ALABAMA STATE BOARD OF MEDICAL EXAMINERS
ADMINISTRATIVE CODE

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20__ Collaborative Practice Registration
Deadline: December 31, 20__

Register online @ http://alrenewals.org
Registration ID:

Alabama Board of Medical Examiners
P.O. Box 946, Montgomery, AL 36101
(334) 242-4116

Complete ALL questions. Include a check for $100.00 payable to the ALABAMA BOARD OF MEDICAL EXAMINERS for EACH Collaborative Practice.

Collaborative Practice Number: CRNP / CNM License #:

Name of CRNP / CNM:

1. Does this nurse practitioner / nurse midwife work at a site other than your primary practice site? YES [ ] NO [ ]
   (If yes, please list sites below. Please check the box next to the sites at which the nurse practitioner / nurse midwife practices with no physician on-site). If more space is needed, please submit additional pages in writing.

   [ ] Practice Site Address: __________________________

   [ ] Practice Site Address: __________________________

   [ ] Practice Site Address: __________________________

   [ ] Practice Site Address: __________________________

2. Are you employed by the nurse practitioner / nurse midwife in this collaborative practice to serve as their collaborating physician at a clinic owned by him / her? YES [ ] NO [ ]

3. Have you been audited by the Collaborative Practice Inspectors within the last 12 months? YES [ ] NO [ ]

4. Have you attended a Collaborative Practice Seminar in the last 24 months? YES [ ] NO [ ]

5. Is your Quality Assurance Documentation up-to-date? YES [ ] NO [ ]

I certify the foregoing information to be correct to the best of my knowledge, information and belief, and attest that I have reviewed and am abiding by the Rules and Regulations of Advanced Practice Nurses: Collaborative Practice, Chapter 540-X-8 that were effective on this date.

Signature ___________________________ Date ___________________________

Supp. 6/30/10 A-3
FAILURE TO PAY THE ANNUAL FEE AND COMPLETE THE COLLABORATIVE PRACTICE REGISTRATION FORM WILL RESULT IN NOTIFICATION THAT THE PHYSICIAN DOES NOT CURRENTLY MEET THE QUALIFICATIONS NECESSARY FOR THE PHYSICIAN TO PARTICIPATE IN THE COLLABORATIVE PRACTICE AND THAT THE PHYSICIAN MUST CEASE PARTICIPATING IN THE COLLABORATIVE PRACTICE.

Author: Alabama State Board of Medical Examiners
APPLICATION FOR CERTIFICATE TO PRACTICE MEDICINE THROUGH ENDORSEMENT

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 ____________________________ (M.D.) ____________________________ (D.O.)
   First ____________________________ Middle ____________________________ Last ____________________________

2. Address ____________________________ Street ____________________________ City ____________________________ State ____________________________ Zip ____________________________

3. Place of Birth ____________________________ Date of Birth ____________________________

Social Security # ____________________________ Telephone (H) ____________________________ Telephone (W)

4. Have you ever been convicted of a felony? (If yes, please provide the name of the court of record)
   YES ______ NO ______

5. 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.)
   YES ______ NO ______

6. Have you ever been convicted of any violation of a state or federal law relating to controlled substance? (If yes, please provide the name of the court of record or a copy of the record of conviction.)
   YES ______ NO ______

7. Have you ever been denied a state or federal controlled substance certificate?
   YES ______ NO ______

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?
   YES ______ NO ______

9. Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice?
   YES ______ NO ______

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?
    YES ______ NO ______

11. To your knowledge, have you ever been or are you now, the subject of an investigation?
    YES ______ NO ______

12. 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.
    YES ______ NO ______

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?
    YES ______ NO ______

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?
    YES ______ NO ______

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?
    YES ______ NO ______

16. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?
    YES ______ NO ______

17. Are you currently engaged in the illegal use of controlled dangerous substances?
    YES ______ NO ______

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?
    YES ______ NO ______

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?
    YES ______ NO ______

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?
    YES ______ NO ______

21. Have you ever been placed on academic or disciplinary probation by a medical school or postgraduate program?
    YES ______ NO ______
22. Have you ever been disciplined for unprofessional conduct/behavior reasons by a medical school or postgraduate program?

<table>
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<th>YES</th>
<th>NO</th>
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23. 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?

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<th>YES</th>
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*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.**

24. Military Service, Branch __________________________ Dates __________________________

25. 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.

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<th>Name of School</th>
<th>Dates Attended</th>
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### II. MEDICAL EDUCATION

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

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<th>Name of School</th>
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### 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.

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Specialty(s) __________________________

Supp. 6/30/10
IV. ORIGINAL LICENSE
(If Applicable)
I was issued my original (first) license in the State of ____________ on ____________ based upon __________________ examination. I certify that this license has not been the subject of any disciplinary action. If so please explain on attached sheet.

V. ACTIVITIES FOLLOWING MEDICAL SCHOOL AND TRAINING
List all practice experience since completion of your formal training giving dates, institutions/hospitals, and complete address. Use separate sheet if necessary.

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

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VII. 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.

__________________________________________  _________________________________________

__________________________________________  _________________________________________

__________________________________________  _________________________________________

VIII. SPEX
1. Have you successfully completed a written licensing examination within the last ten years? YES _____ NO _____
2. Have you been certified or re-certified by an A.M.A. approved Specialty Board within the last ten years? YES _____ NO _____

IX. 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 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 ______________________________________

SWORN to and subscribed before me this ________day of ____________________________, 19 ________.

__________________________________________

Notary Public

My Commission Expires: ____________________________

PHOTOGRAPH
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? Y N
If yes, please attach a copy of the written notification to the individual.

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? Y N
If yes, please attach a copy of the written notification to the individual.

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? Y N
If yes, please attach a copy of the written notification to the individual.

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
Author: Alabama Board of Medical Examiners
Statutory Authority: Code of Ala. 1975, §34-24-70
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 ___________________________ Middle ___________________________ Last ___________________________ (choose one) ___________ M.D. ___________ D.O. ___________

2. Address ___________________________ City ___________________________ State ___________________________ Zip ___________

3. Place of Birth ___________________________ Date of Birth ___________________________

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

4. 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.)

5. 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.)

6. 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.)

7. Have you ever been denied a state or federal controlled substance certificate?

8. Have 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 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. To your knowledge, have you ever been or are you now, the subject of an investigation?

12. 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.

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?

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 or voyeurism?

17. Are you currently engaged in the illegal use of controlled dangerous substances?

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?

21. Have you ever been placed on academic or disciplinary probation by a medical school or postgraduate program?
### Chapter 3 - Appendix B

### Medical Examiners

22. Have you ever been disciplined for unprofessional conduct/behavior reasons by a medical school or postgraduate program?

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23. 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?

*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.*

24. Military Service, Branch __________________________ Dates __________________________

25. Place of Intended Residence in Alabama __________________________

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#### II. MEDICAL EDUCATION

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

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#### III. POST GRADUATE MEDICAL EDUCATION TRAINING

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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.

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### V. HOSPITAL PRIVILEGES

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

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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.


CERTIFICATE OF POST GRADUATE EDUCATION TRAINING

I, ____________________________, Administrator, Medical Education Director or Director of Residency Training Program (indicate which one) of ________________________ certify that the records of this Program show that _______________________________ has successfully completed ________ year/years of post graduate training* in this program from ________ to ________.

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? Yes __ No __

Does this individual’s official record reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons? Yes __ No __

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? Yes __ No __

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.

Rev. 1/2010
STATE OF ALABAMA
BOARD OF MEDICAL EXAMINERS

Complete top section of the form and mail to the Board of each State in which you are now or have ever been licensed to practice. If needed, you may make machine copies of this form for additional copies.

Gentlemen:

I am applying for an Alabama license to practice __________________________. The Alabama Board requires that your Board complete this form in order that I may be considered for licensure.

This is your authority to release any information in your files, favorable or otherwise, to the State of Alabama Board of Medical Examiners.

