

State of Tennessee
Department of Health

TENNESSEE MASSAGE LICENSURE BOARD

665 Mainstream Drive
Nashville, TN 37243

1-800-778-4123, ext. 2532111
615-253-2111
<http://Tennessee.gov>



Application and Procedures for Licensure

Massage Therapist



STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 Mainstream Drive
NASHVILLE, TN 37243

TENNESSEE MASSAGE LICENSURE BOARD
1-800-778-4123 ext. 2532111
(615) 253-2111
LICENSURE APPLICATION INSTRUCTIONS AND CHECK SHEET

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 Tennessee license to practice. **NOTE: All submissions must be executed and dated less than one (1) year before receipt or they will be rejected by the Board.**

LICENSURE BY EXAMINATION

DONE

1. Complete, sign, have notarized and mail the application pages 1 through 6. _____
2. Submit a copy of your birth certificate or other equivalent document (i.e.: photocopy of passport). _____
3. Applicants who are not citizens of the United States or whose birth certificates reflect they were not born in the United States shall submit proof of their immigration status demonstrating their right to live and work in the United States. **All applicants must complete and submit the Declaration of Citizenship.** _____
4. Submit two (2) recent (within the preceding twelve (12) months, original signed and dated letters from health care professionals that include the professional's licensing credentials and attesting to your personal character & professional ethics. _____
5. Submit with your application a check or money order in the amount of **\$280.00** made payable to the State of Tennessee. _____
6. Complete and mail **Attachment 2** to each state, country, or province in which you hold, or have ever held a license or certificate to practice any profession. _____
7. Request verification of successful completion of the MBLEx examination offered by the FSMTB or an examination offered by the NCBTMB be sent to the Board directly from the Institution. _____
8. Complete and mail Attachment 1 to the school(s) in which you completed a massage, bodywork, and or somatic therapy curriculum of no less than five-hundred (500) hours. Schools must be approved by the Tennessee Higher Education Commission or its equivalent in another state or by the Tennessee Board of Regents. Transcripts must show two-hundred (200) hours of sciences, two-hundred (200) hours of massage theory, eighty-five (85) hours of allied modalities, ten (10) hours of ethics and five (5) hours of Tennessee massage statutes and regulations. _____
9. You must complete and return the Mandatory Practitioner Profile Questionnaire with the application. _____

10. A Criminal Background Check is required to be obtained through the vender contracted with the State. For instructions to obtain a criminal background check [click here](#) or go to the Board's main page of it's website.

LICENSURE BY RECIPROCITY

DONE

1. Complete, sign, have notarized and mail the application pages 1 through 6. _____
2. Submit a copy of your birth certificate or other equivalent document (i.e.: photocopy of passport). _____
3. Applicants who are not citizens of the United States or whose birth certificates reflect they were not born in the United States shall submit proof of their immigration status demonstrating their right to live and work in the United States. **All applicants must complete and submit the Declaration of Citizenship.** _____
4. Submit two (2) recent (within the preceding twelve (12) months, original signed and dated letters from health care professionals that include the professional's licensing credentials and attesting to your personal character & professional ethics. _____
5. Submit with your application a check or money order in the amount of **\$280.00** made payable to the State of Tennessee. _____
6. Complete and mail **Attachment 2** to each state, country, or province in which you hold, or have ever held a license or certificate to practice any profession. _____
7. You must complete and return the Mandatory Practitioner Profile Questionnaire with the application. _____
8. A Criminal Background Check is required to be obtained through the vender contracted with the State. For instructions to obtain a criminal background check [click here](#) or go to the Board's main page of its website. _____
9. Applicants who are licensed or have been licensed in another state must complete and mail Attachment 1 to the school(s) in which you completed a massage, bodywork, and or somatic therapy curriculum of no less than five-hundred (500) hours. Transcripts must be sent directly from the school(s) to the Board's Administrative Office. Applicants must also request that verification of having passed the MBLEx examination or the NCBTMB or its successor organization be submitted to the Board Administrative office. _____

OR

To avoid the educational requirements the applicant must request proof from the NCBTMB of their certification for the five (5) year period immediately preceding application for licensure be submitted directly to the Board Administrative Office. The applicant must also submit documentation of engaging in the practice of massage therapy in another state for the five (5) year period immediately preceding application for licensure.

AND

10. All applicants for reciprocity must submit proof of having successfully completed five (5) classroom hours of instruction regarding Tennessee massage statutes and regulations and ten (10) classroom hours of ethics instructions _____

UNDERSTANDING THE APPLICATION PROCESS

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

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:

**Massage Licensure Board
665 Mainstream Drive
Nashville, TN 37243**

**For Federal Express or Special Courier:
Massage Licensure Board
665 Mainstream Drive
Nashville, TN 37228**

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 sixty (60) days from the date of the initial deficiency letter. Files not completed in a timely manner will be closed.
5. Absent any complicating factors, the average application processing time is six weeks. Once the application is completed, your file will be reviewed and an initial licensure determination made. You will be notified by letter of the initial determination.
6. It is recommended that you **do not** make arrangements to accept employment as a massage therapist or open a massage establishment in Tennessee until you are granted a license or authorization from the Board.

