

TRANSMITTAL SHEET FOR
NOTICE OF INTENDED ACTION

Control 540 Department or Agency Alabama State Board of Medical Examiners

Rule No. 540-X-3, Appendix A

Rule Title: Application for Certificate to Practice Medicine through Endorsement

New 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

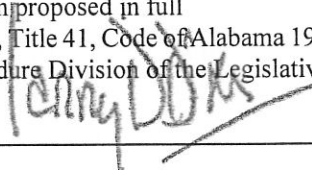
Is the increase in cost, if any, more harmful to the public than the harm that might result from the absence of the proposed rule? NO

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: January 16, 2014

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 A, Application for Certificate to Practice Medicine through Endorsement

INTENDED ACTION: To amend the rule.

SUBSTANCE OF PROPOSED ACTION: To amend the application to add a question asking if applicant has been diagnosed with or treated for any sexual boundary violation

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 Thursday, March 7, 2014. 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: March 7, 2014

CONTACT PERSON AT AGENCY: Patricia E. Shaner



Larry D. Dixon, Executive Director

ALABAMA BOARD OF MEDICAL EXAMINERS
P.O. Box 946 — Montgomery, AL 36101
848 Washington Avenue - 36104
(334) 242-4116

APPLICATION FOR CERTIFICATE TO PRACTICE MEDICINE THROUGH ENDORSEMENT

To The Board of Medical Examiners of the State of Alabama:

I hereby make application for a certificate to practice medicine and surgery in the State of Alabama, and submit the following statement concerning my age, moral character, preliminary and medical education and practice.

M.D.
D.O. (Choose One)

1. Name in Full _____
First Middle Last

2. Address _____
Street City State Zip

3. Place of Birth _____ Date of Birth _____ Email: _____

4. Social Security # _____ Sex _____ Telephone (H) _____ (W) _____

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 |
|---|-------|-------|
| 5. Have you ever been convicted of a felony? (If yes, please provide the name of the court of record or a copy of the record of conviction.) | _____ | _____ |
| 6. Have you ever been convicted of a crime or offense (felony or misdemeanor) related to the practice of medicine? (If yes, please provide the name of the court of record or a copy of the record of conviction.) | _____ | _____ |
| 7. Have you ever been convicted of any violation of a state or federal law relating to controlled substances? (If yes, please provide the name of the court of record or a copy of the record of conviction.) | _____ | _____ |
| 8. Have you ever been denied a state or federal controlled substance certificate? | _____ | _____ |
| 9. 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? | _____ | _____ |
| 10. Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice? | _____ | _____ |
| 11. 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? | _____ | _____ |
| 12. Have you ever had a judgement rendered against you, or action settled relating to performance of your professional service? | _____ | _____ |
| 13. To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this application? | _____ | _____ |
| 14. 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? | _____ | _____ |
| 15. 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?! | _____ | _____ |
| 16. 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? | _____ | _____ |
| 17. Have you ever been treated for pedophilia, exhibitionism, or voyeurism? or for any sexual boundary violation _____ | _____ | _____ |
| 18. Are you currently using controlled dangerous substances?! | _____ | _____ |
| 19. If your answer to question 17 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? | _____ | _____ |
| 20. 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? | _____ | _____ |
| 21. 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? | _____ | _____ |
| 22. Have you ever been placed on academic or disciplinary probation by a medical school or postgraduate program? | _____ | _____ |
| 23. Have you ever been disciplined for unprofessional conduct/behavior reasons by a medical school or postgraduate program? | _____ | _____ |
| 24. Were you notified in writing that there were limitations or special requirements imposed on you because of questions of academic or clinical incompetence, disciplinary problems or any other reason during your medical education or postgraduate training? | _____ | _____ |

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.

25. Military Service, Branch _____ Dates _____

26. Place of Intended Residence in Alabama _____

I. PRELIMINARY AND PRE-MEDICAL EDUCATION

List all schools attended, elementary through college and post-graduate work other than medical school.

