STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243
(800) 778-4123, ext. 532-4384 or (615) 532-3202, ext. 532-4384
www.tennessee.gov

APPLICATION INSTRUCTIONS FOR LICENSURE REINSTATEMENT

Provided below is a checklist for your personal use and convenience containing all the things you must do to receive consideration for reinstatement of your Tennessee license.

		Done
1.	Complete, have notarized, and mail the application pages 1 through 5.	_____
2.	Complete and mail Attachment 1 to each state, country, or province in which you hold or have ever held a license to practice any profession.	_____
3.	Submit a clear and recognizable, recently taken photograph of yourself that shows the full head, face forward from at least the shoulders up. (All professions except Polysomnography)	_____
4.	Submit proof of continuing education as required by your Board.	_____
5.	On October 1, 2008, Public Chapter 927 will become effective requiring physicians who perform Level II office based surgery must so report at the time of initial application, reinstatement or renewal of a medical license. Level II office based surgery means "level II surgery, as defined by the board of medical examiners in its rules and regulations, that is performed outside of a hospital, an ambulatory surgical treatment center, or other medical facility licensed by the Department of Health." The board of medical examiners' rules regarding office based surgery can be found at: http://www.state.tn.us/sos/rules/0880-0880-02.pdf. Please review these rules carefully if you perform level II procedures in your office. Under Public Chapter 927 you are further required to report certain "unanticipated events" to the board of medical examiners within mandated time frames of the occurrence. To review Public Chapter 927 please go to http://state.tn.us/sos/acts/105/pub/pc0927.pdf. It is imperative that you review this new law and adhere to it strictly. (MD and DO reinstatements only)	_____
6.	The "Save Act" requires The Tennessee Department of health (including all Boards, Commissions, and contractors), along with every local health department in the State, to verify that every <u>adult</u> applicant, for a professional license is either a U.S. citizen, a "qualified alien," or a nonimmigrant who meets the requirements set out in 8 U.S.C. 1621. Attachment 2 must be completed and submitted before this application can be processed.	_____

UNDERSTANDING THE APPLICATION PROCESS

1. All application fees are non-refundable. You will be notified of the reinstatement fee once the application has been received in the Board's Administrative Office.

2. All correspondence must be mailed directly to:

Administrator, _____
(Profession)
Tennessee Medical Board Office
665 Mainstream Drive
Nashville, TN 37243

3. A deficiency letter will be sent to you by mail. The supporting documentation (ie: proof of continuing education, etc.) requested in the letter must be received in the board office sixty (60) days from the date of the deficiency letter. Files not completed within sixty (60) days will be closed.

4. Allow fourteen (14) working days for information mailed to our office to be received and placed in your file. Special courier services will not appreciably reduce the processing time. Additionally, if special courier services are used you will be responsible for charges incurred. Please give the administrative office every consideration in this matter.

5. The application process will take six (6) to eight (8) weeks.

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

7. Do not make arrangements to accept employment in your profession in Tennessee until you have received confirmation of your reinstatement.

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

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APPLICATION FOR LICENSURE REINSTATEMENT

Read instructions prior to completing application. Applicants must comply with all instructions. Fill in all blanks; if not applicable, state "N/A".

PERSONAL INFORMATION

Name in full: _____
(*First)* *(Middle/Maiden)* *(Last)*

Reinstatement type. You must check one:

- ❑ Radiologist Assistant
- ❑ Physician Assistant
- ❑ Medical Doctor
- ❑ Medical Office X-Ray Operator
- ❑ Osteopathic Physician
- ❑ Osteopathic Office X-Ray Operator
- ❑ Acupuncturist
- ❑ ADS
- ❑ Clinical Perfusionist
- ❑ Certified Midwife
- ❑ Polysomnography Technologist
- ❑ Genetic Counselor

Have you been known by any other name? Yes ____ No
If yes, list names: _____
_____
_____

Date of Birth: Mo. _____ Day _____ Yr. _____ Social Security Number: ____ - ____ - ____

Place of Birth: _____
(City) *(State)* *(Country)*

Present Mailing Address: _____
_____
_____
_____

Home Phone: ( ) -
Work Phone: ( ) -

U.S. Citizen: Yes* _____ No* _____
*Attachment 2 must be completed by all applicants

Sex: Male _____
Female _____

I intend to do Level II Office Based Surgery which is integral to a planned treatment regimen and not performed on an urgent or emergent basis. Yes _____ No _____ (MD and DO only)

