

APA-2
6/93

**ALABAMA STATE BOARD
OF MEDICAL EXAMINERS**

NOTICE OF INTENDED ACTION

AGENCY NAME: Alabama State Board of Medical Examiners

RULE NO. & TITLE: 540-X-3, Certificate of Qualification, Appendix B, Application for Certificate to Practice Medicine through Examination


INTENDED ACTION: To amend the rule.

SUBSTANCE OF PROPOSED ACTION: To add a statement concerning the statutory authority for requesting, requirement for requesting, uses of and consequences of not supplying an applicant's social security number.

TIME, PLACE, MANNER OF PRESENTING VIEWS: All interested persons may submit data, views, or arguments concerning the proposed new rule(s) and regulation(s) in writing to: Patricia E. Shaner, General Counsel, Alabama State Board of Medical Examiners, Post Office Box 946, Montgomery, Alabama 36101-0946, by mail or in person between the hours of 8:30 a.m. and 4:30 p.m., Monday through Friday, until and including Friday, February 3, 2012. Persons wishing to obtain copies of the text of this rule and submit data, views, or comments or arguments orally should contact Patricia E. Shaner, by telephone (334-242-4116) during said period in order to set up an appointment for a hearing respecting such oral data, views, or arguments.

FINAL DATE FOR COMMENT AND COMPLETION OF NOTICE: February 3, 2012

CONTACT PERSON AT AGENCY: Patricia E. Shaner



Larry D. Dixon, Executive Director

ALABAMA BOARD OF MEDICAL EXAMINERS

P.O. Box 946 — Montgomery, AL 36101
848 Washington Avenue - 36104
(334) 242-4116

APPLICATION FOR CERTIFICATE TO PRACTICE MEDICINE THROUGH ENDORSEMENT

To The Board of Medical Examiners of the State of Alabama:

I hereby make application for a certificate to practice medicine and surgery in the State of Alabama, and submit the following statement concerning my age, moral character, preliminary and medical education and practice.

M.D.
D.O. (Choose One)

1. Name in Full _____
First Middle Last

2. Address _____
Street City State Zip

3. Place of Birth _____ Date of Birth _____ Email: _____

Social Security # _____ Sex _____ Telephone (H) _____ (W) _____

Pursuant to Ala. Code § 30-3-194, it is mandatory that we request and that you provide your social security number (SSN) on this application. The uses of your SSN are limited to the purpose of administering the state child support program and intra-agency for identification purposes. If your SSN is not provided, your application is not complete, and no license will be issued.

	YES	NO
4. Indicate whether you are a citizen of the U.S. If yes, and foreign born, attach proof of citizenship. If no, indicate your status with U.S. immigration and attach a copy of your current Visa or Work Permit.	_____	_____
5. Have you ever been convicted of a felony? (If yes, please provide the name of the court of record or a copy of the record of conviction.)	_____	_____
6. Have you ever been convicted of a crime or offense (felony or misdemeanor) related to the practice of medicine? (If yes, please provide the name of the court of record or a copy of the record of conviction.)	_____	_____
7. Have you ever been convicted of any violation of a state or federal law relating to controlled substances? (If yes, please provide the name of the court of record or a copy of the record of conviction.)	_____	_____
8. Have you ever been denied a state or federal controlled substance certificate?	_____	_____
9. Has your certificate of qualification or license to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation?	_____	_____
10. Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice?	_____	_____
11. Have you ever been denied a certificate of qualification or a license to practice medicine in any state or has your application for a certificate of qualification or license to practice medicine been withdrawn under threat of denial?	_____	_____
12. Have you ever had a judgement rendered against you, or action settled relating to performance of your professional service?	_____	_____
13. To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this application?	_____	_____
14. Within the past two years, have you been diagnosed with or have you been treated for bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder?	_____	_____
15. Do you currently have any mental or physical condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or mental, emotional, or nervous disorder or condition) which in any way currently affects, or if untreated could affect your ability to practice in a competent and professional manner?	_____	_____
16. Within the past five years, have you ever raised the issue of consumption of drugs or alcohol or the issue of a mental, emotional, nervous, or behavioral disorder or condition as a defense, mitigation, or explanation for your actions in the course of any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination by an educational institution; employer; government agency, professional organization or licensing authority?	_____	_____
17. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?	_____	_____
18. Are you currently engaged in the illegal use of controlled dangerous substances?	_____	_____
19. If your answer to the preceding question is yes, are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances?	_____	_____
20. Have you been within the past five years, convicted of driving under the influence (DUI) or have you been charged with DUI and been convicted of a lesser offense such as reckless driving?	_____	_____
21. Has your medical training or medical practice been interrupted or suspended for a period longer than 60 days for any reason other than a vacation?	_____	_____
22. Have you ever been placed on academic or disciplinary probation by a medical school or postgraduate program?	_____	_____
23. Have you ever been disciplined for unprofessional conduct/behavior reasons by a medical school or postgraduate program?	_____	_____
24. Were you notified in writing that there were limitations or special requirements imposed on you because of questions of academic or clinical incompetence, disciplinary problems or any other reason during your medical education or postgraduate training?	_____	_____

