STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
227 FRENCH LANDING, SUITE 300
HERITAGE PLACE METRO CENTER
NASHVILLE, TENNESSEE 37243
www.tennessee.gov

TENNESSEE BOARD OF MEDICAL EXAMINERS

(800) 778-4123, ext. 24384 or (615) 532-3202, ext. 24384

APPLICATION INSTRUCTIONS FOR LICENSURE AS A MEDICAL DOCTOR

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 medicine.

ALL APPLICATION FEES ARE NON-REFUNDABLE.

		Done
1.	Complete, have notarized, and mail the application pages 1 through 6.	________
2.	Complete and mail attachment 1 to your medical school for transcript of courses, grades, and degree. If you are an International Medical School graduate you must **also** ask that your medical school provide to this office documentation proving that they meet or exceed the accreditation requirements of the LCME (Liaison Committee on Medical Education). Documentation must be submitted in English.	________
3.	Complete and mail attachment 2 to each institution in the U.S. at which you received postgraduate medical training. **DO NOT HAVE THIS (VERIFICATION OF POST GRADUATE MEDICAL TRAINING) FORM COMPLETED UNTIL THE APPROPRIATE NUMBER OF YEARS OF POSTGRADUATE EXPERIENCE HAVE BEEN TOTALLY COMPLETED (3 YEARS FOR INTERNATIONAL GRADUATES OR 1 YEAR FOR U.S. AND CANADIAN GRADUATES).**	________
4.	Complete and mail attachment 3 to each state, country, or province in which you hold or have ever held a license to practice any profession.	________
5.	Submit a clear and recognizable recently taken bust photograph of yourself that shows the full head, face forward from at least the shoulders up.	________
6.	Submit proof of the 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, H-1 visas, or current passports are acceptable). License will not be issued to holders of J-1 Training Visa. Visa must allow one to hold employment in the United States.	________
7.	Submit two (2) original letters of recommendation from licensed medical doctors on the signatory's letterhead attesting to your good moral character. The letters must contain original signatures.	________
8.	You must have successfully completed a medical licensure examination or an approved combination of examinations. If you are submitting USMLE scores, **all three steps must be taken and passed within seven years**. Please refer to attachment 4 for information in obtaining scores.	________
9.	If you are an international medical school graduate, you must submit one of the following**:**	
	a. A notarized copy of your original permanent E.C.F.M.G. Certificate;	________

b. If you graduated from a Mexican Medical School, a letter from the E.C.F.M.G. stating that all certificate requirements have been met; or _________

c. If you cannot obtain an original certificate due to the phase out of the E.C.F.M.G., proof of successful completion of U.S.M.L.E. Steps 1 and 2 submitted directly from the testing agency to the Board Administrative Office. _________

10. Complete and mail the Mandatory Practitioner Profile Questionnaire. A Mandatory Practitioner Profile Questionnaire may be downloaded from our website. _________

11. **Attach to the application and submit a check or money order in U.S. funds in the amount of $410, payable to the Tennessee Board of Medical Examiners.** _________

12. On October 1, 2008, Public Chapter 927 will become effective requiring physicians who perform Level II office based surgery must so report at the time of initial application, reinstatement or renewal of a medical license. Level II office based surgery means "level II surgery, as defined by the board of medical examiners in its rules and regulations, that is performed outside of a hospital, an ambulatory surgical treatment center, or other medical facility licensed by the Department of Health." The board of medical examiners' rules regarding office based surgery can be found at: **http://www.state.tn.us/sos/rules/0880-0880-02.pdf**. Please review these rules carefully if you perform level II procedures in your office. Under Public Chapter 927 you are further required to report certain "unanticipated events" to the board of medical examiners within mandated time frames of the occurrence. To review Public Chapter 927 please go to **http://state.tn.us/sos/acts/105/pub/pc0927.pdf**. It is imperative that you review this new law and adhere to it strictly. _________

13. Effective June 1, 2006 applicants for initial licensure in Tennessee must obtain a criminal background check. Click here for instructions. _________

UNDERSTANDING THE APPLICATION PROCESS

1. **All application 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:

   Tennessee Board of Medical Examiners
   Heritage Place Metro Center
   227 French Landing, Suite 300
   Nashville, TN 37243 (37228 for courier service only)

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 Board asks that you please give the Board office every consideration in this matter.