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

EDUCATIONAL AND EMPLOYMENT INFORMATION

Please provide the following information for all educational institutions you have attended beyond junior high or middle school. Use the back of this page if you need additional space.

High School
 From: _____ To: _____
 Mo/Yr Mo/Yr _____ Educational Institution _____ Location

College/University
 From: _____ To: _____
 Mo/Yr Mo/Yr _____ Educational Institution _____ Location

Trade School or Massage Bodywork Training
 From: _____ To: _____
 Mo/Yr Mo/Yr _____ Educational Institution _____ Location

Please complete your last five years employment history starting with the most current position first. Use the back of this page if you need additional space. If not applicable mark this section N/A.

| <u>DATES</u> | <u>LOCATION</u> | <u>POSITION AND DUTIES</u> |
|--|----------------------------|----------------------------|
| From: _____ To: _____ Mo/Yr Mo/Yr | _____ (City) _____ (State) | _____ |
| From: _____ To: _____ Mo/Yr Mo/Yr | _____ (City) _____ (State) | _____ |
| From: _____ To: _____ Mo/Yr Mo/Yr | _____ (City) _____ (State) | _____ |
| From: _____ To: _____ Mo/Yr Mo/Yr | _____ (City) _____ (State) | _____ |
| From: _____ To: _____ Mo/Yr Mo/Yr | _____ (City) _____ (State) | _____ |
| From: _____ To: _____ Mo/Yr Mo/Yr | _____ (City) _____ (State) | _____ |
| From: _____ To: _____ Mo/Yr Mo/Yr | _____ (City) _____ (State) | _____ |
| From: _____ To: _____ Mo/Yr Mo/Yr | _____ (City) _____ (State) | _____ |

LICENSURE AND CERTIFICATION INFORMATION

List below all states, countries or provinces in which you have ever been or currently are licensed or certified as a Massage Therapist. Submit a copy of **Attachment 2** to all such states, countries, or provinces regarding such licensure, certification or permit. Use the back of this page if you need additional space. IN NOT APPLICABLE PUT N/A

| STATE | LICENSE NUMBER | DATE ISSUED | CURRENT STATUS |
|-------|----------------|-------------|----------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

List below all states countries or provinces in which you hold or have ever held a license or certification in any profession other than a Massage Therapist. Submit a copy of **Attachment 2** to all such states, countries or provinces regarding such licensure, certification or permit. Use the back of this page if you need additional space. IF NOT APPLICABLE PUT N/A

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

- | | | | |
|----|---|------------|-----------|
| | | Yes | No |
| 1. | Have you taken and passed an examination offered by the NCBTMB or the MBLEx Examination offered by the FSTMB? If yes check one: NCBTMB _____ MBLEx _____ | _____ | _____ |
| 2. | Have you ever previously applied for a massage therapist license or a massage establishment license in Tennessee? | _____ | _____ |

COMPETENCY INFORMATION

PLEASE ANSWER THE FOLLOWING QUESTIONS. If any answers to the questions in this part are in the affirmative, attach an explanation on a separate sheet. *In support of your explanation, the final documents or orders from the issuing states, courts, or agencies must be submitted along with this application.*

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 exercise reasoned professional judgments and to learn and keep abreast of developments in your profession; and
 - b. The ability to communicate those judgments and 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 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 or disorders, such as, but not limited to; orthopedic, visual, speech and/or hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.
3. **"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.
4. **"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.
5. **"Illegal use of controlled substances"** means the use of controlled substances obtained illegally (e.g. heroin, or cocaine) as well as the use of controlled substances which 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 a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? | | _____ | _____ |
| a. If yes, are they reduced or ameliorated because you receive ongoing treatment (with or without medication) or participate in a monitoring program? | | _____ | _____ |
| b. If you have any limitations or impairments caused by an existing medical condition, are they reduced or ameliorated because of the field of practice, the setting or the manner in which you have chosen to practice? | | _____ | _____ |

[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: | | YES | NO |
|-------------------|---|------------|-----------|
| 2. | Do you currently use chemical substances? If yes, do they in any way impair or limit your ability to practice your profession with reasonable skill and safety? | _____ | _____ |
| 3. | Are you currently engaged in the illegal use of controlled substances? If yes, are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you in order to assure that you are not engaged in the illegal use of controlled substances? | _____ | _____ |
| 4. | Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism? | _____ | _____ |
| 5. | If you have ever held or applied for a license or certificate to practice massage therapy in any state, country or province, has it been or was it ever denied, reprimanded, suspended, restricted, revoked, or otherwise disciplined, curtailed or voluntarily surrendered under threat of investigation or disciplinary action? | _____ | _____ |
| 6. | If you have ever had staff privileges at any hospital or health care facility have they ever been revoked, suspended, curtailed, restricted, limited or otherwise disciplined or voluntarily surrendered under threat or restriction or disciplinary action? | _____ | _____ |
| 7. | Have you ever been convicted of any felony or any misdemeanor other than a minor traffic violation? This includes but not limited to: DUI's, reckless driving, driving on revoked or suspended license. | _____ | _____ |
| 8. | Have you ever been rejected or censured by a professional society? | _____ | _____ |
| 9. | In relation to the performance of your professional services in any profession: | | |
| a. | Have you ever had a final judgment rendered <u>against</u> you; or | _____ | _____ |
| b. | Have you ever had settlement of any legal action rendered <u>against</u> you; or | _____ | _____ |
| c. | Are there any legal actions pending <u>against</u> you or to which you are a party? | _____ | _____ |
| 10. | If you have ever held a license or certificate in any health care profession, has it ever been reprimanded, suspended, restricted, revoked, or otherwise disciplined, curtailed or voluntarily surrendered under threat of investigation or disciplinary action? | _____ | _____ |

