

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 C, Application for a Limited Certificate of Qualification

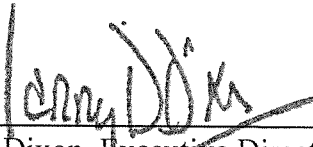
INTENDED ACTION: To amend the rule.

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
(334) 242-4116**

APPLICATION FOR A LIMITED CERTIFICATE OF QUALIFICATION

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

I hereby make application for a limited 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.

- 1. Name in Full _____
- 2. Address _____
- 3. Place of Birth _____ Date of Birth _____
- Social Security # _____ Sex _____ Telephone _____

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. Have you ever been convicted of a felony?	_____	_____
5. Have you ever been convicted of a crime or offense (felony or misdemeanor) related to the practice of medicine?	_____	_____
6. Have you ever been convicted of any violation of a state or federal law relating to controlled substances?	_____	_____
7. Have you ever been denied a state or federal controlled substance certificate?	_____	_____
8. 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?	_____	_____
9. Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice?	_____	_____
10. 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?	_____	_____
11. Have you ever had a judgement rendered against you, or action settled relating to the performance of your professional service?	_____	_____
12. To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this application?	_____	_____
13. 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?	_____	_____
14. 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?'	_____	_____
15. 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?	_____	_____
16. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?	_____	_____
17. Are you currently engaged in the illegal use of controlled dangerous substances?'	_____	_____
18. 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?	_____	_____
19. 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?	_____	_____
20. 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?	_____	_____

'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.

21. Military Service, Branch _____ Dates _____
 22. Place of Intended Residence in Alabama _____

I. PRE-MEDICAL EDUCATION

Name of School	Dates Attended	Degree Conferred
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

II. MEDICAL EDUCATION

List all medical schools attended, dates, and complete addresses of institutions. Do list internship and/or residency training.

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

III. INTERNSHIP AND/OR TRAINING

List all internship and/or residency training since graduation from medical school with dates and complete addresses of institutions. Do not list practice experience.

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

IV. 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. 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 _____, 19 _____.

(SEAL)

Notary Public _____

CERTIFICATION:

My Commission Expires: _____