4. 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.)**

5. 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.

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

7. It is recommended 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 Medical Examiners.

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

For Office Use Only

06-001 $400 06-006 $ 10

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

TENNESSEE BOARD OF MEDICAL EXAMINERS
(800) 778-4123, ext. 24384 or (615) 532-3202, ext. 24384

APPLICATION FOR LICENSURE AS A MEDICAL DOCTOR

READ INSTRUCTIONS PRIOR TO COMPLETING APPLICATION. APPLICANTS MUST COMPLY WITH ALL INSTRUCTIONS.

FILL IN ALL BLANKS; IF NOT APPLICABLE, STATE N/A

Attach to this application a check or money order in the amount of $410, payable in U.S. funds to the Tennessee Board of Medical Examiners.

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. _____ Place of Birth ______________________________
(*City*) (*State or Country*)

Social Security Number: _______ - _______ - ________ U.S. Citizen: Y N Sex: M F

Entitled to Live and Work in U.S.: Y N

Present Mailing Address: __________________________ Home Phone: ( ) - ________
____
__________________________ Work Phone: ( ) - ________

Type of intended primary specialty practice in Tennessee ______________________________________

EDUCATIONAL AND EXAMINATION INFORMATION

PRE-MEDICAL EDUCATION

From: ________ To: __________ ____________________________ ______________________________
Mo/Yr *Mo/Yr* *Educational Institution* *Location*

From: ________ To: __________ ____________________________ ______________________________
Mo/Yr *Mo/Yr* *Educational Institution* *Location*

From: ________ To: __________ ____________________________ ______________________________
Mo/Yr *Mo/Yr* *Educational Institution* *Location*

MEDICAL EDUCATION

I have spent _____ years in the study of medicine in the medical educational institutions below:

From: ________ To: __________ ____________________________ ______________________________
Mo/Yr *Mo/Yr* *Educational Institution* *Location*

From: ________ To: __________ ____________________________ ______________________________
Mo/Yr *Mo/Yr* *Educational Institution* *Location*

Complete Attachment 1 and mail to the school which granted your medical degree

POST-GRADUATE TRAINING

I have spent _____ years in medical training in the medical educational institutions below:

From: ________ To: __________ ____________________________ ______________________________
Mo/Yr *Mo/Yr* *Educational Institution* *Location*

From: ________ To: __________ ____________________________ ______________________________
Mo/Yr *Mo/Yr* *Educational Institution* *Location*

From: ________ To: __________ ____________________________ ______________________________
Mo/Yr *Mo/Yr* *Educational Institution* *Location*

I have taken the following medical licensure examinations: (Check all applicable)

1.____ National Boards (NBME) Certificate Number
2.____ FLEX examination administered by the State of ______________________________on ____________.
(Date(s))
3.____ Licensure by the Medical Council of Canada (LMCC)
4.____ USMLE
5._____ State Board administered by __________________________ prior to 1972.
(State)

Are you Board eligible: Y N Are you Board certified: Y N

If so, identify specialty: ____

I intend to perform Level II Office Based Surgery which is integral to a planned treatment regiment and not performed on an urgent or emergent basis. Y N

PRACTICE AND LICENSURE INFORMATION

Describe in chronological order your professional practice experience and medical activities since graduating from Medical School. Include dates and locations. Additional pages may be attached to this form if necessary. **Any gaps in this chronology must be explained.**

DATE	LOCATION		ACTIVITY
____________ *Mo/Yr*	____________ *(City)*	____________ *(State)*	______________________ ______________________
____________ *Mo/Yr*	____________ *(City)*	____________ *(State)*	______________________ ______________________
____________ *Mo/Yr*	____________ *(City)*	____________ *(State)*	______________________ ______________________
____________ *Mo/Yr*	____________ *(City)*	____________ *(State)*	______________________ ______________________
____________ *Mo/Yr*	____________ *(City)*	____________ *(State)*	______________________ ______________________
____________ *Mo/Yr*	____________ *(City)*	____________ *(State)*	______________________ ______________________

List below and submit a copy of attachment #3 to **ALL STATES, COUNTRIES, OR PROVINCES IN WHICH YOU HAVE EVER BEEN OR ARE CURRENTLY LICENSED AS A MEDICAL DOCTOR.** Additional pages may be added if necessary.