The term "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 condition referred to may have an ongoing impact on one's functioning as a physician within the past two years.

IF ANY OF THE ABOVE ANSWERS ARE IN THE AFFIRMATIVE, PLEASE EXPLAIN IN DETAIL ON AN ATTACHED SHEET AND PROVIDE THE COMPLETE ADDRESS OF ANY PSYCHIATRIST/PSYCHOLOGIST, STATE BOARD, HOSPITAL, ETC.

25. Military Service, Branch _____ Dates _____

26. Place of Intended Residence in Alabama _____

I. PRELIMINARY AND PRE-MEDICAL EDUCATION

List all schools attended, elementary through college and post-graduate work other than medical school.

	Name of School	Dates Attended	Degree Conferred
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____

II. MEDICAL EDUCATION

List all medical schools attended, dates, and complete addresses of institutions. Do not list post graduate medical education training.

	Name of School	Address
1.	From _____ to _____	_____
2.	From _____ to _____	_____
3.	From _____ to _____	_____

III. POST GRADUATE MEDICAL EDUCATION TRAINING

List all post graduate medical education training since graduation from medical school with dates and complete addresses of institutions. Do not list practice experience.

	Hospital/Institution	Address
1.	From _____ to _____	_____
2.	From _____ to _____	_____
3.	From _____ to _____	_____
4.	From _____ to _____	_____
5.	From _____ to _____	_____
6.	From _____ to _____	_____
7.	From _____ to _____	_____
8.	From _____ to _____	_____

Specialty(s) _____

**IV. ORIGINAL LICENSE
(If Applicable)**

I was issued my original (first) license in the State of _____ on _____,
license number _____ based upon _____ examination. I certify that this
license has not been the subject of any disciplinary action. If so please explain on attached sheet.

V. ACTIVITIES FOLLOWING MEDICAL SCHOOL AND TRAINING

List all practice experience since completion of your formal training giving dates, institutions/hospitals, and complete address. Use separate sheet if necessary.

	Place	Address
1. From _____ to _____	_____	_____
2. From _____ to _____	_____	_____
3. From _____ to _____	_____	_____
4. From _____ to _____	_____	_____
5. From _____ to _____	_____	_____
6. From _____ to _____	_____	_____
7. From _____ to _____	_____	_____
8. From _____ to _____	_____	_____
9. From _____ to _____	_____	_____
10. From _____ to _____	_____	_____

VI. HOSPITAL PRIVILEGES

List all hospitals where you have held staff privileges of any type. Attach sheet if necessary.

