



APA-2  
6/93

**ALABAMA STATE BOARD  
OF MEDICAL EXAMINERS**

**NOTICE OF INTENDED ACTION**

**AGENCY NAME:** Alabama State Board of Medical Examiners

**RULE NO. & TITLE:** 540-X-19, Appendix A, Initial Application

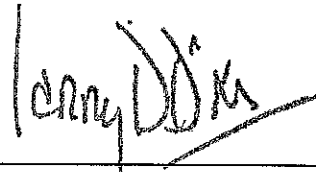
**INTENDED ACTION:** To amend the rule appendix

**SUBSTANCE OF PROPOSED ACTION:** To amend the appendix to reduce the fee required for registration of additional locations where pain management services are provided.

**TIME, PLACE, MANNER OF PRESENTING VIEWS:** All interested persons may submit data, views, or arguments concerning the proposed new rule(s) and regulation(s) in writing to: Patricia E. Shaner, General Counsel, Alabama State Board of Medical Examiners, Post Office Box 946, Montgomery, Alabama 36101-0946, by mail or in person between the hours of 8:30 a.m. and 4:30 p.m., Monday through Friday, until and including Wednesday, June 4, 2014. Persons wishing to obtain copies of the text of this rule and submit data, views, or comments or arguments orally should contact William F. Addison, by telephone (334-242-4116) during said period in order to set up an appointment for a hearing respecting such oral data, views, or arguments. The rule amendment will also be available at the Board's web site, [www.albme.org](http://www.albme.org).

**FINAL DATE FOR COMMENT AND COMPLETION OF NOTICE:** June 4, 2014

**CONTACT PERSON AT AGENCY:** William F. Addison



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Larry D. Dixon, Executive Director

ALABAMA BOARD OF MEDICAL EXAMINERS

P. O. Box 946 – Montgomery, Alabama 36101

848 Washington Avenue – 36104

Application for Alabama Pain Management Registration

\*\*Separate registration required for each location where pain management services are provided\*\*

Name: \_\_\_\_\_ AL License #: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

DEA Number: \_\_\_\_\_ DEA Expiration Date: \_\_\_\_\_

1. Are you registered with PDMP? [ ] Yes [ ] No  
(Attach copy of PDMP registration receipt)

2. Have you ever had a controlled substance registration certificate denied, restricted or disciplined? [ ] Yes [ ] No  
If yes, the attach a summary of each action including the year, state and description of each action.

3. Have you ever had a disciplinary action taken against your medical license in Alabama or any other state? [ ] Yes [ ] No  
If yes, attach an explanation of the action, including the year, state and description of each action.

Please provide the following information for the above location where you provide pain management services: (Attach additional pages if necessary)

Facility Name: \_\_\_\_\_

Physical Address: \_\_\_\_\_  
Street City State Zip

Owners, Co-Owners, Operators: \_\_\_\_\_

Full Name of Medical Director: \_\_\_\_\_

Full names of all physicians providing pain management services at this location:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I swear (affirm) that the information set forth on this application for Alabama Pain Management Registration form is true and correct to the best of my knowledge, information and belief. I also understand that the Board of Medical Examiners may conduct an on-site inspection of my records at any time.

Signature of Physician: \_\_\_\_\_ Date: \_\_\_\_\_

Registration Fees: \$100.00 for first location; \$10.00 for each additional location