STATE	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS

List below **ALL** state, countries, or provinces in which you hold or have ever held a license as a health professional other than a Medical Doctor. Submit a copy of attachment #3 to all such state, country, or province regarding such licensure. Additional pages may be added if necessary.

STATE	PROFESSION	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS

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 medicine"** is to be construed to include all of the following:

    a. The cognitive capacity to make appropriate clinical diagnosis, exercise reasoned medical judgments, to learn, and keep abreast of medical developments;

    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 medical tasks such as physical examination and surgical procedures, 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 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 a medical condition which in any way impairs or limits your ability to practice medicine 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 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:		YES	NO
2.	Do you currently use chemical substances?	_____	_____
	If yes, do they in any way impair or limit your ability to practice medicine 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 medicine in any state, country, or province, has or was it ever been denied, reprimanded, suspended, restricted, revoked, 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, otherwise disciplined, or voluntarily surrendered under threat of restriction or disciplinary action?	_____	_____
7.	Have you ever applied for and been denied a state or federal controlled substance certificate?	_____	_____
	If you have possessed such a certificate has it ever been revoked, suspended, restricted, otherwise disciplined, or voluntarily surrendered under threat of investigation or disciplinary action?	_____	_____
8.	Have you ever been convicted of a felony or a misdemeanor other than a minor traffic offense?	_____	_____
9.	Have you ever been rejected or censured by a medical society?	_____	_____
10.	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;	_____	_____
	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?	_____	_____
11.	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?	_____	_____

Affirmative response <u>requires</u> final documents or orders from the issuing states, courts, and/or agencies.

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.

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
227 FRENCH LANDING, SUITE 300
HERITAGE PLACE METRO CENTER
NASHVILLE, TENNESSEE 37243

TENNESSEE BOARD OF MEDICAL EXAMINERS
(800) 778-4123, ext. 24384 or (615) 532-3202, ext. 24384

APPLICANT: Supply the information requested in this box and then mail this entire form to your medical 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 medicine in the State of Tennessee.

Please forward an original graduate transcript of courses, grades, and degree bearing the institution's official seal to:

State of Tennessee
Board of Medical Examiners
Heritage Place Metro Center
227 French Landing, Suite 300
Nashville, TN 37243 (37228 for courier service only)

Thank you for your cooperation and prompt response.

____ ________________________
Applicant's Signature Date

ATTACHMENT 2

TENNESSEE BOARD OF MEDICAL EXAMINERS
(800) 778-4123, ext. 24384 or (615) 532-3202, ext. 24384

VERIFICATION OF POST GRADUATE MEDICAL TRAINING

APPLICANT: Provide the information requested in the top box and then mail this form to each institution in which you received any postgraduate medical training. If additional forms are required, copy this one.

Institution Administration: I am applying for a Tennessee medical license and hereby authorize you to release any and all information in your files concerning my medical training. I was in training at your institution as follows:

Applicant's name: ____
(Last) (First) (Middle/Maiden)

Name of Institution: ______________________ **Program Title:** ______________________

______________________ **Applicant's Signature** ______________________ **Date**

ADMINISTRATIVE OFFICE OF TRAINING INSTITUTION. NOTE: THIS FORM MUST BE NOTARIZED. Please complete (including questions) and return to:

State of Tennessee
Board of Medical Examiners
Heritage Place Metro Center
227 French Landing, Suite 300
Nashville, TN 37243

	CIRCLE ONE	
Is your training program LCME/AGCME approved?	Yes	No
Was the above program LCME/AGCME approved at the time the applicant completed training?	Yes	No
Were there any adverse charges or actions taken during the residency? If yes, please attach supporting information and/or documentation.	Yes	No
Would you recommend the applicant for licensure?	Yes	No
Did the applicant successfully complete the program?	Yes	No

The Applicant attended the program from __________ (Mo/Yr) to __________ (Mo/Yr). I certify that the information on this form is true and correct.

______________________ Program Director's/Dean's Signature ______________________ Date

Subscribed and sworn before me this the ____ day of ____________________, ______________.