APPLICANT: FILL OUT THE FOLLOWING AFFIDAVIT IN THE PRESENCE OF A NOTARY PUBLIC

AFFIDAVIT AND RELEASE

I, _____ of _____
(Applicant's Name) (City) (State)

being duly sworn and identified as the person referred to in this application and signed photos, attests to the truth of each statement made in said application. I further swear that I have read and understand the law and the rules and regulations which were enclosed in the application packet and agree to abide by them in the practice of my profession 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 an 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 any 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 other qualifications for licensure.

ACKNOWLEDGE that I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical and other qualifications and for resolving any doubts about such qualifications.

AUTHORIZE I hereby 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.

In order to comply with federal statutes, the Board of Massage Licensure is obligated to inform each applicant or licensee from whom it requests a social security number that disclosing such number is mandatory in order for this Board to comply with the requirements of the federal Healthcare Integrity and Protection Data Bank and/or the National Practitioner Data Bank. If the Board is required to make a report about one of its applicants or licensees to either or both of these data banks, it must report that individual's social security number. This application will not be complete if the social security number is omitted. The number will be used for identification purposes and for such other purposes as are allowed by state and federal law.

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

Sworn to before me, this _____ day of _____.

NOTARY PUBLIC

My Commission expires _____

Affix Seal Here



STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 Mainstream Drive
Nashville, TN 37243

TENNESSEE MASSAGE LICENSURE BOARD
1-800-778-4123 ext. 2532111
(615) 253-2111

EDUCATION VERIFICATION

APPLICANT: Supply the information requested in the box below, and then mail this entire form to the educational institution(s) where you completed your five hundred (500) hour massage therapy curriculum. Transcript must show two-hundred (200) hours of sciences, two-hundred (200) hours of massage theory, eighty-five (85) hours of allied modalities, ten (10) hours of ethics and five (5) hours of Tennessee massage statutes and regulations. **NOTE:** Most educational institution(s) require a fee, so you may want to contact the institution(s) before mailing this form. If you attended more than one educational institution, please send copies of this form to each one you intend to rely upon in obtaining licensure.

TO WHOM IT MAY CONCERN:

I am applying for a license to practice as a massage therapist in the State of Tennessee. The Massage Licensure Board requires verification of educational attainment. Please forward an original transcript bearing the institution's official seal to the Board's address below.

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

Applicant's Address: _____

Applicant's Social Security Number: _____ - _____ - _____

Applicant's Student Identification Number: _____

Year of Graduation: _____

Degree Conferred: _____ Date Degree Conferred: _____

Please forward an original graduate transcript bearing the institution's official seal to:

**Massage Licensure Board
665 Mainstream Drive
Nashville, TN 37243**

Thank you for your cooperation and prompt response.

Applicant's Signature

Date



STATE OF TENNESSEE
 DEPARTMENT OF HEALTH
 HEALTH RELATED BOARDS
 665 Mainstream Drive
 Nashville, TN 37243

TENNESSEE MESSAGE LICENSURE BOARD
 1-800-778-4123 ext. 32111
 (615) 253-2111
 CLEARANCE FROM OTHER STATE LICENSURE BOARDS

APPLICANT: Please complete 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. (Copies of this form can be used.) **NOTE:** Some states require a fee for providing clearance information. To expedite your application, you may wish to contact the applicable state(s).

To Be Completed By Applicant (Please Type or Print in Ink)

I, the undersigned applicant, was granted a license/certificate to practice _____ with (check one)
 _____ (Profession)
 License / Certificate / Registry number _____ on _____ in the State of _____
 _____ (Date)
 The Tennessee Massage Licensure Board requests that I submit evidence of the current status of that license/certification in your state.
 You are hereby authorized to release any information in your files, favorable or otherwise, directly to the Tennessee Massage Licensure Board.

Date: _____ Applicant's Signature _____

 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 or Permit:

 _____ (First) _____ (M.I.) _____ (Last)
 License/Certificate/Permit 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, Please attach supporting documentation.

