

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 <u>requires</u> final documents or orders from the issuing states, courts, and/or agencies.	YES	NO
<p>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.</p> <p style="margin-left: 20px;">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.</p>	_____	_____
<p>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?</p>	_____	_____
<p>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.</p>	_____	_____
<p>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?</p>	_____	_____
<p>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?</p>	_____	_____
<p>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?</p>	_____	_____
<p>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?</p>	_____	_____
<p>10. Have you ever been rejected or censured by a professional association or society?</p>	_____	_____
<p>11. In relation to the performance of your professional services in any profession:</p>		
<p style="margin-left: 20px;">a. Have you ever had a final judgment rendered against you;</p>	_____	_____
<p style="margin-left: 20px;">b. Have you ever entered into any settlement of any legal action; or</p>	_____	_____
<p style="margin-left: 20px;">c. Are there any legal actions pending against you or to which you are a party?</p>	_____	_____
<p>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?</p>	_____	_____
<p>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).</p>	_____	_____

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

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, 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 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 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 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 _____, _____.

NOTARY PUBLIC

Affix Seal Here

My Commission expires _____

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.O.A. approved. The transcript must show that the degree was conferred and it must bear the institution's official seal.)
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 United States or Canadian citizenship or evidence of being legally entitled to live and work in the United States or evidence of citizenship and residency in a N.A.F.T.A participating country. (Notarized copies of birth certificates, naturalization papers, current H-1 visa status, or voter registration are acceptable.)
5. A check or money order in the amount of Sixty Dollars (\$60), payable to the Tennessee Board of Osteopathic Examination.

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 Osteopathic Examination
665 Mainstream Drive
Nashville, TN 37243**