



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-12, Qualified Alabama Controlled Substances Registration Certificate (QACSC), Appendix A, Application for QACSC

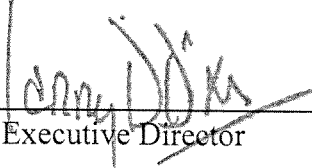
INTENDED ACTION: To amend the appendix

SUBSTANCE OF PROPOSED ACTION: To amend Appendix A to add "For Physician Assistants" and correct language in "warning" box

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, Office of General Counsel, Alabama State Board of Medical Examiners, Post Office Box 946, 848 Washington Avenue (36104), 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 Wednesday, September 4, 2013. Persons wishing to obtain copies of the text of this rule should contact Patricia E. Shaner, Office of General Counsel, (334-242-4116), PO Box 946, 848 Washington Avenue (36104), Montgomery, Alabama 36101-0946.

FINAL DATE FOR COMMENT AND COMPLETION OF NOTICE: September 4, 2013

CONTACT PERSON AT AGENCY: Patricia E. Shaner

  
\_\_\_\_\_  
Larry D. Dixon, Executive Director

-APPLICATION-  
**QUALIFIED**  
**CONTROLLED SUBSTANCES REGISTRATION CERTIFICATE**  
FOR PHYSICIAN ASSISTANTS

Return Completed Application To:  
ALABAMA STATE BOARD OF MEDICAL EXAMINERS  
P.O. Box 946 • Montgomery, Alabama 36101  
(334) 242-4116

WARNING: SECTION 20-2-54~~64~~, CODE OF ALABAMA 1975 (AS AMENDED) STATES THAT A REGISTRATION UNDER SECTION 20-2-54 TO MANUFACTURE, DISTRIBUTE OR DISPENSE A CONTROLLED SUBSTANCE MAY BE SUSPENDED OR REVOKED BY THE CERTIFYING BOARDS UPON A FINDING THAT THE REGISTRANT HAS FURNISHED FALSE OR FRAUDULENT MATERIAL INFORMATION IN ANY APPLICATION FILED UNDER THIS ACT.

All applicants must answer the following questions. If the answer to questions A, B, C, D or E is yes, the applicant must attach a complete explanation detailing all facts and circumstances.

- A. Has your privilege for dispensing or prescribing controlled substances ever been suspended, restricted, revoked or disciplined in any manner in any state? .. ( ) Yes ( ) No
- B. Have you ever been convicted of any state or federal crime relating to any controlled substance? ..... ( ) Yes ( ) No
- C. Has your Federal DEA registration ever been suspended, restricted or revoked? ( ) Yes ( ) No
- D. Have your staff privileges at any hospitals ever been suspended, restricted, revoked or disciplined in any manner for any reason related to the prescribing or dispensing of controlled substances? ..... ( ) Yes ( ) No
- E. 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?\* . ( ) Yes ( ) No
- F. Print DEA number and expiration date \_\_\_\_\_

NOTICE: To lawfully administer, dispense or prescribe controlled substances in the State of Alabama, federal and state statutes require a DEA certificate of registration and a Qualified Alabama Controlled Substances registration Certificate. For further information concerning federal requirements contact DEA, Metairie, LA, 800-882-9539.

- G. Have you completed one year of clinical employment?  
**NOTE:** If yes, complete attached affidavit. .... ( ) Yes ( ) No
- H. Have you completed a board approved pharmacology of controlled substances course or courses?  
**NOTE:** If yes, attach documentation of completion ..... ( ) Yes ( ) No

\* 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 assistant within the last two years.

**FEE FOR THIS CERTIFICATE IS \$110.00. ENCLOSE YOUR CHECK WITH APPLICATION**

I swear (affirm) that the information set forth in this application for Qualified Alabama Controlled Substances registration Certificate is true and correct to the best of my knowledge, information and belief.

Date: \_\_\_\_\_ Signature of Applicant (P. A.) \_\_\_\_\_

Date: \_\_\_\_\_ Signature of Supervising Physician \_\_\_\_\_

P.A. Name: \_\_\_\_\_ P.A. License No.: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_



# ALABAMA BOARD OF MEDICAL EXAMINERS

## Proof of Clinical Employment

§20-2-63(2)

### AFFIDAVIT

I, \_\_\_\_\_ License # \_\_\_\_\_ hereby certify that I have received a minimum of 12 months of active, clinical employment with physician supervision following National Commission on Certification of Physician Assistants (NCCPA) certification, from the following employers:

\_\_\_\_\_  
Employer

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
Phone #

\_\_\_\_\_  
Supervisor

\_\_\_\_\_  
Employed From: To:

\_\_\_\_\_  
Employer

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
Phone #

\_\_\_\_\_  
Supervisor

\_\_\_\_\_  
Employed From: To:

\_\_\_\_\_  
Employer

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
Phone #

\_\_\_\_\_  
Supervisor

\_\_\_\_\_  
Employed From: To:

Signed:

\_\_\_\_\_  
Physician Assistant

Sworn to and subscribed to before me on this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_.

\_\_\_\_\_  
Notary Public  
My Commission Expires: