# TRANSMITTAL SHEET FOR NOTICE OF INTENDED ACTION

Control 540 Departmen	nt or Agency Alabai	ma State Board of Med	ical Examiners
Rule No. <u>540-X-19</u> , Apper Rule Title: <u>Initial Applicat</u>			
NewNew		Repeal	Adopt by Doform
Would the absence of the p significantly harm or endan health, welfare, or safety?	roposed rule	ropear	Adopt by Reference YES
Is there a reasonable relatio state's police power and the public health, safety, or well	protection of the		YES
Is there another, less restric regulation available that co- protect the public?	tive method of uld adequately		NO
Does the proposed rule have directly or indirectly increa of any goods or services inv to what degree?	sing the costs		NO
Is the increase in cost, if any to the public than the harm from the absence of the pro	that might result	٠	NO
Are all facets of the rulemal designed solely for the purp they have, as their primary protection of the public?	ose of, and so		YES
*******	***	the tile the the the the size of a size of	
Does the proposed rule have			**************************************
If the proposed rule has an orequired to be accompanied subsection (f) of Section 41	by a fiscal note pre-	pared in accordance wi	th
**************************************		********	**********
I certify that the attached pr compliance with the require all applicable filing require Service.	ments of Chapter 22	2, Title 41, Code of Alastrative Procedure Div	abama 1975, and that it conforms to ision of the Legislative Reference
Signature of certifying offic	er	(chry DD)	V
Date: <u>April 18, 2014</u>		and the same of th	

### 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

<u>SUBSTANCE OF PROPOSED ACTION</u>: 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.

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

CONTACT PERSON AT AGENCY: William F. Addison

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\*\*

N	ame:	AL I	AL License #:					
A	ddress:							
Street		City	S	StateEmail:		Zip		
Telephone:		Fax:	]					
D	EA Number:	DEA Expirat	tion Date: _					
1.	Are you registered with P (Attach copy of PDMP re		[	] Yes	[	] No		
2.	2. Have you ever had a controlled substance registration certificate denied, restricted or disciplined?  If yes, the attach a summary of each action including the year, state and description of each action.			] Yes	Ę	] No		
3.	Have you ever had a disci medical license in Alaban If yes, attach an explanat year, state and descriptio	. [	] Yes	[	] No			
se	rvices: (Attach additional p	information for the above locatio ages if necessary)		provide pa	in ma	nagement		
Pl	nysical Address:							
	Street	City		State		Zip		
О	wners, Co-Owners, Operato	ers:						
F	ull Name of Medical Direct	or:						
	Full names of all physic	cians providing pain management	t services at	this locatio	n:			
I :	swear (affirm) that the informative and correct to the best of my	tion set forth on this application for A	Alabama Pain I also unders	Managemer	nt Regi	stration form is		
E	xaminers may conduct an on-si	te inspection of my records at any tin	me.					
Si	ignature of Physician:	Г	Date:					

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