STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243
www.tennessee.org

TENNESSEE BOARD OF MEDICAL EXAMINERS
(800) 778-4123, ext. 532-4384 or (615) 532-3202, ext. 532-4384

APPLICATION INSTRUCTIONS FOR TENNESSEE DISTINGUISHED FACULTY MEDICAL LICENSURE

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 medicine.

DONE

1. Complete and mail the application pages 1 through 6. _____

2. Complete and mail Attachment 1 to your medical school for transcript of courses, grades, and degree. _____

3. Submit a clear and recognizable, recently taken bust photograph of yourself that shows the full head, face forward from at least the shoulders up. _____

4. Submit proof of your citizenship in the United States or Canada or evidence of being legally entitled to live and work in the United States. (Notarized copies of birth certificates, naturalization papers, H-1 visas, or current passports are acceptable.) _____

5. **Attach to the application and submit a check or money order in the amount of $510.00, payable to the Tennessee Board of Medical Examiners.** _____

6. Have a letter submitted directly from the Dean of an accredited medical college in Tennessee stating that you have a full-time appointment at the rank of professor. _____

7. Have letters of support attesting to your distinguished status sent directly from all of the following on their letterheads:

   (a) The Dean of the appointing/employing medical college. _____

   (b) All department chairperson, at the appointing medical college, who are directly involved with your faculty assignments. _____

   (c) Have a total of five (5) letters of recommendation submitted directly from academic colleagues from outside Tennessee including other nationally or internationally recognized experts in your specialty area and/or from former medical school deans. _____

8. Have certifications submitted of your current and active membership in good standing in at least two (2) medical specialty societies that have restricted and selective membership based on academic and/or practice related criteria. (Medical societies must provide a copy of membership criteria) Certification must be sent directly to the Board office from the society. _____

9. Have certifications sent from at least two (2) medical educational institutions, either abroad or in the United States, which indicate that you have been or were invited to be a lecturer or visiting professor. These should indicate the applicable dates, lecture topics, and/or educational assignments. _____

10. Submit the dates, location, and sponsoring specialty organizations for at least two (2) national or international medical meetings at which you delivered scholarly medical papers along with copies of at least two (2) such delivered papers. The meetings must have been conducted by or for your speciality membership. _____

11. Complete and submit along with your application the *Practitioner Profile Questionnaire* which is online at http://tn.gov/assets/entities/health/attachments/PH-3585.pdf. _____

12. **A criminal background check is required.** For instructions to obtain a criminal background check, go to http://tn.gov/health/article/CBC-instructions _____

13. All applicants must complete, sign and have notarized the Declaration of Citizenship form and submit the documents required by the Declaration of Citizenship form. The Declaration of Citizenship is available online at: https://www.tn.gov/content/dam/tn/health/healthprofboards/PH-41833.pdf. _____

UNDERSTANDING THE APPLICATION PROCESS

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:

Tennessee Board of Medical Examiners
665 Mainstream Drive
Nashville, TN 37243 (37228 for overnight or special courier mail)

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. Periodic updates for applications will be mailed to the address provided by the applicant.

5. 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 by certified mail. The supporting documentation requested in the letter must be received in the Board office ninety (90) days from the date of the initial deficiency letter. Files not completed within ninety (90) days will be closed.

6. Absent any complicating factors, the average application processing time is eight (8) weeks. Once the application is completed, your file will be promptly reviewed and an initial licensure determination made. You will be notified by letter of the initial determination. If approved, you may begin work upon receipt of the approval letter. Your official license will not be released until the Board ratifies the initial approval.

7. If an address change occurs at any time during the application process, you must notify the Board office, in writing, immediately. All correspondence and certificates are mailed to the address submitted by the applicant.

8. All documents which are provided to this office in conjunction with your request for a medical license becomes part of the public record and must be released pursuant to a public records request.

9. You have the option to receive all correspondence from the Department of Health electronically. Should you “opt in,” you will no longer receive physical mail from this office. Opting in does not discharge your obligation to provide the Department with a current physical address and email address. You are required by statute and rule to notify the Department of an address change within thirty (30) days of any such change.

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

For Office Use Only	
06-001	$500
06-006	$ 10
Total	$510

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

TENNESSEE BOARD OF MEDICAL EXAMINERS
(800) 788-4123, ext. 532-4384 or (615) 532-3202, ext. 532-4384

APPLICATION FOR DISTINGUISHED FACULTY LICENSURE AS A MEDICAL DOCTOR

READ INSTRUCTIONS PRIOR TO COMPLETING APPLICATION. APPLICANTS MUST COMPLY WITH ALL INSTRUCTIONS.

Attach to this application a check or money order in the amount of $510, payable to the Tennessee Board of Medical Examiners.