Please print or type your full name

Signature

License Number

Address

City

State

Zip Code

THE SECTION BELOW IS TO BE COMPLETED BY AN OFFICIAL OF THE BOARD

Return to:
State of Alabama Board of Medical Examiners
P.O. Box 946
Montgomery, Alabama 36101-0946

This is to certify that the records of the Board of Medical Examiners of the State of __________________________ indicate that __________________________

was issued license number __________________________ dated __________________________ to practice __________________________

on the basis of State Exam FLEX Reciprocity/Endorsement National Boards __________________________

This license is current and in good standing: Yes _____ No ______

Derogatory Information __________________________

Remarks __________________________

Date __________________________ Signed:

Title: __________________________

State Board __________________________

SERVICE PRINTING CO. (334) 289-0059

Supp. 6/30/10 A-16
Authors: Wendell R. Morgan, Patricia E. Shaner
Statutory Authority: Code of Ala. 1975, §§34-24-70, 34-24-73, 34-24-75
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 __________________

Y  E S
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, revoked, currenlty, or voluntarily surrendered under threat of suspension or revocation?

9. Have your staff privileges at any hospital or health care facility been revoked, suspended, or 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 judgment rendered against you, or action certied 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, schizoaffective, paranoid, or any other psychiatric 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 affects you or if untreated could affect your ability to practice in a competent and professional manner?

15. Within the past five years, have you ever been tried for the manufacture and distribution of illegal substances?

16. Have you ever been convicted of a crime or offense (felony or misdemeanor) related to the practice of medicine?

17. Are you currently engaged in the illegal use of controlled dangerous substances?

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 convicted of a crime or offense (felony or misdemeanor) related to the practice of medicine?

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?

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.
21. Military Service, Branch ___________________________ Dates ___________________________

22. Place of Intended Residence in Alabama ___________________________

PRE-MEDICAL EDUCATION

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II. MEDICAL EDUCATION

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

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III. INTERNSHIP AND/OR TRAINING

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

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IV. AFFIDAVIT AND RELEASE

I, _______________________________________________________, certify under 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 inaccurate 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, to any person or organization having a legitimate need for the information.

Date ___________________________                      Applicant's Signature ___________________________

County of ___________________________________________

State of ___________________________________________

SWORN to and subscribed before me this ______ day of ___________________________ 19

(SEAL)

Notary Public

My Commission Expires: ___________________________

CERTIFICATION:

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

Dean - School of Medicine

Director - Residency Training Program

Supp. 12/31/07 A-19
CERTIFICATE OF EXECUTIVE DIRECTOR OF BOARD ISSUING ORIGINAL LICENSE

I, ___________________________________________ Executive Director of __________________________________________,

Board of Medical Examiners, certify that __________________________________________ was granted Certificate/License NO. __________________________________________ to practice medicine/osteopathy in the State of __________________________________________ on the Month: ______ Day: ______ Year: ______ based on __________________________________________,

and that said certificate or license has not been revoked or subject to disciplinary action.

I further certify that __________________________________________ in his written exam before this Board, obtained a general average of __________________________________________ percent in the following branches:

__________________________________________
__________________________________________
__________________________________________
__________________________________________

Acting on behalf of the __________________________________________ Board of Medical Examiners, I hereby certify to the reputability of Dr. __________________________________________ based on the records, and recommend him to the Alabama Board of Medical Examiners.

__________________________________________
Executive Director, Secretary, Chairman

Date __________________________________________

Place __________________________________________

(SEAL OF BOARD)

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.
Authors: Wendell R. Morgan, Patricia E. Shaner
Statutory Authority: Code of Ala. 1975, §§34-24-70, 34-24-73, 34-24-75
History: Amended: Filed July 26, 1999; effective August 30, 1999.
CERTIFICATION

DATE:_____________________

TO:  State Board of Medical Examiners

This is to certify that ____________________, M.D./D.O. has agreed to perform no fewer than 100 hours of voluntary professional services annually at the ____________________, (Clinic Name) located at ____________________, Alabama, which is an established free medical clinic operating under the provisions of Ala. Code §6-5-660 and provides outpatient medical care to patients under able to pay for it.

Clinic or Facility Administrator

Address

Telephone

Facsimile
Author: Board of Medical Examiners
APPLICATION FOR A CERTIFICATE OF QUALIFICATION UNDER THE RETIRED SENIOR VOLUNTEER PHYSICIAN PROGRAM (RSVP)

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 under the RSVP, 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: __________

4. Have you ever been convicted of a felony?

   YES  NO

5. Have you ever been convicted of a crime or offense (felony or misdemeanor) related to the practice of medicine?

   YES  NO

6. Have you ever been convicted of any violation of a state or federal law relating to controlled substances?

   YES  NO

7. Have you ever been denied a state or federal controlled substance certificate?

   YES  NO
8. 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? 

9. Have your staff privileges at any hospital or health care facility ever 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 judgment 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? 

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 or voyeurism?
17. Are you currently engaged in the illegal use of controlled dangerous substances? ___ ___

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? ___ ___

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.

21. Military Service: Branch: __________________________________________

       Dates: __________________________________________

22. Place of Intended Residence in Alabama: __________________________________________

I. PRE-MEDICAL EDUCATION

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II. MEDICAL EDUCATION

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

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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.

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IV. CERTIFICATION OF APPLICANT TO PARTICIPATE IN THE RETIRED SENIOR VOLUNTEER PHYSICIAN PROGRAM

1. I hereby certify that I am now or was licensed to practice medicine in the states of (list states), that my license to practice medicine in each of the states indicated is now or was on the date of expiration unrestricted and in good standing and that there are no currently pending disciplinary actions or investigations concerning my license to practice medicine in any of the states listed above. I further certify that my license to practice medicine in the states listed above has never been revoked, suspended, placed on probation, or otherwise subject to disciplinary action and that I have not had my hospital medical staff privileges revoked, suspended, curtailed, limited, or surrendered while under investigation.

2. I certify that I am fully retired from the active practice of medicine, however, I wish to volunteer my services as a physician in a free medical clinic located in ______________________, Alabama and it is my expectation that I will provide not less than 100 hours of voluntarily services for the calendar year __________.
I further certify that I will limit my medical practice to the provision of outpatient services at the free medical clinic listed above or at such other free medical clinic or non-profit organization or facility that has been approved by the Board.

3. I understand and acknowledge that issuance of a certificate of qualification and license to practice medicine under the Retired Senior Volunteer Physician Program requires that I comply with the continuing medical education requirement for physicians as specified in Chapter 14 of the rules and regulations of the State Board of Medical Examiners.

V. 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.

Applicant's Signature: ___________________________________________ Date: __________

County of __________________________
State of __________________________

SWORN to and subscribed before me this ___ day of _____________________, 20__.

______________________________________________
Notary Public
My Commission Expires: ___________________
Chapter 3/Appendix E

Author: Board of Medical Examiners
RETIRED SENIOR VOLUNTEER PROGRAM CERTIFICATE OF QUALIFICATION RENEWAL APPLICATION

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.

********************************************************************************

Full Name: 

Name of Qualified Clinic or Nonprofit Organization: 

License Number: ___________________________ Date Issued: ___________________________ 

Do you limit your practice to the confines of the institution? ____________________________________________

Have you ever been convicted of a felony? ____________________________________________

Have you ever been convicted of a crime or offense (felony or misdemeanor) related to the practice of medicine? ____________________________________________

Have you ever been convicted of any violation of a state or federal law relating to controlled substances? ____________________________________________

Have you ever been denied a state or federal controlled substance certificate? ____________________________________________

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? ____________________________________________

Have your staff privileges at any hospital or health care facility ever been revoked, suspended, curtailed, limited or placed under conditions restricting your practice? ____________________________________________

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? ____________________________________________

Have you ever had a judgment rendered against you, or action settled relating to the performance of your professional service? ____________________________________________

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? ____________________________________________
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?

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?

Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?

Are you currently engaged in the illegal use of controlled dangerous substances?

