



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

TENNESSEE BOARD OF MEDICAL EXAMINERS  
COMMITTEE FOR CLINICAL PERFUSIONISTS  
(800) 778-4123, ext. 24384 or Local (615) 532-3202, ext. 24384  
[www.tennessee.gov](http://www.tennessee.gov)

APPLICATION INSTRUCTIONS FOR LICENSURE AS A CLINICAL PERFUSIONIST  
APPLICATION CHECK SHEET

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 Tennessee license to practice. **NOTE: All submissions must be executed and dated less than one (1) year before receipt or they will be rejected by the Committee.**

**Licensure by Examination:**

**Done**

1. Complete, sign, have notarized and mail the application pages 1 through 6. \_\_\_\_\_
2. Attach to the application a clear, recognizable, recently taken passport size photograph of yourself. \_\_\_\_\_
3. Request that a graduate transcript from a perfusion education program, the educational standards of which have been established by the ACPE and approved by CAHEA or its successor, be submitted directly from the educational institution to the Administrative Office. The transcript must show the program has been successfully completed and carry the official seal of the institution. Complete and mail Attachment 1 to your graduate school. \_\_\_\_\_
4. If you are or have ever been licensed, certified, registered, or permitted by any state or country to practice as a Perfusionist or other health professional, you must complete and mail Attachment 1 to each and every state. Copies of Attachment 1 may be duplicated to accommodate each request. \_\_\_\_\_
5. Submit two (2) original letters of recommendation from medical professionals who can attest to your character as a Perfusionist. These letters must be written within the preceding 12 months, identify the individuals as medical professionals, and **must be originals** on the signator's letterhead. \_\_\_\_\_
6. Attach to the application a check or money order in the amount of \$360 made payable to the Committee for Clinical Perfusionists. \_\_\_\_\_
7. Cause to be submitted directly from ABCP proof of successfully completing the ABCP examination. See Attachment 2. \_\_\_\_\_
8. Criminal Background Check. Click [here](#) for instructions. \_\_\_\_\_

**Licensure by Grandfather Clause**

**Done**

Any person who is currently actively practicing perfusion is eligible to receive a license as a clinical perfusionist upon further showing satisfactory proof of the existence on, January 1, 2000, of all of the following requirements:

1. Cause to be submitted to the Administrative Office items 1 through 6, listed above except item number 3. Also do number 8. 

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2. Proof of four (4) years experience within the immediately preceding six (6) years (between January 1, 1994 and January 1, 2000) operating cardiopulmonary bypass systems during cardiac surgical cases in a licensed health care facility. Proof that the experience obtained in that four (4) year period was obtained while the person's primary functions in that health care facility was operation of the cardiopulmonary systems. Satisfactory proof shall include written job descriptions from employing facilities that cover the entire four (4) year period and letters from each of the following officials at the licensed health care facilities attesting to the fact that all requirements have been met:
  - (a) a cardiac surgeon(s);
  - (b) applicant's immediate supervisor(s), and
  - (c) the chief of medical staff.

All documents must be submitted directly from the employing facility or signatory to the Committee's Administrative Office.

**Licensure by Reciprocity**

**Done**

To become licensed in Tennessee as a clinical perfusionist based on licensure or certification in another state, an applicant must:

1. Cause to be submitted to the Administrative Office all of items 1 through 6 except item number 3. Also do number 8 and one of the following must also be submitted: 

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  - (a) Be licensed or certified in another state that has licensure or certification requirements substantially equivalent, as determined by the committee, to the requirements of the Tennessee "Clinical Perfusionist Act" (T.C.A. 63-28-101 et. seq). Please submit a copy of the rules in place when licensure or certification was awarded and have submitted to the Administrative Office proof of a current, active clinical perfusionists license/certificate that is in good standing and without any restriction or encumbrance in another state. Submit Attachment 1 to all licensure/certifications that apply. 

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  - (b) Cause to have submitted to the Administrative Office a current certificate as a certified clinical perfusionist issued by the ABCP. 

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## Provisional License

A provisional license may be issued to an applicant who has applied for but has yet to take the licensure examination. To obtain a provisional license an applicant must cause to be submitted to the Administrative Office all of items 1 through 6 above and submit attachment 2 to the ABCP National Office. Applicants must have made application to sit for the licensure exam and sign the ABCP verification release form (attachment 2) allowing ABCP to release all exam scores to the Tennessee Board of Medical Examiners. Additionally, holders of a provisional license must work under the supervision and control of a licensed clinical perfusionist at all times during which clinical perfusion is performed. Therefore, please have your supervising clinical perfusionist(s) fill out Attachment 4 and return it to the Committee's administrative office.