_____ Authorized Signature _____ Title _____ Date _____

State Board: Please return this form to: **Massage Licensure Board**
 665 Mainstream Drive
 Nashville, TN 37243



STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243

DECLARATION OF CITIZENSHIP
MUST ACCOMPANY ALL APPLICATIONS FOR INITIAL LICENSURE OR REINSTATEMENT OF LICENSURE

The "SAVE Act" requires Tennessee Department of Health (including all Boards, Commissions, and contractors), along with every local health department in the State, to verify that *every adult* applicant for a professional license is either a U.S. citizen, a "qualified alien," or a nonimmigrant who meets the requirements set out at 8 U.S.C. 1621.

I am a(n) _____
Healthcare Profession (Please Print) License number if applicable

Please Print Legibly

1. Name: _____
Last First Middle Maiden_
2. Mailing Address: _____
3. Phone Number: Home: (____)____-____ Office: (____)____-____ Fax: (____)____-____
4. I am a United States Citizen: ___Yes ___No
5. I am a foreign national not physically present in the United States ___Yes ___No. If you answered yes, to this question please sign this form in the presence of a notary and return it with your application. No further documentation is required.
6. Applicants Claiming United States Citizenship **MUST** provide one of the following:
 - a) Tennessee Driver's License, or photo ID issued by Department of Safety.
 - b) A valid driver license or ID issued by another state, provided its issuance requirements meet Department of Safety criteria.
 - c) An official birth certificate issued by a U.S. state, territory, or other jurisdiction. Puerto Rican birth certificates issued before July 1, 2010 do not count.
 - d) A federally issued birth certificate.
 - e) A valid, unexpired U.S. passport.
 - f) A report of birth abroad of a U.S. citizen.
 - g) A certificate of citizenship.
 - h) A certificate of naturalization.
 - i) A U.S. citizen ID card.
 - j) Any successor document to #'s a-i above.
 - k) SSN that the entity or local health department may verify with the Social Security Administration in accordance with federal law.
7. If you checked "No" in question 4 please indicate from the list below which category applies to you: (circle one)
 - a) Permanent Residents

- b) A nonimmigrant applicant for a professional or commercial license whose visa for entry into the United States is related to such employment, or a nonimmigrant under the Immigration and Nationality Act (8 U.S.C. 1101 *et seq.*).
- c) Asylees who meet the qualifications set out in 8 U.S.C. 1158
- d) Refugees who meet the qualifications set out in 8 U.S.C. 1157
- e) Persons who have been "paroled into the United States," under 8 U.S.C. 1182(d)(5) or whose deportation has been withheld under 8 U.S.C. 1253.
- f) Cuban or Haitian entrants as defined by section 501(e) of the Refugee Education Assistance Act of 1980
- g) Persons granted conditional entry into the U.S. under 8 U.S.C. 1153(a)(7) before April 1, 1980, because of persecution or fear of persecution on account of race, religion, or political opinion or because of being uprooted by catastrophic national calamity.
- h) An alien who has been "battered" or subjected to "extreme cruelty" by a parent or spouse as defined by 8 U.S.C. 1641(c), and also meets the qualifications set out 8 U.S.C. 1641(c)(1)(B). Under the circumstances set out in 8 U.S.C. 1641(c)(2) and (3), victims' children, or the parents of children who are victims, may also apply for benefits as qualified aliens.

Applicants claiming **qualified alien status** (question 7 above), please submit two of the following forms of "documentation of identity and immigration status" as determined by U.S. Homeland Security to be acceptable for verification through the SAVE program. Common types of documents used to verify immigration status are listed below. (Note: If you can provide only one document, your status will be verified through the U.S. Department of Homeland Security's SAVE program):

I-327 (Reentry Permit)

I-551 (Permanent Resident Card or "Green Card")

I-571 (Refugee Travel Document)

I-766 (Employment Authorization Card)

Machine Readable Immigrant Visa (with Temporary I-551 language)

Temporary I-551 stamp (on passport or I-94)

I-94 (Arrival/Departure record)

Unexpired foreign passport

WT/WB Admission Stamp in unexpired foreign passport

I-20 (Certificate of Eligibility for Nonimmigrant F(1) student status- "student visa")

DS2019 (Certificate of Eligibility for Exchange Visitor (J-1) Status)

I affirm under the penalty of perjury that the above is true and correct.

Signed this ____ day of _____, 20__.

Signature

Sworn to before me this ____ day of _____, 20__.

NOTARY PUBLIC

AFFIX SEAL HERE

My Commission Expires: _____

If an applicant is discovered to be an unqualified alien, or otherwise ineligible for benefits under the Act, all recurring benefits provided to that applicant must be immediately terminated. Anyone who purposefully makes a false, fictitious, or fraudulent claim of U.S. citizenship or qualified alien status will be liable under the Tennessee Medicaid False Claims Act, or Tennessee's False Claims Act. Any person who conspires to defraud the state or any local health department by securing a false claim allowed or paid to another person in violation of the Act may be liable under Tennessee's False Claims Act. Upon discovery of an applicant's false, fictitious, or fraudulent claim of U.S. citizenship, state governmental entities and local health departments must also file a criminal complaint with the United States Attorney.