	Name of School	Dates Attended	Degree Conferred
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____

II. MEDICAL EDUCATION

List all medical schools attended, dates, and complete addresses of institutions. Do not list post graduate medical education training.

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

III. POST GRADUATE MEDICAL EDUCATION TRAINING

List all post graduate medical education training since graduation from medical school with dates and complete addresses of institutions. Do not list practice experience.

	Hospital/Institution	Address
1. From _____ to _____	_____	_____
2. From _____ to _____	_____	_____
3. From _____ to _____	_____	_____
4. From _____ to _____	_____	_____
5. From _____ to _____	_____	_____
6. From _____ to _____	_____	_____
7. From _____ to _____	_____	_____
8. From _____ to _____	_____	_____

Specialty(s) _____

**IV. ORIGINAL LICENSE
(If Applicable)**

I was issued my original (first) license in the State of _____ on _____,
license number _____ based upon _____ examination. I certify that this
license has not been the subject of any disciplinary action. If so please explain on attached sheet.

V. ACTIVITIES FOLLOWING MEDICAL SCHOOL AND TRAINING

List all practice experience since completion of your formal training giving dates, institutions/hospitals, and complete address. Use separate sheet if necessary.

	Place	Address
1. From _____ to _____	_____	_____
2. From _____ to _____	_____	_____
3. From _____ to _____	_____	_____
4. From _____ to _____	_____	_____
5. From _____ to _____	_____	_____
6. From _____ to _____	_____	_____
7. From _____ to _____	_____	_____
8. From _____ to _____	_____	_____
9. From _____ to _____	_____	_____
10. From _____ to _____	_____	_____

VI. HOSPITAL PRIVILEGES

List all hospitals where you have held staff privileges of any type. Attach sheet if necessary.

	Hospital	Address
1. From _____ to _____	_____	_____
2. From _____ to _____	_____	_____
3. From _____ to _____	_____	_____
4. From _____ to _____	_____	_____
5. From _____ to _____	_____	_____
6. From _____ to _____	_____	_____
7. From _____ to _____	_____	_____
8. From _____ to _____	_____	_____
9. From _____ to _____	_____	_____
10. From _____ to _____	_____	_____
11. From _____ to _____	_____	_____
12. From _____ to _____	_____	_____
13. From _____ to _____	_____	_____
14. From _____ to _____	_____	_____

**VII. STATE LICENSURE
(If Applicable)**

List all states where you have been licensed to practice medicine or have applied for a license to practice medicine. It is a requirement that each state complete one of the verification forms which will be attached to your application.

VIII. SPECIALTY BOARD CERTIFICATION

Are you CURRENTLY certified by one of the specialty boards approved by the American Board of Medical Specialties or the American Osteopathic Association? YES _____ NO _____

(If your answer is YES you must have your Specialty Board send verification directly to this office.)

IX. SPEX

1. Have you successfully completed a written licensing examination within the last ten years? YES _____ NO _____
2. Have you been certified or re-certified by one of the specialty boards approved by the American Board of Medical Specialties or the American Osteopathic Association? YES _____ NO _____

X. 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, that the photograph submitted is a true likeness of myself and was taken within sixty days prior to the date of this application. 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.

Date _____

Applicant's Signature

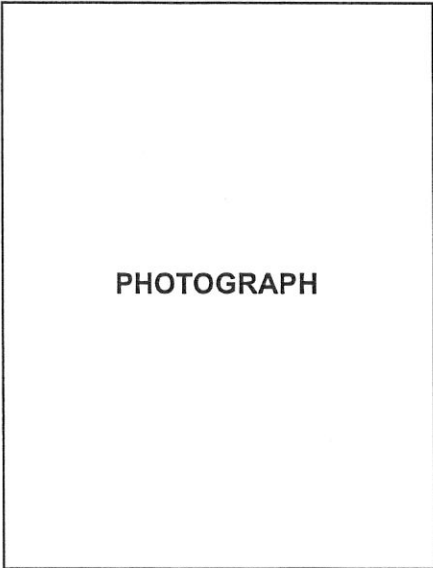
County of _____

State of _____

SWORN to and subscribed before me this _____ day of _____, 20 _____.

