# TRANSMITTAL SHEET FOR NOTICE OF INTENDED ACTION

Control <u>540</u> Department or Agency <u>Alal</u> Rule No. <u>540-X-12</u> , <u>Appendix A</u>	bama State Board of Medical Examiners	
Rule Title: Oualified Alabama Controlled S	Substances Registration Certificate (QACSC)	
New X Amend	Repeal Adopt by Reference	<del></del>
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?		
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	No. 2. Apr Company of the Company
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 im		*****
If the proposed rule has an economic impact, required to be accompanied by a fiscal note publication (f) of Section 41-22-23, Code of A	prepared in accordance with	
************	*************	<b>.</b>
Certification of Authorized Official	************************************	****
I certify that the attached proposed rule has be compliance with the requirements of Chapter all applicable filing requirements of the Adm Service.	peen proposed in full r 22, Title 41, Code of Alabama 1975, and that it con inistrative Procedure Division of the Legislative Re	nforms to ference
Signature of certifying officer	(dny DDK)	
Date: July 22, 2013		

## ALABAMA STATE BOARD OF MEDICAL EXAMINERS

## **NOTICE OF INTENDED ACTION**

**AGENCY NAME:** 

Alabama State Board of Medical Examiners

RULE NO. & TITLE:

540-X-12, Qualified Alabama Controlled Substances Registration

Certificate (QACSC), Appendix A, Application for QACSC

<u>INTENDED ACTION</u>:

To amend the appendix

SUBSTANCE OF PROPOSED ACTION: To amend Appendix A to add "For Physician

Assistants" and correct language in "warning" box

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, Office of General Counsel, Alabama State Board of Medical Examiners, Post Office

Box 946, 848 Washington Avenue (36104), 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 Wednesday, September 4, 2013. Persons wishing to obtain copies of the text of this rule should contact Patricia E.

Shaner, Office of General Counsel, (334-242-4116), PO Box 946, 848 Washington Avenue (36104), Montgomery, Alabama 36101-

0946.

FINAL DATE FOR COMMENT AND COMPLETION OF NOTICE: September 4, 2013

**CONTACT PERSON AT AGENCY:** 

Patricia E. Shaner

Larry D. Dixon, Executive Director

#### -APPLICATION-QUALIFIED

# CONTROLLED SUBSTANCES REGISTRATION CERTIFICATE

FOR PHYSICIAN ASSISTANTS

Return Completed Application To:

ALABAMA STATE BOARD OF MEDICAL EXAMINERS
P.O. Box 946 • Montgomery, Alabama 36101
(334) 242-4116

WARNING: SECTION 20-2-5464, CODE OF ALABAMA 1975 (AS AMENDED) STATES THAT A REGISTRATION UNDER SECTION 20-2-54 TO MANUFACTURE, DISTRIBUTE OR DISPENSE A CONTROLLED SUBSTANCE—MAY BE SUSPENDED OR REVOKED BY THE CERTIFYING BOARDS UPON A FINDING THAT THE REGISTRANT HAS FURNISHED FALSE OR FRAUDULENT MATERIAL INFORMATION IN ANY APPLICATION FILED UNDER THIS ACT.

All applicants must answer the following questions. If the answer to questions A, B, C, D or E is yes, the applicant must attach a complete explanation detailing all facts and circumstances.

	A.	Has your privilege for dispensing or prescribing controlled substances ever been suspended, restricted, revoked or disciplined in any manner in any state? ( ) Yes ( ) No
	B.	Have you ever been convicted of any state or federal crime relating to any controlled substance?
	C.	Has your Federal DEA registration ever been suspended, restricted or revoked? ( ) Yes ( ) No
	D.	Have your staff privileges at any hospitals ever been suspended, restricted, revoked or disciplined in any manner for any reason related to the prescribing or dispensing of controlled substances?
	E.	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?* . ( ) Yes ( ) No
	F.	Print DEA number and expiration date
stat	e statute	Γο lawfully administer, dispense or prescribe controlled substances in the State of Alabama, federal and es require a DEA certificate of registration and a Qualified Alabama Controlled Substances registration For further information concerning federal requirements contact DEA, Metairie, LA, 800-882-9539.
	G.	Have you completed one year of clinical employment?  NOTE: If yes, complete attached affidavit
	Н.	Have you completed a board approved pharmacology of controlled substances course or courses?  NOTE: If yes, attach documentation of completion
	have a	term "currently" does not mean on the day of, or even in the weeks or months preceding the etion of this application. Rather, it means recently enough so that the condition referred to may n ongoing impact on one's functioning as a physician assistant within the last two years.
FEE I	FOR T	THIS CERTIFICATE IS \$110.00. ENCLOSE YOUR CHECK WITH APPLICATION
I swear Certific	(affirm) ate is tru	) that the information set forth in this application for Qualified Alabama Controlled Substances registration ue and correct to the best of my knowledge, information and belief.
Date:	***************************************	Signature of Applicant (P. A.)
Date:	***************************************	Signature of Supervising Physician
		<u>P.A.</u> License No.:
Addres		
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# ALABAMA BOARD OF MEDICAL EXAMINERS

Proof of Clinical Employment §20-2-63(2)

# AFFIDAVIT

Employer			Street Address	
Employer			Street Address	
City	State	Zip	Phone #	
Supervisor			Employed From: To:	, <u>, , , , , , , , , , , , , , , , , , </u>
Employer			Street Address	···
City	State	Zip	Phone #	
Supervisor			Employed From: To:	
Employer			Street Address	
City	State	Zip	Phone #	
Supervisor			Employed From: To:	
		Signed:	Physician Assistant	
Sworn to and subscribed to before me on this		1		