TENNESSEE DEPARTMENT OF HEALTH

MANDATORY PRACTITIONER PROFILE QUESTIONNAIRE FOR LICENSED HEALTH CARE PROVIDERS

The Health Care Consumer Right-to-Know Act of 1998, T.C.A. §§ 63-51-101, *et seq.*, requires designated licensed health professionals to furnish certain information to the Tennessee Department of Health, and is requested in this questionnaire. From the information submitted, the Department compiles practitioner profiles which the law requires to be made available to the public via the World Wide Web and our toll-free telephone line. Each practitioner who has submitted information must update that information in writing by notifying the Department of Health, within 30 days after the occurrence of an event or an attainment of a status that is required to be reported by the law. A copy of your initial or updated profile will be furnished to you for your review prior to publication. That opportunity will allow you to make corrections, additions and helpful explanatory comments. Failure to comply with the requirement to submit and update profiling information may result in a delay or denial of your licensure application and/or may result in disciplinary action against your license. The professions required to submit a profile questionnaire are:

| | |
|--|---------------------------------|
| Advanced Practice Nurses | Nursing Home Administrators |
| Alcohol and Drug Counselors | Occupational Therapists |
| Audiologists | Optometrists |
| Chiropractic Physicians | Orthopedic Physician Assistants |
| Clinical Pastoral Therapists | Osteopathic Physicians |
| Dentists | Pharmacists |
| Dietitian/Nutritionists | Physician Assistants |
| Dispensing Opticians | Physical Therapists |
| Electrologists | Podiatrists |
| Licensed Registered Respiratory Therapists | Professional Counselors |
| Licensed Certified Respiratory Therapists | Psychologists |
| Licensed Laboratory Personnel | Respiratory Care Assistants |
| Marital & Family Therapists | Social Workers |
| Massage Therapists | Speech Language Pathologists |
| Medical Doctors | Veterinarians |

A blank copy of the profile questionnaire may be obtained from the following web site address:
<http://health.state.tn.us/Downloads/q6019027.pdf>.

INSTRUCTIONS

QUESTIONNAIRE DEADLINE The provider must complete and submit the questionnaire before a license will be granted. Providers who have completed a similar questionnaire for another state's licensing board are, nevertheless, required to complete and submit this form. Changes to the questionnaire must be submitted within 30 days of the change.

COMPLETING THE QUESTIONNAIRE Complete the questionnaire by typing the information or by printing neatly in block letters in ball point pen. If a question does not apply to you, indicate so by checking the "Does not apply" box. **Illegible questionnaires will be returned.** If you need further instruction, contact your profession's licensing board by calling (615) 532-3202 or by calling toll free at (800) 778-4123.

SUBMITTING THE QUESTIONNAIRE Mail the completed profile questionnaire to:

Tennessee Board of (*board for your profession*)
Healthcare Provider Information
665 Mainstream Drive
Nashville, TN 37243

- ▶ Do not return pages 1 through 4 with the questionnaire to the department.
- ▶ Keep a copy of the questionnaire for your records.

The following numbered parts correspond to the matching number on the questionnaire form.

I. PRACTITIONER DATA

Complete Part I, noting the following:

- **License number:** Fill in your Tennessee license number and indicate your profession in the space provided. **If you have not been issued a license number, please leave this blank.**
- **Social security number:** **Your social security number will not be published or in any way given out to the public. It is required for in-house tracking purposes only.**
- **Primary Practice Address:** Complete the practice address (if applicable). If your practice address is also your home address, you should know the Department is prohibited from placing your home address on the Internet without your request to do so. There is a box to check in Part I to request this. Retirees: Write in "N/A" for practice address. If you do not have a practice address at the time of completing this questionnaire, you must report your practice address within 30 days of obtaining a practice address.
- **Supervising Physician:** Physician assistants and advanced practice nurses must list all supervising physicians. In addition, advanced practice nurses must also complete the Notice and Formulary if you are prescribing. The Notice and Formulary is available online at <http://health.state.tn.us/boards/Nursing/applications.htm>.

II. GRADUATE/POSTGRADUATE MEDICAL/PROFESSIONAL EDUCATION AND TRAINING

List chronologically medical/health professional related graduate/postgraduate education and training completed. Exclude any program or courses taken to satisfy continuing education requirements for licensure renewal. Provide information about health related degrees you have received including your licensure degree.

III. SPECIALTY BOARD CERTIFICATIONS

Provide information on any certification, specialty or subspecialty from any specialty board recognized by the American Medical Association, American Osteopathic Medical Association, American Podiatry Association, American Chiropractic Association, American Dental Association or any other specialty certifying body as determined by your Tennessee licensing board.

IV. FACULTY APPOINTMENTS

Answer ALL yes/no questions with a "yes" or "no" response. A brief statement in the space provided should follow a "yes" answer. If the space is insufficient for your response, attach an additional page, being sure to number the response to match the appropriate question.

V. STAFF PRIVILEGES

A. List all hospitals at which you hold staff privileges. The definition for "hospital" can be found at T.C.A. § 68-11-201.

