

APA-2
6/93

ALABAMA MEDICAL LICENSURE COMMISSION

NOTICE OF INTENDED ACTION

AGENCY NAME: Alabama Medical Licensure Commission

RULE NO. & TITLE: Chapter 2, Appendix E - Retired Senior Volunteer Program
Renewal Application

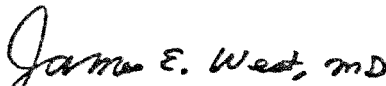
INTENDED ACTION: To amend Chapter 2, Appendix E- RSVP renewal application

SUBSTANCE OF PROPOSED ACTION: To clean up renewal form and remove questions
that are 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 Thursday,
December 6, 2012. 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: December 6, 2012

CONTACT PERSON AT AGENCY: Karen H. Silas



James E. West, M.D., Chairman

CHAPTER 2--APPENDIX E

Appendix E/Ch. 2

Retired Senior Volunteer Program: Application for Renewal of License to Practice
Medicine or Osteopathy

Retired Senior Volunteer Program License Renewal for 20__

Deadline is December 31, 20__

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

NO FEE REQUIRED TO RENEW THIS LICENSE

Complete Both sides including signature.

Correct or supply all information

Incomplete applications will be returned

Failure to Renew this License will Result in License Becoming Inactive Without Further Notice
Under the Restrictions of the Retired Senior Volunteer Program

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

NAME

~~Use Only for Change of Mailing Address~~

BUSINESS NAME

ADDRESS LINE 1

ADDRESS LINE 2

CITY, STATE, ZIP

License#

Issue Date:

Office Physical Address:

Address Line 1

Address Line 2

City, State, Zip

~~Home Mailing~~ 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

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 have a current collaborative agreement with a nurse practitioner or midwife? —~~

~~Yes, Answer Questions 3a through 7~~

~~No, Answer Questions 4 through 7~~

~~3a. Does the nurse practitioner/midwife practice at a site other than your office? Yes No~~

~~3b. Are you employed by the nurse practitioner/midwife or a corporation owned by the nurse practitioner/midwife? Yes No~~

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

~~4. Do you currently conduct office based surgery involving the administration of parenteral medication for analgesia/sedation, general anesthesia or major regional block anesthesia? —~~

~~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 services (OB/GYN, general medicine, family medicine, general pediatrics, general internal medicine, general psychiatry or child psychiatry)?

Yes, Answer Questions 5 and 6

No, Do not answer Questions 5 and 6

5. Does your practice include the delivery of primary care medical services in Alabama?

(-) Yes, Answer Questions 6 and 7

(-) No, Do not answer Questions 6 and 7

5. Approximately how many hours per week do you 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 hours per week do you practice the above defined primary care services in Alabama?

Approximately _____ hours per week

6. Approximately how many patient office visits per week do you have involving the above defined primary care or mental health services in Alabama?

Approximately _____ office visits per week.

7. ~~Approximately how many patient encounters (office, hospital, ER, etc.) per week do you have involving the above defined primary care services in Alabama?~~

Approximately _____ encounters 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 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? | <input type="checkbox"/> | <input type="checkbox"/> |

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?

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 Application To:

Medical Licensure Commission

P.O. Box 887

Montgomery, AL 36101-0887

Author:

Statutory Authority: Code of Alabama 1975

History: **Approved** June 23, 2004. **Filed as Emergency Rule** July 1, 2004
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