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?

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?

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.

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

Date: ___________________________  Applicant: ________________________________

********************************************************************************

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

Clinic or Facility Administrator
Author: Board of Medical Examiners


ALABAMA BOARD OF MEDICAL EXAMINERS
ADMINISTRATIVE CODE

CHAPTER 3 - APPENDIX G

ALABAMA BOARD OF MEDICAL EXAMINERS
Limited Certificate of Qualification Renewal Application

Section 34-24-75, Code of Alabama 1975, as amended, required that all physicians holding limited licenses apply to the Board of Medical Examiners for the renewal of their certificate of qualification prior to the Medical Licensure Commission renewing the actual 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 so that we may obtain the certification of either the Dean, Program Director or Chief Medical Officer. Please attach the $45 renewal fee made payable to the Board of Medical Examiners.

Name:

Name of Institution:

License Number:

Date Issued:

Position Held:

Number of Years:

Do you limit your practice to the confines of the institution?

If the answer is no, please explain.

Do you plan to obtain a full license in Alabama?

If the answer is no, please explain.

Have you ever been arrested for a violation of any Federal, State or Local statute?

If the answer is yes, please explain.

Have you ever been directed to appear before any medical examining board, hospital staff, professional society or institution for disciplinary action?

If the answer is yes, please explain.

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

Do you currently have any mental or physical condition or impairment (excluding, 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?

Within the past five years, have you ever used 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?

Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism?

Are you currently engaged in the illegal use of controlled dangerous substances?

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?

Have you been, within the past five (5) 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?

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 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 details 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

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

[Signature]

Dean, Program Director, Chief Medical Officer
ALABAMA BOARD OF MEDICAL EXAMINERS
ADMINISTRATIVE CODE

CHAPTER 3 - APPENDIX H

REDSTATEMENT APPLICATION
ALABAMA BOARD OF MEDICAL EXAMINERS

1. NAME ________________________________

2. ADDRESS ________________________________

3. INITIAL LICENSE NUMBER ________________________ ISSUED:

4. INITIAL CERTIFICATION NUMBER ________________________ ISSUED:

5. DATE OF SUSPENSION OF LICENSE ________________________________

6. REASONS FOR REVOCATION/SUSPENSION/VOLUNTARY SURRENDER OF CERTIFICATE OR LICENSE (Please give detailed reasons - if necessary you may use an additional sheet of paper and attach to this application):

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

YES NO

7. Have you ever been convicted of a felony?

8. Have you ever been convicted of a crime or offense, felony or misdemeanor related to the practice of medicine?

9. Have you ever been denied a state or federal controlled substances certificate?

10. Have you ever been denied a state or federal controlled certificate?

11. 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?

12. Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, denied or placed under conditions restricting your practice?

13. 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?

14. Have you ever had a judgment rendered against you, or action settled relating to the performance of your professional service?

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

16. 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?

17. 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?

18. Have you ever been diagnosed as having or have you ever been treated for poliomyelitis, tuberculosis or venereal?

19. Are you currently engaged in the illegal use of controlled dangerous substances?
20. 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?

YES  
NO

21. Have you been, within the past five (5) 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?

22. 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 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 the answer to any of these questions is YES give complete detailed and/or current status of charges on separate attachment)

I hereby authorize the release of any information, favorable or otherwise concerning me, in your files to the Alabama Board of Medical Examiners. A photostat copy of this authorization shall be as valid as the original.

________________________________________
Applicant's Signature

Please list below all states in which you have applied for licensure

________________________________________
________________________________________

I hereby certify that the information contained herein is true and accurate to the best of my ability

________________________________________
Date

________________________________________
Applicant's Signature

SWORN before me this ___ day of ________ , 19____

________________________________________
Notary Public
My Commission Expires: ____________________
ALABAMA BOARD OF MEDICAL EXAMINERS
ADMINISTRATIVE CODE

CHAPTER 4 - APPENDIX A

-APPLICATION-CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE

WARNING: SECTION 20-2-54. CODE OF ALABAMA 1975 (1981 CUMULATIVE SUPPLEMENT) STATES THAT A REGISTRATION UNDER SECTION 20-2-54 TO MANUFACTURE, DISTRIBUTE OR DISPENSE A CONTROLLED SUBSTANCE MAY BE SUSPENDED Return Completed Application To: OR REVOKED BY THE CERTIFYING BOARDS UPON A FINDING THAT THE REGISTRANT HAS FURNISHED FALSE OR FRAUDULENT MATERIAL INFORMATION IN ANY APPLICATION FILED UNDER THIS ACT.

ALABAMA STATE BOARD OF MEDICAL EXAMINERS
P.O. Box 946 • Montgomery, Alabama 36101
(334) 242-4116

(I) All applicants must answer the following questions. If the answer to questions A, B, C, D, or E is yes, the applicant must attach a complete explanation detailing all facts and circumstances.

A. Has your privilege for dispensing or prescribing controlled substances ever been suspended, restricted, or revoked in any state?...........................................( ) Yes ( ) No

B. Have you ever been convicted of any state or federal crime relating to any controlled substance?.................................................................( ) Yes ( ) No

C. Has your Federal DEA registration ever been suspended, restricted or revoked?............................................................................................( ) Yes ( ) No

D. Have your staff privileges at any hospitals ever been suspended, restricted or revoked for any reason related to the prescribing or dispensing of controlled substances?.........................................................................................( ) Yes ( ) No

E. 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?*........( ) Yes ( ) No

F. Print DEA number and expiration date _____________________________________

NOTICE: To lawfully administer, dispense or prescribe controlled substances in the State of Alabama, federal and state statutes require a DEA certificate of registration and an Alabama controlled substances registration certificate. For further information concerning federal requirements contact DEA, Metairie, LA, (504) 882-9239.

NOTE: Without a current DEA Certificate your ACSC alone will not authorize you to prescribe, maintain, dispense or administer controlled substances.

G. Do you dispense controlled substances, other than pharmaceutical samples, from any practice location? If yes, I confirm my Registration Form is on file with the ALBME.................................................................( ) Yes ( ) No

Supp. 12/31/07 A-37
*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 last two years.

**THE ANNUAL FEE FOR THIS CERTIFICATE IS $150.00. ENCLOSE YOUR CHECK WITH APPLICATION**

I swear (affirm) that the information set forth in this application for Alabama controlled substances registration certificate is true and correct to the best of my knowledge, information and belief.

Date __________  Signature of Applicant ____________________________
Dispensing Physician’s Registration Form

Physician Name: ___________________________ LIC. # ____________________
Primary practice location: __________________________
City_________________________ State_______ Zip_________ Phone No. ____________
DEA No.____________________ Expiration date____________________

Additional practice location: __________________________
City_________________________ State_______ Zip_________ Phone No. ____________
DEA No.____________________ Expiration Date____________________

Additional practice location: __________________________
City_________________________ State_______ Zip_________ Phone No. ____________
DEA No.____________________ Expiration Date____________________

Additional practice location: __________________________
City_________________________ State_______ Zip_________ Phone No. ____________
DEA No.____________________ Expiration Date____________________

Additional practice location: __________________________
City_________________________ State_______ Zip_________ Phone No. ____________
DEA No.____________________ Expiration Date____________________

Completed this _______ day of ____________________________ 20.

I hereby certify the foregoing information to be correct to the best of my knowledge, information and belief.

_________________________________________
Physician/Osteopath Signature

NOTE: The rules of the Board of Medical Examiners require that a new registration form be filed when there is any change in the registrants’ principal or additional practice locations.
Author: Board of Medical Examiners
Statutory Authority:
**APPLICATION FOR REGISTRATION OF PHYSICIAN ASSISTANT**

**PHYSICIAN TO COMPLETE:**

<table>
<thead>
<tr>
<th>Supervising Physician Name in Full</th>
<th>Date of Birth</th>
<th>Social Security No.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Ala. Medical License Number</th>
<th>Date of Birth</th>
<th>Social Security No.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medical Specialty</th>
<th>Board Certified:</th>
<th>Board Eligible</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td>YES</td>
<td>NO</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Principal Practice Location Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

(If mailing address is different please provide here)

<table>
<thead>
<tr>
<th>Telephone Number:</th>
<th>FAX Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. List the name, practice site address and designated working hours per week of each physician assistant and/or CRNP and/or CNM currently registered to you.