VI. MANAGED CARE AND TENNCARE PLANS

A. In the spaces provided, answer information about the Managed Care plans in which you participate and accept as a provider, if any. If the space is insufficient for your response, attach an additional page, being sure to number the response to match the appropriate question.

B. In the spaces provided, answer information about the TennCare plans in which you participate and accept as a provider, if any. If the space is insufficient for your response, attach an additional page, being sure to number the response to match the appropriate question.

VII. FINAL DISCIPLINARY ACTION

These questions refer to final disciplinary or adverse actions taken within the previous **ten (10) years**, whether in this state or any other jurisdiction. The term **final** means the matter was fully adjudicated at a hearing and the appeal's period expired, or that the applicable board issued an agreed order or consent decree.

In the "Description of Violation" spaces, indicate the nature of the conduct in question such as malpractice, unethical conduct, drug-related, sex related, impairment, fraud, etc.

In the "Description of Action" spaces, indicate the type of disciplinary action imposed against your professional license such as censure, reprimand, probation, etc.

The term **disciplinary action** includes, but is not limited to:

- Probation
- Limitation/Restriction
- Suspension
- Revocation
- Voluntary relinquishment in lieu of disciplinary action
- Any other adverse action taken against a license or privilege by a medical/health related institution
- Compulsory surrender of license or privilege
- Civil or other monetary fine or penalty
- Resignation from or non-renewal of medical staff membership at a hospital in lieu of, or in settlement of, a pending disciplinary case related to competence or character
- Restriction of privileges in lieu of, or in settlement of, a pending disciplinary case related to competence or character

If you answer "yes" to any of the questions regarding Final Disciplinary Actions and/or Criminal Offenses and if the action is under appeal, you must attach a copy of the notice of appeal. Note: You must submit a copy of the final written order of disposition immediately after the appeal is disposed of by the adjudicating authority. Please read questions B and C in Part VII in their entirety before answering those questions.

VIII. CRIMINAL OFFENSES

This part requires you to report any state or federal felony criminal offense convictions. It also requires the reporting of misdemeanor offenses, regardless of classification, in which any element of the offense involves sex; alcohol or drugs; physical injury or threat of injury to any person; abuse or neglect of any minor, spouse or the elderly; fraud or theft in Tennessee or another jurisdiction; or unlicensed practice within the most recent ten (10) years. If you answer "yes" to this question and the offense is under appeal, you must submit a copy of the notice of appeal of that criminal offense. Immediately upon disposition of the appeal, you must submit a copy of the final written order of disposition. If any misdemeanor conviction reported is expunged, a copy of the order of expungement signed by the judge must be submitted to the Department before the conviction will be removed from any profile.

IX. LIABILITY CLAIMS

This section requires you to indicate all medical malpractice court judgments, arbitration awards, or settlements in which a payment was awarded to a complaining party beginning with judgments or settlements entered or executed after May 19, 1998. That means if the act or event leading to the claim occurred in, for instance, 1995, but was finally adjudicated against you after May 19, 1998, you must indicate that claim in the space provided. JUDGMENTS OR SETTLEMENTS BELOW THE FOLLOWING AMOUNTS ARE NOT REQUIRED TO BE SUBMITTED.

- A) For Medical Doctors and Osteopathic Physicians, judgments or settlements below \$75,000 are not required to be submitted.
- B) For Chiropractors, judgments or settlements below \$50,000 are not required to be submitted.
- C) For Dentists, judgments or settlements below \$25,000 are not required to be submitted.
- D) For all other professions, judgments or settlements below \$10,000 are not required to be submitted.

Pending malpractice claims are not required to be reported unless/until final adjudication against you.

X. OPTIONAL INFORMATION

This section is voluntary. You may list, briefly describe, and submit any information/documentation regarding your professional practice in the spaces provided. Attach an additional sheet labeled with the question number if additional space is required.

Practitioner's Name _____ License # _____

Profession _____

TENNESSEE BOARD OF *(board for your profession)*
HEALTHCARE PROVIDER INFORMATION
TENNESSEE DEPARTMENT OF HEALTH
OFFICE OF HEALTH RELATED BOARDS
227 FRENCH LANDING, SUITE 300
HERITAGE PLACE, METROCENTER
NASHVILLE, TENNESSEE 37243

I. PRACTITIONER DATA

A. PROFESSION: _____ LICENSE NUMBER: _____

B. SOCIAL SECURITY NUMBER: _____ (This will **not** be published).

C. NAME (INCLUDE MAIDEN AND ON 2ND/3RD LINES ANY ALIASES, IF APPLICABLE):

CURRENT NAME:

(LAST) (FIRST) (MIDDLE AND MAIDEN NAME)
(IF APPLICABLE)

FORMER NAME(S):

(LAST) (FIRST) (MIDDLE)

(LAST) (FIRST) (MIDDLE)

D. PRIMARY PRACTICE ADDRESS (attach additional sheets if necessary):

(PRACTICE NAME)

(STREET NUMBER AND NAME)

(CITY) (STATE) (ZIP CODE)

Check here if your primary practice address is your home address and you want it to be published as part of the profile and on the web site.

