



APA-2  
6/93

ALABAMA MEDICAL LICENSURE COMMISSION

NOTICE OF INTENDED ACTION

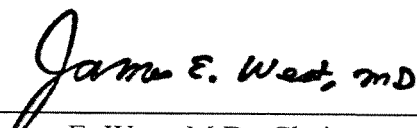
AGENCY NAME: Alabama Medical Licensure Commission  
RULE NO. & TITLE: 545-X-2, Appendix B, Medical License Renewal Application  
INTENDED ACTION: To amend 545-X-2, Appendix B, Medical License Renewal Application

SUBSTANCE OF PROPOSED ACTION: To collect additional primary care data for use by the Alabama Department of Public Health/Remove questions no longer required.

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: Karen H. Silas, Executive Assistant, Alabama Medical Licensure Commission, Post Office Box 887, Montgomery, Alabama 36101-0887, 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, April 5, 2013. Persons wishing to obtain copies of the text of this rule and submit data, views or comments or arguments orally should contact Karen H. Silas, by telephone (334/242-4153) 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: April 5, 2013

CONTACT PERSON AT AGENCY: Karen H. Silas

  
\_\_\_\_\_  
James E. West, M.D., Chairman

**CHAPTER 2--APPENDIX B**  
**Appendix B/Ch. 2**

20\_\_ Alabama Medical License Renewal Application

Deadline is December 31, 20\_\_

**Fees:**

**Renewal Fee \$300: October 1 – December 31**

**Late Fee \$100 plus Renewal Fee \$300 (Total \$400): January 1 – January 31**  
*(After January 31 – Reinstatement is required)*

Renew Online @ \_\_\_\_\_

*FAILURE TO RENEW THIS LICENSE TO PRACTICE MEDICINE OR OSTEOPATHY BY JANUARY 31 WILL RESULT IN LICENSE BECOMING INACTIVE WITHOUT FURTHER NOTICE*

Medical Licensure Commission of the State of Alabama  
Post Office Box 887  
Montgomery, Alabama 36101-0887  
334/242-4153

Complete Both sides including signature  
Correct or supply all information  
Return with \$300.00 renewal fee  
Incomplete applications will be returned  
Failure to Renew this License to Practice Medicine or Osteopathy by January 31 will Result in License Becoming Inactive Without Further Notice.

*Under Alabama law, this document is a public record and if requested it will be provided in it's entirety.*

NAME	<del>Use Only for Change of Mailing Address</del> _____ _____ _____
BUSINESS NAME	
ADDRESS LINE 1	
ADDRESS LINE 2	
CITY, STATE, ZIP	

License#  
Issue Date:

Physical ~~Office~~ Address:  
Address Line 1  
Address Line 2  
City, State, Zip

Mailing Home Address:  
Address Line 1  
Address Line 2  
City, State, Zip

(Alabama) County:  
Business Phone:  
Fax Number:

(Alabama) County:  
Home Phone:

Primary Specialty:  
Secondary Specialty:

Board Certified: Yes  No   
Board Certified: Yes  No

Form of Practice:  Resident  Intern  Fellowship  Solo  Partnership (2, 3, or 4)  
 Group  
Group Name:

Primary Hospital where you have staff privileges:  
City/State:

Are you licensed in another state: Yes  No  If yes, please list:

1. Are you actively engaged in clinical practice in the State of Alabama?

Yes  Answer Questions 2 through 7 6

No  Answer Question 2 only

2. What is your principal county of practice? (indicate state if principal county is not in Alabama)

Other county(ies) of practice? (indicate state, if counties are not in Alabama)

Check "None" if you only practice in the indicated principal county.  None

3. Do you currently perform/offer to perform any office based surgery/procedure which requires  
1) moderate sedation, deep sedation, or general anesthesia; 2) liposuction when infiltration  
methods such as the tumescent technique are used; or 3) any procedure in which propofol is  
administered, given or used?

Yes  No

### **Primary Care Information**

Primary care is defined as: Basic or general health care focused on the point at which a patient ideally first seeks assistance from the medical care system, exclusive of an emergency situation.

4. Does your practice include the delivery of primary care or mental health medical services (OB/GYN, general medicine, family medicine, general pediatrics, general internal medicine, general psychiatry or child psychiatry) in Alabama?

