APA-1
Revised 4/2018

TRANSMITTAL SHEET FOR
NOTICE OF INTENDED ACTION

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

____ New __X__ Amend ____ Repeal ____ Adopt by Reference

Would the absence of the proposed rule significantly harm or endanger the public health, welfare, or safety?	NO
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 action relate to or affect in any manner any litigation which the agency is a party to concerning the subject matter of the proposed rule?	NO

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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 Cindy J. Donnelly

Date: 6/20/18

APA-2

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 A, Application for Certificate of Qualification to Practice Medicine in Alabama

INTENDED ACTION: To amend the rule/appendix

SUBSTANCE OF PROPOSED ACTION: Amend for online completion

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: Carla H. Kruger, Office of the 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 Aug. 3, 2018. Persons wishing to obtain copies of the text of this rule and submit data, views, or comments or arguments orally should contact Carla H. Kruger, 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: Aug. 3, 2018

CONTACT PERSON AT AGENCY: Carla H. Kruger

Amy T. Dorminey, Board Secretary

ALABAMA BOARD OF MEDICAL EXAMINERS

P.O. Box 946 / Montgomery, AL 36101-0946 / (334) 242-4116

APPLICATION FOR CERTIFICATE OF QUALIFICATION TO PRACTICE MEDICINE IN ALABAMA

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

To the Alabama Board of Medical Examiners:
I hereby make application for a 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~~_____ ~~City~~_____ ~~State~~_____ ~~Zip~~_____

~~Place of Birth~~_____ ~~Date of Birth~~_____ ~~Sex~~_____

Social Security Number #*_____ ~~Telephone (H)~~_____ ~~Telephone (W)~~_____

* 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)

Place of Birth
Country of Birth
City of Birth
State/Providence of Birth
Gender/Sex (at birth)
Date of Birth

Contact Information
The address and contact methods provided should be how the Board or Commission can contact the license applicant directly. Please DO NOT provide contact information for office managers, assistances, or license assistant companies.
Address
Contact Methods
Email Address
Home Telephone Number
Work Telephone Number

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

		~~YES~~	~~NO~~
1.	Have you ever been convicted of a felony? (~~If yes~~You answered 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 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"~~You answered 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.

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? ____ ____
15. Have you ever been placed on academic or disciplinary probation by a medical school or postgraduate program?
16. Have you ever been disciplined for unprofessional conduct/behavior reasons by a medical school or postgraduate program?
17. 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? ____ ____

Please provide the following information:

~~Place~~ City of intended residence in Alabama*

_____

* Please enter the City where you intend to live in Alabama. If you will be living outside of Alabama please type "Out of State" in the field.

Education Information

When entering dates attended in the education sections if you don't know the exact date use the first date of the month. (Example: you attended from August 1990 – July 1994, Enter 08/01/1990 – 07/01/1994)

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

List all schools attended, undergraduate work other than medical school, dates, attended, and degree conferred.

School Name

State Date

End Date

Degree Received

	Date	Name of School	Degree
1.	From_____ to _____		
2	From_____ to _____		
3.	From_____ to _____		
4.	From_____ to _____		

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

	Date	Name of School	Address
1.	From_____ to _____		
2	From_____ to _____		
3.	From_____ to _____		
4.	From_____ to _____		
5.	From_____ to _____		
6.	From_____ to _____		
7.	From_____ to _____		

List all medical Schools attended, dates, and complete addresses of institutions. Do Not list post-graduate medical education training.

Medical School Name

Start Date

End Date

Street Address

Suite

City

State

Zip

Country

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.

	Date	Name of School	Address
1.	From_____ to _____		
2	From_____ to _____		
3.	From_____ to _____		
4.	From_____ to _____		

5. From_____ to _____ _____ _____

6. From_____ to _____ _____ _____

7. From_____ to _____ _____ _____

List all post-graduate medical education training since graduation from medical school, dates, and complete address of institutions. DO NOT list practice experience.

Facility Name

Start Date

End Date

Street Address

Suite

City

State

Zip

Country

Specialty(s):

_____

Specialty Board Certification:

Are you CURRENTLY certified by one of the specialty boards approved by the American Board of Medical Specialties or the American Osteopathic Association? If Yes, have your specialty board send verification to the Board. ( ) Yes ( ) No

Original Full License (if applicable):

Provide name of state/territory, date issued, license number, and examination taken.

