

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 F

Rule Title: Retired Senior Volunteer Physician Program Certificate of Qualification Renewal Application

X 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 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 \_\_\_\_\_

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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.

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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 F, Retired Senior Volunteer Physician Program  
Renewal Application


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

**SUBSTANCE OF PROPOSED ACTION:** Application form being modified for online  
completion, modification of questions concerning mental health and reletter as Appendix  
D

**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

540-X-3, Appendix D  
Retired Senior Volunteer Program Certificate  
of Qualification Renewal Application

NEW

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

Alabama Board of Medical Examiners  
Retired Senior Volunteer Program Certificate of Qualification Renewal Application

Ala. Code § 34-24-75 requires that all physicians holding limited licenses under retired the senior volunteer program apply to the Board of Medical Examiners for renewal of the certificate of qualification prior to renewal of the license. In accordance with this section, you are required to accurately complete this application. Once the application has been completed, please return it to the institution to obtain the certification of the qualified clinic or nonprofit organization.

Full name  
Name of qualified clinic or nonprofit organization  
License number  
Date issued

Please answer yes or no to the following questions (if any below answers are in the affirmative, please explain in detail and provide the complete name and address of any psychiatrist/psychologist, state board, hospital, etc.)

1. Do you limit your practice to the confines of the institution?
2. Have you ever been convicted of a felony?
3. Have you ever been convicted of a crime or offense (felony or misdemeanor) related to the practice of medicine?
4. Have you ever been convicted of any violation of a state or federal law relating to controlled substances?
5. Have you ever been denied a state or federal controlled substance certificate?
6. Has your certificate of qualification or license to practice medicine in any state ever been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation?
7. Have your staff privileges at any hospital or health care facility ever been revoked, suspended, curtailed, limited or placed under conditions restricting your practice?
8. 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?
9. Have you ever had a judgment rendered against you or action settled relating to the performance of your professional service?

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. 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?

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?

I hereby certify that the foregoing is true and correct to the best of my knowledge.

Date

Applicant's signature

I hereby certify that the information contained in this renewal application is true to the best of my knowledge.

Date

Type or print Clinic or Facility Administrator name

Clinic/Facility Administrator signature

ALABAMA BOARD OF MEDICAL EXAMINERS
Retired Senior Volunteer Program Certificate of Qualification Renewal Application

Section 34-24-75, Code of Alabama 1975, as amended, requires that all physicians holding limited licenses under retired senior volunteer program apply to the Board of Medical Examiners for renewal of the certificate of qualification prior to renewal of the license. In accordance with this section you are required to accurately complete this application. Once the application has been completed please return it to the institution to obtain the certification of the qualified clinic or nonprofit organization.

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Full Name: \_\_\_\_\_

Name of Qualified Clinic or Nonprofit Organization: \_\_\_\_\_

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

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.

Table with 3 columns: Question, YES, NO. Contains 9 numbered questions regarding medical practice restrictions and convictions.

- 10. 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? \_\_\_\_\_
- 11. 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? \_\_\_\_\_
- 12. 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? \_\_\_\_\_
- 13. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism, or for any sexual boundary violation? \_\_\_\_\_
- 14. Are you currently engaged in the illegal use of controlled dangerous substances? \_\_\_\_\_
- 15. 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? \_\_\_\_\_
- 16. 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? \_\_\_\_\_
- 17. 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? \_\_\_\_\_

The term "currently does not mean on the date 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.**

I hereby certify that the foregoing is true and correct to the best of my knowledge.

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

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I hereby certify that the information contained in this renewal application is true to the best of my knowledge.

\_\_\_\_\_  
Clinic or Facility Administrator