Email address: _____

Do you wish to receive notification, including renewal notification , from the Department of Health via email? Y N

PRACTICE AND LICENSURE INFORMATION

Present practice setting _____

_____

_____

Reason for leaving present practice _____

_____

_____

Reason for reactivating your Tennessee license _____

_____

_____

If applicable, reason license was not renewed _____

_____

_____

Type of intended specialty practice in Tennessee (MD and DO only) _____

_____

_____

Please complete your employment history since at least 1 year before the expiration date of the Tennessee license/registration, starting with the most current position first. Explain any breaks in employment. Use the back of this page, if you need additional space. **This section is required and your application will not be reviewed for approval until a complete work history has been received.**

Employment Dates	**Location**	**Job Duties**	**Job Title**
_____ to _____ mo/yr mo/yr	Employer _____ Address _____ _____ _____	_____ _____ _____ _____	_____
_____ to _____ mo/yr mo/yr	Employer _____ Address _____ _____ _____	_____ _____ _____ _____	_____
_____ to _____ mo/yr mo/yr	Employer _____ Address _____ _____ _____	_____ _____ _____ _____	_____

List below all states, countries, or provinces in which you have ever been or are currently licensed in your profession or any other health profession. Submit a copy of Attachment 1 to all such states, countries, or provinces regarding such licensure. Additional pages may be added if necessary.

STATE	**PROFESSION**	**LICENSE NUMBER**	**DATE ISSUED**	**CURRENT STATUS**
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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, and/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 make appropriate clinical diagnoses (if within the scope of professional practice), exercise reasoned practice judgments, learn, and keep abreast of developments in your profession;

    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, 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 that 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 medications) 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 and/or Committee 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 as defined on the previous page?		
If yes, do they in any way impair or limit your ability to practice your profession with reasonable skill and safety?		
Please list: _____		
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 in any state, country, or province, has it ever been denied, reprimanded, suspended, restricted, revoked, 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, otherwise disciplined, or voluntarily surrendered under threat of restriction or disciplinary action?		
7. Have you ever applied for and been denied a state or federal controlled substance certificate?		
If you have possessed such a certificate, has it ever been revoked, suspended, restricted, otherwise disciplined, or voluntarily surrendered under threat of investigation or disciplinary action?		
8. Have you ever been convicted of a felony or a misdemeanor other than a minor traffic offense?		
9. Have you ever been rejected or censured by a medical society?		
10. 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;		
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?		
11. If you have ever held a license or certificate in any health care profession, has it ever been reprimanded, suspended, restricted, revoked, 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 attest 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 regarding the practice of my profession, which are posted on the Board's Internet site and/or were provided to me by the Board office, and agree to abide by them in the practice of medicine in the State of Tennessee.

I HEREBY:

SIGNIFY my willingness to appear to answer such questions as the Board and/or Committee may find necessary, which may include a full Board interview.

RELEASE to the Board and/or Committee, 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 and/or Committee, 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 other qualifications.

RELEASE from liability the Board and/or Committee, 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, 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**

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

_____
NOTARY PUBLIC **AFFIX SEAL HERE**

My Commission Expires _____

ATTACHMENT 1

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243
1-800-778-4123 or 615-532-3202
www.tennessee.gov

CLEARANCE FROM OTHER STATE LICENSURE BOARDS

APPLICANT: Please provide the information requested in the top box and then mail one (1) 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).

_____ was granted a license to practice _____
(Name of Applicant) *(Profession)*
with license number _____ on _____ in the State of _____.
(Date)
The State of Tennessee requests that I submit evidence of the current status of my license in your state. You are hereby authorized to release any information in your files, favorable or otherwise, directly to:

Administrator, _____ (Profession)
Tennessee Medical Board Office
665 Mainstream Drive
Nashville, TN 37243

_____
Applicant's Signature

_____ _____
Date Applicant's typed or printed name

ADMINISTRATIVE OFFICE OF STATE LICENSURE BOARD, PLEASE COMPLETE:

Name In Full As It Appears On License _____

License Number _____ Profession _____ Date Issued _____

Basis of issuance (Check One) _____ Endorsement/Reciprocity with _____ (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, an explanation must be attached.

_____ _____ _____
Authorized Signature Title Date

ATTACHMENT 2

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__.

_____ AFFIX SEAL HERE
NOTARY PUBLIC

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.