PERSONAL INFORMATION

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

Have you been known by any other name? Yes _____ No _____ If yes, list name(s): _____

_____
_

Date of Birth: Mo._____ Day_____ Yr. _____ Are you a U.S. Citizen? Y N Gender: M F

Social Security Number: _____-_____-_____ Race: _____

Are you entitled to Live and Work in U.S.? Y N

Are you a member of the U.S. armed forces who has, within the preceding 180 days, retired from the armed forces, received any discharge other than a dishonorable discharge from the armed forces, or been released from active duty to a reserve component of the armed forces? Y N (If yes, please provide proof of status.)

Are you the spouse of a member of the armed forces who has been transferred by the military to Tennessee or who has, within the preceding 180 days, retired from the armed forces, received a discharge other than a dishonorable discharge from the armed forces or been released from active duty to a reserve component? Y N (If yes, please provide proof of same.)

Present Mailing Address: _____ Home Phone: (_____) _____-_____

_____

_____ Work Phone: (_____) _____-_____

Email address:_____

Do you wish to receive notification, including renewal notification, from the Department of Health via email? Y N
Please note, by opting in, all correspondence from the Department of Health will be delivered to the email address on file for you. You will no longer receive physical mail from our office.

EDUCATIONAL AND EXAMINATION INFORMATION

PRE-MEDICAL EDUCATION

From: _____ To: _____ _____ _____
MM/YY *MM/YY* *Educational Institution* *Location*

From: _____ To: _____ _____ _____
MM/YY *MM/YY* *Educational Institution* *Location*

From: _____ To: _____ _____ _____
MM/YY *MM/YY* *Educational Institution* *Location*

MEDICAL EDUCATION

I have spent _____ years in the study of medicine in the medical educational institutions below:

From: _____ To: _____ _____ _____
MM/YY *MM/YY* *Educational Institution* *Location*

From: _____ To: _____ _____ _____
MM/YY *MM/YY* *Educational Institution* *Location*

POSTGRADUATE TRAINING

I have spent _____ years in medical training in the medical educational institutions below:

From: _____ To: _____ _____ _____
MM/YY *MM/YY* *Educational Institution* *Location*

From: _____ To: _____ _____ _____
MM/YY *MM/YY* *Educational Institution* *Location*

From: _____ To: _____ _____ _____
MM/YY *MM/YY* *Educational Institution* *Location*

I have taken the following medical licensure examinations: (Check all applicable)

1. ____ National Boards (NBME) Certificate Number
2. ____ FLEX examination administered by the State of _____ on _____
(Date(s))
3. ____ Licensure by the Medical Council of Canada (LMCC)
4. ____ USMLE
5. ____ State Board administered by _____ prior to 1972.
(State)

Have you previously applied for a medical license in Tennessee? Y N

I intend to perform Level II Office Based Surgery which is integral to a planned treatment regimen and not performed on an urgent or emergent basis. Y N

If you intend to perform Level III Office Based Surgery, you must apply for and obtain a permit prior to engaging in such practice. You may access the application by visiting: https://tn.gov/assets/entities/health/attachments/PH-3963.pdf

Name and address of educational institution at which you are receiving a professorial appointment:

_____

_____

_____

PUBLICATION AND LICENSURE INFORMATION

List and provide citations to any and all publications in professional journals in which you are the author or coauthor. Additional pages may be attached to this form if necessary.

_____

_____

_____

_____

_____

_____

_____

	YES	NO
Are you or have you ever been licensed to practice medicine in another state?	___	___
Are you or have you ever been licensed in any other profession in Tennessee or another state?	___	___

List below all states, countries or provinces in which you have ever been or currently are licensed, permitted or certified. Submit a copy of **Attachment 1** to all such states, countries, or provinces regarding such licensure, certification or permit. Use the back of this page if you need additional space.

STATE	PROFESSION	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS

Do you have a DEA Registration? Y N

If yes, please provide:

_____

_____

If you have any NPI number, please provide:

_____

Please complete your entire employment history starting with the most current position first. Use the back of this page if you need additional space.

DATES	LOCATION	POSITION AND DUTIES
From: _____ To: _____ (MM/YY) (MM/YY)	_____ (City) _____ (State)	_____
From: _____ To: _____ (MM/YY) (MM/YY)	_____ (City) _____ (State)	_____
From: _____ To: _____ (MM/YY) (MM/YY)	_____ (City) _____ (State)	_____

COMPETENCY INFORMATION

PLEASE ANSWER THE FOLLOWING QUESTIONS. If you answer "yes" to any of the questions in this part, you must supplement your affirmative response with a thorough explanation on a separate page. **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. Additional information may be requested and/or required before a licensure decision may be made.**

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 and treatment decisions, exercise reasonable medical judgment, and keep abreast of medical education.

   b. The ability to communicate those judgments and medical 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 professional 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 including, but not limited to: orthopedic, visual, speech and/or hearing impairments, emotional or mental illness, specific learning disabilities, drug addiction, and alcoholism.

