ALABAMA STATE BOARD OF MEDICAL EXAMINERS

848 Washington Ave, Montgomery, AL 36104-0946 / (334) 242-4116

Application for a Certificate of Qualification under the Retired Senior Volunteer Program

To the Alabama Board of Medical Examiners:

I hereby make application for a limited certificate of qualification to practice medicine in the state of Alabama under the RSVP, and submit the following statement concerning my age, moral character, preliminary and medical education and practice:

Name in full: _____ MD____ DO____
(First) (Middle) (Last)

Alternate name(s) used: _____

Address: _____
(Street) (City) (State) (Zip)

Email address: _____ Place of Birth: _____ DOB: _____

Social Security Number: _____ *(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)*

Sex: _____ Telephone (H or C): _____ Telephone (W): _____

The address and contact methods provided should be how the Board or Commission can contact the license applicant directly. Please DO NOT provide contact information for office managers, assistants, or license assistance companies.

Please answer **Yes** or **No** to the following questions (if any below answers are in the affirmative, please explain in detail and provide the complete name and address of any psychiatrist/psychologist, state board, hospital, etc.):

1. Have you ever been convicted of a felony? **Yes** ☐ **No** ☐
2. Have you ever been convicted of a crime or offense (felony or misdemeanor) related to the practice of medicine? **Yes** ☐ **No** ☐
3. Have you ever been convicted of any violation of a state or federal law relating to controlled substances? **Yes** ☐ **No** ☐
4. Has your DEA registration or any state controlled substance certificate been denied or subject to any discipline, including but not limited to the following: revocation; suspension; probation; restriction(s); condition(s); reprimand or fine; or has your DEA registration or any state controlled substance certificate been voluntarily surrendered while under investigation ? **Yes** ☐ **No** ☐

5. Has your certificate of qualification or license to practice medicine in any state ever been denied or subject to any discipline, including but not limited to the following: revocation; suspension; probation; restriction(s); condition(s); reprimand or fine; or has your certificate of qualification or license to practice medicine in any state been voluntarily surrendered while under investigation or under threat of discipline? **Yes** ☐ **No** ☐

6. Have your staff privileges at any hospital or health care facility ever been revoked, suspended, curtailed, limited or placed under conditions restricting your practice? **Yes** ☐ **No** ☐

7. 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? **Yes** ☐ **No** ☐

8. Have you ever had a judgment rendered against you, or action settled relating to the performance of your professional service? **Yes** ☐ **No** ☐

9. To your knowledge, are you the subject of an investigation or proposed action by any licensing board/agency as of the date of this application? **Yes** ☐ **No** ☐

10. 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? **Yes** ☐ **No** ☐

11. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, or voyeurism? **Yes** ☐ **No** ☐

12. Are you currently* engaged in the excessive use of alcohol, controlled substances, or the use of illegal drugs, or received any therapy or treatment for alcohol or drug use, sexual boundary issues or mental health issues? (If you are an anonymous participant in the Alabama Professionals Health Program and are in compliance with your contract, you may answer "No" to this question. Such answer for this purpose will not be deemed upon certification as providing false information to the Alabama Board of Medical Examiners or the Medical Licensure Commission of Alabama). If you answered Yes, a description is required. **Yes** ☐ **No** ☐

IMPORTANT: The Board recognizes that licensees encounter health conditions, including those involving mental health and substance use disorders, just as their patients and other health care providers do. The Board expects its licensees to address their health concerns and ensure patient safety. Options include anonymously self-referring to the Alabama Professionals Health

Program (334) 954-2596, a physician advocacy organization dedicated to improving the health and wellness of medical professionals in a confidential manner. The failure to adequately address a health condition, where the licensee is unable to practice medicine with reasonable skill and safety to patients, can result in the Board taking action against the license to practice medicine.

_____Please initial certifying that you understand and acknowledge your duty as a licensee to address any such condition as stated above.

