



State of Tennessee

Department of Health

Tennessee Board of Social Worker Licensure

**227 French Landing, Suite 300
Heritage Place, Metro Center
Nashville, TN 37243**

**1-800-778-4123 ext 25088
(615) 532-5088**

www.state.tn.us/health

Application and Procedures for Licensure

LICENSED BACCALAUREATE SOCIAL WORKER

Below is an explanation of the items requested to be submitted in the checklist. When reviewing the checklist, refer to this section if you need clarification.

1. It is the applicant's responsibility to review the current Rules and Laws for Social Workers. To determine if you meet the qualifications for licensure, you may obtain a copy by going to www.health.state.tn.us.
2. Fill out the application completely making sure that you indicate the correct level of licensure. The application must be signed. Incomplete forms will be returned thus delaying the application process.
3. **FEES.** Check or money order is to be made payable to the Board of Social Workers in the amount indicated according to the method under which you are applying. The fee amount being collected with the application includes the state regulatory fee of ten dollars (\$10).
4. **PHOTOGRAPH.** Submit a recent passport size photograph (taken within the last twelve (12) months) preceding the date the application is submitted to the Board office.
5. **TRANSCRIPT.** Must be sent to the Board's office directly from the institution. Please instruct the institution to indicate any name change since completion of the course work.
6. **VERIFICATION OF LICENSURE.** Must be sent from each state licensing board which indicates the applicant holds a certificate or license and whether it is in good standing presently, or was at the time it became inactive.
7. **VERIFICATION OF EXAM.** Exam results must be sent from the testing agency (ASWB) to the administration office indicating level of exam.
8. Criminal background check (for instructions [click here](#)).
NOTE: applicants applying for licensure by exam must have successfully taken and passed the ASWB exam before applying for the criminal background check.
9. Send your application, fees and supporting materials to:

Board of Social Worker Licensure
227 French Landing, Suite 300
Heritage Place, Metro Center
Nashville, TN 37243

GENERAL INFORMATION

Individuals who do not qualify for licensure at this time are encouraged to complete deficient requirements if you intend to practice as a social worker in Tennessee.

It is the applicant's responsibility to keep the Board notified whenever a change of name or mailing address occurs. Such notification must be in writing and you must reference your profession and the Board in your correspondence. Supporting documentation and written request for a name change must state the reason for the change, i.e., marriage, divorce, etc .

Every effort is made to keep you informed, in writing, of the status of your application and to process your application in a timely, efficient manner. Inquiries regarding the status of a file will be responded to in writing.

**APPLICATION PROCESS
FOR LICENSED BACCALAUREATE SOCIAL WORKER**

SECTION I

LICENSED BACCALAUREATE SOCIAL WORKER BY EXAM:

CHECK LIST FOR LICENSED BACCALAUREATE SOCIAL WORK

You send	You request others to send
_____ Completed and signed application	_____ Official transcripts (page 13)
_____ Fees of \$110.00 (\$50.00 application fee plus \$50.00 license fee plus \$10.00 State regulatory fee) payable to the Board of Social Worker Licensure	_____ Verification of licensure, if licensed in other jurisdiction regardless of the status of the license (i.e., inactive) (page 11)
_____ Passport-style photograph	_____ Criminal Background Check (once you have successfully passed the ASWB exam you must apply for the criminal background check).
_____ Completed Mandatory Practitioner Profile Questionnaire (mail with the application)	

WHEN DEEMED ELIGIBLE, LICENSE WILL BE MAILED WITHIN TWO (2) WEEKS FOLLOWING THE NEXT SCHEDULED BOARD MEETING.

