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 F
Rule Title: Retired Senior Volunteer Program Certificate of Qualification Renewal Application
_______ 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 F, Retired Senior Volunteer Program Certificate of Qualification Renewal Application

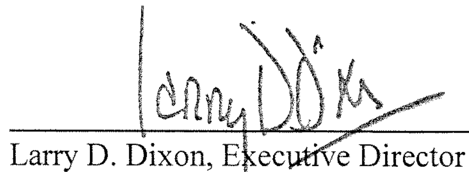
INTENDED ACTION: To amend the rule.

SUBSTANCE OF PROPOSED ACTION: To add a place to elicit applicant's social security number, and 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**
**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:** __________

**Social Security Number:** ______________________
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 |
|---|---|---|
| Do you limit your practice to the confined 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.

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.

______________________________

Clinic or Facility Administrator