<table>
<thead>
<tr>
<th>NAME</th>
<th>ADDRESS</th>
<th>HOURS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. Have you ever had a physician assistant certified or registered to you by the Alabama Board of Medical Examiners?

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If the answer is YES, list the names of the assistant(s) in the spaces provided.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. Is the physician assistant for whom registration is sought employed by you or by your group, partnership or professional corporation?

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If the answer is NO, Appendix C to Chapter 7 must be submitted.

I hereby certify that the foregoing information is correct to the best of my knowledge, information and belief, and that I have reviewed and understand the current rules and regulations of the Alabama Board of Medical Examiners pertaining to physician assistants and understand my responsibilities.

Date:  

**Primary Supervising Physician Signature:**

In accordance with Rule 540-X-7-.21 confirmed receipt of this application will be sent by mail, unless a FAX number is provided where the confirmation can be transmitted by FAX.

A physician assistant previously approved to practice under the provisions of Chapter 7 of the Board of Medical Examiners Rules and Regulations may continue in the supervised practice with this interim supervising physician and may continue until such time as this application is approved or denied, provided the supervising physician meets the qualifications established in Rule 540-X-7-.17.
PHYSICIAN ASSISTANT TO COMPLETE:

| Physician Assistant Name in Full | Ala. P. A. License Number | Date of Birth | Social Security No. | / | / |
|--------------------------------|---------------------------|---------------|---------------------|

1. Have you ever been certified or registered as a physician assistant by the Alabama Board of Medical Examiners?

   YES _____ NO _____ If the answer is YES, list the names of the physicians in the spaces provided.

   ____________________________________  ____________________________________
   ____________________________________  ____________________________________

2. Are you currently certified or registered to any other primary certifying physician? If the answer is YES, in the space below give the physician name, physician practice location, assistant's certification or registration number, and assistant's number of hours per week for each primary supervising physician. (There are spaces for three separate registrations.)

   NAME ____________________________________  ____________________________________
   ADDRESS ____________________________________  ____________________________________
   REGISTRATION No. __________  __________
   HOURS per week __________  __________

I hereby certify that the foregoing information is correct to the best of my knowledge, information and belief; and that I have reviewed and understand the current rules and regulations of the Alabama Board of Medical Examiners pertaining to physician assistants and understand my responsibilities.

Date: ____________________________  Physician Assistant Signature: ____________________________

Office Use

<table>
<thead>
<tr>
<th>PLEASE NOTE &amp; RESPOND TO THE FOLLOWING AS APPROPRIATE FOR THIS REGISTRATION REQUEST.</th>
</tr>
</thead>
<tbody>
<tr>
<td>FEE: Each new registration requires submission of a $100.00 fee. Please attach check payable to Alabama Board of Medical Examiners.</td>
</tr>
<tr>
<td>JOB DESCRIPTION: Please attach a completed job description signed by the physician and the assistant.</td>
</tr>
<tr>
<td>FORMULARY: If assistant is to be granted legend drug prescribing authority attach a completed and signed formulary.</td>
</tr>
<tr>
<td>APPENDIX C : If assistant is employed by an entity other than the physician, the physician’s group or professional corporation please include a completed Appendix C. Include a separate sheet for responses if required.</td>
</tr>
<tr>
<td>COVERING PHYSICIAN LETTERS: The absence of “covering physician” letter(s) indicates that when the primary physician is not working, the assistant is not working. (A “sample” form was included in the registration package.)</td>
</tr>
</tbody>
</table>

THIS IS A TWO PAGE FORM. PLEASE COMPLETE BOTH SIDES & REVIEW INSTRUCTIONS BEFORE SUBMISSION
PHYSICIAN ASSISTANT JOB DESCRIPTION

Name of Physician Assistant: ________________________________

Name of Primary Supervising Physician: ________________________________

Physician’s Principal Practice Location Address: ________________________________
________________________________ Telephone Number: ( ) ____________________

Medical Specialty of Primary Supervising Physician ________________________________

1. A Supervising Physician shall delegate only tasks and procedures to his or her Assistant which are within the Supervising Physician’s scope of practice and are customary to the practice of the Physician. **However, the Physician Assistant may not perform any procedure not listed under #2 below without prior approval of the Alabama Board of Medical Examiners.** The Assistant may work in any setting that is within the scope of his or her Supervising Physician’s practice. The Supervising Physician’s scope of practice shall be defined for the purpose of this section as those tasks and procedures which the Supervising Physician is qualified by training or expertise to perform.

2. The following list represents the duties which may be performed by the Assistant.

   a. Perform complete, detailed and accurate histories, review patient records to develop comprehensive medical status reports, and order laboratory, radiological and diagnostic studies appropriate for complaint, age, race, sex and physical condition of the patient.

   b. Do complete physical examinations and record pertinent data in acceptable medical forms.

   c. Make medical diagnoses and institute therapy or referrals of patients to the appropriate health care facilities, agencies, other resources of the community, or other physicians.

   d. Institute emergency measures and emergency treatment or appropriate stabilization measures in situations such as cardiac arrest, shock, hemorrhage, convulsions, poisoning, and emergency obstetric delivery.

   e. Arrange hospital admissions and discharges at the direction of the Supervising Physician; perform hospital rounds and record appropriate patient progress notes; accurately and appropriately transcribe and execute specific orders at the direction of the Supervising Physician; compile detailed narrative and case summaries; complete forms pertinent to patients’ medical records; issue diagnostic orders, which must be signed within specified time period as defined by hospital guidelines.

   f. Interpret and evaluate patient data to determine patient management and treatment.

   g. Provide instructions and guidance regarding medical care matters to patients.

   h. Perform or assist in the following routine laboratory medical techniques and the following routine therapeutic procedures:

      (1) The drawing of arterial, venous or peripheral blood and the routine examination of the blood.

      (2) Urinary bladder catheterization and routine urinalysis.

      (3) Nasogastric intubation and gastric lavage.

      (4) The collection of and the examination of the stool.

      (5) The collection of materials for bacteriological or viral culture.

      (6) The performance of pulmonary function tests.

      (7) Performing electrocardiograms.

      (8) Injections - subcutaneous, intramuscular, intravenous (Note: injections to any other sites, for example, joints, must be requested.)

Supp. 6/30/10 A-43
(9) Immunizations.
(10) Debridement, suture and care of superficial wounds.
(11) Removal of sutures.
(12) Administration of subcutaneous local anesthesia.
(13) Strapping, casting and splinting of sprains and fractures.
(14) Removal of cast.
(15) Incision and drainage of superficial skin infections.

i. Perform or assist in the following surgical procedures:
(1) Pre and post-op care.
(2) Surgical assisting.
(3) Wound debridement.
(4) Incise and drain abscesses (superficial only).
(5) Biopsies (facial biopsies must be requested).
(6) Insert and remove drains (excluding paracentesis, thoracentesis, thoracostomy tube
insertion, ventriculostomy insertion, and placement of any percutaneous drain into a
body cavity).
(7) Suturing-single layer closure of the face.
(8) IV cutdown.
(9) Vein harvesting.
(10) Closure—may close the outermost layer of the fascia, subcutaneous tissue, dermis and
epidermis on extremities; over thoracic or abdominal cavities approval to close
subcutaneous, dermis and epidermis only.
(11) Intensive care.

j. Additional duties requested for the Assistant (i.e. diagnostic or surgical procedures requiring
additional training). Provide documentation of the training and/or certification which qualifies
the Assistant to perform each additional duty/procedure which is requested. Training for the
additional duty/procedure shall have been previously approved by the Board pursuant to Rule
540-X-7-.25(8) and (7).

k. Provide emergency medical services in the event of declared national emergency or natural
disaster in accordance with the requirements of Rule 540-X-7-.25.

