



STATE OF TENNESSEE  
DEPARTMENT OF HEALTH  
HEALTH RELATED BOARDS

BOARD FOR PROFESSIONAL COUNSELORS, MARITAL & FAMILY THERAPISTS,  
AND CLINICAL PASTORAL THERAPISTS

227 French Landing, Suite 300  
Heritage Place Metro Center  
NASHVILLE, TENNESSEE 37243

[www.tennessee.gov](http://www.tennessee.gov)

(800) 778-4123, ext. 25138

(615) 532-3202, ext. 25138

APPLICATION FOR LICENSE AS A LICENSED PASTORAL THERAPIST

\_\_\_\_\_ Exam

\_\_\_\_\_ Endorsement

INSTRUCTIONS

1. Complete this application, have it notarized, and mail it to the above address. **Type or print legibly.**
2. Enclose a non-refundable check for \$210, payable to the Board for Professional Counselors, Marital & Family Therapists, and Licensed Pastoral Therapists.
3. If you are applying by endorsement as a fellow or diplomate of the A.A.P.C., disregard instructions 4 and 8 through 13 and do not complete pages 2 and 5. Instead enclose, or have sent, proof of being a fellow or diplomate and proof of current A.A.P.C. membership.
4. If you are applying by endorsement as a certified member of the A.A.P.C., disregard instructions 3 and 8 through 13 and do not complete pages 2 and 5. Instead enclose, or have sent, two (2) notarized affidavits signed by certified mental health professionals attesting to your period of service (5 year minimum) as a clinical pastoral therapist or pastoral counselor.
5. Enclose a certified photocopy of your birth certificate.
6. Attach a recent (within the last twelve (12) months) "passport" style photograph to the front of this application.
7. Enclose, or have sent to the above address, two (2) original and recent letters typed on the signator's letterhead. These letters must verify your good moral character and ethics.
8. Have your graduate transcript(s) sent directly from the educational institution(s) to the above address.
9. Have the Pastoral Counselors Examination Service send proof of successful completion of their written examination directly to the above address unless you have not yet taken the exam.
10. Enclose proof of successful completion of a practicum consisting of at least one (1) unit of full-time clinical pastoral education in a program accredited by the Association for Clinical Pastoral Education.
11. Enclose proof of successful completion of an internship consisting of at least two (2) years of clinical pastoral therapy training.
12. Enclose a copy of your graduate school catalog.
13. Have your supervisor complete page 5 and enclose it or have it sent to the above address.
14. If you have ever been licensed in any other states as a Clinical Pastoral Therapist, enclose a copy of those state's statutes and rules and complete page 6. Also enclose a copy of your original licenses and renewal certificates from those states.
15. You will be registered to take the oral and/or the written exam (from the Pastoral Counselors Examination Service), and contacted accordingly.

NAME \_\_\_\_\_  
First Middle and/or Maiden Last

DATE OF BIRTH \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_

*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*

CURRENT HOME MAILING ADDRESS: \_\_\_\_\_ CURRENT PRACTICE ADDRESS: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

HOME PHONE # \_\_\_\_\_ WORK PHONE # \_\_\_\_\_

List all states where you currently have or have ever had a Clinical Pastoral Therapy license.

**COURSE WORK SUMMARY**

All courses listed on this page must also appear on the transcript sent directly from your college or university to the Board's Administrative Office.

<u>COURSE NAME</u>	<u>*CREDIT HOURS</u>	<u>INSTITUTION</u>
CORE CLINICAL THEORY (15 hour minimum)		
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PASTORAL COUNSELING THEORY (15 hour minimum)		
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

AREAS OF SPECIALIZATION (15 hour minimum, examples are psychodynamic psychotherapy, marital & family therapy, cognitive therapy, and behavioral therapy)		
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

DIAGNOSIS AND TREATMENT OF MENTAL DISORDERS		
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

\*Convert all quarter credit hours to semester credit hours; # quarter hours x .67 = # of semester hours

## COMPETENCY INFORMATION

**PLEASE ANSWER THE FOLLOWING QUESTIONS.** If any answers to 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 clinical pastoral therapy”** is to be construed to include all of the following:
  - a. The cognitive capacity to make appropriate diagnosis or evaluation, exercise reasoned judgment, to learn, and keep abreast of professional developments;
  - 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; and
  - c. The physical capability to perform required tasks and 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 disease, 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 clinical pastoral therapy 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.]