______________________ Notary Public (Affix Seal Here)

My Commission Expires:

ATTACHMENT 3

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

TENNESSEE BOARD OF MEDICAL EXAMINERS
(800) 778-4123, ext. 24384 or (615) 532-3202, ext. 24384

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
Heritage Place Metro Center
227 French Landing, Suite 300
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

ATTACHMENT 4

Tennessee Requires Medical Examination Scores be Sent Directly to the Tennessee Board of Medical Examiners

In order to have medical examination scores reported to the Tennessee Board please read the following:

For FLEX, SPEX and USMLE scores contact the Federation of State Medical Boards to obtain a score reporting form at:

Federation of State Medical Boards of the U.S., Inc.
Federation Place
Suite 300
400 Fuller Wiser Road
Euless, TX 76039-3855
(800) 876-5396

or download the form from the web site at:

http://www.fsmb.org

For NBME Parts I, II, and III or any **COMBINATION** OF NBME Parts, the request form is now available on the NBME web site at:

http://www.nbme.org/programs/nbmecert.asp

National Board of Medical Examiners
P.O. Box 48014
Newark, NJ 07101-4814

For NBME Parts I, II, and III administered by ECFMG or for information concerning FMGEMS contact:

Educational Commission for Foreign Medical Graduates
3624 Market Street
Philadelphia, PA 19104
Phone (215) 386-5900

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

TENNESSEE BOARD OF MEDICAL EXAMINERS
(800) 778-4123, ext. 24384 or (615) 532-3202, ext. 24384

APPLICANT: USE THIS FORM ONLY IF YOU HAVE TAKEN A STATE EXAM PRIOR TO DECEMBER 1972. IF YOU HAVE, COMPLETE THE INFORMATION IN THE BOX AND THEN SEND IT TO THE STATE BOARD FOR WHICH YOU TOOK THE EXAMINATION:

Full Name:____
(Last) (First) (Middle/Maiden)

Social Security Number: ________-______-________ State License Number: ____________

CERTIFICATE OF SECRETARY OF STATE BOARD ISSUING ORIGINAL LICENSE

I, ______________________________, Secretary of the ______________________
(State)
Board of Medical Examiners, certify that ______________________________ of
(Applicant's Name)
______________________________ was granted License/Certificate number __________
(City & State)
to practice Medicine in this State on the ____ day of __________, ________. I further certify that the aforesaid in the written examination before this Board, which was administered on ________________,
(Date)
obtained a general average of ________ percent and the following percentages on each subject:

Subject	Percent	Subject	Percent

Acting on behalf of the ______________________ Board of Medical Examiners, I hereby
(State)
certify that the Applicant successfully completed the state licensure examination.

Seal of the Board ______________________________ Date: __________
Board Secretary's Signature

Please return to: **State of Tennessee**
Board of Medical Examiners
Heritage Place Metro Center
227 French Landing, Suite 300
Nashville, TN 37243

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.

<u>Pending</u> 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.

Practitioner’s Name ______________________________ **License #** ________________

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 2ND/3RD 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)

____

(STREET NUMBER AND NAME)

____

(CITY) (STATE) (ZIP CODE)

☐ 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.

E. E-MAIL ADDRESS ____ ☐

Your e-mail address will be published unless you elect not to by checking here.

F. WEB PAGE ADDRESS ____________________________________ ☐

Your web page address will be published unless you elect not to by checking here.

G. TELEPHONE: (_____)______________________________

Your telephone number will be published unless you elect not to by checking here. ☐

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. ____

Practitioner's Name ______________________________________ **License #** __________________
Profession ____

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 ❑ NO ❑

	AGENCY NAME/ADDRESS	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION
2.	________	________	________	________
	________		________	________
	________		________	________

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❑ NO ❑

	AGENCY NAME/ADDRESS	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION
3.	________	________	________	________
	________		________	________
	________		________	________

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❑ NO ❑

Practitioner's Name ______________________ **License #** ____________
Profession ______________________

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.				
2.				
3.				

1. IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❑ NO ❑
2. IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❑ NO ❑
3. IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❑ NO ❑

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 <u>any</u> 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.			
3.			

2. If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❑ NO ❑
3. If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❑ NO ❑

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 ❑ NO ❑
2.	______________________	__________	______________________
	If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal)		YES ❑ NO ❑
3.	______________________	__________	______________________
	If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal)		YES ❑ NO ❑

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.

____ Date:__________________
(Signature of Provider)