3. List each practice site where this Job Description will be utilized, including address and phone
number:

4. List the name and designated working hours per week of each Assistant at each practice site
where this Job Description will be utilized:

5. Is there a request for the applying Assistant to practice in a remote site?
   Yes ______  No ______

   If yes, attach a letter from the Physician requesting approval to utilize the assistant at a
remote site and complete the following information:
Name, address and telephone number of remote site: ____________________________

Number of hours the sponsoring physician will be spending in the remote site weekly: __________
Number of hours the Assistant will spend in the remote site weekly: _______________________
Number of hours both will be present together: _________________________________

Provide a plan describing the practice location, facilities and arrangements for appropriate communication, consultation and review. Attach an additional sheet.

6. Provide a written plan for review of medical records and patient outcomes.

7. Will this Assistant be authorized to have prescriptive privileges? yes _____ no _____

If yes, attach a completed Formulary which is a list of the legend drugs which are authorized by the Physician to be prescribed by the Assistant. The formulary approved under the Guidelines of the Board of Medical Examiners should be utilized and attached as the authorized legend drugs to be prescribed.

8. Will this Assistant be authorized to have prescriptive privileges to prescribe controlled substances as allowed under Alabama Code Section 20-2-60, et. seq.? yes ______ no ______

If yes, the application for a Qualified Alabama Control Substance Certificate will be mailed to the address submitted on this registration application.

We hereby certify under penalty of law of the State of Alabama that the foregoing information in this Assistant Job Description is correct to the best of our knowledge and belief. We certify that we have reviewed the current rules and regulations of the State of Alabama pertaining to assistants to physicians and understand our responsibilities. We understand that we are equally responsible for the actions of the Assistant to the Physician.

_________________________ / ________________________________ / __________
Print Name                        Signature of Primary Supervising Physician         Date

_________________________ / ________________________________ / __________
Print Name                        Signature of Assistant to Physician           Date
SUPPLEMENTAL CERTIFICATE TO APPLICATION
FOR REGISTRATION AS A PHYSICIAN ASSISTANT

To: ________________________________________________________________

(Name and Address of Hospital or Corporate Employer)

The State Board of Medical Examiners has been presented with an application from ____________________________________________ for certification as a physician assistant to ___________________________ M.D. Information available to the Board indicates that ___________________________, M.D., is an employee of ____________________________, and that ___________________________, Physician Assistant, is an employee of _____________________________.

To assist the Board in evaluating this application, it is requested that this questionnaire be filled out and executed by the President, Chairman, Chief Executive Officer or Chief Administrative Officer of the corporation or other legal entity that employs the physician and/or the physician assistant. These questions relate directly to the supervisory relationship contemplated by Board Rules, Chapter 540-X-7. When an additional explanation is to be provided, please attach additional information on separate pages.

1. Is the physician whose name appears above, employed by you to engage in the full-time practice of medicine? ______ If the answer to this question is no, please provide the Board with details of the employment agreement between your corporation and the physician.

2. Does the physician whose name is stated above have the unqualified authority to terminate the employment of the physician assistant registered to him? ______ If the answer to this question is no, please set out in detail the steps required to terminate the employment of the physician assistant and identify the officer or officers of the corporation authorized to make that decision.

3. Does the physician whose name is stated above, have the unqualified authority to determine the levels of compensation to be paid to the physician assistant registered to him? ______ If the answer to this question is no, please set forth in detail the manner in which the compensation of the physician assistant is established and the identification of the officer or officers of the corporation who are authorized to establish increase or reduce the compensation of the physician assistant.

4. Does the physician whose name appears above have the unqualified authority in matters relating to patient care to enforce compliance with orders and directives issued to the physician assistant? ______ Please describe in detail the manner in which such orders and directives may be enforced.

5. Is the physician assistant whose name appears above subject to the supervision, direction or control of any officer, director, supervisor or employee of the corporation other than the
physician to whom he is registered? ______. If the answer to this question is yes, please explain in detail, identifying the individual exercising the supervision, direction or control and the circumstances in which such supervision, direction and control would be exercised.

6. In matters relating to patient care, is the physician assistant whose name appears above subject to the immediate supervision, direction or control of any non-physician? If yes, explain the relationship.

7. Will the physician assistant whose name appears above be expected or required to perform any part of his or her duties at any time when the physician to whom he or she is registered is not on duty and physically present on the premises of the hospital, clinic, or facility where the physician’s assistant services will be rendered? ______. If the answer to this question is yes, please explain in detail all such circumstances.

I understand that the information submitted herein is to be used by the Board of Medical Examiners as the basis for registered of a physician assistant and that the furnishing of false or misleading information or the future occurrence of substantial departures from or violations of the standards and procedures outlined in this response, may be considered by the Board as grounds for termination of the registration of the physician assistant.

The undersigned hereby certifies that the foregoing information is true and correct to the best of my knowledge, information and belief.

Name of the Corporation

Title of Officer Signing Certificate

Printed Name of the Officers Signing Certificate

Signature

SWORN TO AND SUBSCRIBED before me this the _____ day of ____________________, ______.

____________________________

NOTARY PUBLIC
My Commission Expires: ____________________

History: Originally adopted and approved: January 19, 1983
Amended: January 16, 1985
Effective Date: February 20, 1985
Amended/Approved: July 17, 2002
Effective Date: October 24, 2002
Authors: Wendell R. Morgan and Patricia E. Shaner,
Attorneys for the Board of Medical Examiners
APPLICATION FOR LICENSURE OF PHYSICIAN ASSISTANT

I. Physician Assistant's Name in Full

Home Address __________________________ City __________ State ______ Zip

Place of Birth __________________________ Date of Birth __________ Sex

Social Security # ______ / ______ / ______ Home telephone number (______)

II. If you answer yes to any of the following questions attach detailed explanation or document requested

1. Have you ever been convicted of a felony? ________ ______
2. Have you ever been convicted of a crime or offense (felony or misdemeanor) related to the practice of medicine? ________ ______
3. Have you ever been convicted of any violation of a state or federal law relating to controlled substances? ________ ______
4. Have you ever been denied a state or federal controlled substance certificate? ________ ______
5. Have you ever been denied prescription privileges for non-controlled or legend drugs by any state or federal authority? ________ ______
6. Has your certification or license to practice as a physician assistant in any state been suspended, revoked, restricted, curtailed, or voluntarily surrendered while under investigation in any state? ________ ______
7. 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 while under investigation? ________ ______
8. Have you ever been denied a certification or license to practice as a physician assistant in any state or has your application for certification or for a license to practice as a physician assistant 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. Have you successfully completed the Physician Assistant National Certifying Examination? ________ ______
   If YES, ATTACH VERIFYING DOCUMENTATION from the National Commission on Certification of Physician Assistants (NCCPA).
   If NO, have you ever taken the examination? YES___ NO
   Are you registered to take the next PANCE offered? YES___ NO
   If YES, ATTACH VERIFYING DOCUMENTATION from the NCCPA.

11. Are you currently registered, certified to or working for any other primary supervising physician either in Alabama or another state? IE Are you presently working as a physician assistant? If so, answer yes.
   If YES, attach a list with name and principal practice location of each primary supervising physician to whom you are certified. In addition, state your designated working hours per week for each physician listed.

12. Have you ever been certified as a physician assistant by the Alabama Board of Medical Examiners in the past? ________ ______
   If YES, please list names of physicians in the spaces provided.

13. Within the past two years, have you been diagnosed with or have you been treated for bipolar 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? ________ ______

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 or voyeurism? __________ __________

17. Are you currently engaged in the illegal use of controlled dangerous substances?¹ __________ __________
   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?
   YES __________ NO __________

18. 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? __________ __________

19. 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? __________ __________
   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 an assistant to a physician within the past two years.

