

TRANSMITTAL SHEET FOR
NOTICE OF INTENDED ACTION

Control 545 Department or Agency Alabama Medical Licensure Commission

Rule No. Chapter 2- Appendix B

Rule Title: Alabama Medical License Renewal Application

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 Reference Service.

Signature of certifying officer James E. West, MD

Date: Sept 12, 2017

APA-2
6/93

ALABAMA MEDICAL LICENSURE COMMISSION

NOTICE OF INTENDED ACTION

AGENCY NAME: Alabama Medical Licensure Commission

RULE NO. & TITLE: Chapter 2- Appendix B, Alabama Medical License Renewal Application

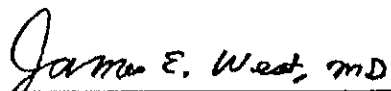
INTENDED ACTION: To repeal & replace previous Chapter 2- Appendix B

SUBSTANCE OF PROPOSED ACTION: To replace renewal application questions prior to the 2017 renewal period in order to protect personal and confidential licensee information and to collect additional information as requested by the Ala. Dept of Public Health.

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: Karen H. Silas, Executive Assistant, Alabama Medical Licensure Commission, Post Office Box 887, Montgomery, Alabama 36101-0887, by mail or in person between the hours of 8:30 a.m. and 4:30 p.m., Monday through Friday, until and including Friday, November 3, 2017. Persons wishing to obtain copies of the text of this rule and submit data, views or comments or arguments orally should contact Karen H. Silas, by telephone (334/242-4153) during said period in order to set up an appointment for a hearing respecting such oral data, views, or arguments.

FINAL DATE FOR COMMENT AND COMPLETION OF NOTICE: November 3, 2017

CONTACT PERSON AT AGENCY: Karen H. Silas



James E. West, M.D., Chairman

CHAPTER 2--APPENDIX B "REPEALED"
Appendix B/Ch. 2

20__ Alabama Medical License Renewal Application

Deadline is December 31, 20__

Fees:

Renewal Fee \$300: October 1 – December 31

\$100 Late Fee Added (Total \$400): January 1 – January 31

(After January 31 – Reinstatement is required)

Renew Online @ _____

FAILURE TO RENEW THIS LICENSE TO PRACTICE MEDICINE OR OSTEOPATHY BY JANUARY 31 WILL RESULT IN LICENSE BECOMING INACTIVE WITHOUT FURTHER NOTICE

Medical Licensure Commission
Post Office Box 887
Montgomery, Alabama 36101-0887
334-242-4153

Complete all pages, including signature
Correct or supply all information
Return with \$300.00 renewal fee
Incomplete applications will be returned

Under Alabama law, this document is a public record and if requested it will be provided in it's entirety.

What is your current status? () Active () Retired

(If retired, you may skip Practice Information and Primary care Information sections below)

Physical Home Address (No P.O. Boxes)

ADDRESS LINE 1

ADDRESS LINE 2

CITY, STATE, ZIP

Home Telephone

Home Email

County:

Physical Practice/Work Address: (No P.O. Boxes)

Address Line 1

Address Line 2

City, State, Zip

Practice/Work Phone:

Work Email

County:

Mailing Address: (For Official Correspondence Only)

Address Line 1

Address Line 2

City, State, Zip

Please designate a "Public Address". The public address will be the address given out if an address is requested. () Home () Mailing () Practice/Work

Practice Information

Primary Specialty:
Secondary Specialty:

Board Certified: Yes No
Board Certified: Yes No

Primary Hospital where you have staff privileges:
City/State:

Are you licensed in another state: Yes No If yes, please list:

1. Are you actively engaged in clinical practice in the State of Alabama?
Yes Answer Questions 2 through 6
No Answer Question 2 only

2. What is your principal county of practice? (indicate state if principal county is not in Alabama)

Other county(ies) of practice? (indicate state, if counties are not in Alabama)
Check "None" if you only practice in the indicated principal county. None

3. Do you currently perform/offer to perform any office based surgery/procedure which requires 1) moderate sedation, deep sedation, or general anesthesia; 2) liposuction when infiltration methods such as the tumescent technique are used; or 3) any procedure in which Propofol is administered, given or used?
 Yes No

Primary Care Information

Primary care is defined as: Basic or general health care focused on the point at which a patient ideally first seeks assistance from the medical care system, exclusive of an emergency situation.

4. Does your practice include the delivery of primary care or mental health services (OB/GYN, general medicine, family medicine, general pediatrics, general internal medicine, general psychiatry or child psychiatry)?

Yes, answer questions 5 and 6
 No, skip questions 5 and 6

5. Approximately how many hours per week do you perform direct patient care in your office involving the above defined primary care or mental health services in Alabama?
Approximately _____ hours per week

6. Approximately how many patient office visits per week do you have involving the above defined primary care or mental health services in Alabama?
Approximately _____ office visits per week.

