APA-1
6/93

TRANSMITTAL SHEET FOR NOTICE OF INTENDED ACTION

Control 540 Department or Agency Alabama State Board of Medical Examiners
Rule No. 540-X-3, Appendix B
Rule Title: Application for Certificate to Practice Medicine through Examination

_____ New _____ Amend __X__ Repeal _____ Adopt by Reference

Would the absence of the proposed rule significantly harm or endanger the public health, welfare, or safety?	YES
Is there a reasonable relationship between the state's police power and the protection of the public health, safety, or welfare?	YES
Is there another, less restrictive method of regulation available that could adequately protect the public?	NO
Does the proposed rule have the effect of directly or indirectly increasing the costs of any goods or services involved and, if so, to what degree?	NO
Is the increase in cost, if any, more harmful tot he public than the harm that might result from the absence of the proposed rule?	NO
Are all facets of the rulemaking process designed solely for the purpose of, and so they have, as their primary effect, the protection of the public?	YES

****

Does the proposed rule have an economic impact? NO

If the proposed rule has an economic impact, the proposed rule is required to be accompanied by a fiscal note prepared in accordance with subsection (f) of Section 41-22-23, Code of Alabama 1975.

****

Certification of Authorized Official

I certify that the attached proposed rule has been proposed in full compliance with the requirements of Chapter 22, Title 41, Code of Alabama 1975, and that it conforms to all applicable filing requirements of the Administrative Procedure Division of the Legislative Services Agency.

Signature of certifying officer 

Date: December 14, 2017

APA-2
6/93

ALABAMA STATE BOARD
OF MEDICAL EXAMINERS

NOTICE OF INTENDED ACTION

AGENCY NAME: Alabama State Board of Medical Examiners

RULE NO. & TITLE: 540-X-3, Appendix B, Application for Certificate to Practice Medicine through Examination

INTENDED ACTION: To repeal the Appendix

SUBSTANCE OF PROPOSED ACTION: Repeal Appendix (examination no longer administered through State Board of Medical Examiners)

TIME, PLACE, MANNER OF PRESENTING VIEWS: All interested persons may submit data, views, or arguments concerning the proposed new rule(s) and regulation(s) in writing to: Patricia E. Shaner, General Counsel, Alabama State Board of Medical Examiners, Post Office Box 946, Montgomery, Alabama 36101-0946, by mail or in person between the hours of 8:30 a.m. and 4:30 p.m., Monday through Friday, until and including February 2, 2018. Persons wishing to obtain copies of the text of this rule and submit data, views, or comments or arguments orally should contact Patricia E. Shaner, by telephone (334-242-4116) during said period in order to set up an appointment for a hearing respecting such oral data, views, or arguments. Additionally, the intended action is available at the Board's web site, www.albme.org.

FINAL DATE FOR COMMENT AND COMPLETION OF NOTICE: February 2, 2018

CONTACT PERSON AT AGENCY: Patricia E. Shaner

Edward H. Munson, Jr., Acting Executive Director

ALABAMA BOARD OF MEDICAL EXAMINERS

P.O. Box 946 — Montgomery, AL 36101
848 Washington Avenue - 36104
(334) 242-4116

APPLICATION FOR CERTIFICATE TO PRACTICE MEDICINE THROUGH EXAMINATION

To The Board of Medical Examiners of the State of Alabama:

I hereby make application for a certificate to practice medicine and surgery in the State of Alabama, and submit the following statement concerning my age, moral character, preliminary and medical education and practice.

1. Name in Full _____ (First / Middle / Last) M.D D.O. (Choose One)
2. Address _____ (Street / City / State / Zip)
3. Place of Birth _____ Date of Birth _____ Email: _____

Social Security # _____ Sex _____ Telephone (H) _____ (W) _____

Pursuant to Ala. Code §30-3-194, it is mandatory that we request and that you provide your social security number (SSN) on this application. The uses of your SSN are limited to the purpose of administering the state child support program and intra-agency for identification purposes. If your SSN is not provided, your application is not complete and no license will be issued.