**QUESTIONS:**

**YES                      NO**

- |   |       |       |
|---|-------|-------|
| 2. Do you currently use chemical substances?  | _____ | _____ |
| a. If yes, do they in any way impair or limit your ability to practice clinical pastoral therapy with reasonable skill and safety?  | _____ | _____ |
| 3. Are you currently engaged in the illegal use of controlled substances?   | _____ | _____ |
| a. 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?  | _____ | _____ |



**VERIFICATION OF SUPERVISED EXPERIENCE**

**TO BE COMPLETED BY THE APPLICANT'S SUPERVISOR**

PLEASE COMPLETE THIS FORM AND RETURN IT TO THE ADDRESS BELOW. TYPE OR PRINT LEGIBLY. ON YOUR LETTERHEAD STATIONERY DESCRIBE THE SUPERVISED CLINICAL EXPERIENCE, INCLUDING ALL LOCATIONS. ENCLOSE PROOF OF BEING AN APPROVED SUPERVISOR. AN APPROVED SUPERVISOR IS A CERTIFIED CLINICAL PASTORAL THERAPIST WHO HAS MET ONE (1) OF THE THREE (3) FOLLOWING REQUIREMENTS:

1. Is a diplomat of the American Association of Pastoral Counselors;
2. Is a fellow of the American Association of Pastoral Counselors who is under supervision of a supervisor; or
3. Is a Board approved clinical pastoral therapy supervisor who submits evidence of:
  - A. Five (5) years full-time experience in clinical pastoral therapy practice and supervision;
  - B. One hundred twenty-five (125) hours of supervision specifically in the skill of providing supervision to clinical pastoral therapists; and
  - C. A recommendation for Board approved supervisor status from the individual who provided supervision of the one hundred twenty-five (125) hours listed above.

NAME OF APPLICANT: \_\_\_\_\_

NAME OF SUPERVISOR: \_\_\_\_\_

TITLE OF SUPERVISOR: \_\_\_\_\_

CLINICAL PASTORAL THERAPY LICENSE NUMBER OF SUPERVISOR NAMED ABOVE (IF LICENSED): \_\_\_\_\_

THE ABOVE APPLICANT HAS SUCCESSFULLY COMPLETED SUPERVISED CLINICAL TRAINING DURING THE PERIOD \_\_\_\_\_, \_\_\_\_\_ TO \_\_\_\_\_, \_\_\_\_\_, AS FOLLOWS:

1. Total hours of **CLINICAL CONTACT IN CLINICAL PASTORAL THERAPY** provided by the applicant during the time you supervised him/her. \_\_\_\_\_ hours
2. Total hours of **INDIVIDUAL SUPERVISION** of this work (270 are required). \_\_\_\_\_ hours

I CERTIFY THAT THE INFORMATION GIVEN AND THE ENCLOSED PROOF OF SUPERVISORY QUALIFICATIONS ARE CORRECT AND ACCURATE.

\_\_\_\_\_  
SUPERVISOR'S SIGNATURE \_\_\_\_\_  
DATE

SWORN TO BEFORE ME THIS \_\_\_\_\_ DAY OF \_\_\_\_\_, \_\_\_\_\_.

\_\_\_\_\_  
NOTARY PUBLIC  
MY COMMISSION EXPIRES \_\_\_\_\_

Affix seal here.

SEND TO: Board for PC/MFT/CPT  
227 French Landing, Suite 300  
Heritage Place Metro Center  
Nashville, TN 37243

THIS PAGE MAY BE DUPLICATED IF NEEDED.



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CLEARANCE FROM OTHER STATE CLINICAL PASTORAL THERAPY LICENSING BOARDS

Please complete the top portion and mail this form to the regulatory board in each state where you hold or have held a license to practice as a Clinical Pastoral Therapist. (If additional forms are required, this form may be duplicated.)

NOTE: Some states require a fee for providing clearance 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 \_\_\_\_\_
Lic. # Date

The Tennessee Board for Professional Counselors, Marital & Family Therapists, and Clinical Pastoral Therapists requests that I submit evidence that my license 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 for Professional Counselors, Marital and Family Therapists, and Clinical Pastoral Therapists.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

SSN#: \_\_\_\_\_ Printed Name: \_\_\_\_\_

THIS PORTION IS TO BE COMPLETED BY STATE LICENSING BOARD

License Number: \_\_\_\_\_ Date Issued: \_\_\_\_\_

Basis of Issuance: Examination: National State Other
Endorsement/Reciprocity
Other

License currently registered: Yes No

Derogatory Information on File: Yes No
If "yes", please attach explanation.

Authorized Signature Title Date





# 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.

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

<b>I. PRACTITIONER DATA</b>		
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 <sup>ND</sup> /3 <sup>RD</sup> LINES ANY ALIASES, IF APPLICABLE):	
	CURRENT NAME:	
	_____ (LAST)	_____ (FIRST) _____ (MIDDLE) (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  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

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)  
 G6019027

Date: \_\_\_\_\_