CME Certification: (Check one)

(a) I hereby certify that I have met or will meet by December 31 the annual minimum continuing education requirement of 25 AMA PRA Category I Credits™ or equivalent continuing medical education for the calendar year 20__ and have or will have supporting documentation if audited.

(b) I certify that I am exempt from the minimum continuing medical education requirement for the following reason:

(Must Check One if "b" is selected above)

I do not reside in the State of Alabama and do not have a significant portion of my medical practice in the State of Alabama.

I was exempt from the CME requirement for the previous calendar year 20__, and I moved my residence to the State of Alabama during the calendar year 20__.

I received my initial license to practice medicine in Alabama in the calendar year 20__.

I have obtained a retirement waiver from the Board of Medical Examiners, and I do not engage in the practice of medicine in any form.

I have obtained a waiver from the Board of Medical Examiners due to illness, disability or other hardship condition which existed in the calendar year 20__.

I am enrolled or was enrolled in a residency training program or clinical fellowship program during the calendar year 20__.

I am exempt from the CME requirement for the calendar year 20__ because I am a member of a branch of the armed services and I was deployed for military service in the calendar year 20__.

Professional Responsibility Certification

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. Have you been charged with a criminal offense (felony or misdemeanor) within the past year? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Has your certificate of qualification or license to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered while under investigation, or threat of suspension or revocation within the past year? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited, placed under conditions restricting your practice or voluntarily surrendered within the past year? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you been denied a certificate of qualification or 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 within the past year? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you had a judgment rendered against you, or action settled relating to the performance of your professional service within the past year? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. To your knowledge, are you the subject of an investigation, or has a formal complaint against | | |

your license been filed by any licensing Board/Agency as of the date of this application within the past year?

7. Within the past year, have you been diagnosed with or have you been treated for bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder?

8. 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 or, within the past year, have you applied for and/or have you received any payment or other compensation for any mental or physical condition?

(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 that the condition referred to may have an ongoing impact on one's functioning as a physician, or within the past two years.)

9. Within the past year, have you 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?

10. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or for any sexual boundary violation?

11. Have you engaged in the unauthorized use of controlled substances within the past twelve months?

12. Are you currently participating in the Alabama Physician's Health Program or any supervised rehabilitation program which monitors you in order to assure that you are not engaging in the unauthorized use of controlled substances or alcohol?

13. Have you been, within the past year, 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. Within the past year 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 or maternity leave?

IF YOU ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE INCLUDE A

DETAILED EXPLANATION WITH YOUR APPLICATION

I certify that all information on this form is correct.

Signature _____ Date

- Complete all pages, including signature.
- Correct or supply all information.
- Incomplete application will be returned.

Return with \$300.00 renewal fee to:

Medical Licensure Commission
P.O. Box 887
Montgomery, AL 36101-0887

Author: Alabama Medical Licensure Commission

Statutory Authority: Code of Alabama 1975

History: Amended: Filed July 1997; effective August 27, 1997. **Amended:** Filed March 4, 2003; effective April 8, 2003.

Amended: Approved for Publication January 28, 2004

Filed: January 30, 2004

Approved for Adoption: April 21, 2004; **Effective Date:** May 28, 2004

Repeal and Replace: Approved for Publication November 17, 2005; **Filed:** November 28, 2005

Approved for Adoption: February 22, 2006; **Filed:** February 27, 2006; **Effective Date:** April 3, 2006. **Amended/Approved:** August 22, 2007; Emergency Rule Effective September 4, 2007.

Approved for Adoption: November 28, 2007; Effective date January 4, 2007.

Amended: Approved for Publication January 27, 2010.

Filed: February 4, 2010; Final Approval April 28, 2010; Filed May 5, 2010; Effective Date June 9, 2010;

Amended: ER Adopted May 23, 2012, Filed ER May 25, 2012

Approved: May 23, 2012; Filed May 25, 2012

Final File August 30, 2012; Effective October 4, 2012

Amended: Approved for Publication September 26, 2012; Filed w/LR February 12, 2013#2;

Final Approval May 22, 2013, Filed June 5, 2013; Effective Date July 10, 2013

Amended: ER Adopted August 27, 2014- Filed ER September 3, 2014

Approved for Adoption & Publication: August 27, 2014; Filed w/LR September 4, 2014.

Adopted November 20, 2014; Final File LR November 26, 2014; Effective January 1, 2015.

Amended: Approved for Publication August 31, 2015; Filed September 10, 2015; Final Adoption November 19, 2015; Filed December 1, 2015; Effective January 15, 2016.