		YES	NO
4	Indicate whether you are a citizen of the U.S. If yes, and foreign born, attach proof of citizenship. If no, indicate your status with U.S. immigration and attach a copy of your current Visa or Work Permit.		
5.	Have you ever been convicted of a felony? (If yes, please provide the name of the court of record or a copy of the record of conviction.)		
6.	Have you ever been convicted of a crime or offense (felony or misdemeanor) related to the practice of medicine? (If yes, please provide the name of the court of record or a copy of the record of conviction.)		
7.	Have you ever been convicted of any violation of a state or federal law relating to controlled substances? (If yes, please provide the name of the court of record or a copy of the record of conviction.)		
8.	Have you ever been denied a state or federal controlled substance certificate?		
9.	Has your certificate of qualification or license to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation?		
10.	Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice?		
11.	Have you ever been denied a certificate of qualification or a license to practice medicine in any state or has your application for a certificate of qualification or license to practice medicine been withdrawn under threat of denial?		
12.	To your knowledge, have you ever been or are you now, the subject of an investigation?		
13.	Have you previously taken any written licensing examination in this or any other state? If yes, please list the examination(s) and the date(s) taken on a separate sheet of paper.		
14.	Within the past two years, have you been diagnosed with or have you been treated for bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder?		
15.	Do you currently have any mental or physical condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or mental, emotional, or nervous disorder or condition) which in any way currently affects, or if untreated could affect your ability to practice in a competent and professional manner?[1]		
16.	Within the past five years, have you ever raised the issue of consumption of drugs or alcohol or the issue of a mental, emotional, nervous, or behavioral disorder or condition as a defense, mitigation, or explanation for your actions in the course of any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination by an educational institution; employer; government agency, professional organization or licensing authority?		
17.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?		
18.	Are you currently engaged in the illegal use of controlled dangerous substances?[1]		
19.	If your answer to the preceding question is yes, are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances?		
20.	Have you been within the past five years, convicted of driving under the influence (DUI) or have you been charged with DUI and been convicted of a lesser offense such as reckless driving?		
21.	Has your medical training or medical practice been interrupted or suspended for a period longer than 60 days for any reason other than a vacation?		
22.	Have you ever been placed on academic or disciplinary probation by a medical school or postgraduate program?		

	YES	NO
23. Have you ever been disciplined for unprofessional conduct/behavior reasons by a medical school or postgraduate program?	_____	_____
24. Were you notified in writing that there were limitations or special requirements imposed on you because of questions of academic or clinical incompetence, disciplinary problems or any other reason during your medical education or postgraduate training?	_____	_____

[1]The term "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 condition referred to may have an ongoing impact on one's functioning as a physician within the past two years.

IF ANY OF THE ABOVE ANSWERS ARE IN THE AFFIRMATIVE, PLEASE EXPLAIN IN DETAIL ON AN ATTACHED SHEET AND PROVIDE THE COMPLETE ADDRESS OF ANY PSYCHIATRIST/PSYCHOLOGIST, STATE BOARD, HOSPITAL, ETC.

25. Military Service, Branch _____ Dates _____

26. Place of Intended Residence in Alabama _____

I. PRELIMINARY AND PRE-MEDICAL EDUCATION

List all schools attended, elementary through college and post-graduate work other than medical school.

	Name of School	Dates Attended	Degree Conferred
1.			
2.			
3.			
4.			
5.			
6.			
7.			

II. MEDICAL EDUCATION

List all medical schools attended, dates, and complete addresses of institutions. Do <u>not</u> list post graduate medical education training.

	Name of School	Address
1. From _____ to _____		
2. From _____ to _____		
3. From _____ to _____		

III. POST GRADUATE MEDICAL EDUCATION TRAINING

List all post graduate medical education training since graduation from medical school with dates and complete addresses of institutions. Do not list practice experience.

	Hospital/Institution	Address
1. From _____ to _____		
2. From _____ to _____		
3. From _____ to _____		
4. From _____ to _____		
5. From _____ to _____		
6. From _____ to _____		

Specialty(s) _____

IV. ACTIVITIES FOLLOWING MEDICAL SCHOOL AND TRAINING

List all practice experience since completion of your residency training giving dates, institutions/hospitals, and complete address. Use separate sheet if necessary.

	Place	Address
1. From _____ to _____		
2. From _____ to _____		
3. From _____ to _____		
4. From _____ to _____		
5. From _____ to _____		
6. From _____ to _____		
7. From _____ to _____		
8. From _____ to _____		
9. From _____ to _____		
10. From _____ to _____		

V. HOSPITAL PRIVILEGES

List all hospitals where you have held staff privileges of any type. Attach sheet if necessary.

	Hospital	Address
1. From _____ to _____		
2. From _____ to _____		
3. From _____ to _____		
4. From _____ to _____		
5. From _____ to _____		
6. From _____ to _____		
7. From _____ to _____		
8. From _____ to _____		
9. From _____ to _____		
10. From _____ to _____		
11. From _____ to _____		
12. From _____ to _____		
13. From _____ to _____		
14. From _____ to _____		

VI. STATE LICENSURE
(If Applicable)

List all states where you have been licensed to practice medicine or have applied for a license to practice medicine. It is a requirement that each state complete one of the verification forms which will be attached to your application.

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

VII. AFFIDAVIT AND RELEASE

I, _____, certify after being duly sworn, that all of the information supplied in the foregoing application is true and correct to the best of my knowledge, that the photograph submitted is a true likeness of myself and was taken within sixty days prior to the date of this application. I acknowledge that any false or untrue statement or representation made in this application may result in the revocation of my license to practice medicine granted to me and criminal prosecution to the fullest extent of the law.