SECTION II

LICENSED BACCALAUREATE SOCIAL WORKER BY RECIPROCITY:

CHECK LIST FOR LICENSED BACCALAUREATE SOCIAL WORK

You Send	You request others to send
_____ Completed and signed application	_____ Official transcripts (page 13)
_____ Fees of \$ 110.00 (\$50.00 application fee plus \$ 50.00 license fee plus \$ 10.00 State regulatory fee) payable to the Board of Social Worker Licensure	_____ Verification of licensure, if licensed in other jurisdiction regardless of the status of the license (i.e., inactive) (page 11)
_____ Passport-style photograph	_____ Verification of applicant taking and passing the ASWB examination (page 12)
_____ A copy of the original State’s law and rules, if available	_____ Criminal Background Check For instructions click here
_____ Photo copy of the original license from the original state of licensure with applicants current license number, if available	
_____ Photo copy of the applicants current renewal certificate with the license number and expiration date	
_____ Completed Mandatory Practitioner Profile Questionnaire (mail with the application)	

WHEN DEEMED ELIGIBLE, LICENSE WILL BE MAILED WITHIN TWO (2) WEEKS FOLLOWING THE NEXT SCHEDULED BOARD MEETING.

**APPLICATION
FOR TEMPORARY LICENSED BACCALAUREATE SOCIAL WORKER**

SECTION III

Temporary license can be issued for licensed Baccalaureate Social Worker who graduated from a university, college, or school of social work that at the time of the applicant's graduation has applied for, but has not yet received, accreditation by the Council on Social Work Education.

CHECK LIST FOR TEMPORARY LICENSE

You send	You request others to send
_____ Completed and signed application	_____ Official transcripts (page 11)
_____ Fees of \$60.00 (\$50.00 temporary fee plus \$10.00 State regulatory fee) payable to the Board of Social Worker Licensure	_____ Verification of degree and accreditation status (page 10)
_____ Passport-style photograph	_____ Criminal Background Check For instruction click here
_____ Completed Mandatory Practitioner Profile Questionnaire (mail with the application)	

PLEASE NOTE A TEMPORARY LICENSED BACCALAUREATE SOCIAL WORKER MUST SUBMIT AN APPLICATION FOR LICENSED BACCALAUREATE SOCIAL WORKER SIXTY (60) DAYS AFTER HIS/HER EDUCATION INSTITUTION RECEIVES ACCREDITATION FROM THE COUNCIL ON SOCIAL WORK EDUCATION, OR THE TEMPORARY LICENSE SHALL NO LONGER BE VALID.

WHEN DEEMED ELIGIBLE, LICENSE WILL BE MAILED WITHIN TWO (2) WEEKS FOLLOWING THE NEXT SCHEDULED BOARD MEETING.

**ATTACH
PASSPORT TYPE
PHOTO HERE**



Application Fee 45-001 \$50
Licensing Fee 45-001 \$50
State Reg Fee 45-006 \$10
\$110

**Tennessee Board of Social Worker Licensure
227 French Landing, Suite 300
Heritage Place, Metro Center
Nashville, TN 37243**

Temporary Fee 45-001 \$50
State Reg Fee 45-006 \$10
\$60

615-532-5088 or 800-778-4123 ext 25088
www.state.tn.us/health

Licensed Baccalaureate Social Worker

Please indicate by checking one:

Exam: _____ **LBSW**
Reciprocity: _____ **LBSW**
Temporary: _____ **LBSW**

NAME: _____
(Last) (First) (Middle/Maiden)

NOTE: This name will be used to register you with the testing agency (ASWB). You will be required to present the original ASWB Authorization Letter and one currently valid, non-expired government-issued photo-bearing i.d. (driver's license, military i.d., passport, etc.) at the testing center. The name on your i.d. MUST match your name as it appears on your Authorization Letter. You will not be allowed to test and will forfeit your exam fee without the Authorization Letter and proper identification.

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: (_____) _____ HOME E-MAIL: _____

SOCIAL SECURITY NO: _____ - _____ - _____ BIRTH DATE: _____ / _____ / _____

RACE: _____ SEX: _____

You must put your social security number on this form for the application to be complete. State and federal law require social security numbers on this application. Tenn. Code. Ann. § 36-5-1301(a), as authorized by 42 U.S.C. § 405(c)(2)(C)(i). The number will be used to verify your identity, to ask questions about your financial responsibility, and for any other purpose allowed by state or federal law. When you provide your social security number on this application and sign the form, you are agreeing that Department of Health may use your social security number in furtherance of federal and state law, for example, to collect delinquent fees.