## UNDERSTANDING THE APPLICATION PROCESS

**If an address change occurs at any time, you must notify the Committee's administrative office, in writing, immediately.**

1. All application fees and provisional licensure fees are non-refundable.
2. All documents and fees required to be submitted by you or which must be requested from the appropriate institutions in this application process, must be mailed directly to:

Committee of Clinical Perfusionists  
227 French Landing, Suite 300  
Heritage Place Metro Center  
Nashville, TN 37243

For Federal Express or Special Courier:  
Committee of Clinical Perfusionists  
227 French Landing, Suite 300  
Heritage Place Metro Center  
Nashville, TN 37228

3. 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 Committee asks that you please give the administrative office every consideration in this matter.
4. If necessary documentation has not been received when your application has been received by the Committee's administrative office, an initial deficiency letter will be sent to you. The supporting documentation requested in the letter must be received in the Committee's administrative office sixty (60) days from the date of the initial deficiency letter. Files not completed within sixty (60) days will be closed.
5. Absent any complicating factors, the average application processing time is six weeks. Once the application is completed, your file will be promptly reviewed and an initial certification determination made. You will be promptly notified by letter of the initial determination and if your application is approved you will be able to view certification approval on the Internet at [www.state.tn.us/health](http://www.state.tn.us/health).
6. It is recommended that you do not make arrangements to accept employment as a Clinical Perfusionist in Tennessee until you are granted a license by the Committee of Clinical Perfusionist.

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

**IMPORTANT: You must have a Tennessee license issued by the Committee of Clinical Perfusionists in your possession before you may lawfully practice.**

ATTACH A  
CURRENT FULL-  
FACE  
PHOTOGRAPH



FOR OFFICIAL USE  
ONLY

2984-001 \$350.00  
2984-006 \$ 10.00

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APPLICATION FOR  
LICENSED CLINICAL PERFUSIONIST

Please **check** the appropriate category for which you are applying:

License by Exam     License by Grandfather Clause     License by Reciprocity     Provisional License

PERSONAL INFORMATION

PLEASE PRINT IN INK

Name: \_\_\_\_\_  
Last First Middle Maiden

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Mailing Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Zip \_\_\_\_\_

Phone: Home: (\_\_\_\_) \_\_\_\_\_ Office: (\_\_\_\_) \_\_\_\_\_

Place of Birth: \_\_\_\_\_ Sex: (optional, for statistical purposes only)

Female \_\_\_\_\_

Male \_\_\_\_\_

U.S. Citizen: Yes \_\_\_ No \_\_\_

**EDUCATIONAL AND EMPLOYMENT INFORMATION**

Please provide the following information for all educational institutions you have attended beyond high school. Use the back of this page if you need additional space. (Send Attachment 4 to the educational institution where you completed your program.)

From: _____ Mo/Yr	To: _____ Mo/Yr	_____	_____
		Educational Institution	Location
From: _____ Mo/Yr	To: _____ Mo/Yr	_____	_____
		Educational Institution	Location
From: _____ Mo/Yr	To: _____ Mo/Yr	_____	_____
		Educational Institution	Location
From: _____ Mo/Yr	To: _____ Mo/Yr	_____	_____
		Educational Institution	Location

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

<u><b>DATES</b></u>	<u><b>LOCATION</b></u>	<u><b>POSITION AND DUTIES</b></u>
From: _____ Mo/Yr	To: _____ Mo/Yr	_____
	(City) (State)	_____
From: _____ Mo/Yr	To: _____ Mo/Yr	_____
	(City) (State)	_____
From: _____ Mo/Yr	To: _____ Mo/Yr	_____
	(City) (State)	_____
From: _____ Mo/Yr	To: _____ Mo/Yr	_____
	(City) (State)	_____
From: _____ Mo/Yr	To: _____ Mo/Yr	_____
	(City) (State)	_____
From: _____ Mo/Yr	To: _____ Mo/Yr	_____
	(City) (State)	_____
From: _____ Mo/Yr	To: _____ Mo/Yr	_____
	(City) (State)	_____

**LICENSURE INFORMATION**

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.

<b>STATE</b>	<b>LICENSE NUMBER</b>	<b>DATE ISSUED</b>	<b>CURRENT STATUS</b>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List below **ALL** states, countries or provinces in which you hold or have ever held a license, certification or permit as a health professional other than perfusionist. 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.

<b>STATE</b>	<b>PROFESSION</b>	<b>LICENSE NUMBER</b>	<b>DATE ISSUED</b>	<b>CURRENT STATUS</b>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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, 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 exercise reasoned professional judgments and to learn and keep abreast of developments in your profession; and
b. The ability to communicate those judgments and 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 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 or disorders, such as, but not limited to; orthopedic, visual, speech and/or hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV, tuberculosis, drug addiction and alcoholism.
3. "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.
4. "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 functioning as a licensee, or within the past two (2) years.
5. "Illegal use of controlled substances" means the use of controlled substances obtained illegally (e.g. heroin, or cocaine) as well as the use of controlled substances which 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 a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety?
a. If yes, are they reduced or ameliorated because you receive ongoing treatment (with or without medication) 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 Committee 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 an unrestricted license should be issued, whether conditions should be imposed or whether you are not eligible for licensure.]

