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

APPLICATION INSTRUCTIONS FOR REGISTRATION AS A SURGICAL ASSISTANT

Provided below is a checklist for your personal use and convenience containing all items that must be completed before your application for a Tennessee Surgical Assistant registration will be considered.

ALL APPLICATION FEES ARE NON-REFUNDABLE

1. Complete and mail application pages 1 through 6. Do not leave any questions or prompts blank. _____

2. If you are seeking registration pursuant to the certification pathway, you will need to provide proof of certification. _____

3. If you are seeking registration pursuant to the training pathway, please complete the top portion of **Attachment 1** and submit the form to your training program's administrative office for further completion. This document should be submitted directly to the Board's administrative office from your training program's administrative office. _____

4. Complete and mail **Attachment 2** to each state, country, or province in which you hold or have ever held a license to practice any medical profession. _____

5. Attach to the application and submit a check or money order is U.S. funds in the amount of $60.00, payable to the State of Tennessee ($50 application fee plus $10.00 State Regulatory Fee) _____

6. Proof of United States citizenship or evidence of being legally entitled to live or work in the United States (e.g. copy of birth certificate, current passport or see Declaration of Citizenship for qualified alien status) _____

7. A criminal background check is required. For instructions to obtain a criminal background check, go to https://www.tn.gov/content/tn/health/health-professionals/criminal-background-check.html. _____

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. _____

Division of Health Licensure and Regulation · Office of Health Related Boards
665 Mainstream Drive ·Nashville, TN 37234 · tn.gov/health

UNDERSTANDING THE APPLICATION PROCESS

1. **All application fees are non-refundable. Accordingly, please familiarize yourself with the laws, rules and requirements for licensure prior to submitting your application.**

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's Administrative Office 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 may be closed.)**

6. If an address change occurs at any time during the application process, you must notify the Board office, in writing, immediately.

7. 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.

8. All documents which are provided to this office in conjunction with your application to register as a surgical assistant 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 process your application in an efficient manner.

Office Use Only
1640-001 - $50.00
1640-006 - $10.00
Total - $60.00

BOARD OF MEDICAL EXAMINERS
(800) 778-4123, ext. 532-4384 or Local (615) 532-3202, ext. 532-4383

APPLICATION FOR REGISTRATION AS A SURGICAL ASSISTANT

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

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.)

Current 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.

QUALIFICATIONS FOR REGISTRATION

In order to qualify for registration, you must qualify under one of the following pathways (certification, training or experience):

CERTIFICATION PATHWAY

I am currently certified by the:

☐ National Surgical Assistant Association Certification No.: _____

☐ National Board of Surgical Technology and Surgical Assisting Certification No.: _____

☐ National Commission for Certification of Surgical Assistants Certification No.: _____

TRAINING PATHWAY

☐ I successfully completed a surgical assistant training program as a member of a branch of the armed forces of the United States.

If you make this selection, appropriate proof of your training must accompany this application.
(Appropriate proof includes transcripts or diplomas.)

_____ From: _____ To: _____
Name of Training Program MM/YY MM/YY

_____
Street Address

_____
City, State

PRACTICE AND LICENSURE INFORMATION

	YES	NO
Are you or have you ever been licensed, registered or certified to practice as a surgical assistant 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. Use the back of this page if you need additional space.

STATE	PROFESSION	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS

Intended practice location in Tennessee:

Name: _____

Address: _____

_____

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.

DATES	LOCATION	POSITION AND DUTIES
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, 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 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 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.

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: Please respond to ALL questions. If you answer "YES" to any question, please attach a written explanation.	**YES**	**NO**
1. Do you currently have any physical or psychological limitations or impairments caused by an existing medical condition which are reduced or ameliorated by ongoing treatment or monitoring, or the field of practice, the setting or the manner in which you have chosen to practice?	____	____
2. Do you currently use any chemical substances which in any way impair or limit your ability to practice medicine with reasonable skill and safety?	____	____

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

		YES	NO
3.	At any time within the past two years, have you engaged in the illegal use of illicit or controlled substances?	_____	_____
4.	Are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you to assure that you do not consume alcohol and/or do not engage in the illegal use of illicit or controlled substances?	_____	_____
5.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or other diagnosis of a predatory nature?	_____	_____
6.	Have you ever held or applied for a license or certificate to practice as a surgical assistant 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?	_____	_____
7.	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?	_____	_____
8.	In relation to the performance of your professional services in any profession:		
	a. Have you ever had a final judgment rendered against you;	_____	_____
	b. Have you ever entered into any settlement of any legal action; or	_____	_____
	c. Are there any legal actions pending against you or to which you are a party?	_____	_____
9.	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?	_____	_____
10.	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).	_____	_____

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

AFFIDAVIT AND RELEASE

I, _____, of _____
(*Applicant's Name) – Please Print* *(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 laws governing the practice of my profession, which are posted on the Board's website at http://tn.gov/health/article/ME-statutes, and agree to abide by them in my practice as a surgical assistant 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 my profession.

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/or 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/or other qualifications for licensure.

ACKNOWLEDGE that I, as an applicant for licensure, have the burden of producing accurate and 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**

ATTACHMENT 1 - OPTIONAL (This form is only required if you are seeking registration pursuant to the training pathway)

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

VERIFICATION OF TRAINING COMPLETED DURING YOUR SERVICE AS A MEMBER OF A BRANCH OF THE U.S. ARMED FORCES

APPLICANT: Provide the information requested in the top box and then mail this form to each institution in which you received training. If additional forms are required, copy this one.

Institution Administration: I am applying for registration as a surgical assistant in Tennessee and hereby authorize you to release any and all information in your files concerning my training. I was in training at your institution as follows:

Applicant's name: _____
(Last) (First) (Middle/Maiden)

_____ From: _____ To: _____
Name of Training Program

_____
Street Address

_____
City, State

Applicant's Signature_____

THIS PORTION IS TO BE COMPLETED BY THE TRAINING PROGRAM'S ADMINISTRATIVE OFFICE

Please complete (including questions) and return to:

State of Tennessee
Board of Medical Examiners
665 Mainstream Drive
Nashville, TN 37243

CIRCLE ONE

Is your training program sponsored, organized or administered by a branch of the armed forces of the United States? Yes No

Were there any adverse actions taken against the applicant during the training? Yes No
If yes, please attach supporting information and/or documentation.

Would you recommend the applicant for licensure? Yes No

The applicant attended the program from _____ to _____. I certify that the information on this form is true and correct.
(MM/YY) (MM/YY)

_____
_

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 (OPTIONAL: This form is only required if you currently or have ever held a license to practice a medical profession in another state)

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

VERIFICATION OF OTHER STATE LICENSE/CERTIFICATE/REGISTRATION

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 medical profession. (You may copy this form.) **NOTE:** Some states require a fee to process verification of licensure information.

I, the undersigned applicant, was granted a **(circle one)** license/certificate/registration to practice _____
(Profession)

numbered _____ 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 the Tennessee Board of Medical Examiners.

_____
Applicant's Signature

Date: _____

_____
Applicant's typed or printed name

To Be Completed By Administrative Office of State Licensure Board

Name In Full As it Appears On License/Certificate/Registration:

_____
(First) (M.I.) (Last)

License/Certificate/Permit Number: _____ Profession: _____

Is the license currently active and registered? Yes ____ No ____
Is there any derogatory information on file? Yes ____ No ____
(If yes, please attach supporting documents)

_____ _____ _____
Authorized Signature Title Date

Please mail directly to: Board of Medical Examiners' Surgical Assistants Registry
665 Mainstream Drive
Nashville, TN 37243