

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 C

Rule Title: Application for a Limited Certificate of Qualification

New       Amend       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 to the 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

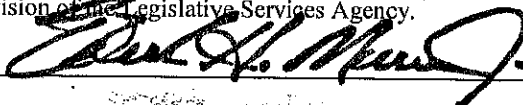
If the proposed rule has an economic impact, the proposed rule is required to be accompanied by a fiscal note prepared in accordance with subsection (f) of Section 41-22-23, Code of Alabama 1975.

\*\*\*\*\*

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 C, Application for Limited Certificate of Qualification

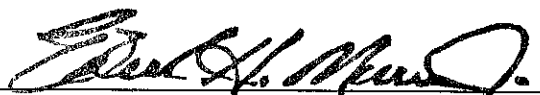
**INTENDED ACTION:** To repeal and replace the Appendix

**SUBSTANCE OF PROPOSED ACTION:** New Appendix formatted for online completion, modification of questions concerning mental health, re-lettered as Appendix B

**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](http://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

**NEW**

Alabama Board of Medical Examiners  
PO Box 946  
Montgomery AL 36101  
848 Washington Avenue – 36104  
(334) 242-43116

To the Alabama Board of Medical Examiners:

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

Type in the following:

Name in full (First, Middle, Last, M.D./D.O.)

Address (Street, City, State, Zip)

Email address

Place of birth

Date of birth

Social Security Number (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)

Sex

Telephone (H)

Telephone (W)

Answer yes or no. If any below answers are in the affirmative, please explain in detail and provide the complete name and address of any state board, hospital, psychiatrist/psychologist, etc.

1. 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)
2. 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)
3. 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)
4. Have you ever been denied a state or federal controlled substance certificate?

5. 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?
6. Have your staff privileges at any hospital or health care facility been revoked,, suspended, curtailed, limited, or placed under conditions restricting your practice?
7. 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 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?
8. Have you ever had a judgment rendered against you, or action settled relating to performance of your professional service?
9. To your knowledge, are you the subject of an investigation by any licensing board/agency as of the date of this application?
10. 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?
11. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, or voyeurism?
12. Are you currently\* engaged in the excessive use of alcohol, controlled substances, or the use of illegal drugs, or received any therapy or treatment for alcohol or drug use, sexual boundary issues or mental health issues? (If you are an anonymous participant in the Alabama Physician Health Program and are in compliance with your contract, you may answer "No" to this question, such answer for this purpose will not be deemed upon certification as providing false information to the Alabama Board of Medical Examiners or the Medical Licensure Commission of Alabama).

If you answer "Yes," then a description is required.

**IMPORTANT:** The Board recognizes that licensees encounter health conditions, including those involving mental health and substance use disorders, just as their patients and other health care providers do. The Board expects its licensees to address their health concerns and ensure patient safety. Options include anonymously self-referring to the Alabama Physician Health Program (334-954-2596), a physician advocacy organization dedicated to improving the health and wellness of medical professionals in a confidential manner. The failure to adequately address a health condition, where the licensee is unable to practice medicine with reasonable skill and safety to patients, can result in the Board taking action against the license to practice medicine.

\_\_\_\_\_ Please initial certifying that you understand and acknowledge your duty as a licensee to address any such condition as stated above.

\*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.

13. Within the past five years, have you been 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?

14. 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?

Pre-medical education: List all schools attended, undergraduate and post-graduate work other than medical school, dates attended, and degree conferred.

Medical education: List all medical schools attended, dates, and complete addresses of institutions. Do not list post-graduate medical education training.

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

Affidavit and release:

Affidavit and release:

I, [name prints here], 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 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 connection 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.

Applicant's signature

Notarization

Certification: This is to certify that the aforementioned individual is making application for a limited certificate of qualification at this institution.

Signature:

Type or print name of Dean-School of Medicine or Director-Residency Training Program

Under Alabama law, this document is a public record and will be provided upon request.

Print application, sign in presence of Notary Public, have Dean-Medical School or Director-Residency Training Program sign, and return original to the Alabama Board of Medical Examiners.

ALABAMA BOARD OF MEDICAL EXAMINERS

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

APPLICATION FOR A LIMITED CERTIFICATE OF QUALIFICATION

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

I hereby make application for a limited 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 \_\_\_\_\_
- 2. Address \_\_\_\_\_
- 3. Place of Birth \_\_\_\_\_ Date of Birth \_\_\_\_\_

Social Security # \_\_\_\_\_ Sex \_\_\_\_\_ Telephone \_\_\_\_\_

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. Have you ever been convicted of a felony?	_____	_____
5. Have you ever been convicted of a crime or offense (felony or misdemeanor) related to the practice of medicine?	_____	_____
6. Have you ever been convicted of any violation of a state or federal law relating to controlled substances?	_____	_____
7. Have you ever been denied a state or federal controlled substance certificate?	_____	_____
8. 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?	_____	_____
9. Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice?	_____	_____
10. 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?	_____	_____
11. Have you ever had a judgement rendered against you, or action settled relating to the performance of your professional service?	_____	_____
12. To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this application?	_____	_____
13. 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?	_____	_____
14. 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? <sup>1</sup>	_____	_____
15. 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?	_____	_____
16. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism, or for any sexual boundary violation?	_____	_____
17. Are you currently engaged in the illegal use of controlled dangerous substances? <sup>1</sup>	_____	_____
18. 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?	_____	_____
19. 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?	_____	_____
20. 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?	_____	_____

<sup>1</sup>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.

21. Military Service, Branch \_\_\_\_\_ Dates \_\_\_\_\_

22. Place of Intended Residence in Alabama \_\_\_\_\_

**I. PRE-MEDICAL EDUCATION**

	Name of School	Dates Attended	Degree Conferred
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

**II. MEDICAL EDUCATION**

List all medical schools attended, dates, and complete addresses of institutions. Do list internship and/or residency training.

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

**III. INTERNSHIP AND/OR TRAINING**

List all internship and/or residency training since graduation from medical school with dates and complete addresses of institutions. Do not list practice experience.

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

**IV. 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. 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 connection 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 \_\_\_\_\_

County of \_\_\_\_\_

State of \_\_\_\_\_

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

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

(SEAL)

\_\_\_\_\_  
Notary Public

CERTIFICATION:

My Commission Expires: \_\_\_\_\_

This is to certify that the aforementioned individual is making application for a limited certificate of qualification at this institution.