EDUCATIONAL INFORMATION:

NAME OF COLLEGE/UNIVERSITY: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

DEGREE RECEIVED: _____ DATE CONFERRED: _____ / _____ / _____

Do you or have you ever held a certificate or license to practice social work in any other state?

YES: _____ NO: _____

If yes, you must submit a letter of good standing from each state in which you have or have ever held a certificate and/or license.

_____/_____, _____/_____, _____/_____
(State) (License number) (State) (License number) (State) (License number)

EMPLOYMENT HISTORY:

CURRENT EMPLOYER: _____

EMPLOYER ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

WORK PHONE: (_____) _____ - _____ WORK E-MAIL: _____

JOB TITLE: _____ TYPE OF POSITION: _____

FULL TIME: _____ PART TIME: _____ WORKING IN PROFESSION: YES: _____ NO: _____

EMPLOYMENT DATES: FROM: ____/____/____ TO: ____/____/____

SUPERVISOR'S NAME: _____

MAJOR RESPONSIBILITIES: _____

LICENSURE INFORMATION: RECIPROCITY APPLICANTS

1. Have you taken and passed the ASWB Basic exam? YES: _____ NO: _____
 2. If yes, please have the ASWB send a copy of your test scores.
-
-

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 purpose of these questions, the following phrases or words have the following meanings:

1. "Ability to practice social work" is to be construed to include all of the following:
 - a. The cognitive capacity to make appropriate diagnosis or evaluation, exercise reasonable judgment, to learn, and keep abreast of developments in the field of social work.
 - b. The ability to communicate those judgments and information to clients and other health care providers, with or without the use of aids or devices, such as voice amplifiers.

2. "Chemical Substance" 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.
3. "Currently" does not mean on the day of or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one's function as a licensee or within the past two (2) years.

QUESTION:	YES	NO
1. Do you currently have a medical condition which in any way impairs or limits your ability to practice social work with reasonable skill and safety?	_____	_____
a. If yes, are they reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program?	_____	_____
b. If you have any limitations or impairments caused by an existing medical condition, are they reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice?	_____	_____
(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 be determined whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure).		
2. Do you currently use chemical substance?	_____	_____
a. If yes, please submit a letter from your physician regarding your prescribed medication. (Must be submitted on physician letter head, and must contain information on whether this medication will impair or limit your ability to practice social work with reasonable skill and safety).		
3. Are you currently engaged in the illegal use of controlled substance?	_____	_____
a. If yes, are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaged in the Illegal use of controlled substance? (Submit a letter from your Physician regarding your Treatment) .	_____	_____
4. Have you ever been diagnosed as have or have you ever been treated for pedophilia, exhibitionism, or voyeurism?	_____	_____
5. If you have ever held or applied for a license to practice social work in any state, country, or province, was or has it ever been denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	_____	_____

QUESTION:	YES	NO
6. If you have ever had staff privileges at any hospital or health care facility, have they ever been revoked, suspended, curtailed, restricted, limited, otherwise disciplined, or voluntarily surrendered under threat of restriction or disciplinary action?	_____	_____
7. Have you ever been convicted of a felony or a misdemeanor other than a minor traffic violation?	_____	_____
8. Have you ever been rejected or censured by a professional association?	_____	_____
9. 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 had a settlement of any legal action rendered against you?	_____	_____
c. Are there any legal actions pending against you or to which you are a party?	_____	_____
10. If you have ever held a license or certificate in any health care profession, has it ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	_____	_____

**AFFIDAVIT OF APPLICANT
APPLICANT'S CONSENT AND RELEASE**

In applying for licensure in the State of Tennessee, I HEREBY:

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 competency, character, health status, ethical qualifications, ability to work cooperatively with others, and other qualifications.

CONSENT TO THE RELEASE of such information.

RELEASE FROM LIABILITY the Board, its staff, and all their representatives for their acts performed and statements made in good faith and without malice in connection with evaluation of my application, my credentials, and my qualification.

ACKNOWLEDGE THAT I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical, and other qualifications, and also for resolving any doubt about such qualifications.