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

III. APPLICANT’S EDUCATION (since graduating from high school): ATTACH A COPY of your diploma(s) reflecting graduation from a Physician Assistant program.

<table>
<thead>
<tr>
<th>Date</th>
<th>Name of School</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. From___ to ___</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. From___ to ___</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. From___ to ___</td>
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<td></td>
</tr>
</tbody>
</table>

IV. APPLICANT’S ACTIVITIES since graduation from high school: (cover all time periods - attach additional sheets if needed)

<table>
<thead>
<tr>
<th>Date</th>
<th>Place of employment or activity</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. From___ to ___</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. From___ to ___</td>
<td></td>
<td></td>
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<tr>
<td>3. From___ to ___</td>
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<tr>
<td>4. From___ to ___</td>
<td></td>
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<tr>
<td>5. From___ to ___</td>
<td></td>
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</tr>
</tbody>
</table>

V. CERTIFICATION or LICENSURE:
List all states where you have been certified / registered / licensed or have applied for certification / registration / licensure as a Physician Assistant. It is a requirement that each state complete one of the verification forms and return it directly to this agency where it will be attached to your application for licensure. It is your responsibility to make the written request to each state. Make copies of the form is needed.

<table>
<thead>
<tr>
<th>State 1</th>
<th>State 2</th>
<th>State 3</th>
<th>State 4</th>
<th>State 5</th>
<th>State 6</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

VI. 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 herein is a true likeness of the assistant 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 any certification / licensure granted.
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 of 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:_________________________  Physician Assistant’s Signature

County of _______________________  State of _______________________

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

(SEAL)  Notary Public Signature

My Commission Expires:

ATTACH PHOTOGRAPH HERE
### PHYSICIAN TO COMPLETE:

<table>
<thead>
<tr>
<th>Supervising Physician Name in Full</th>
<th>__________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ala. Medical License Number</td>
<td>__________</td>
</tr>
<tr>
<td>Date of Birth</td>
<td>__________</td>
</tr>
<tr>
<td>Social Security No.</td>
<td>___ / __ /</td>
</tr>
<tr>
<td>Medical Specialty</td>
<td>__________</td>
</tr>
<tr>
<td>Board Certified: YES NO</td>
<td>YES NO</td>
</tr>
<tr>
<td>Board Eligible</td>
<td>YES NO</td>
</tr>
<tr>
<td>Principal Practice Location Address</td>
<td>__________</td>
</tr>
</tbody>
</table>

(If mailing address is different please provide here)

| Telephone Number: (__________) | __________ |
| FAX Number: (__________)       | __________ |

1. List the name, practice site address and designated working hours per week of each anesthesiologist assistant currently registered to you.

| NAME | __________ |
| ADDRESS | __________ |
| HOURS | __________ |

2. Have you ever had an anesthesiologist assistant certified or registered to you by the Alabama Board of Medical Examiners?

| YES______ NO______ | If the answer is YES, list the names of the assistant(s) in the spaces provided. |

3. Is the anesthesiologist assistant for whom registration is sought employed by you or by your group, partnership or professional corporation?

| YES______ NO______ | If the answer is NO, Appendix G to Chapter 7 must be submitted. |

I hereby certify that the foregoing information is correct to the best of my knowledge, information and belief; and that I have reviewed and understand the current rules and regulations of the Alabama Board of Medical Examiners pertaining to anesthesiologist assistants and understand my responsibilities.

| Date: | __________ |
| Primary Supervising Physician Signature: | __________ |

In accordance with Rule 540-X-7-.51 confirmed receipt of this application will be sent by mail, unless a FAX number is provided where the confirmation can be transmitted by FAX.

A anesthesiologist assistant previously approved to practice under the provisions of Chapter 7 of the Board of Medical Examiners Rules and Regulations may continue in the supervised practice with this interim supervising physician and may continue until such time as this application is approved or denied, provided the supervising physician meets the qualifications established in Rule 540-X-7-.47.
ANESTHESIOLOGIST ASSISTANT TO COMPLETE:

Assistant Name in Full __________
Ala. A. A. License Number __________
Date of Birth __________
Social Security No. __________ / __________ / __________

1. Have you ever been certified or registered as a anesthesiologist assistant by the Alabama Board of Medical Examiners?
   YES _____ NO _____ If the answer is YES, list the names of the physicians in the spaces provided.

2. Are you currently certified or registered to any other primary certifying physician? If the answer is YES, in the space below give the physician name, physician practice location, assistant’s certification or registration number, and assistant’s number of hours per week for each primary supervising physician. (There are spaces for three separate registrations.)

   NAME ____________________________________________________________________________
   ADDRESS __________________________________________________________________________
   REGISTRATION No. ___________________________________________________________________
   HOURS per week ______________________________________________________________________

I hereby certify that the foregoing information is correct to the best of my knowledge, information and belief; and that I have reviewed and understand the current rules and regulations of the Alabama Board of Medical Examiners pertaining to anesthesiologist assistants and understand my responsibilities.

Date: ________________  Anesthesiologist Assistant Signature: ________________

Office Use

<table>
<thead>
<tr>
<th>PLEASE NOTE &amp; RESPOND TO THE FOLLOWING AS APPROPRIATE FOR THIS REGISTRATION REQUEST.</th>
</tr>
</thead>
<tbody>
<tr>
<td>FEE: Each new registration requires submission of a $100.00 fee. Please attach check payable to Alabama Board of Medical Examiners.</td>
</tr>
<tr>
<td>JOB DESCRIPTION: Please attach a completed job description signed by the physician and the assistant.</td>
</tr>
<tr>
<td>APPENDIX G: If assistant is employed by an entity other than the physician, the physician’s group or professional corporation please include a completed Appendix G. Include a separate sheet for responses if required.</td>
</tr>
<tr>
<td>COVERING PHYSICIAN LETTERS: The absence of “covering physician” letter(s) indicates that when the primary physician is not working, the assistant is not working. (A “sample” form was included in the registration package.)</td>
</tr>
</tbody>
</table>

THIS IS A TWO PAGE FORM. PLEASE COMPLETE BOTH SIDES & REVIEW INSTRUCTIONS BEFORE SUBMISSION
ANESTHESIOLOGIST ASSISTANT JOB DESCRIPTION

Name of Anesthesiologist Assistant: (Print or Type)

Name of Primary Supervising Anesthesiologist: (Print or Type)

Anesthesiologist’s Principal Practice Location Address: (Print or Type)

Telephone Number ( )

Listed below are duties approved by the Board as a basic job description. Any additional duties requested must be listed on page 2. Any additional duties must be individually considered and approved by the Board before performing them.

The following list includes the basic roles and functions to be performed by the Anesthesiologist Assistant. The list includes the acts, tasks and functions which the AA will be allowed to perform under supervision of an anesthesiologist, as well as those limited actions to be taken in life-threatening emergency conditions.

1. Administers anesthesia under the supervision of an anesthesiologist.

2. Performs initial acute cardio-pulmonary resuscitation in life-threatening situations as directed by a physician.

3. Establishes multi-parameter monitoring of patients prior to, during and after anesthesia or in other acute care situations. This may include invasive / non-invasive monitoring under the direct supervision of an anesthesiologist. Also, other monitoring as may be developed for anesthesia and intensive care use may be incorporated.

4. Manages perioperative anesthetic care, including ventilatory support and other respiratory care parameters as directed by an anesthesiologist.

5. Assists in research projects as carried out by an anesthesiologist.

6. Instructs others in principles and practices of anesthesia, respiratory care and cardio-pulmonary resuscitation as directed by the anesthesiologist.

