STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 Mainstream Drive
NASHVILLE, TENNESSEE 37243
www.tennessee.gov

TENNESSEE BOARD OF MEDICAL EXAMINERS, BOARD OF OSTEOPATHIC PHYSICIANS AND BOARD OF PHYSICIAN ASSISTANTS
(800) 778-4123, ext. 532-4384 or (615) 532-3202, ext. 532-4384

APPLICATION INSTRUCTIONS FOR SPECIAL VOLUNTEER LICENSE

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 Special Volunteer License.

Information Required for Tennessee Licensees

		Done
1.	Complete, have notarized, and mail the application pages 1 through 4.	_____
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.	Request the site of the free health clinic in which you intend to practice submit directly to this office a letter informing us of the clinic's location you will be working and a notarized copy of the IRS ruling that provides proof of the clinic's private, not-for-profit status.	_____

Information Required for Non-Tennessee Licensees

1.	Complete items 1, 2 and 3 above.	_____
2.	Submit a clear and recognizable, recently taken, bust photograph which shows the full head, face forward from at least the top of the shoulders up.	_____
3.	Provide two (2) letters attesting to the applicant's character, from medical professionals on the signator's letterhead. The letters must be original and dated within the last year.	_____
4.	Provide proof of citizenship or evidence of being legally entitled to live and work in the United States. Such evidence may include notarized copies of birth certificates, naturalization papers or current Visa status.	_____
5.	Complete and mail the Mandatory Practitioner Profile Questionnaire pages 1 through 6.	_____

UNDERSTANDING THE APPLICATION PROCESS

1. All documents 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 courier service only)

2. **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.

3. 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.)**

4. Absent any complicating factors, the average application processing time is eight (8) weeks. Once the application is completed, your file will be reviewed and an initial licensure determination made. You will be promptly notified by letter of the initial determination.

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

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

STATE OF TENNESSEE
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665 Mainstream Drive
Nashville, Tennessee 37243

APPLICATION FOR SPECIAL VOLUNTEER LICENSE

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 as it will appear on license: _____
(*First*) (*Middle*) (*Last*)

Special Volunteer Type. You must check one:

- ❑ Medical Doctor
- ❑ Osteopathic Physician
- ❑ Physician Assistant

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

Date of Birth: Mo. _____ Day _____ Yr. _____ Place of Birth _____
(*City*) (*State or Country*)

Social Security Number: _____ - _____ - _____ U.S. Citizen: Yes _____ No _____

Sex: Male _____ Female _____

Entitled to Live and Work in U.S.: Yes No

Email address: _____

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

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

_____ Work Phone: (_____) _____ - _____

Type of intended primary specialty practice in Tennessee, if applicable _____

Name and address of not-for-profit organization.

_____

_____

_____

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).	_____	_____

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

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 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 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 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, 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.

I, _____ hereby certify that I will limit my practice of medicine exclusively to the patients receiving service from _____ which is a not-for-profit organization and that such practice is without compensation.

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 _____, _____.

_____ Affix Seal Here
NOTARY PUBLIC

My Commission expires

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

CLEARANCE FROM OTHER STATE LICENSURE BOARDS

APPLICANT: Please provide 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. (You may copy this form.) **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 Board of Medical Examiners of Tennessee requests that I submit evidence of the current status of that license in your state. You are hereby authorized to release any information in your files, favorable or otherwise, directly to:

State of Tennessee
Board of Medical Examiners
665 Mainstream Drive
Nashville, TN 37243

Date: _____ _____
Applicant's Signature

_____
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: _____ 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, an explanation must be attached.

_____ _____ _____
Authorized Signature Title Date