THIS CERTIFIES THAT THE INFORMATION SUBMITTED BY ME IN MY APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

(Applicant's Signature)

(Date)



STATE OF TENNESSEE
 DEPARTMENT OF HEALTH
BUREAU OF HEALTH LICENSURE AND REGULATION
DIVISION OF HEALTH RELATED BOARDS
 227 FRENCH LANDING, SUITE 300
 HERITAGE PLACE, METRO CENTER
 NASHVILLE, TN 37243

TENNESSEE BOARD OF SOCIAL WORKER LICENSURE

VERIFICATION OF DEGREE AND ACCREDITATION STATUS

If you have graduated from a Social Work program and the program has not received full accreditation, please complete Section 1 and send this form to the institution for verification.

SECTION 1

(Name of Applicant)	(Name of Program)
(Social Security No.)	(Address)
	(City/ State / Zip)

SECTION 2

This section must be completed by the authorized representative of the institution that granted the degree.

(Institution name)	(Program Director print name)	
(Address)	(Signature)	(Date)
(City/ State / Zip)	Date applied for accreditation: _____ / _____ / _____	
(Degree)	Date degree was conferred: _____ / _____ / _____	



STATE OF TENNESSEE
DEPARTMENT OF HEALTH
BUREAU OF HEALTH LICENSURE AND REGULATION
DIVISION OF HEALTH RELATED BOARDS
227 FRENCH LANDING, SUITE 300
HERITAGE PLACE, METRO CENTER
NASHVILLE, TN 37243

TENNESSEE BOARD OF SOCIAL WORKER LICENSURE

VERIFICATION OF LICENSURE

Please complete the top portion and mail this form to the regulatory board in each state where you hold or have held a license or certificate to practice as a Social Worker. (If additional forms are required, this form may be duplicated.) Please disregard this page if you are not licensed or certified or have never been licensed or certified as a social worker in another state.

NOTE: Some states require a fee for providing verification information. In order to expedite your application, you may wish to contact the applicable state or states.

I was granted _____ on _____ by the State of _____
(License #) (Date)

The Tennessee Board of Social Worker Licensure requests that I submit evidence that my license or certificate in your state is in good standing. You are hereby authorized to release any information in your files, favorable or otherwise, directly to the Tennessee Board of Social Worker Licensure. Your early attention is appreciated. _____
(Signature) (Date)

THIS PORTION IS TO BE COMPLETED BY STATE LICENSING BOARD VERIFYING LICENSURE

Name of Licensee	Licensure Level	License No.	Date Issued
Please Verify All Requirements Met in Your Jurisdiction			
Education: ____ BSW from CSWE Accredited School ____ MSW from CSWE Accredited School	Experience clinical: ____ # Months Post LMSW Clinical Experience ____ # Hours of face to face supervision ____ # Hours clinical experience	Experience non-clinical: ____ # Months Post LMSW Non-clinical Experience ____ # Hours of face to face supervision ____ # Hours non-clinical experience	
Exam Taken ____ ASWB (Only ASWB will be accepted) ____ Other _____	Date Exam Passed	Level Exam Taken	If no Exam score is on file, how was licensure obtained? ____ Grandfathered ____ Endorsement: If endorsement, what state? _____
License Current? ____ Yes ____ No	Expiration Date ____/____/____	Complaints and/or Disciplinary Action ____ Yes* ____ No	

***Explain Complaints or Disciplinary Actions (please enclose a copy of any board order)**

(Signature of person completing form) (Title) (Date)

(Print name of person completing form) (Phone number)

Board Seal Here



TENNESSEE DEPARTMENT OF HEALTH

MANDATORY PRACTITIONER PROFILE QUESTIONNAIRE FOR LICENSED HEALTH CARE PROVIDERS

The Health Care Consumer Right-to-Know Act of 1998, T.C.A. §§ 63-51-101, *et seq.*, requires designated licensed health professionals to furnish certain information to the Tennessee Department of Health, and is requested in this questionnaire. From the information submitted, the Department compiles practitioner profiles which the law requires to be made available to the public via the World Wide Web and our toll-free telephone line. Each practitioner who has submitted information must update that information in writing by notifying the Department of Health, Healthcare Provider Information Unit, within 30 days after the occurrence of an event or an attainment of a status that is required to be reported by the law. A copy of your initial or updated profile will be furnished to you for your review prior to publication. That opportunity will allow you to make corrections, additions and helpful explanatory comments. Failure to comply with the requirement to submit and update profiling information may result in a delay or denial of your licensure application and/or may result in disciplinary action against your license.