State/Territory	Date Issued	License Number	Examination Taken

Has this license been the subject of any disciplinary action? ( ) Yes ( ) No If yes, please provide summary and supporting documentation.

Activities following Medical School and Training: List all practice experience since completion of your formal training, providing dates, institutions/hospitals, and complete addresses.

	Date	Name of Institution/Hospital	Address
1.	From_____ to _____	_____	_____
2	From_____ to _____	_____	_____
3.	From_____ to _____	_____	_____
4.	From_____ to _____	_____	_____
5.	From_____ to _____	_____	_____
6.	From_____ to _____	_____	_____
7.	From_____ to _____	_____	_____

List all practice experience since completion of your formal training, providing dates, institutions/hospitals, and complete addresses.

Facility/Hospital Name

Start Date

End Date

Street Address

Suite

City

State

Zip

Country

Hospital Privileges~~: List all hospitals where you have held staff privileges of any type, providing dates, hospital names, and complete addresses.~~

	~~Date~~	~~Name of 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_____~~		

List all hospitals where you have held staff privileges of any type, providing dates, hospital names and complete addresses.

Hospital Nmae

Start Date

End Date

Street Address

Suite

City

State

Zip

Country

Please explain for period of time unaccounted for

License Information

Specialty(s): (Choose from list)

Specialty Board Certification: Are you CURRENTLY certified by one of the specialty boards approved by the American Board of Medical Specialties or the American Osteopathic Association?

You answered Yes, have your specialty board send verification to the Alabama Board of Medical Examiners.

Please List your Specialty Board Certification(s)

Have you ever been issued a full unrestricted medical license in another State? (Please exclude any limited licenses or training permits)

Original Full License

It is a requirement that the original state of issue will have to provide a written verification directly to the Board.

Please provide the following information on the first original medical license received.

State that issued the original first license

Date original first license was issued

Original first license number

Examination taken to receive original first license

Has this license been the subject of any disciplinary action?

You answered yes, please provide a summary and supporting documentation

State Licensure:

List all states where you have been licensed to practice medicine. It is a requirement that each state provide a written verification directly to the Board. List all licenses including training or educational licenses. Please Note: training and education licenses do not require a written verification.

State

Type of License

SPEX: Requirement

~~Have you successfully completed a written licensing examination within the last ten years? ( ) Yes ( ) No~~

Have you been certified or re-certified within the past ten years by one of the specialty boards approved by the American Board of Medical Specialties or the American Osteopathic Association? ~~( ) Yes ( ) No~~

Have you successfully completed a written licensing examination within the last ten years?

What was the date the written licensing examination was taken?

Please select the licensing examination you have taken within the last ten years:

USMLE

Date initially passed Step 1:

Number of attempts to pass Step 1:

If you took Step 2 before it was split into tow parts enter you attempts in Step CS and Enter 0 (zero) in Step 2 CK.

Number of attempts to pass Step 2 CS:

Number of attempts to pass Step 2 CK:

Number of attempts to pass Step 3:

Date initially passed Step 3:

According to the information provided the applicant does not qualify for a certificate of qualification (COQ) to practice medicine in the state of Alabama without taking and passing the SPEX. If the applicant would like to continue with the application process once the board is in receipt of all required information and the application is considered complete the Alabama Board of Medical Examiners will endorse the applicant for the SPEX. NOTE: The applicant will have 1 year from the date the application is submitted to submit all information, take and pass the SPEX. If the SPEX scores are not submitted and received by the board within this 1 year period the applicant will have to start the application process again and pay all required fees again.

I, understand in order to qualify for a certificate of qualification (COQ) to practice medicine in Alabama I will have to take and pass the SPEX and I wish to continue with the application.

_____

Affidavit and Release:

I,_____certify after being duly sworn, that all of the information supplied in the ~~foregoing~~ submitted 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

Date: _____ County of _____

State of _____

SWORN to and subscribed before me this _____ day of

_____, _____

Attach Photograph
If one was not uploaded

_____
Notary Public Signature

My Commission Expires: _____

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

The Alabama Board of Medical Examiners will enforce the Board's rules and options for the issuance of Non-Disciplinary Citation and Administrative Charge when an applicant falsifies an application.

Print ~~application~~ affidavit and release, sign in presence of Notary Public, attach color picture if not uploaded, and return original to the Alabama Board of Medical Examiners.