State of Tennessee
Department of Health
665 Mainstream Drive
Nashville, TN 37243

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

APPLICATION FOR A LOCUM TENENS LICENSE AS AN OSTEOPATHIC DOCTOR

ATTACH THE FOLLOWING TO THIS APPLICATION AND MAIL TO:
Board of Osteopathic Examination
665 Mainstream Drive
Nashville, TN 37243

1. A check or money order for $310.00, payable to the Tennessee Board of Osteopathic Examination.
2. A clear and recognizable, recently taken, bust photograph.
3. Evidence of current licensure in good standing in another state (only need one). Attachment 2
4. A notarized copy of a specialty certification from a recognized specialty or a letter from your training program director which states that you are eligible to apply for the certification examination.
5. Proof of 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, resident alien cards, green cards, current H-1 Visa status, U.S. passport, or voter registration are acceptable.)
6. Complete and submit along with your application the Practitioner Profile Questionnaire which is online at https://www.tn.gov/content/dam/tn/health/healthprofboards/PH-3585.pdf. You are required by law to update your profile within 30 days of any such change as long as you have an active license.
7. Criminal Background Check. For instructions to obtain a criminal background check, go to http://tn.gov/health/article/CBC-instructions
8. 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. Absent any complicating factors, the application process may take up to eight (8) weeks.
3. 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. If an address change occurs at any time during the application process, you must notify the board office in writing immediately.
5. It is strongly encouraged that you do NOT make arrangements to accept employment as a physician in Tennessee until you are granted a license number by the board of osteopathic examination.
6. 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.
7. 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.

TAPE SIGNED PICTURE HERE

For Office Use Only
1907-001 $300
1907-006 10

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

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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 $310, payable to the Tennessee Board of Osteopathic Examination.

PERSONAL INFORMATION

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

Have you been known by any other name? Y N If yes, list names: _____
_____

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

Are you a U.S. Citizen? Y N Gender: M F Race: _____

Are you entitled to Live or 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.

Type of intended primary specialty practice in Tennessee _____

EDUCATIONAL INFORMATION

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*

Are you Board eligible? Y N Are you Board certified? Y N

Identify the specialty in which you are board eligible or board certified: _____

LICENSURE INFORMATION

	YES	NO
Have you previously applied for a license to practice osteopathic medicine in Tennessee?	_____	_____
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.	_____	_____

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://www.tn.gov/content/dam/tn/health/healthprofboards/PH-3964.pdf

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

PRACTICE INFORMATION

Intended practice location in Tennessee:

Name: _____

Address: _____

Intended duration of initial work in Tennessee: _____

Briefly describe the reason why this license is desired and the situation in which it will be used: _____
_____
_____

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

Company/ Employer:	**Address: (City, and State)**	**Position:**	**Duties:**	**Dates From: Mo./Yr.**	**To: Mo./Yr.**

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 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 professional association or 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, registration, privilege or certificate in any profession that has ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action in any jurisdiction?	_____	_____
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, _____, D.O., of _____
(Applicant's Name) *(City)* *(State)*

being duly sworn and identified as the person referred to in this application and signed photo, 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, which 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 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 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, TN 37243

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LOCUM TENENS PHYSICIAN

NOTIFICATION OF PRACTICE SETTING

Practice Setting Dates: _____

Practice Setting Location: _____
_____
_____

Please describe the reason for this practice:
(If the reason is to substitute or provide coverage, include the doctor's name and specialty)

_____
_____
_____
_____
_____
_____
_____

Name: _____ **Date:** _____

Signature: _____ **License #D.O.L.T:** _____

ATTACHMENT 2

State of Tennessee
Department of Health
Health Related Boards
665 Mainstream Drive
Nashville, TN 37243

TENNESSEE BOARD OF OSTEOPATHIC EXAMINATION
(615) 532-3202, ext. 532-4384 or (800) 778-4123, 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. (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 Board of Osteopathic Examination 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 Osteopathic Examination
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