A blank copy of the profile questionnaire may be obtained from the following web site address: <http://tennessee.gov/health>. Then select "Forms and Publications," then "Consumer Right-To-Know," then "Mandatory Practitioner Profile Questionnaire for Licensed Health Care Providers."

INSTRUCTIONS

QUESTIONNAIRE DEADLINE The provider must complete and submit the questionnaire before a license will be granted. Providers who have completed a similar questionnaire for another state's licensing board are, nevertheless, required to complete and submit this form.

COMPLETING THE QUESTIONNAIRE Complete the questionnaire by printing neatly in block letters in ball point pen or by typing the information. If a question does not apply to you, indicate so by checking the "Does not apply" box. **Illegible questionnaires will be returned.** If you need further instruction, contact your profession's licensing board by calling (615) 532-3202 or by calling toll free at (800) 778-4123.

SUBMITTING THE QUESTIONNAIRE Mail the completed profile questionnaire to:

Healthcare Provider Information Manager
Tennessee Department of Health
Division of Health Related Boards
227 French Landing, Suite 300
Heritage Place, MetroCenter
Nashville, TN 37243

- ▶ **Do not return pages 1 through 4 with the questionnaire to the department**
- ▶ **Keep a copy of the questionnaire for your records.**

The following numbered parts correspond to the matching number on the questionnaire form.

I. PRACTITIONER DATA

Complete Part I, noting the following:

- License number: Fill in your license number and indicate your profession in the space provided.
- Social security number: **Your social security number will not be published or in any way given out to the public. It is required for in-house tracking purposes only.**
- Primary Practice Address: Complete the practice address (if applicable). If your practice address is also your home address, you should know the Department is prohibited from placing your home address on the Internet without your request to do so. There is a box to check in Part I to request this. Retirees: Write in "N/A" for practice address.

II. GRADUATE/POSTGRADUATE MEDICAL/PROFESSIONAL EDUCATION AND TRAINING

List chronologically medical/health professional related graduate/postgraduate education and training completed. Exclude any program or courses taken to satisfy continuing education requirements for licensure renewal. Provide information about health related degrees you have received including your licensure degree.

III. SPECIALTY BOARD CERTIFICATIONS

Provide information on any certification, specialty or subspecialty from any specialty board recognized by the American Medical Association, American Osteopathic Medical Association, American Podiatry Association, American Chiropractic Association, American Dental Association or any other specialty certifying body as determined by your Tennessee licensing board.

IV. FACULTY APPOINTMENTS

Answer ALL yes/no questions with a “yes” or “no” response. A brief statement in the space provided should follow a “yes” answer. If the space is insufficient for your response, attach an additional page, being sure to number the response to match the appropriate question.

V. STAFF PRIVILEGES

List all hospitals at which you hold staff privileges. The definition for “hospital” can be found at T.C.A. § 68-11-201.

In the spaces provided, answer information about the TennCare plans in which you participate and accept as a provider, if any. If there are more than five (5), please enclose an attachment.

VII. FINAL DISCIPLINARY ACTION

These questions refer to final disciplinary or adverse actions taken within the previous **ten (10) years**, whether in this state or any other jurisdiction. The term **final** means the matter was fully adjudicated at a hearing and the appeal’s period expired, or that the applicable board issued an agreed order or consent decree.

In the “Description of Violation” spaces, indicate the nature of the conduct in question such as malpractice, unethical conduct, drug-related, sex related, impairment, frauds, etc.

In the “Description of Action” spaces, indicate the type of disciplinary action imposed against your professional license.