7. Assists an anesthesiologist in gathering routine perioperative data.

8. The choice of anesthesia and drugs to be employed are prescribed by an anesthesiologist for each patient except:

   (a) where standard orders for the conduct of specified anesthetic are prescribed; and

   (b) where life threatening emergencies arise necessitating the utilization of standard therapeutic or resuscitation procedures. An anesthesiologist will be immediately available for consultation regarding changes from standard procedures.
9. ADDITIONAL DUTIES REQUESTED FOR THE ANESTHESIOLOGIST ASSISTANT (i.e. procedures requiring additional training). Provide, as an attachment to this Job Description, documentation of the training and/or certification which qualifies the anesthesiologist assistant to perform each additional duty/procedure which is requested. Training for the additional duty/procedure shall have been previously approved by the Board pursuant to Rule 540-X-7-55(6) and (7).

10. List each practice site where this Job Description will be utilized, including address and phone number:

11. List the name and designated working hours per week of each anesthesiologist assistant at the practice site where this Job Description will be utilized:

12. Provide emergency medical services in the event of declared national emergency or natural disaster in accordance with the requirements of Rule 540-X-7-.53.

We hereby certify under penalty of law of the State of Alabama that the foregoing information in this Anesthesiologist Assistant Job Description is correct to the best of our knowledge and belief. We certify that we have reviewed the current rules and regulations of the State of Alabama pertaining to anesthesiologist assistants and understand our responsibilities. We understand that we are equally responsible for the actions of the Anesthesiologist Assistant.

Print Name
Signature of Primary Supervising Anesthesiologist
Date

Print Name
Signature of Anesthesiologist Assistant
Date
SUPPLEMENTAL CERTIFICATE TO APPLICATION
FOR REGISTRATION AS AN ANESTHESIOLOGIST ASSISTANT

To: __________________________________________
    (Name and Address of Hospital or Corporate Employer)

The State Board of Medical Examiners has been presented with an application from
for registration as an anesthesiologist assistant to __________________________ M.D.
Information available to the Board indicates that __________________________ , M. D., is
an employee of __________________________ (legal entity), and that __________________________ ,
Anesthesiologist Assistant, is an employee of __________________________ (legal entity).

To assist the Board in evaluating this application, it is requested that this questionnaire be filled out
and executed by the President, Chairman, Chief Executive Officer or Chief Administrative Officer of the
corporeation or other legal entity that employs the physician and the anesthesiologist assistant. These questions
relate directly to the supervisory relationship contemplated by Board Rules, Chapter 540-X-7. When an
additional explanation is to be provided, please attach additional information on separate pages.

1. Is the anesthesiologist whose name appears above, employed by you to engage in the full-time
   practice of anesthesiology? ______ If the answer to this question is no, please provide the Board with
details of the employment agreement between your corporation and the anesthesiologist.

2. Does the anesthesiologist whose name is stated above have the unqualified authority to terminate the
   employment of the anesthesiologist assistant registered to him? ______ If the answer to this question
   is no, please set out in detail the steps required to terminate the employment of the anesthesiologist
   assistant and identify the officer or officers of the corporation authorized to make that decision.

3. Does the anesthesiologist whose name is stated above, have the unqualified authority to determine
   the levels of compensation to be paid to the anesthesiologist assistant registered to him? ______ If the answer to this question
   is no, please set forth in detail the manner in which the compensation of
   the anesthesiologist assistant is established and the identification of the officer or officers of the
   corporation who are authorized to establish increase or reduce the compensation of the
   anesthesiologist assistant.

4. Does the anesthesiologist whose name appears above have the unqualified authority in matters
   relating to patient care to enforce compliance with orders and directives issued to the anesthesiologist
   assistant? ______ Please describe in detail the manner in which such orders and directives may be
   enforced.

5. Is the anesthesiologist assistant whose name appears above subject to the supervision, direction or
   control of any officer, director, supervisor or employee of the corporation other than the
   anesthesiologist to whom he or she is registered? ______ If the answer to this question is yes, please
   explain in detail, identifying the individual exercising the supervision, direction or control and the
   circumstances in which such supervision, direction and control would be exercised.
6. In matters relating to patient care, is the anesthesiologist assistant whose name appears above subject to the immediate supervision, direction or control of any non-physician? ______. If yes, explain the relationship.

7. Will the anesthesiologist assistant whose name appears above be expected or required to perform any part of his or her duties at any time when the anesthesiologist to whom he or she is registered is not on duty and physically present on the premises of the hospital, clinic, or facility where the anesthesiologist assistant services will be rendered? ______. If the answer to this question is yes, please explain in detail all such circumstances.

I understand that the information submitted herein is to be used by the Board of Medical Examiners as the basis for certification of an anesthesiologist assistant and that the furnishing of false or misleading information or the future occurrence of substantial departures from or violations of the standards and procedures outlined in this response, may be considered by the Board as grounds for termination of the certification of the anesthesiologist assistant.

The undersigned hereby certifies that the foregoing information is true and correct to the best of my knowledge, information and belief.

Name of the Corporation

Title of Officer Signing Certificate

Printed Name of the Officers Signing Certificate

Signature

SWORN TO AND SUBSCRIBED before me this the _____ Day of ______________________, 20____.

NOTARY PUBLIC

My Commission Expires:

History: Originally adopted and approved: January 19, 1983
Amended: January 16, 1985
Effective Date: February 20, 1985
Amended/Approved: July 17, 2002.
Effective Date: October 24, 2002
Author: Wendell R. Morgan, General Counsel
APPLICATION FOR LICENSURE OF ANESTHESIOLOGY ASSISTANT

I. Anesthesiology Assistant’s Name in Full

Home Address __________________________ City __________ State __________ Zip

Place of Birth __________________________ Date of Birth __________ Sex

Social Security # ______ / ______ / ______ Home telephone number (________)

II. If you answer yes to any of the following questions attach detailed explanation or document requested

1. Have you ever been convicted of a felony? ______

2. Have you ever been convicted of a crime or offense (felony or misdemeanor) related to the practice of medicine? ______

3. Have you ever been convicted of any violation of a state or federal law relating to controlled substances? ______

4. Have you ever been denied a state or federal controlled substance certificate? ______

5. Have you ever been denied prescription privileges for non-controlled or legend drugs by any state or federal authority? ______

6. Has your certification or license to practice as an anesthesiology assistant in any state been suspended, revoked, restricted, curtailed, or voluntarily surrendered while under investigation in any state? ______

7. 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 while under investigation? ______

8. Have you ever been denied a certification or license to practice as an anesthesiologist assistant in any state or has your application for certification or for a license to practice as an anesthesiologist assistant 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. Have you successfully completed the Anesthesiology Assistant National Certifying Examination? ______

   If YES, ATTACH VERIFYING DOCUMENTATION from the National Commission on Certification of Anesthesiology Assistants (NCCAA). ______

   If NO, have you ever taken the examination? YES____ NO ______

   Are you registered to take the next examination offered? YES____ NO ______

   If YES, ATTACH VERIFYING DOCUMENTATION from the NCCAA. ______

11. Are you currently registered, certified to or working for any other primary supervising physician either in Alabama or another state? ie Are you presently working as an anesthesiologist assistant? If so, answer yes. ______

   If YES, attach a list with name and principal practice location of each primary supervising physician to whom you are certified. In addition, state your designated working hours per week for each physician listed. ______

12. Have you ever been certified as an anesthesiologist assistant by the Alabama Board of Medical Examiners in the past? ______

   If YES, please list names of physicians in the spaces provided. ______

13. Within the past two years, have you been diagnosed with or have you been treated for bipolar 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? ______
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 or voyeurism?

17. Are you currently engaged in the illegal use of controlled dangerous substances? 

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?

YES ____ NO ____

18. 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?

19. 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 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 an assistant to a physician within the past two years.

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

III. APPLICANT'S EDUCATION (since graduating from high school): ATTACH A COPY of your diploma(s) reflecting graduation from a Anesthesiologist Assistant program.