Yes, Answer Questions 5 and 6

No, Do not answer Questions 5 and 6

5. Approximately how many hours per week do you practice perform direct patient care in your office involving the above defined primary care or mental health services in Alabama?

Approximately \_\_\_\_\_ hours per week

6. Approximately how many patient ~~encounters (office, hospital, ER, etc.)~~ office visits per week do you have involving the above defined primary care or mental health services in Alabama? Approximately \_\_\_\_\_ ~~encounters~~ office visits per week.

**CME Certification: (Check one)**

(a)  I hereby certify that I have met or will meet by December 31 the annual minimum continuing education requirement of 25 hours of AMA PRA Category I Credits™ or equivalent continuing medical education for the calendar year 20\_\_ and have or will have supporting documentation if audited.

(b)  I certify that I am exempt from the minimum continuing medical education requirement for the following reason: (Check One)

I do not reside in the State of Alabama and do not have a significant portion of my medical practice in the State of Alabama.

I was exempt from the CME requirement for the previous calendar year 20\_\_, and I moved my residence to the State of Alabama during the calendar year 20\_\_.

I received my initial license to practice medicine in Alabama in the calendar year 20\_\_.

I have obtained a retirement waiver from the Board of Medical Examiners, and I do not engage in the practice of medicine in any form.

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 am enrolled or was enrolled in a residency training program or clinical fellowship program during the calendar year 20\_\_.

I am exempt from the CME requirement for the calendar year 20\_\_ because I am a member of a branch of the armed services and I was deployed for military service in the calendar year 20\_\_.

- |  | YES                      | NO                       |
|--|--------------------------|--------------------------|
| 1. Have you been charged with any offense (felony or misdemeanor) within the past year?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. 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 within the past year?                             | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice, within the past year?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you 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 within the past year? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you had a judgment rendered against you, or action settled relating to the performance of your professional service within the past year?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. To your knowledge, are you the subject of an investigation, or has a formal complaint against   |                          |                          |

your license been filed by any licensing Board/Agency as of the date of this application within the past year?

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

8. 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 or, within the past year, have you applied for and/or have you received any payment or other compensation for any mental or physical condition?

9. Within the past year, have you 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?

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

11. Have you engaged in the illegal use of controlled dangerous substances within the past twelve months?

12. If your answer to the preceding question is yes, are you currently participating in a supervised rehabilitation program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances?

13. 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?

14. 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 or maternity leave?

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 that the condition referred to may have an ongoing impact on one's functioning as a physician, or within the past two years.

IF YOU ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE INCLUDE A DETAILED EXPLANATION WITH YOUR APPLICATION

I certify that all information on this form is correct.

\_\_\_\_\_ Signature \_\_\_\_\_ Date

- Complete both sides, including signature.
- Correct or supply all information.
- Incomplete application will be returned.

Return with \$300.00 renewal fee to:  
 Medical Licensure Commission  
 P.O. Box 887  
 Montgomery, AL 36101-0887

**Author:**

**Statutory Authority:** Code of Alabama 1975

**History: Amended:** Filed July 1997; effective August 27, 1997. **Amended:** Filed March 4, 2003; effective April 8, 2003.

**Amended:** Approved for Publication January 28, 2004

**Filed:** January 30, 2004

**Approved for Adoption:** April 21, 2004; **Effective Date:** May 28, 2004

**Repeal and Replace:** Approved for Publication November 17, 2005; **Filed:** November 28, 2005

**Approved for Adoption:** February 22, 2006; **Filed:** February 27, 2006; **Effective Date:** April 3, 2006. **Amended/Approved:** August 22, 2007; Emergency Rule Effective September 4, 2007.

**Approved for Adoption:** November 28, 2007; Effective date January 4, 2007.

**Amended:** Approved for Publication January 27, 2010.

**Filed:** February 4, 2010; Final Approval April 28, 2010; Filed May 5, 2010; Effective Date June 9, 2010;

**Amended:** ER Adopted May 23, 2012, Filed ER May 25, 2012

Approved: May 23, 2012; Filed May 25, 2012

Final File August 30, 2012; Effective October 4, 2012

**Amended:** Approved for Publication September 26, 2012; Filed w/LR February 12, 2013#2;