The term **disciplinary action** includes, but is not limited to:

- Probation
- Limitation/Restriction
- Suspension
- Revocation
- Voluntary relinquishment in lieu of disciplinary action
- Any other adverse action taken against a license or privilege by a medical/health related institution
- Compulsory surrender of license or privilege
- Civil or other monetary fine or penalty
- Resignation from or non-renewal of medical staff membership at a hospital in lieu of, or in settlement of, a pending disciplinary case related to competence or character
- Restriction of privileges in lieu of, or in settlement of, a pending disciplinary case related to competence or character

If you answer “yes” to any of the questions in this section and if the action is under appeal, you must attach a copy of the notice of appeal. Note: You must submit a copy of the final written order of disposition immediately after the appeal is disposed of by the adjudicating authority. Please read questions B and C in Part VII in their entirety before answering those questions.

VIII. CRIMINAL OFFENSES

This part requires you to report any state or federal felony criminal offense convictions. It also requires the reporting of misdemeanor offenses, regardless of classification, in which any element of the offense involves sex; alcohol or drugs; physical injury or threat of injury to any person; abuse or neglect of any minor, spouse or the elderly; fraud or theft in Tennessee or another jurisdiction; or unlicensed practice within the most recent ten (10) years. If you answer "yes" to this question and the offense is under appeal, you must submit a copy of the notice of appeal of that criminal offense. Immediately upon disposition of the appeal, you must submit a copy of the final written order of disposition. If any misdemeanor conviction reported is expunged, a copy of the order of expungement signed by the judge must be submitted to the Department before the conviction will be removed from any profile.

IX. LIABILITY CLAIMS

This section requires you to indicate all medical malpractice court judgments, arbitration awards, or settlements in which a payment was awarded to a complaining party beginning with judgments or settlements entered or executed after May 19, 1998. That means if the act or event leading to the claim occurred in, for instance, 1995, but was finally adjudicated against you after May 19, 1998, you must indicate that claim in the space provided. **JUDGMENTS OR SETTLEMENTS BELOW THE FOLLOWING AMOUNTS ARE NOT REQUIRED TO BE SUBMITTED.**

- A) For Medical Doctors and Osteopathic Physicians, judgments or settlements below \$75,000 are not required to be submitted.
- B) For Chiropractors, judgments or settlements below \$50,000 are not required to be submitted.
- C) For Dentists, judgments or settlements below \$25,000 are not required to be submitted.
- D) For all other professions, judgments or settlements below \$10,000 are not required to be submitted.

Pending malpractice claims are not required to be reported unless/until final adjudication against you.

X. OPTIONAL INFORMATION

This section is voluntary. You may list, briefly describe, and submit any information/documentation regarding your professional practice in the spaces provided. Attach an additional sheet labeled with the question number if additional space is required.

Profession _____

**HEALTHCARE PROVIDER INFORMATION MANAGER
TENNESSEE DEPARTMENT OF HEALTH
DIVISION OF HEALTH RELATED BOARDS
227 FRENCH LANDING, SUITE 300
HERITAGE PLACE, METROCENTER
NASHVILLE, TENNESSEE 37243**

I. PRACTITIONER DATA				
A.	PROFESSIONAL LICENSE NUMBER: _____	PROFESSION: _____		
B.	SOCIAL SECURITY NUMBER: _____ (This will not be published as part of the profile or website).			
C.	NAME (INCLUDE MAIDEN AND ON 2 ND /3 RD LINES ANY ALIASES, IF APPLICABLE):			
	CURRENT NAME:			
	_____ (LAST)	_____ (FIRST)		
		_____ (MIDDLE AND MAIDEN NAME) (IF APPLICABLE)		
	FORMER NAME(S):			
	_____ (LAST)	_____ (FIRST)		
		_____ (MIDDLE)		
	_____ (LAST)	_____ (FIRST)		
		_____ (MIDDLE)		
D.	PRIMARY PRACTICE ADDRESS:			
	_____ (PRACTICE NAME)	<input type="checkbox"/> Check here if your primary practice address is your home address and you want it to be published as part of the profile and on the web site.		
	_____ (STREET NUMBER AND NAME)			
	_____ (CITY)		_____ (STATE)	_____ (ZIP CODE)
E.	E-MAIL ADDRESS _____			
	Your e-mail address will be published unless you elect not to by checking here. <input type="checkbox"/>			
F.	WEB PAGE ADDRESS _____			
	Your web page address will be published unless you elect not to by checking here. <input type="checkbox"/>			
G.	TELEPHONE: (_____) _____			
	Your telephone number will be published unless you elect not to by checking here. <input type="checkbox"/>			
H.	LANGUAGES, OTHER THAN ENGLISH: Indicate languages other than English or translation services that may be available at your primary practice location.			
	1. _____ 2. _____			
I.	SUPERVISING PHYSICIAN, If you are required by law to be supervised by a physician (physician assistant or nurse practitioner) indicate the name(s) and address(es) of each supervising physician. If you need more space, attach additional sheets:			
	1. _____			
	2. _____			