Notary Public

My Commission Expires: _____



THE ALBME WILL ENFORCE THE BOARD'S RULES AND OPTIONS FOR THE ISSUANCE OF NON-DISCIPLINARY CITATION AND ADMINISTRATIVE CHARGE WHEN AN APPLICANT FALSIFIES AN APPLICATION.

ALABAMA BOARD OF MEDICAL EXAMINERS

P.O. Box 946 — Montgomery, Alabama 36101

848 Washington Avenue — 36104

APPENDIX A

MEDICAL SCHOOL CERTIFICATION

CERTIFICATE OF DEAN OR PRESIDENT

It is hereby certified that _____ of _____
matriculated in _____ at _____ from _____
to _____ and received a diploma from _____
conferring the degree of Doctor of Medicine/Osteopathy on _____.

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the individual's medical education. Please circle the correct response and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation.

Does this individual's official record reflect that he/she was ever placed on academic or disciplinary probation?
If yes, please attach a copy of the written notification to the individual. Y N

Does this individual's official record reflect that he/she was ever disciplined for unprofessional conduct/
behavioral reasons by the medical school or parent university? If yes, please attach a copy of the written
notification to the individual of the disciplinary action. Y N

Does this individual's official record reflect that that there were any limitations or special requirements
imposed on him/her because of questions of academic or clinical incompetence, disciplinary problems,
or any other reason? If yes, please attach a copy of the written notification to the individual. Y N

Date _____

President, Secretary or Dean

(SEAL)

INSTRUCTIONS TO INDIVIDUAL COMPLETING THIS FORM:

Please fill in all applicable spaces and return to the Alabama Board of Medical Examiners at the above address, Please do not send this application back to the applicant as the Board will not consider this certificate unless it is received directly from the institution.

ALABAMA BOARD OF MEDICAL EXAMINERS
P.O. Box 946 — Montgomery, Alabama 36101
848 Washington Avenue - 36104

APPENDIX B

POST GRADUATE EDUCATION CERTIFICATE

CERTIFICATE OF POST GRADUATE EDUCATION TRAINING

I, _____, Administrator, Medical Education Director OR Director of Residency Training Program (circle one)
of _____ certify that the records of this Program show that
_____ is currently enrolled in the ___ year of post graduate training OR has successfully
completed ___ year/years of post graduate training* in this program from _____ 20 ___ to _____ 20 ___.

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the individual's post graduate training. Please circle the correct response and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation.

Does this individual's official record reflect that he/she was ever placed on academic or disciplinary probation?
If yes, please attach a copy of the written notification to the individual. Y N

Does this individual's official record reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons? If yes, please attach a copy of the written notification to the individual of the disciplinary action. Y N

Does this individual's official record reflect that he/she was ever notified in writing that there were any limitations or special requirements imposed on him/her because of questions of academic or clinical competence, disciplinary problems, or any other reason? If yes, please attach a copy of the written notification to the individual. Y N

Date _____

Administrator of Hospital
Medical Education Director
Director of Residency Training

(SEAL OF PROGRAM)

Candidates who graduated from an LCME accredited medical school or AOA approved College of Osteopathy need one (1) year certified.

Candidates who graduated from a NON-LCME accredited medical school or NON-AOA accredited College of Osteopathy need three (3) years certified.

*"has completed ___ years of post graduate training" means the applicant has successfully completed or met the program's established criteria, standards or requirements which are necessary for promotion to the next level of post graduate training or the applicant has successfully completed or met the program's established criteria, standards or requirements which are necessary for completion of this program.

Note to applicant: Merely accumulating 12 months or 36 months of post graduate or residency training shall not be evidence satisfactory to the Board that the applicant has fulfilled the post graduate requirement necessary for qualifying for the issuance of a certificate of qualification for a license to practice medicine in Alabama.