	Hospital	Address
1. From _____ to _____	_____	_____
2. From _____ to _____	_____	_____
3. From _____ to _____	_____	_____
4. From _____ to _____	_____	_____
5. From _____ to _____	_____	_____
6. From _____ to _____	_____	_____
7. From _____ to _____	_____	_____
8. From _____ to _____	_____	_____
9. From _____ to _____	_____	_____
10. From _____ to _____	_____	_____
11. From _____ to _____	_____	_____
12. From _____ to _____	_____	_____
13. From _____ to _____	_____	_____
14. From _____ to _____	_____	_____

**VII. STATE LICENSURE
(If Applicable)**

List all states where you have been licensed to practice medicine or have applied for a license to practice medicine. It is a requirement that each state complete one of the verification forms which will be attached to your application.

VIII. SPECIALTY BOARD CERTIFICATION

Are you CURRENTLY certified by one of the specialty boards approved by the American Board of Medical Specialties or the American Osteopathic Association? YES _____ NO _____

(If your answer is YES you must have your Specialty Board send verification directly to this office.)

IX. SPEX

- 1. Have you successfully completed a written licensing examination within the last ten years? YES _____ NO _____
- 2. Have you been certified or re-certified by one of the specialty boards approved by the American Board of Medical Specialties or the American Osteopathic Association? YES _____ NO _____

X. AFFIDAVIT AND RELEASE

I, _____, certify after being duly sworn, that all of the information supplied in the foregoing application is true and correct to the best of my knowledge, that the photograph submitted is a true likeness of myself and was taken within sixty days prior to the date of this application. I acknowledge that any false or untrue statement or representation made in this application may result in the revocation of my license to practice medicine granted to me and criminal prosecution to the fullest extent of the law.

I further authorize the release of this application and any information submitted with it or information collected by the Alabama Board of Medical Examiners in connection with this application, including derogatory information, to any person or organization having a legitimate need for the information and release the Alabama Board of Medical Examiners from all liability for the release of this information.

I further authorize the release of information, including derogatory information, which may be in the possession of other individuals or organizations to the Alabama Board of Medical Examiners and release this person or any organization from any liability for the release of information.

Date _____

Applicant's Signature

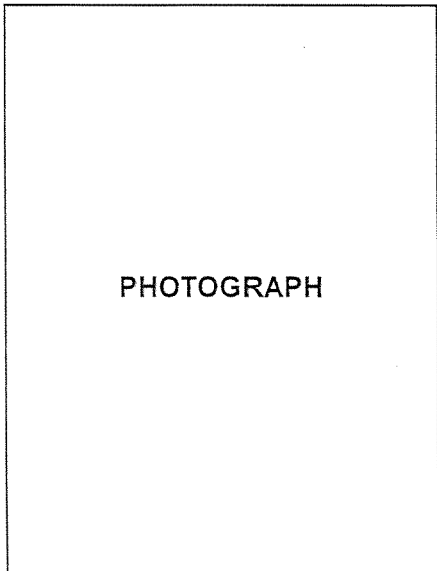
County of _____

State of _____

SWORN to and subscribed before me this _____ day of _____, 20 _____.

Notary Public

My Commission Expires: _____



THE ALBME WILL ENFORCE THE BOARD'S RULES AND OPTIONS FOR THE ISSUANCE OF NON-DISCIPLINARY CITATION AND ADMINISTRATIVE CHARGE WHEN AN APPLICANT FALSIFIES AN APPLICATION.

ALABAMA BOARD OF MEDICAL EXAMINERS

P.O. Box 946 — Montgomery, Alabama 36101

848 Washington Avenue — 36104

APPENDIX A

MEDICAL SCHOOL CERTIFICATION

CERTIFICATE OF DEAN OR PRESIDENT

It is hereby certified that _____ of _____
matriculated in _____ at _____ from _____
to _____ and received a diploma from _____
conferring the degree of Doctor of Medicine/Osteopathy on _____.

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the individual's medical education. Please circle the correct response and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation.