E. E-MAIL ADDRESS: _____
Your e-mail address will be published unless you elect not to by checking here.

F. WEB PAGE ADDRESS: _____
Your web page address will be published unless you elect not to by checking here.

G. PRACTICE TELEPHONE: (_____) _____
Your telephone number will be published unless you elect not to by checking here.

H. LANGUAGES, OTHER THAN ENGLISH: Indicate languages other than English or translation services that may be available at your primary practice location.

1. _____ 2. _____

I. SUPERVISING PHYSICIAN: If you are required by law to be supervised by a physician (physician assistant or advanced practice nurse) indicate the name(s) and address(es) of each supervising physician. If you need more space, attach additional sheets:

1. _____

2. _____

Practitioner's Name _____ License # _____

Profession _____

II. GRADUATE/ POSTGRADUATE MEDICAL EDUCATION AND TRAINING

A. What school(s)/educational programs have you attended? And, what type(s) of degree(s) do you hold? Do not include coursework taken to meet the continuing education requirement for licensure renewal. (Authority: T.C.A. §63-51-105(a)(6) and (7))

| PROGRAM/INSTITUTION | CITY/STATE/COUNTRY | DATE OF GRADUATION MM/DD/YYYY | TYPE OF DEGREE |
|---------------------|--------------------|----------------------------------|----------------|
| 1. | | | |
| 2. | | | |
| 3. | | | |

B. List in chronological order from date of graduation to the present, all completed medical/professional graduate and/or post-graduate training (internship, residency, fellowship or other program). Do not include coursework taken to meet continuing education requirements for licensure renewal. (Authority: T.C.A. § 63-51-105(a)(6))

| PROGRAM AND SPECIALTY AREA (INTERNSHIP, RESIDENCY, FELLOWSHIP, ETC.) | LOCATION OF TRAINING (CITY, STATE, COUNTRY) | FROM MM/DD/YYYY | TO MM/DD/YYYY |
|--|--|--------------------|------------------|
| 1. | | | |
| 2. | | | |

III. SPECIALTY BOARD CERTIFICATIONS:

Do you hold a certification, specialty or subspecialty from any specialty board recognized by the board regulating the profession for which you are licensed? (see instructions) YES NO

(Authority: T.C.A. § 63-51-105(a)(8)) If "Yes", complete section below

| CERTIFYING BODY/BOARD INSTITUTION | CERTIFICATION/SPECIALTY/SUBSPECIALTY |
|-----------------------------------|--------------------------------------|
| 1. | |
| 2. | |
| 3. | |
| 4. | |
| 5. | |

Practitioner's Name _____ License # _____

Profession _____

IV. FACULTY APPOINTMENTS

A. Have you had the responsibility for graduate medical education within the last ten (10) years? (Authority: T.C.A. § 63-51-105(a)(10)) YES NO

B. Do you currently hold a faculty appointment at a medical/health related institution of higher learning? (Authority: T.C.A. § 63-51-105(a)(10)) YES NO

If "YES", list the title of the appointment, name(s) and city/state of institution(s). (Attach additional sheets, clearly labeled with this question number, if necessary.)

| | TITLE | INSTITUTION | CITY/STATE |
|----|-------|-------------|------------|
| 1. | _____ | _____ | _____ |
| 2. | _____ | _____ | _____ |
| 3. | _____ | _____ | _____ |

V. STAFF PRIVILEGES

A. Do you currently hold staff privileges at a hospital? (Authority: T.C.A. §63-51-105(a)(9)) YES NO

If "YES", list each hospital at which you currently have staff privileges: (Attach additional sheets, clearly labeled with this question number, if necessary)

| | NAME OF HOSPITAL | CITY/STATE |
|----|------------------|------------|
| 1. | _____ | _____ |
| 2. | _____ | _____ |
| 3. | _____ | _____ |
| 4. | _____ | _____ |
| 5. | _____ | _____ |

VI. MANAGED CARE PLANS

A. Do you participate in any managed care plans? (Authority: T.C.A. §63-51-105(a)(15)) YES NO

If "YES", list each: (Attach additional sheets, clearly labeled with this question number, if necessary)

| | NAME OF MANAGED CARE PLAN |
|----|---------------------------|
| 1. | _____ |
| 2. | _____ |
| 3. | _____ |
| 4. | _____ |
| 5. | _____ |

Practitioner's Name _____ License # _____

Profession _____

B. Do you currently participate in and accept any TennCare plan(s) as a provider? YES NO

If "YES", list each plan in which you currently participate or accept as a provider: (Authority: T.C.A. § 63-51-105(a)(16))

NAME OF TENNCARE PLAN

1. _____
2. _____
3. _____
4. _____
5. _____

VII. FINAL DISCIPLINARY ACTION (See Instructions):

A. Within the previous ten (10) years, have you ever had any final disciplinary action taken against you by the agency regulating your license, in this state or any other jurisdiction? (Authority: T.C.A. § 63-51-105(a)(8)) YES NO

If "YES", list name(s) and address(es) of agency(s) and a brief description of the final disciplinary action(s) and stated reason(s) for taking the action. (Attach additional sheets, clearly labeled with this question number, if necessary.)

