores. | _____ |
| 8. If you are an international medical school graduate, you must submit one of the following: | |
| a. A notarized copy of your original permanent E.C.F.M.G. Certificate; | _____ |
| b. If you graduated from a Mexican Medical School, a letter from the E.C.F.M.G. stating that all certificate requirements have been met; or | _____ |

- c. If you cannot obtain an original certificate due to the phase out of the E.C.F.M.G., proof of successful completion of U.S.M.L.E. Steps 1 and 2 submitted directly from the testing agency to the Board Administrative Office. _____
- 9. 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. _____
- 10. **Attach to the application and submit a check or money order in U.S. funds in the amount of \$510, payable to the Tennessee Board of Medical Examiners.** _____
- 11. **A criminal background check is required.** For instructions to obtain a criminal background check, go to <http://tn.gov/health/article/CBC-instructions> _____
- 12. 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>. _____

UNDERSTANDING THE APPLICATION PROCESS

- 1. **All application fees are non-refundable.**
- 2. All documents and fees 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)**
- 3. **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.
- 4. 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. 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.)**
- 5. 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.
- 6. **If an address change occurs at any time during the application process, you must notify the Board office, in writing, immediately.**
- 7. It is recommended that you do not make arrangements to accept employment as a physician at St. Jude Children’s Research Hospital until you are granted a license number by the Board of Medical Examiners.
- 8. You have the option to receive all correspondence from the Department of Health electronically. Should you “opt in,” you will no longer receive physical mail from this office. Opting in does not discharge your obligation to provide the Department with a current physical address and email address. You are required by statute and rule to notify the Department of an address change within thirty (30) days of any such change.
- 9. All documents which are provided to this office in conjunction with your request for a medical license becomes part of the public record and must be released pursuant to a public records request.

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



For Office Use Only

06-001 \$500

06-006 \$ 10

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TENNESSEE BOARD OF MEDICAL EXAMINERS
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APPLICATION FOR ST. JUDE CHILDREN'S RESEARCH HOSPITAL GLOBAL COLLABORATION
LICENSE

READ INSTRUCTIONS PRIOR TO COMPLETING APPLICATION. APPLICANTS MUST COMPLY WITH ALL INSTRUCTIONS.

Attach to this application a check or money order in the amount of \$510, payable in U.S. funds to the Tennessee Board of Medical Examiners.

PERSONAL INFORMATION

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

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

Date of Birth: Mo. ____ Day ____ Yr. ____ Social Security Number: ____ - ____ - ____

Are you a U.S. Citizen? Y N Gender: M F Race: _____

Are you entitled to Live and Work in 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 Mailing Address: _____ Home Phone: (____) ____ - ____

_____ Work Phone: (____) ____ - ____

Email address: _____

Do you wish to receive notification, including renewal notification, from the Department of Health via email? Y N
Please note, by opting in, all correspondence from the Department of Health will be delivered to the email address on file for you. You will no longer receive physical mail from our office.

Type of intended primary specialty practice in Tennessee _____

PRACTICE AND LICENSURE INFORMATION

YES NO

Are you or have you ever been licensed to practice medicine in another state? ___ ___

Are you or have you ever been licensed in any other profession in Tennessee or another state? ___ ___

List below all states, countries or provinces in which you have ever been or currently are licensed, permitted or certified. Submit a copy of **Attachment 1** to all such states, countries, or provinces regarding such licensure, certification or permit. Use the back of this page if you need additional space.

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

Do you have a DEA Registration? Y N

If yes, please provide:

Please complete your employment history starting with the most current position first. You may use a separate sheet of paper if you need additional space.

<u>DATES</u>		<u>LOCATION</u>		<u>POSITION AND DUTIES</u>
From: _____	To: _____	_____	_____	_____
MM/YY	MM/YY	(City)	(State)	_____
From: _____	To: _____	_____	_____	_____
MM/YY	MM/YY	(City)	(State)	_____
From: _____	To: _____	_____	_____	_____
MM/YY	MM/YY	(City)	(State)	_____
From: _____	To: _____	_____	_____	_____
MM/YY	MM/YY	(City)	(State)	_____
From: _____	To: _____	_____	_____	_____
MM/YY	MM/YY	(City)	(State)	_____

