



**STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
227 FRENCH LANDING, SUITE 300
HERITAGE PLACE METRO CENTER
NASHVILLE, TN 37243
(800) 778-4123, ext. 24384 or (615) 532-3202, ext. 24384
www.tennessee.gov**

APPLICATION INSTRUCTIONS FOR LICENSURE REINSTATEMENT

Provided below is a checklist for your personal use and convenience containing all the things you must do to receive consideration for reinstatement of your Tennessee license.

- | | <u>Done</u> |
|---|-------------|
| 1. Complete, have notarized, and mail the application pages 1 through 5. | _____ |
| 2. Complete and mail Attachment 1 to each state, country, or province in which you hold or have ever held a license to practice any profession. | _____ |
| 3. Submit a clear and recognizable, recently taken photograph of yourself that shows the full head, face forward from at least the shoulders up. (All professions except Polysomnography) | _____ |
| 4. Submit proof of continuing education as required by your Board. | _____ |
| 5. 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. (MD and DO reinstatements only) | _____ |

UNDERSTANDING THE APPLICATION PROCESS

1. All application fees are non-refundable. You will be notified of the reinstatement fee once the application has been received in the Board's Administrative Office.
2. All correspondence must be mailed directly to:

Administrator, _____
(Profession)
Tennessee Medical Board Office
227 French Landing, Suite 300
Heritage Place Metro Center
Nashville, TN 37243

3. A deficiency letter will be sent to you by mail. The supporting documentation (ie: proof of continuing education, etc.) requested in the letter must be received in the board office sixty (60) days from the date of the deficiency letter. Files not completed within sixty (60) days will be closed.

4. Allow fourteen (14) working days for information mailed to our office to be received and placed in your file. Special courier services will not appreciably reduce the processing time. Additionally, if special courier services are used you will be responsible for charges incurred. Please give the administrative office every consideration in this matter.
5. The application process will take six (6) to eight (8) weeks.
6. If an address change occurs at any time during the application process, you must notify the Board office, in writing, immediately.
7. Do not make arrangements to accept employment in your profession in Tennessee until you have received confirmation of your reinstatement.

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



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APPLICATION FOR LICENSURE REINSTATEMENT

Read instructions prior to completing application. Applicants must comply with all instructions. Fill in all blanks; if not applicable, state "N/A".

PERSONAL INFORMATION

Name in full: _____
(First) (Middle/Maiden) (Last)

Reinstatement type. You must check one:

- | | |
|--|---|
| <input type="checkbox"/> Radiologist Assistant | <input type="checkbox"/> Acupuncturist |
| <input type="checkbox"/> Physician Assistant | <input type="checkbox"/> ADS |
| <input type="checkbox"/> Medical Doctor | <input type="checkbox"/> Clinical Perfusionist |
| <input type="checkbox"/> Medical Office X-Ray Operator | <input type="checkbox"/> Certified Midwife |
| <input type="checkbox"/> Osteopathic Physician | <input type="checkbox"/> Polysomnography Technologist |
| <input type="checkbox"/> Osteopathic Office X-Ray Operator | |

Have you been known by any other name? Yes _____ No _____
If yes, list names: _____

Date of Birth: Mo. _____ Day _____ Yr. _____ Social Security Number: _____ - _____ - _____

Place of Birth: _____
(City) (State) (Country)

Present Mailing Address: _____ Home Phone: (____) _____ - _____

_____ Work Phone: (____) _____ - _____

U.S. Citizen: Yes _____ No _____ Sex: Male _____
Female _____

I intend to do Level II Office Based Surgery which is integral to a planned treatment regimen and not performed on an urgent or emergent basis. Yes _____ No _____ (MD and DO only)

PRACTICE AND LICENSURE INFORMATION

Present practice setting _____

Reason for leaving present practice _____

Reason for reactivating your Tennessee license _____

If applicable, reason license was not renewed _____

Type of intended specialty practice in Tennessee (MD and DO only) _____

Please complete your employment history since at least 1 year before the expiration date of the Tennessee license/registration, starting with the most current position first. Explain any breaks in employment. Use the back of this page, if you need additional space. **This section is required and your application will not be reviewed for approval until a complete work history has been received.**

<u>Employment Dates</u>	<u>Location</u>	<u>Job Duties</u>	<u>Job Title</u>
_____ to _____ mo/yr mo/yr	Employer _____ Address _____ _____ _____	_____ _____ _____	_____
_____ to _____ mo/yr mo/yr	Employer _____ Address _____ _____ _____	_____ _____ _____	_____
_____ to _____ mo/yr mo/yr	Employer _____ Address _____ _____ _____	_____ _____ _____	_____

List below all states, countries, or provinces in which you have ever been or are currently licensed in your profession or any other health profession. Submit a copy of Attachment 1 to all such states, countries, or provinces 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 your profession"** is to be construed to include all of the following:
 - a. The cognitive capacity to make appropriate clinical diagnoses (if within the scope of professional practice), exercise reasoned practice judgments, learn, and keep abreast of developments in your profession;
 - 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 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 your profession 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 and/or 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 you are not eligible for licensure.]

COMPETENCY INFORMATION CONTINUED

QUESTIONS:	YES	NO
2. Do you currently use chemical substances as defined on the previous page? 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 in any state, country, or province, has 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?	_____	_____

AFFIDAVIT AND RELEASE

I, _____, of _____
(Applicant's Name) (City) (State)

being duly sworn and identified as the person referred to in this application attest to the truth of each statement made in said application. I further swear that I have read and understand the law and the rules and regulations 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 and/or Committee may find necessary, which may include a full Board interview.

RELEASE to the Board and/or Committee, 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 my profession.

AUTHORIZE the Board and/or Committee, 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 and/or Committee, 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 _____, 20_____.

NOTARY PUBLIC

AFFIX SEAL HERE

My Commission Expires _____



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CLEARANCE FROM OTHER STATE LICENSURE BOARDS

APPLICANT: Please provide the information requested in the top box and then mail one (1) 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).

_____ was granted a license to practice _____
 (Name of Applicant) (Profession)
 with license number _____ on _____ in the State of _____.
 (Date)

The State of Tennessee requests that I submit evidence of the current status of my license in your state. You are hereby authorized to release any information in your files, favorable or otherwise, directly to:

Administrator, _____ (Profession)
Tennessee Medical Board Office
227 French Landing, Suite 300
Heritage Place Metro Center
Nashville, TN 37243

_____ Applicant's Signature

_____ Applicant's typed or printed name

_____ Date

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 _____