77-001 $25
77-006 $ 5
TOTAL $30

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
www.tennessee.gov

APPLICATION FOR A SPECIAL TRAINING LICENSE AS A MEDICAL DOCTOR

APPLICANT: Provide the information required in the Personal and Competency Information portions of this application, sign, have the affidavit notarized, and then submit the entire application to the appropriate training program personnel. The sponsoring institution must submit this application simultaneously with all required documentation. It is vitally important that you provide the required documentation to the program personnel as early as possible. 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. You are required by law update your profile within 30 days of any change as long as you have an active license. Failure to do so may subject you to disciplinary action. A criminal background check is required. For instructions to obtain a criminal background check, go to http://tn.gov/health/article/CBC-instructions. All applicants must complete, sign and have notarized the Declaration of Citizenship form and submit the documents required by the Declaration of Citizenship form. This form is available online at: https://www.tn.gov/content/dam/tn/health/healthprofboards/PH-41833.pdf.

Applicant's Name: ____
(First) *(Middle and/or Maiden)* Last

Date of Birth: ____________________ Social Security Number: _____-_____-_________
(Month) (Day) (Year)

Present Home Mailing Address: ______________________________
____
____
____

Home Phone: (______)____________-________________

Residency or Fellowship Institution's Address: ______________________________
____
____
____

Work Phone: (______)____________-________________

Email Address:____

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

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 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 website at http://share.tn.gov/sos/rules/0880/0880-02.20150426.pdf, 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 which 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 accurate and 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**

SPONSORSHIP INFORMATION

THIS PORTION OF THE APPLICATION MUST BE COMPLETED BY THE DEAN OR PROGRAM DIRECTOR RESPONSIBLE FOR THE TRAINING PROGRAM

I, the undersigned, am submitting an application on behalf of ______________________________
(Applicant's Name)

to practice medicine in Tennessee with a special training license. **I am enclosing the following documents concerning this applicant with this application:**

1. An original medical school transcript sent directly from the applicant's medical school to me. [Note: the school's curriculum must be A.M.A. approved or for international medical school graduates, the medical school curriculum must be Tennessee Board approved pursuant to Rule 0880-2-.04(3). The transcript must show that the degree was conferred and it must bear the institution's official seal.] A notarized copy of the applicant's diploma will be accepted pending receipt of the original transcript.

2. A clear and recognizable, recently taken photograph of the applicant that shows the full head, face forward from at least the top of the shoulders up.

3. Two (2) original letters from medical professionals on the signatory's letterhead attesting to the applicant's good moral character.

4. Proof of the applicant's 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, or J-1 visas.) For purposes of the J-1 visa, the Board will accept a temporary visa or its application pending receipt of a notarized copy of the visa itself upon issuance.

5. A check or money order in the amount of Thirty Dollars ($30), payable to the Tennessee Board of Medical Examiners.

6. For International Medical School Graduates Only. A notarized copy of the applicant's original permanent E.C.F.M.G. Certificate. A notarized copy of the temporary certificate issued to the applicant will be accepted pending receipt of notarized copies of the original permanent certificate subsequently issued. [If the applicant is graduating from a Mexican Medical School, a letter from the E.C.F.M.G. stating that all certificate requirements have been met will be acceptable. If the applicant cannot obtain an original certificate due to the phase out of the E.C.F.M.G., proof of successful completion of the U.S.M.L.E. Steps 1 and 2 sent directly to you from the testing agency will be acceptable.]

Tennessee licensed physician(s) who will have primary supervisory responsibility for the applicant:

Name and License Number: ______________________________
Name and License Number: ______________________________

Sponsoring Medical School: ______________________________
____
____
____

DEAN'S OR PROGRAM DIRECTOR'S NAME AND TITLE:
____
____
(Please type or print)

SIGNATURE ______________________________

DATE ______________________________

Please mail to: Board of Medical Examiners
665 Mainstream Drive
Nashville, TN 37243