**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.*

13. Within the past five years, have you been 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? **Yes** ☐ **No** ☐

14. Has your medical education, training or practice been interrupted or suspended, or have you ceased to engage in direct patient care, for a period longer than 60 days for any reason other than a vacation or for the birth or adoption of a child? **Yes** ☐ **No** ☐

Education Information

When entering dates attended in the education sections if you don't know the exact date use the first date of the month. (Example: you attended from August 1990 – July 1994, Enter 08/01/1990 – 07/01/1994)

Pre-Medical Education: List all schools attended, undergraduate work other than medical school, dates attended, and degree conferred.

	Date	Name of School	Degree
1.	From _____ To _____	_____	_____
2.	From _____ To _____	_____	_____
3.	From _____ To _____	_____	_____
4.	From _____ To _____	_____	_____

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

Date	Name of Schools	Degree
1. From _____ To _____	_____	_____
2. From _____ To _____	_____	_____
3. From _____ To _____	_____	_____
4. From _____ To _____	_____	_____

Post-graduate Medical Education Training: List all post-graduate medical education training since graduation from medical school, dates, and complete addresses of institutions. Do not list practice experience.

Date	Facility Name and Address
1. From _____ To _____	_____
2. From _____ To _____	_____
3. From _____ To _____	_____
4. From _____ To _____	_____
5. From _____ To _____	_____

Certification:

1. I hereby certify that I am now or was licensed to practice medicine in the states of _____ _____, that my license to practice medicine in each of the states indicated is now or was on the date of expiration unrestricted and in good standing and that there are no currently pending disciplinary actions or investigations concerning my license in any of the states listed above. I further certify that my license to practice medicine in the states listed above has never been revoked, suspended, placed on probation, or otherwise subject to disciplinary action and that I have not had my hospital medical staff privileges revoked, suspended, curtailed, limited, or surrendered while under investigation.

2. I certify that I am fully retired from the active practice of medicine; however, I wish to volunteer my services as a physician in a free medical clinic located in _____, Alabama, and it is my expectation that I will provide not less than 100 hours of voluntary services for the calendar year _____.

3. I understand and acknowledge that issuance of a certificate of qualification and license to practice medicine under the Retired Senior Volunteer Physician Program requires that I comply with the continuing medical education requirement for physicians as specified in Chapter 14 of the rules of the Alabama Board of Medical Examiners.

Release:

I, _____, certify , that all of the information supplied in the submitted 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 and criminal prosecution to the fullest extent of the law.

I further consent to and 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 I release the Alabama Board of Medical Examiners from all liability for the release of this information. I further consent to and 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 I release this individual or organization from any liability for the release of information.

Attach Photograph
If one was not uploaded

Applicant's [typed] Signature: _____

Date: _____

I understand and agree that by typing my name, I am providing an electronic signature that has the same legal effect as a written signature pursuant to Ala. Code §§ 8-1A-2 and 8-1A-7. I attest that the foregoing information has been provided by me and is true and correct to the best of my knowledge, information and belief.

Under Alabama law, this document is a public record and will be provided upon request.

Print or upload signed affidavit and release, attach color picture if not uploaded, and return original to the Alabama Board of Medical Examiners.

(Letterhead)

CERTIFICATION OF FREE CLINIC

DATE:_____

TO: State Board of Medical Examiners

This is to certify that _____, M.D./D.O. has agreed to perform no fewer than 100 hours of voluntary professional services annually at the _____, located at _____, Alabama, which is an established free medical clinic operating under the provisions of Ala. Code §6-5-660 and provides outpatient medical care to patients unable to pay for it.

(Clinic Name)

I understand and agree that by typing my name, I am providing an electronic signature that has the same legal effect as a written signature pursuant to Ala. Code §§ 8-1A-2 and 8-1A-7. I attest that the foregoing information has been provided by me and is true and correct to the best of my knowledge, information and belief.

_____
Clinic or Facility Administrator

_____
Address

_____

_____
Telephone

_____
Email Address