Does this individual's official record reflect that he/she was ever placed on academic or disciplinary probation?
If yes, please attach a copy of the written notification to the individual. Y N

Does this individual's official record reflect that he/she was ever disciplined for unprofessional conduct/
behavioral reasons by the medical school or parent university? If yes, please attach a copy of the written
notification to the individual of the disciplinary action. Y N

Does this individual's official record reflect that that there were any limitations or special requirements
imposed on him/her because of questions of academic or clinical incompetence, disciplinary problems,
or any other reason? If yes, please attach a copy of the written notification to the individual. Y N

Date _____

President, Secretary or Dean

(SEAL)

INSTRUCTIONS TO INDIVIDUAL COMPLETING THIS FORM:

Please fill in all applicable spaces and return to the Alabama Board of Medical Examiners at the above address, Please do not send this application back to the applicant as the Board will not consider this certificate unless it is received directly from the institution.

ALABAMA BOARD OF MEDICAL EXAMINERS
P.O. Box 946 — Montgomery, Alabama 36101
848 Washington Avenue - 36104

APPENDIX B

POST GRADUATE EDUCATION CERTIFICATE

CERTIFICATE OF POST GRADUATE EDUCATION TRAINING

I, _____, Administrator, Medical Education Director or Director of Residency Training Program (indicate which one) of _____ certify that the records of this Program show that _____ has successfully completed _____ year/years of post graduate training* in this program from _____ 20 _____ to _____ 20 _____.

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the individual's post graduate training. Please circle the correct response and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation.

Does this individual's official record reflect that he/she was ever placed on academic or disciplinary probation?
If yes, please attach a copy of the written notification to the individual. Y N

Does this individual's official record reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons? If yes, please attach a copy of the written notification to the individual of the disciplinary action. Y N

Does this individual's official record reflect that he/she was ever notified in writing that there were any limitations or special requirements imposed on him/her because of questions of academic or clinical competence, disciplinary problems, or any other reason? If yes, please attach a copy of the written notification to the individual. Y N

Date _____

Administrator of Hospital
Medical Education Director
Director of Residency Training

(SEAL OF PROGRAM)

Candidates who graduated from an LCME accredited medical school or AOA approved College of Osteopathy need one (1) year certified.

Candidates who graduated from a NON-LCME accredited medical school or NON-AOA accredited College of Osteopathy need three (3) years certified.

*"has completed _____ years of post graduate training" means the applicant has successfully completed or met the program's established criteria, standards or requirements which are necessary for promotion to the next level of post graduate training or the applicant has successfully completed or met the program's established criteria, standards or requirements which are necessary for completion of this program.

Note to applicant: Merely accumulating 12 months or 36 months of post graduate or residency training shall not be evidence satisfactory to the Board that the applicant has fulfilled the post graduate requirement necessary for qualifying for the issuance of a certificate of qualification for a license to practice medicine in Alabama.

INSTRUCTIONS TO INDIVIDUAL COMPLETING THIS FORM:

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P.O. Box 946 — Montgomery, Alabama 36101

APPENDIX C
ORIGINAL LICENSURE

CERTIFICATE OF EXECUTIVE DIRECTOR OF BOARD ISSUING ORIGINAL LICENSE

I, _____ Executive Director of _____
Board of Medical Examiners, certify that _____ was granted Certificate/License
NO. _____ to practice medicine/osteopathy in the State of _____ on
the _____ based on _____
Month Day Year
and that said certificate or license has not been revoked or subject to disciplinary action.

I further certify that _____ in his written exam before this Board, obtained a general
average of _____ percent in the following branches:

Acting on behalf of the _____ Board of Medical Examiners, I hereby certify to the reputability of Dr.
_____ based on the records, and recommend him to the Alabama Board of Medical Examiners.

Executive Director, Secretary, Chairman

Date _____

(SEAL OF BOARD)

Place _____

INSTRUCTIONS TO INDIVIDUAL COMPLETING THIS FORM:

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this application back to the applicant as the Board will not consider this certificate unless it is received directly from the institution.