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

- | | | |
|--|--------------|--------------|
| <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>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>_____</p> | <p>_____</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>_____</p> | <p>_____</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>_____</p> | <p>_____</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>_____</p> | <p>_____</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>_____</p> | <p>_____</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>_____</p> | <p>_____</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>_____</p> | <p>_____</p> |
| <p>10. Have you ever been rejected or censured by a medical society?</p> | <p>_____</p> | <p>_____</p> |
| <p>11. In relation to the performance of your professional services in any profession:</p> | | |
| <p>a. Have you ever had a final judgment rendered against you;</p> | <p>_____</p> | <p>_____</p> |
| <p>b. Have you ever entered into any settlement of any legal action; or</p> | <p>_____</p> | <p>_____</p> |
| <p>c. Are there any legal actions pending against you or to which you are a party?</p> | <p>_____</p> | <p>_____</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>_____</p> | <p>_____</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> | <p>_____</p> | <p>_____</p> |

ATTACHMENT 1



**STATE OF TENNESSEE
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APPLICANT: Supply the information requested in this box and then mail this entire form to your medical school.

Full Name:	_____	_____	_____
	(Last)	(First)	(Middle/Maiden)
Address:	_____	Social Security Number:	_____ - _____ - _____

Student Identification Number:	_____		
Year of Graduation:	_____		
Degree Obtained:	_____		

TO WHOM IT MAY CONCERN:

I am applying for a St. Jude Children's Research Hospital Global Collaboration License in the State of Tennessee.

Please forward an original graduate transcript of courses, grades, and degree bearing the institution's official seal to:

**State of Tennessee
Board of Medical Examiners
665 Mainstream Drive
Nashville, TN 37243 (37228 for courier service only)**

Thank you for your cooperation and prompt response.

Applicant's Signature

Date

ATTACHMENT 2



STATE OF TENNESSEE
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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 _____
 _____ (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**

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 3



**Tennessee Requires Medical Examination
Scores be Sent Directly to the
Tennessee Board of Medical Examiners**

In order to have medical examination scores reported to the Tennessee Board please read the following:

For FLEX, SPEX and USMLE scores contact the Federation of State Medical Boards to obtain a score reporting form at:

Federation of State Medical Boards of the U.S., Inc.
Federation Place
Suite 300
400 Fuller Wiser Road
Eules, TX 76039-3855
(800) 876-5396

or download the form from the web site at:

<http://www.fsmb.org>

For NBME Parts I, II, and III or any **COMBINATION** OF NBME Parts, the request form is now available on the NBME web site at:

<http://www.nbme.org/programs/nbmecert.asp>

National Board of Medical Examiners
P.O. Box 48014
Newark, NJ 07101-4814

For NBME Parts I, II, and III administered by ECFMG or for information concerning FMGEMS contact:

Educational Commission for Foreign Medical Graduates
3624 Market Street
Philadelphia, PA 19104
Phone (215) 386-5900



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APPLICANT: USE THIS FORM ONLY IF YOU HAVE TAKEN A STATE EXAM PRIOR TO DECEMBER 1972. IF YOU HAVE, COMPLETE THE INFORMATION IN THE BOX AND THEN SEND IT TO THE STATE BOARD FOR WHICH YOU TOOK THE EXAMINATION:

Full Name:	_____		_____
	(Last)	(First)	(Middle/Maiden)
Social Security Number:	_____ - _____ - _____	State License Number:	_____

CERTIFICATE OF SECRETARY OF STATE BOARD ISSUING ORIGINAL LICENSE

I, _____, Secretary of the _____
(State)

Board of Medical Examiners, certify that _____ of
(Applicant's Name)
_____ was granted License/Certificate number _____
(City & State)

to practice Medicine in this State on the ____ day of _____, _____. I further certify that the
aforesaid in the written examination before this Board, which was administered on _____,
(Date)

obtained a general average of _____ percent and the following percentages on each subject:

Subject	Percent	Subject	Percent
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Acting on behalf of the _____ Board of Medical Examiners, I hereby
(State)

certify that the Applicant successfully completed the state licensure examination.

Seal of the Board _____ Date: _____
Board Secretary's Signature

Please return to: **State of Tennessee
Board of Medical Examiners
665 Mainstream Drive
Nashville, TN 37243**