INSTRUCTIONS TO INDIVIDUAL COMPLETING THIS FORM:

Please fill in all applicable spaces and return to the Alabama Board of Medical Examiners at the above address. Please do not send this application back to the applicant as the Board will not consider this certificate unless it is received directly from the institution.

ALABAMA BOARD OF MEDICAL EXAMINERS
P.O. Box 946 — Montgomery, Alabama 36101

APPENDIX C
ORIGINAL LICENSURE

CERTIFICATE OF EXECUTIVE DIRECTOR OF BOARD ISSUING ORIGINAL LICENSE

I, _____ Executive Director of _____
Board of Medical Examiners, certify that _____ was granted Certificate/License
NO. _____ to practice medicine/osteopathy in the State of _____ on
the _____ based on _____
Month Day Year
and that said certificate or license has not been revoked or subject to disciplinary action.

I further certify that _____ in his written exam before this Board, obtained a general
average of _____ percent in the following branches:

Acting on behalf of the _____ Board of Medical Examiners, I hereby certify to the reputability of Dr.
_____ based on the records, and recommend him to the Alabama Board of Medical Examiners.

Executive Director, Secretary, Chairman

(SEAL OF BOARD)

Date _____

Place _____

INSTRUCTIONS TO INDIVIDUAL COMPLETING THIS FORM:

Please fill in all applicable spaces and return to the Alabama Board of Medical Examiners at the above address, Please do not send this application back to the applicant as the Board will not consider this certificate unless it is received directly from the institution.

**ALABAMA BOARD OF MEDICAL EXAMINERS
DECLARATION OF CITIZENSHIP AND LAWFUL PRESENCE OF AN
ALIEN FOR PUBLIC BENEFITS AND LICENSING/PERMITTING PROGRAMS**

Title IV of the federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 8 U.S.C. § 1621, provides that, with certain exceptions, only United States citizens, United States non-citizen nationals, non-exempt "qualified aliens" (and sometimes only particular categories of qualified aliens), nonimmigrants, and certain aliens paroled into the United States are eligible to receive covered state or local public benefits.

With certain exceptions, Ala. Code §§ 31-13-1, *et. seq.*, prohibits aliens unlawfully present in the U.S. from receiving state or local benefits. Every U.S. Citizen applying for a state or local public benefit must sign a declaration of Citizenship, and the lawful presence of an alien in the U.S. must be verified by the Federal Government.

Ala. Code §§ 31-13-1, *et. seq.*, also requires every individual applying for a permit or license to demonstrate his/her U.S. citizenship or if the applicant is an alien, he/she must demonstrate his/her lawful presence in the United States.

Directions: This form must be completed and submitted by individuals applying for licenses or permits.

SECTION 1 --- APPLICANT INFORMATION

NAME: _____
(Print or Type) (Last) (First) (M.I.)

DATE OF BIRTH: _____

SECTION II --- U.S. CITIZENSHIP OR NATIONAL STATUS

Are you a citizen or national of the United States (check one) Yes No

If you answered **YES**: (1) Provide an original (only in person at agency office) or legible copy of document from attached List A or other document that demonstrates U.S. citizenship or nationality and (2) Complete Section IV.

If you answered **No**: Complete Sections III and IV.
Name of document provided: _____

SECTION III -- ALIEN STATUS

Are you an alien lawfully present in the United States? Yes No

If you answered **Yes**: (1) Provide an original (only in person at agency office) or legible copy of the front and back (if any) of a document from attached List B or other document that demonstrates lawful presence in the United States. (2) Complete Section IV. Information from the documentation provided will be used to verify lawful presence through the United States Government.

If you answered **No**: Complete Section IV.
Name of document provided: _____

SECTION IV -- DECLARATION

I declare under penalty of perjury under the laws of the State of Alabama that the answers and evidence I provided are true and correct to the best of my knowledge.