I further authorize the release of this application and any information submitted with it or information collected by the Alabama Board of Medical Examiners in connect with this application, including derogatory information, to any person or organization having a legitimate need for the information and release the Alabama Board of Medical Examiners from all liability for the release of this information.

I further authorize the release of information, including derogatory information, which may be in the possession of other individuals or organizations to the Alabama Board of Medical Examiners and release this person or any organization from any liability for the release of information.

Date _____ _____
Applicant's Signature

County of _____

State of _____

SWORN to and subscribed before me this _____ day of _____, 20 _____.

_____
Notary Public

My Commission Expires: _____

PHOTOGRAPH

THE ALBME WILL ENFORCE THE BOARD'S RULES AND OPTIONS FOR THE ISSUANCE OF NON-DISCIPLINARY CITATION AND ADMINISTRATIVE CHARGE WHEN AN APPLICANT FALSIFIES AN APPLICATION.

ALABAMA BOARD OF MEDICAL EXAMINERS
P.O. Box 946 — Montgomery, Alabama 36101
848 Washington Avenue — 36104

APPENDIX A

MEDICAL SCHOOL CERTIFICATION

CERTIFICATE OF DEAN OR PRESIDENT

It is hereby certified that _____ of _____

matriculated in _____ at _____ from _____

to _____ and received a diploma from _____

conferring the degree of Doctor of Medicine/Osteopathy on _____.

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the individual's medical education. Please circle the correct response and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation.

Does this individual's official record reflect that he/she was ever placed on academic or disciplinary probation? If yes, please attach a copy of the written notification to the individual. Y N

Does this individual's official record reflect that he/she was ever disciplined for unprofessional conduct/ behavioral reasons by the medical school or parent university? If yes, please attach a copy of the written notification to the individual of the disciplinary action. Y N

Does this individual's official record reflect that that there were any limitations or special requirements imposed on him/her because of questions of academic or clinical incompetence, disciplinary problems, or any other reason? If yes, please attach a copy of the written notification to the individual. Y N

Date _____

_____
President, Secretary or Dean

(SEAL)

INSTRUCTIONS TO INDIVIDUAL COMPLETING THIS FORM:

Please fill in all applicable spaces and return to the Alabama Board of Medical Examiners at the above address, Please do not send this application back to the applicant as the Board will not consider this certificate unless it is received directly from the institution.

Rev. 11/2009

ALABAMA BOARD OF MEDICAL EXAMINERS

P.O. Box 946 — Montgomery, Alabama 36101
848 Washington Avenue - 36104

APPENDIX B

POST GRADUATE EDUCATION CERTIFICATE

CERTIFICATE OF POST GRADUATE EDUCATION TRAINING

I, _____, Administrator, Medical Education Director **OR** Director of Residency Training Program (circle one)

of _____ certify that the records of this Program show that

_____ is currently enrolled in the ___ year of post graduate training **OR** has successfully

completed ____ year/years of post graduate training* in this program from _____ 20 _____ to _____ 20 _____.

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the individual's post graduate training. Please circle the correct response and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation.

Does this individual's official record reflect that he/she was ever placed on academic or disciplinary probation? If yes, please attach a copy of the written notification to the individual. Y N

Does this individual's official record reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons? If yes, please attach a copy of the written notification to the individual of the disciplinary action. Y N

Does this individual's official record reflect that he/she was ever notified in writing that there were any limitations or special requirements imposed on him/her because of questions of academic or clinical competence, disciplinary problems, or any other reason? If yes, please attach a copy of the written notification to the individual. Y N

Date _____

_____
Administrator of Hospital
Medical Education Director
Director of Residency Training

(SEAL OF PROGRAM)

Candidates who graduated from an LCME accredited medical school or AOA approved College of Osteopathy need one (1) year certified.

Candidates who graduated from a NON-LCME accredited medical school or NON-AOA accredited College of Osteopathy need three (3) years certified.

*"has completed ____ years of post graduate training" means the applicant has successfully completed or met the program's established criteria, standards or requirements which are necessary for promotion to the next level of post graduate training or the applicant has successfully completed or met the program's established criteria, standards or requirements which are necessary for completion of this program.

Note to applicant: Merely accumulating 12 months or 36 months of post graduate or residency training shall not be evidence satisfactory to the Board that the applicant has fulfilled the post graduate requirement necessary for qualifying for the issuance of a certificate of qualification for a license to practice medicine in Alabama.

INSTRUCTIONS TO INDIVIDUAL COMPLETING THIS FORM:
Please fill in all applicable spaces and return to the Alabama Board of Medical Examiners at the above address. Please do not send this application back to the applicant as the Board will not consider this certificate unless it is received directly from the institution.