<table>
<thead>
<tr>
<th>Date</th>
<th>Name of School</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. From _______ to _______</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 From _______ to _______</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. From _______ to _______</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

IV. APPLICANT'S ACTIVITIES since graduation from high school: (cover all time periods - attach additional sheets if needed)

<table>
<thead>
<tr>
<th>Date</th>
<th>Place of employment or activity</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. From _______ to _______</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 From _______ to _______</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. From _______ to _______</td>
<td></td>
<td></td>
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<tr>
<td>4. From _______ to _______</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 From _______ to _______</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

V. CERTIFICATION or LICENSURE:
List all states where you have been certified / registered / licensed or have applied for certification / registration / licensure as a Anesthesiologist Assistant. It is a requirement that each state complete one of the verification forms and return it directly to this agency where it will be attached to your application for licensure. It is your responsibility to make the written request to each state. Make copies of the form is needed.
VI. 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 herein is a true likeness of the assistant 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 any certification / licensure granted.

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 of 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: _____________________ Anesthesiologist Assistant's Signature ___

County of __________________________ State of __________________________

SWORN to and subscribed before me this ______ Day of __________________________, 20______

(SEAL) Notary Public Signature

My Commission Expires:

ATTACH PHOTOGRAPH HERE
PHYSICIAN ASSISTANT / ANESTHESIOLOGIST ASSISTANT
LICENSE RENEWAL - 20__
DEADLINE - DECEMBER 31, 20__
Renew Online: http://alrenewals.org

License# :
Registration ID:

1. Have you been convicted of a felony within the past year?  □ YES □ NO

2. Have you been convicted within the past year of a crime or offense (felony or misdemeanor) related to the practice of medicine?  □ YES □ NO

3. Have you been convicted within the past year of any violation of a state or federal law relating to controlled substances?  □ YES □ NO

4. Within the past year, has your PA/AA certificate or license in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered while under investigation?  □ YES □ NO

5. Within the past year, have your privileges at any hospital or healthcare facility been revoked, suspended, curtailed, limited, placed under conditions restricting your practice, or voluntarily surrendered while under investigation?  □ YES □ NO

6. Have you been denied a PA/AA certificate or license in any state or has your application for a certificate or licensee been withdrawn under threat of denial within the past year?  □ YES □ NO

7. Are you currently certified to any other primary supervising physician(s)?  □ YES □ NO

If YES, attach a list with name and principal practice location of each primary supervising physician to whom you are certified. In addition, state your designated working hours per week for each physician listed.

8. Have you had within the past year a judgment rendered against you or action settled relating to the performance of your professional service?  □ YES □ NO

9. Within the past two years, have you been diagnosed with or have you been treated for bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder?  □ YES □ NO

10. 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?

11. Within the past two 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?  


 YES  NO

12. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?  


13. Are you currently engaged in the illegal use of controlled dangerous substances?  


14. 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?  


15. 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?  


16. 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?  


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 an assistant to 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.

CME Certification (Check one):

☐ I hereby certify that I have met the annual minimum continuing medical education requirement of twenty five (25) hours of AMA PRA Category 1 Credits™ or equivalent continuing medical education for the calendar year 20___ and have supporting documentation if audited.

☐ I hereby certify that I am exempt from the minimum continuing medical education requirement for the following reason (check one):

☐ I received my initial license to practice in Alabama in the calendar year 20___.

☐ I am a member of a branch of the U. S. armed services and was deployed for military service in the calendar year 20___.

Supp. 6/30/10  A-61
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 certify the foregoing information to be correct to the best of my knowledge, information and belief, and attest that I have reviewed and am abiding by the Rules and Regulations which were effective on this date.

Signature: __________________________ Date: __________________________

FAILURE TO APPLY FOR LICENSE RENEWAL AND PAY RENEWAL FEE WILL RESULT IN THE LICENSE AUTOMATICALLY BEING PLACED IN AN INACTIVE STATUS MAKING IT ILLEGAL FOR THE HOLDER TO PRACTICE AS A PHYSICIAN ASSISTANT EFFECTIVE JANUARY 1, 20__. 
ALABAMA BOARD OF MEDICAL EXAMINERS
CHAPTER 540-X-7
APPENDIX J

APPLICATION FOR ANESTHESIOLOGIST ASSISTANT LICENSE RENEWAL - 20__

(Repealed 9/9/09)
APPLICATION FOR REINSTATEMENT OF
PHYSICIAN ASSISTANT/ANESTHESIOLOGIST ASSISTANT LICENSE

1. NAME

2. ADDRESS

3. INITIAL LICENSE NUMBER ISSUED

4. DATE OF REVOCATION/SUSPENSION/SURRENDER OF LICENSE:

5. REASONS FOR REVOCATION/SUSPENSION/VOLUNTARY SURRENDER OF LICENSE (Please give detailed reasons - if necessary you may use an additional sheet of paper and attach it to the application):


1. Have you ever been convicted of a felony?

2. Have you ever been convicted of a crime or offense (felony or misdemeanor) related to the practice of medicine?

3. Have you ever been convicted of any violation of a state or federal law relating to controlled substances?

4. Have you ever been denied a state or federal controlled substance certificate?

5. Have you ever been denied prescription privileges for non-controlled or legend drugs by any state or federal authority?

6. Has your certification or license to practice as a physician assistant in any state been suspended, revoked, restricted, curtailed, or voluntarily surrendered while under investigation in any state?

7. 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 while under investigation?

8. Have you ever been denied a certification or license to practice as a physician assistant in any state or has your application for certification or for a license to practice as a physician assistant 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. Are you currently registered, certified to or working for any other primary supervising physician in another state? ie Are you presently working as a physician assistant? If so, answer yes. If YES, attach a list with name and principal practice location of each primary supervising physician to whom you are certified. In addition, state your designated working hours per week for each physician listed.

11. Have you ever been certified as a physician assistant by the Alabama Board of Medical Examiners in the past?

   If YES, please list names of physicians in the spaces provided

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

7. 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?

8. 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?

9. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?

10. Are you currently engaged in the illegal use of controlled dangerous substances?

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?

YES _____ NO

11. 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?

12. 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?

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 an assistant to a physician within the past two years.

If the answer to any of these questions is YES, give complete detailed and/or current status of charges on separate attachment)

I hereby authorize the release of any information, favorable or otherwise concerning me, in your files to the Alabama Board of Medical Examiners. A photostat copy of this authorization shall be as valid as the original.

Applicant’s Signature

Please list below all states in which you hold or have applied for licensure:

__________________________________________

__________________________________________

__________________________________________

__________________________________________

I hereby certify that the information contained herein is true and accurate to the best of my ability.

__________________________________________

Date

Applicant’s Signature

SWORN to and subscribed before me this _____day of ______________________, 20__.

Notary Public
Author: Alabama State Board of Medical Examiners
Statutory Authority:
ALABAMA BOARD OF MEDICAL EXAMINERS
ADMINISTRATIVE CODE

CHAPTER 11 - APPENDIX A
INITIAL SURVEY OF FOREIGN MEDICAL SCHOOLS
(REPEALED)

Author: 
Statutory Authority: 
History: Repealed: Filed May 20, 1996; effective June 24, 1996.
ALABAMA BOARD OF MEDICAL EXAMINERS
ADMINISTRATIVE CODE

CHAPTER 11 – APPENDIX B
BY THE ALABAMA BOARD OF MEDICAL EXAMINERS DESCRIPTIVE DATA ON A
FOREIGN MEDICAL SCHOOL
(REPEALED)

Author:
Statutory Authority:
History: Repealed: Filed May 20, 1996; effective June 24, 1996.
ALABAMA BOARD OF MEDICAL EXAMINERS
ADMINISTRATIVE CODE

CHAPTER 11 - APPENDIX C
STANDARDS FOR APPROVAL OF FOREIGN MEDICAL SCHOOLS
(REPEALED)

Author: Wendell R. Morgan
ALABAMA BOARD OF MEDICAL EXAMINERS
ADMINISTRATIVE CODE

CHAPTER 11 - APPENDIX D
PROCEDURES FOR THE SITE VISIT AND THE SITE VISIT TEAM
(REPEALED)

Author:
Statutory Authority:
History: Repealed: Filed May 20, 1996; effective June 24, 1996.