APPLICANT'S SIGNATURE DATE

LIST A

DOCUMENTS DEMONSTRATING U.S. CITIZENSHIP

- (1) The applicant's driver's license or nondriver's identification card issued by the division of motor vehicles or the equivalent governmental agency of another state within the United States if the agency indicates on the applicant's driver's license or nondriver's identification card that the person has provided satisfactory proof of United States citizenship.
- (2) The applicant's birth certificate that satisfactorily verifies United States citizenship.
- (3) Pertinent pages of the applicant's United States valid or expired passport identifying the applicant and the applicant's passport number.
- (4) The applicant's United States naturalization documents or the number of the certificate of naturalization.
- (5) Other documents or methods or proof of United States citizenship issued by the federal government pursuant to the Immigration and Nationality Act of 1952, and amendments thereto.
- (6) The applicant's Bureau of Indian Affairs card number, tribal treaty card number, or tribal enrollment number.
- (7) The applicant's consular report of birth abroad of a citizen of the United States of America.
- (8) The applicant's certificate of citizenship issued by the United States Citizenship and Immigration Services.
- (9) The applicant's certification of report of birth issued by the United States Department of State.
- (10) The applicant's American Indian card, with KIC classification, issued by the United States Department of Homeland Security.
- (11) The applicant's final adoption decree showing the applicant's name and United States birthplace.
- (12) The applicant's official United States military record of service showing the applicant's place of birth in the United States.
- (13) An extract from a United States hospital record of birth created at the time of the applicant's birth indicating the applicant's place of birth in the United States.

Ala. Act #2011-535, Section 30(c) and Section 29(k).

LIST B

DOCUMENTS INDICATING STATUS OF QUALIFIED ALIENS, NONIMMIGRANTS, AND ALIENS PAROLED INTO U.S. FOR LESS THAN ONE YEAR

The documents listed below that are registration documents are indicated with an asterisk (“*”).

a. **“Qualified Aliens”**

Evidence of “Qualified Alien” status includes the following:

Alien Lawfully Admitted for Permanent Residence

- Form I-551 (Alien Registration Receipt Card, commonly known as a “green card”); or
- Unexpired Temporary I-551 stamp in foreign passport or on * I Form-94.

Asylee

- * Form I-94 annotated with stamp showing grant of asylum under section 208 of the INA;
- * Form I-688B (Employment Authorization Card) annotated “274.a12(a)(50”;
- * Form I-766 (Employment Authorization Document) annotated “A5”;
- Grant letter from the Asylum Office of the U.S. Citizenship and Immigration Service; or
- Order of an immigration judge granting asylum.

Refugee

- * Form I-94 annotated with stamp showing admission under § 207 of the INA;
- * Form I-688B (Employment Authorization Card) annotated “274a.12(a)(3)”;
- * Form I-766 (Employment Authorization Document) annotated “A3”

Alien Paroled Into the U.S. for at Least One Year

- * Form I-94 with stamp showing admission for at least one year under section 212(d)(5) of the INA.
(Applicant cannot aggregate periods of admission for less than one year to meet the one year requirement.)

Alien Whose Deportation or Removal Was Withheld

- * Form I-688B (Employment Authorization Card) annotated “274a.12(a)(10);
- * Form I-766 (Employment Authorization Document) annotated “A10”; or
- Order from an immigration judge showing deportation withheld under §243(h) of the INA as in effect prior to April 1, 1997, or removal withheld under § 241(b)(3) of the INA.

Alien Granted Conditional Entry

- * Form I-94 with stamp showing admission under §203(a)(7) of the INA;
- * Form I-688B (Employment Authorization Document) annotated “274a.12(a)(3)”;
- * Form I-766 (Employment Authorization Document) annotated “A3.”

Cuban / Haitian Entrant

- * Form I-551 (Alien Registration Receipt Card, commonly known as a “green card”) with the code CU6, CU7, or CH6;
- Unexpired temporary I-551 stamp in foreign passport or on * Form I-94 with the code CU6 or CU7; or
- Form I-94 with stamp showing parole as “Cuba/Haitian Entrant” under Section 212(d)(5) of the INA.

Alien Who Has Been Declared a Battered Alien Subjected to Extreme Cruelty

- U.S. Citizenship and Immigration Service petition and supporting documentation