

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-7, Assistants to Physicians, Appendix I, Physician Assistant/Anesthesiologist Assistant License Renewal Application

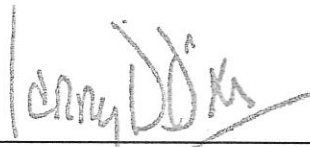
INTENDED ACTION: To amend the rule.

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 36101-0946 – 848 Washington Avenue, Montgomery, AL 36101

Phone: (334) 242-4116 FAX: (334) 242-4155

PHYSICIAN ASSISTANT / ANESTHESIOLOGIST ASSISTANT

LICENSE RENEWAL – 20__

DEADLINE - DECEMBER 31, 20__

Renew Online: <http://alrenewals.org>

License# :

Registration ID:

Social Security No.:

! Complete **BOTH** pages including signature.

! Remember to include appropriate documentation or response for any "yes" answers.

! Include a check for \$100.00 payable to Alabama Board of Medical Examiners.

YES NO

1. Have you been convicted of a felony within the past year?
2. Have you been convicted within the past year of a crime or offense (felony or misdemeanor) related to the practice of medicine?
3. Have you been convicted within the past year of any violation of a state or federal law relating to controlled substances?
4. Within the past year, has your PA/AA certificate or license in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered while under investigation?
5. Within the past year, have your privileges at any hospital or health care facility been revoked, suspended, curtailed, limited, placed under conditions restricting your practice, or voluntarily surrendered while under investigation?
6. Have you been denied a PA/AA certificate or license in any state or has your application for a certificate or licensee been withdrawn under threat of denial within the past year?
7. Are you currently certified to any other primary supervising physician(s)?
If YES, attach a list with name and principal practice location of each primary supervising physician to whom you are certified. In addition, state your designated working hours per week for each physician listed.
8. Have you had within the past year a judgment rendered against you or action settled relating to the performance of your professional service?
9. Within the past two years, have you been diagnosed with or have you been treated for bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder?
10. 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

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in any way currently affects, or if untreated could affect, your ability to practice in a competent and professional manner?

11. Within the past two 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?

YES NO

12. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, or voyeurism or for any sexual boundary violation?
13. Are you currently engaged in the illegal use of controlled dangerous substances?¹
14. 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?

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15. 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?
16. 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?

¹The 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 an assistant to 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.

CME CERTIFICATION (Check one):

I hereby certify that I have met the annual minimum continuing medical education requirement of twenty five (25) hours of AMA PRA Category 1 Credits™ or equivalent continuing medical education for the calendar year 20__ and have supporting documentation if audited.

I hereby certify that I am exempt from the minimum continuing medical education requirement for the following reason (check one):

I received my initial license to practice in Alabama in the calendar year 20__.

I am a member of a branch of the U. S. armed services and was deployed for military service in the calendar year 20__.

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 certify the foregoing information to be correct to the best of my knowledge, information and belief, and attest that I have reviewed and am abiding by the Rules and Regulations which were effective on this date.

Signature:

Date:

FAILURE TO APPLY FOR LICENSE RENEWAL AND PAY RENEWAL FEE WILL RESULT IN THE LICENSE AUTOMATICALLY BEING PLACED IN AN INACTIVE STATUS MAKING IT ILLEGAL FOR THE HOLDER TO PRACTICE AS A PHYSICIAN ASSISTANT EFFECTIVE JANUARY 1, 20__.