**COMPETENCY INFORMATION continued**

		<b>YES</b>	<b>NO</b>
2.	Do you currently use chemical substances?	_____	_____
	If yes, do they in any way impair or limit your ability to practice your profession with reasonable skill and safety?	_____	_____
	Please list: _____ _____		
3.	Are you currently engaged in the illegal use of controlled substances?	_____	_____
	If yes, are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you in order to assure that you are not engaged in the illegal use of controlled substances?	_____	_____
4.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?	_____	_____
5.	If you have ever held or applied for a license or certificate to practice as a Perfusionist in any state, country or province, has it been or was it ever denied, reprimanded, suspended, restricted, revoked, or otherwise disciplined, curtailed or voluntarily surrendered under threat of investigation or disciplinary action?	_____	_____
6.	If you have ever had staff privileges at any hospital or health care facility have they ever been revoked, suspended, curtailed, restricted, limited or 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 society?	_____	_____
9.	In relation to the performance of your professional services in any profession:		
	a. Have you ever had a final judgment rendered <u>against</u> you; or	_____	_____
	b. Have you ever had settlement of any legal action rendered <u>against</u> you; or	_____	_____
	c. Are there any legal actions pending <u>against</u> 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, or otherwise disciplined, curtailed or voluntarily surrendered under threat of investigation or disciplinary action?	_____	_____



ATTACHMENT 1



STATE OF TENNESSEE  
DEPARTMENT OF HEALTH  
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[www.tennessee.gov](http://www.tennessee.gov)

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).

**To Be Completed By Applicant (Please Print In Ink)**

I, the undersigned applicant, was granted a (**circle one**) license or certificate to practice \_\_\_\_\_  
(Profession)  
numbered \_\_\_\_\_ on \_\_\_\_\_ in the State of \_\_\_\_\_  
(Date)

The Committee of Clinical Perfusionists 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 the Tennessee Committee of Clinical Perfusionists.

Date \_\_\_\_\_ Applicant's Signature \_\_\_\_\_  
Applicant's typed or printed name \_\_\_\_\_

**To Be Completed By Administrative Office of State Licensure Board**

Name In Full As it Appears On License/Certificate or Permit:

\_\_\_\_\_  
(First) (M.I.) (Last)  
License/Certificate/Permit Number: \_\_\_\_\_ Profession: \_\_\_\_\_

Date Issued: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Basis of Issuance: \_\_\_\_\_ Endorsement/Reciprocity with \_\_\_\_\_  
(Check One) (State)  
\_\_\_\_\_ Written Examination \_\_\_\_\_

Is the license currently active and registered? Yes \_\_\_\_\_ No \_\_\_\_\_  
Is there any derogatory information on file? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please attach supporting documentation.

Authorized Signature \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

Please mail directly to: Committee for Clinical Perfusionists  
227 French Landing, Suite 300  
Heritage Place Metro Center,  
Nashville, TN 37243



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**ABCP VERIFICATION**

Please complete this form and mail it to the address below:

**Send to:**

**American Board of Cardiovascular  
Perfusion National Office  
207 N. 25th Avenue  
Hattiesburg, MS 39401**

**To Be Completed By Applicant (Please Print In Ink)**

Dear ABCP Official:

I am applying for a license to practice as a Clinical Perfusionist in the State of Tennessee. By signing this document I authorize the American Board of Cardiovascular Perfusion National Office to release my exam scores directly to the State Board of Medical Examiners' Committee for Clinical Perfusionists.

Applicant's Name: \_\_\_\_\_  
(First) (Middle) (Last)

Social Security No.: \_\_\_\_\_  
Signature for Release of Information

**PLEASE MAIL SCORES DIRECTLY TO:**

**Committee for Clinical Perfusionists  
227 French Landing, Suite 300  
Heritage Place Metro Center  
Nashville, TN 37243**

**ATTACHMENT 3**



**STATE OF TENNESSEE  
DEPARTMENT OF HEALTH  
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**TRANSCRIPT REQUEST**

**APPLICANT:** supply the information requested in this box and then mail this entire form to your graduate school.

Full Name: _____		
(Last)	(First)	(Middle/Maiden)
Address: _____		Social Security Number: _____ - _____ - _____
_____		
_____		
_____		
Student Identification Number: _____		
Year of Graduation: _____		
Degree Obtained: _____		

**TO WHOM IT MAY CONCERN:**

I am applying for a license to practice as a clinical perfusionist in the State of Tennessee. Please forward an original graduate transcript bearing the institution's official seal to:

**Tennessee Board of Medical Examiners  
Committee for Clinical Perfusionist  
227 French Landing, Suite 300  
Heritage Place Metro Center  
Nashville, TN 37243**

Thank you for cooperation and prompt response.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date



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**SUPERVISING LICENSED CLINICAL PERFUSIONIST**

This section must be completed by the supervising clinical perfusionist(s).  
(This page may be duplicated if necessary)

**List all practice settings:**

1) **Setting:**

\_\_\_\_\_  
Supervising Clinical Perfusionist

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Tennessee License Number

2) **Setting:**

\_\_\_\_\_  
Supervising Clinical Perfusionist

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Tennessee License Number

3) **Setting:**

\_\_\_\_\_  
Supervising Clinical Perfusionist

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Tennessee License Number

4) **Setting:**

\_\_\_\_\_  
Supervising Clinical Perfusionist

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Tennessee License Number