II. GRADUATE/ POSTGRADUATE MEDICAL EDUCATION AND TRAINING

A. What school(s)/educational programs have you attended? And, what type(s) of degree(s) do you hold? Do not include coursework taken to meet the continuing education requirement for licensure renewal. (Authority: T.C.A. §63-51-105(a)(6) and (7))

PROGRAM/INSTITUTION	CITY/STATE/ COUNTRY	DATE OF GRADUATION	TYPE OF DEGREE
1.			
2.			
3.			
4.			
5.			
6.			

B. List in chronological order from date of graduation to the present, all completed medical/professional graduate and/or post-graduate training (internship, residency, fellowship or other program). Do not include coursework taken to meet continuing education requirements for licensure renewal. (Authority: T.C.A. § 63-51-105(a)(6))

PROGRAM AND SPECIALTY AREA (INTERNSHIP, RESIDENCY, FELLOWSHIP, ETC.)	LOCATION OF TRAINING (CITY,STATE,COUNTRY)	FROM MM/DD/YYYY	TO MM/DD/YYYY
1.			
2.			
3.			
4.			

Practitioner's Name _____ License # _____
 Profession _____

III. SPECIALTY BOARD CERTIFICATIONS:

Do you hold a certification, specialty or subspecialty from any specialty board recognized by the board regulating the profession for which you are licensed? (see instructions) YES NO
 (Authority: T.C.A. § 63-51-105(a)(8)) If "Yes", complete section below

CERTIFYING BODY/BOARD INSTITUTION	CERTIFICATION/SPECIALTY/SUBSPECIALTY
1.	
2.	
3.	
4.	
5.	

IV. FACULTY APPOINTMENTS

A. Have you had the responsibility for graduate medical education within the last ten (10) years? (Authority: T.C.A. § 63-51-105(a)(10)) YES NO
 B. Do you currently hold a faculty appointment at a medical/health related institution of higher learning? (Authority: T.C.A. § 63-51-105(a)(10)) YES NO

If "YES", list the title of the appointment, name(s) and city/state of institution(s). (Attach additional sheets, clearly labeled with this question number, if necessary.)

	TITLE	INSTITUTION	CITY/STATE
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

V. STAFF PRIVILEGES

A. Do you currently hold staff privileges at a hospital? (Authority: T.C.A. §63-51-105(a)(9)) YES NO
 If "YES", list each hospital at which you currently have staff privileges: (Attach additional sheets, clearly labeled with this question number, if necessary)

Name of Hospital	City/State
1.	
2.	
3.	
4.	
5.	

Practitioner's Name _____ License # _____
 Profession _____

B. Do you currently participate in and accept any TennCare plan(s) as a provider? YES NO
 If "YES", list each plan in which you currently participate or accept as a provider: (Authority: T.C.A. § 63-51-105(a)(16))

Name of TennCare Plan

1. _____
2. _____
3. _____
4. _____
5. _____

VII. FINAL DISCIPLINARY ACTION (See Instructions):

A. Within the previous ten (10) years, have you ever had any final disciplinary action taken against you by the agency regulating your license, in this state or any other jurisdiction? (Authority: T.C.A. § 63-51-105(a)(8))
 YES NO

If "YES", list name(s) and address(es) of agency(s) and a brief description of the final disciplinary action(s) and stated reason(s) for taking the action. (Attach additional sheets, clearly labeled with this question number, if necessary.)