3. "**Minor Traffic Offense**" generally means moving and non-moving violations punishable by fines only and does not include offenses such as driving under the influence or while intoxicated or reckless driving.

4. "**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.

5. "Currently" does not mean on the day of or even in the weeks or months preceding the completion of the application; rather, it means within the past two years or recently enough so that the use of drugs or alcohol or other medical conditions may have an ongoing impact on one's functioning as a physician.

6. "**Illegal use of illicit or controlled substances**" means the use of 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 any condition that is causing impairment that affects your ability to practice medicine with reasonable skill and safety in a competent, ethical and professional manner? *(You may answer no if you are being appropriately treated and are not impaired.)*	____	____
2. Do you currently use any medications or substances (legal, OTC, prescribed or illicit) which in any way impairs or limits your ability to practice medicine with reasonable skill and safety in a competent, ethical and professional manner?	____	____

If so, please list: _____

[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: Please respond to ALL questions. If you answer "YES" to any question, please attach a written explanation. Affirmative response requires final documents or orders from the issuing states, courts, and/or agencies.	**YES**	**NO**
3. During the past two years, did you engage in any activity involving substances, either alcohol or controlled/illicit drugs, that has created or might create a challenging pathway for you in your current or future professional career if continued? If so and you answer "yes" to this question, the Board is prepared to offer an evaluation by the Tennessee Medical Foundation's Physicians Health Program to determine the best pathway to licensure for you as you begin or continue your career in the State of Tennessee. It should be noted, however, that if such activity is not revealed, but manifests at some later time in your career, the Board, in its role as the protector of the health, safety and welfare of people in the State of Tennessee, will be able to pursue a disciplinary action on your license.	_____	_____
4. Are you currently participating in a Professional Health Program (PHP) or similar type program that provides monitoring and advocacy for you for a physical, mental health or substance use disorder which has caused you impairment?	_____	_____
5. Have you ever been diagnosed as having or have you ever been treated for a paraphilia or other type disease of a predatory nature such as, but not limited to pedophilia, exhibitionism, voyeurism, etc.	_____	_____
6. Have you ever held or applied for a license or certificate to practice medicine in any state, country, or province, that has been or was ever denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	_____	_____
7. Have you ever had staff privileges at any hospital or health care facility that were ever revoked, suspended, curtailed, restricted, limited, otherwise disciplined, or voluntarily surrendered under threat of restriction or disciplinary action?	_____	_____
8. Have you ever applied for or held a state or federal controlled substance certificate that was ever denied, revoked, suspended, restricted, voluntarily surrendered or otherwise disciplined or surrendered under threat of restriction or disciplinary action?	_____	_____
9. Have you ever been convicted (including a nolo contendere plea or guilty plea) of a felony or misdemeanor (other than a minor traffic offense) whether or not sentence was imposed or suspended?	_____	_____
10. Have you ever been rejected or censured by a medical society?	_____	_____
11. In relation to the performance of your professional services in any profession:		
a. Have you ever had a final judgment rendered against you;	_____	_____
b. Have you ever entered into any settlement of any legal action; or	_____	_____
c. Are there any legal actions pending against you or to which you are a party?	_____	_____
12. Have you ever held a license or certificate in any health care profession that has ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	_____	_____
13. My name has been placed on the registry of persons who have abused, neglected or misappropriated the property of vulnerable individuals (Tennessee abuse registry or an abuse registry in another state).	_____	_____

AFFIDAVIT AND RELEASE

I, _____, M.D., of _____
(Applicant's Name) *(City)* *(State)*
being duly sworn and identified as the person referred to in this application, attests to the truth of each made in said application. I further swear that I have read and understand the law and the Rules and Regulations that were enclosed in the application packet 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 may find necessary, which may include a full Board 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 medicine.

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/or other qualifications.

RELEASE from liability the Board, its staff, and all their representatives and any and all organizations that provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character, and/or 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**

ATTACHMENT 1

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

TENNESSEE BOARD OF MEDICAL EXAMINERS
(800) 778-4123, ext. 532-4384 or (615) 532-3202, ext. 532-4384

APPLICANT: Supply the information requested in this box and then mail this entire form to your medical school.

Full Name: _____
(Last) (First) (Middle/Maiden)

Address: _____ Social Security Number: ___ - ___ - ___
_____
_____
_____

Student Identification Number: _____

Year of Graduation: _____

Degree Obtained: _____

TO WHOM IT MAY CONCERN:

I am applying for a license to practice medicine in the State of Tennessee.

Please forward an original graduate transcript of courses, grades, and degree bearing the institution's official seal to:

State of Tennessee
Board of Medical Examiners
665 Mainstream Drive
Nashville, TN 37243 (37228 for courier service only)

Thank you for your cooperation and prompt response.

_____ _____
Applicant's Signature Dat