APA-1
6/93

TRANSMITTAL SHEET FOR NOTICE OF INTENDED ACTION

Control 540 Department or Agency Alabama State Board of Medical Examiners
Rule No. 540-X-3, Appendix E
Rule Title: Application for a Certificate of Qualification under the Retired Senior Volunteer Physician Program (RSVP)
_____ New __X__ Amend _____ Repeal _____ Adopt by Reference

Would the absence of the proposed rule significantly harm or endanger the public health, welfare, or safety?	YES
Is there a reasonable relationship between the state's police power and the protection of the public health, safety, or welfare?	YES
Is there another, less restrictive method of regulation available that could adequately protect the public?	NO
Does the proposed rule have the effect of directly or indirectly increasing the costs of any goods or services involved and, if so, to what degree?	NO
Is the increase in cost, if any, more harmful tot he public than the harm that might result from the absence of the proposed rule?	NO
Are all facets of the rulemaking process designed solely for the purpose of, and so they have, as their primary effect, the protection of the public?	YES

****

Does the proposed rule have an economic impact? NO

If the proposed rule has an economic impact, the proposed rule is required to be accompanied by a fiscal note prepared in accordance with subsection (f) of Section 41-22-23, Code of Alabama 1975.

****

Certification of Authorized Official
I certify that the attached proposed rule has been proposed in full compliance with the requirements of Chapter 22, Title 41, Code of Alabama 1975, and that it conforms to all applicable filing requirements of the Administrative Procedure Division of the Legislative Reference Service.

Signature of certifying officer _____

Date: December 16, 2011

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-3, Certificate of Qualification, Appendix E, Application for a Certificate of Qualification under the Retired Senior Volunteer Physician Program (RSVP)

INTENDED ACTION: To amend the rule.

SUBSTANCE OF PROPOSED ACTION: To add a statement concerning the statutory authority for requesting, requirement for requesting, uses of and consequences of not supplying an applicant's social security number.

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 Friday, February 3, 2012. Persons wishing to obtain copies of the text of this rule and submit data, views, or comments or arguments orally should contact Patricia E. Shaner, 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.

FINAL DATE FOR COMMENT AND COMPLETION OF NOTICE: February 3, 2012

CONTACT PERSON AT AGENCY: Patricia E. Shaner

Larry D. Dixon, Executive Director

ALABAMA BOARD OF MEDICAL EXAMINERS
540-X-3 – APPENDIX E
ALABAMA BOARD OF MEDICAL EXAMINERS
P.O. Box 946--Montgomery, AL 36101
(334) 242-4116

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: _____

Pursuant to Ala. Code § 30-3-194, it is mandatory that we request and that you provide your social security number (SSN) on this application. The uses of your SSN are limited to the purpose of administering the state child support program and intra-agency for identification purposes. If your SSN is not provided, your application is not complete, and no license will be issued.

		YES	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 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

	Name of School	Dates Attended	Degree Conferred
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

II. MEDICAL EDUCATION

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

		Name of School	Address
1.	From ____ to ____	_____	_____
2.	From ____ to ____	_____	_____

3. From ____ to ____ _____ _____

III. INTERNSHIP AND/OR TRAINING

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

		Name of School	Address
1.	From ____ to ____	_____	_____
2.	From ____ to ____	_____	_____
3.	From ____ to ____	_____	_____

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

1. I hereby certified 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: _____