AGENCY NAME/ADDRESS	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION
1. _____ _____	_____	_____	_____
IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal)			YES <input type="checkbox"/> NO <input type="checkbox"/>
2. _____ _____	_____	_____	_____
IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal)			YES <input type="checkbox"/> NO <input type="checkbox"/>
3. _____ _____	_____	_____	_____
IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal)			YES <input type="checkbox"/> NO <input type="checkbox"/>

B. Within the previous ten (10) years, have you ever had your hospital privileges revoked or involuntarily restricted or reasons related to competence or character by the hospital's governing body? (Authority: T.C.A. § 63-51-105(a)(4))
 YES NO

If "YES", list name(s) and address(es) medical institution(s) and a brief description of the final disciplinary action(s) and stated reason(s) for the action. (Attach additional sheets, clearly labeled with this question number, if necessary)

HOSPITAL NAME/ADDRESS	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION
1. _____ _____	_____	_____	_____
IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal)			YES <input type="checkbox"/> NO <input type="checkbox"/>
2. _____ _____	_____	_____	_____
IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal)			YES <input type="checkbox"/> NO <input type="checkbox"/>
3. _____ _____	_____	_____	_____
IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal)			YES <input type="checkbox"/> NO <input type="checkbox"/>

C. Within the previous ten (10) years, have you ever been asked to or allowed to resign from or had any medical staff privileges restricted or not renewed by any hospital in lieu of or in settlement of a pending disciplinary action related to competence or character? (Authority: T.C.A.: § 63-51-105(a)(4))
 YES NO

If "YES", list name(s) and address(es) of the hospital(s) and a brief description of the final disciplinary action(s) and stated reason(s) for the action. (Attach additional sheets, clearly labeled with this question number, if necessary)

HOSPITAL NAME/ADDRESS	DATE	DESCRIPTION OF ACTION
1. _____ _____	_____	_____
2. _____ _____	_____	_____
IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal)		YES <input type="checkbox"/> NO <input type="checkbox"/>
3. _____ _____	_____	_____
IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal)		YES <input type="checkbox"/> NO <input type="checkbox"/>

Practitioner's Name _____ License# _____
 Profession _____

VIII. CRIMINAL OFFENSES (See Instructions)

Have you within the most recent ten (10) years, been found guilty, regardless of whether adjudication of guilt was withheld, or pled guilty or nolo contendere to a criminal misdemeanor or felony in any jurisdiction? (Authority: T.C.A. § 63-51-105(a)(1)) YES NO

If "YES" briefly describe the offense(s):

	DESCRIPTION OF OFFENSE	DATE	JURISDICTION
1.	_____	_____	_____
	If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal)		YES <input type="checkbox"/> NO <input type="checkbox"/>
2.	_____	_____	_____
	If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal)		YES <input type="checkbox"/> NO <input type="checkbox"/>
3.	_____	_____	_____
	If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal)		YES <input type="checkbox"/> NO <input type="checkbox"/>

IX. LIABILITY CLAIMS

Have you had a medical malpractice court judgment, arbitration award, or settlement against you since May 19, 1998? (Authority: T.C.A. § 63-51-105(a)(5)) If "YES", indicate a brief description of the nature(s) of the claim, the date(s) of the claim report(s), and the amount of the judgment(s), award or settlement(s): YES NO

	ENTRY DATE OF DISPOSITION ORDER OR SETTLEMENT	AMOUNT
1.	_____	_____
2.	_____	_____
3.	_____	_____

X. OPTIONAL INFORMATION:

A. PUBLICATIONS: List any publications you have authored in peer-reviewed medical literature: (optional) (Authority: T.C.A. § 63-51-105(a)(11))

	TITLE	PUBLICATION	DATE
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

B. PROFESSIONAL OR COMMUNITY SERVICE ACTIVITIES AWARDS: List any information regarding professional or community service associates, activities and awards: (optional) (Authority: T.C.A. § 63-51-105(a)(12))

	COMMUNITY SERVICE/AWARD/HONOR	ORGANIZATION
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

I affirm these statements are true and correct and recognize that providing false information may result in disciplinary action against my license pursuant to T.C.A. §§ 63-51-113 and/or 63-51-118.

 (Signature of Provider) Date: _____