Repealed: Approved August 23, 2017; Filed September 12, 2017

CHAPTER 2--APPENDIX B "NEW RULE"

Appendix B/Ch. 2

20XX Alabama Medical License Renewal Application

Deadline: December 31, 20XX

Failure to renew this license by January 31 will result in license becoming inactive without further notice.

Under Alabama law, this document is a public record and if requested it will be provided in its' entirety.

CME Certification: (Select One)

I hereby certify that I have met or will meet by December 31 the annual minimum continuing education requirement of 25 AMA PRA Category I Credits™ or equivalent continuing medical education for the calendar year 20XX and have or will have supporting documentation if audited.

I certify that I am exempt from the minimum continuing medical education requirement for the following reason: (Select One)

I do not reside in the State of Alabama and do not have a significant portion of my medical practice in the State of Alabama

I was exempt from the CME requirement for the previous calendar year 20XX, and I moved my residence to the State of Alabama during the calendar year 20XX.

I received my initial license to practice medicine in Alabama in the calendar year 20XX.

I have obtained a retirement waiver from the Board of Medical Examiners, and I do not engage in the practice of medicine in any form.

I have obtained a waiver from the Board of Medical Examiners due to illness, disability or other hardship condition which existed in the calendar year 20XX.

I am enrolled or was enrolled in a residency training program or clinical fellowship program during the calendar year 20XX.

I am exempt from the CME requirement for the calendar year 20XX because I am a member of a branch of the armed services and I was deployed for military service in the calendar year 20XX.

Practice Information

1. Are you actively engaged in clinical practice in the State of Alabama?
Yes No

2. What type of specialty area do you practice?

3. Do you currently perform/offer to perform any office based surgery/procedure which requires 1) moderate sedation, deep sedation, or general anesthesia; 2) liposuction when infiltration methods such as the tumescent technique are used; or 3) any procedure in which Propofol is administered, given or used?
Remember: Office-based surgery is surgery* performed outside a hospital or outpatient facility licensed by the Alabama Department of Public Health.

*Definition of Surgery: Surgery, which involves the revision, destruction, incision or structural alteration of human tissue performed, using a variety of methods and instruments, is a discipline that includes the operative and non-operative care of individuals in need of such intervention, and demands pre-operative assessment, judgement, technical skills, post-operative management and follow-up.

Primary Care Information

4. Does your practice included the delivery of primary care or mental health services, defined as basic or general health care focused on the point at which a patient ideally first seeks assistance from the medical care system, exclusive of an emergency situation? It does

NOT include administrative, hospitalists, research, teaching, inpatient, emergency/urgent care, or specialized care.)

5. What is your National Provider Identifier (NPI) Number?
6. Do you work for the military, Veterans Administration, or a federal/state correctional facility?
7. Are you planning to retire in the next 12 months?
8. Are you an intern or resident?
9. What are your practice addresses? (Please include street, city, county, and zip code for each address)
10. How many hours per week do you provide direct patient care? (Do NOT include on call, hospital or nursing home rounds, drug rehab centers, jail, emergency room shifts, or similar sites.)
11. What percentage of the total patient base is on Medicaid? (If none, enter zero)
12. Is a formal sliding fee scale used, based on the patient's income or ability to pay? (Must be available to all uninsured patients.)

NOTE: Repeat questions 9 through 12 for each practice location.

Professional Responsibility Certification

SINCE YOUR LAST RENEWAL:

1. Have you been "charged" with "any" criminal offense (felony or misdemeanor) (This includes driving under the influence (DUI), even if you were convicted of a lesser offense)? Yes No (If yes, please include a detailed explanation)

2. Has your certificate of qualification or license to practice medicine or osteopathy in any state been suspended, revoked, restricted, curtailed, voluntarily surrendered, or disciplined in any manner? Yes No (If yes, please include a detailed explanation)

3. Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited, restricted or voluntarily surrendered? Yes No (If yes, please include a detailed explanation)

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 Commission 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.***

9. 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 or maternity leave? Yes No (If yes, please include a detailed explanation)

I understand and agree that by typing my name, I am providing an electronic signature that has the same legal effect as a written signature pursuant to Ala. Code §§ 8-1A-2 and 8-1A-7. I attest that the foregoing information has been provided by me and is true and correct to the best of my knowledge, information and belief.

Knowingly providing false information to the Alabama Board of Medical Examiners or Medical Licensure Commission of Alabama could result in disciplinary action.

Author: Alabama Medical Licensure Commission

Statutory Authority: Code of Alabama 1975

History: Amended: Filed July 1997; effective August 27, 1997. **Amended:** Filed March 4, 2003; effective April 8, 2003.

Amended: Approved for Publication January 28, 2004

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