| AGENCY NAME/ADDRESS | DATE | DESCRIPTION OF VIOLATION | DESCRIPTION OF ACTION |
|---------------------|------|--------------------------|-----------------------|
|---------------------|------|--------------------------|-----------------------|

- | | | | |
|----------|-------|-------|-------|
| 1. _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES NO

- | | | | |
|----------|-------|-------|-------|
| 2. _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES NO

Practitioner's Name _____ License # _____

Profession _____

B. Within the previous ten (10) years, have you ever had your hospital privileges revoked or involuntarily restricted or reasons related to competence or character by the hospital's governing body? (Authority: T.C.A. § 63-51-105(a)(4)) YES NO

If "YES", list name(s) and address(es) medical institution(s) and a brief description of the final disciplinary action(s) and stated reason(s) for the action. (Attach additional sheets, clearly labeled with this question number, if necessary)

| HOSPITAL NAME/ADDRESS | DATE | DESCRIPTION OF VIOLATION | DESCRIPTION OF ACTION |
|-----------------------|------|--------------------------|-----------------------|
|-----------------------|------|--------------------------|-----------------------|

| | | | |
|----------|-------|-------|-------|
| 1. _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES NO

| | | | |
|----------|-------|-------|-------|
| 2. _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES NO

C. Within the previous ten (10) years, have you ever been asked to or allowed to resign from or had any medical staff privileges restricted or not renewed by any hospital in lieu of or in settlement of a pending disciplinary action related to competence or character? (Authority: T.C.A.: § 63-51-105(a)(4))

YES NO

If "YES", list name(s) and address(es) of the hospital(s) and a brief description of the final disciplinary action(s) and stated reason(s) for the action. (Attach additional sheets, clearly labeled with this question number, if necessary)

| HOSPITAL NAME/ADDRESS | DATE | DESCRIPTION OF ACTION |
|-----------------------|------|-----------------------|
|-----------------------|------|-----------------------|

| | | |
|----------|-------|-------|
| 1. _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES NO

| | | |
|----------|-------|-------|
| 2. _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES NO

Practitioner's Name _____ License # _____

Profession _____

VIII. CRIMINAL OFFENSES (See Instructions)

Have you within the most recent ten (10) years, been found guilty, regardless of whether adjudication of guilt was withheld, or pled guilty or nolo contendere to a criminal misdemeanor or felony in any jurisdiction? (Authority: T.C.A. § 63-51-105(a)(1)) YES NO

If "YES" briefly describe the offense(s):

| DESCRIPTION OF OFFENSE(S) | DATE | JURISDICTION |
|---------------------------|-------|--------------|
| 1. _____ _____ | _____ | _____ |

If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES NO

| | | |
|-------------------|-------|-------|
| 2. _____ _____ | _____ | _____ |
|-------------------|-------|-------|

If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES NO

| | | |
|-------------------|-------|-------|
| 3. _____ _____ | _____ | _____ |
|-------------------|-------|-------|

If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES NO

IX. LIABILITY CLAIMS

Have you had a medical malpractice court judgment, arbitration award, or settlement against you since May 19, 1998? (Authority: T.C.A. § 63-51-105(a)(5)) YES NO

If "YES", indicate a brief description of the nature(s) of the claim, the date(s) of the claim report(s), and the amount of the judgment(s), award or settlement(s):

| ENTRY DATE OF DISPOSITION ORDER OR SETTLEMENT | AMOUNT |
|---|--------|
| 1. _____ | _____ |
| 2. _____ | _____ |
| 3. _____ | _____ |
| 4. _____ | _____ |

Practitioner's Name _____ License # _____

Profession _____

X. OPTIONAL INFORMATION:

A. PUBLICATIONS: List any publications you have authored in peer-reviewed medical literature: (optional)
(Authority: T.C.A. § 63-51-105(a)(11))

| | TITLE | PUBLICATION | DATE |
|----|-------|-------------|-------|
| 1. | _____ | _____ | _____ |
| 2. | _____ | _____ | _____ |
| 3. | _____ | _____ | _____ |
| 4. | _____ | _____ | _____ |

B. PROFESSIONAL OR COMMUNITY SERVICE ACTIVITIES AWARDS: List any information regarding professional or community service associates, activities and awards: (optional) (Authority: T.C.A. § 63-51-105(a)(12))

| | COMMUNITY SERVICE/AWARD/HONOR | ORGANIZATION |
|----|-------------------------------|--------------|
| 1. | _____ | _____ |
| 2. | _____ | _____ |
| 3. | _____ | _____ |
| 4. | _____ | _____ |

I affirm these statements are true and correct and recognize that providing false information may result in disciplinary action against my license pursuant to T.C.A. §§ 63-51-113 and/or 63-51-118.

(Signature of Provider) Date: _____

REMINDER: Each practitioner who has submitted information must update that information in writing by notifying the Department of Health, Healthcare Provider Information Unit, within 30 days after the occurrence of an event or an attainment of a status that is required to be reported by the law.