

ALABAMA BOARD OF MEDICAL EXAMINERS

P.O. Box 946 — Montgomery, AL 36101

(334) 242-4116

**APPLICATION FOR CERTIFICATE OF QUALIFICATION FOR A SPECIAL PURPOSE LICENSE TO PRACTICE
MEDICINE OR OSTEOPATHY**

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

I hereby make application for a certificate of qualification to practice medicine or osteopathy across state lines in the State of Alabama, and submit the following statement concerning my qualifications for a special purpose license

- 1. Name in Full _____
- 2. Principal Practice Address Street/P.O. Box _____ City _____ State _____ Zip _____
- 3. Place of Birth _____ Date of Birth _____ MD _____ DO _____
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.

- 4. List all states where you are licensed to practice medicine or osteopathy. It is required that each state complete one of the verification forms which will be attached to your application.

- | | YES | NO |
|--|-------|-------|
| 5. 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 or disciplined in any manner? | _____ | _____ |
| 6. 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any state or has your application for a certificate of qualification or license to practice medicine or osteopathy been withdrawn under threat of denial? | _____ | _____ |
| 7. Has a disciplinary action been initiated in any state in which you currently hold a license to practice medicine or osteopathy? | _____ | _____ |

IF ANY OF THE ABOVE ANSWERS ARE IN THE AFFIRMATIVE, PLEASE EXPLAIN IN DETAIL ON AN ATTACHED SHEET

DECLARATION FOR CERTIFICATE OF QUALIFICATION FOR SPECIAL PURPOSE LICENSE

In connection with my application for a certificate of qualification for a special purpose license to practice medicine or osteopathy across state lines, I understand and acknowledge that:

- a. A special purpose license only permits the holder to engage in the practice of medicine across state lines on patients located in the State of Alabama but does not authorize the holder to be physically present and engage in the general practice of medicine within the State of Alabama.
- b. It is the affirmative duty of the holder of a special purpose license to report to the Alabama Board of Medical Examiners in writing within fifteen days of the initiation of any disciplinary action against the license to practice medicine or osteopathy of the licensee by any state or territory in which the license is licensed.
- c. By accepting a special purpose license, the licensee agrees to produce patient records or materials as requested by the Board of Medical Examiners or the Medical Licensure Commission and to appear before the Board or the Commission or any of its committees following the receipt of a written notice by the Board or Commission.
- d. The issuance of a special purpose license subjects the licensee to the jurisdiction of the Alabama Board of Medical Examiners and the Medical Licensure Commission of Alabama and the respective statutes and regulations under which they operate, including all matters related to discipline.

- e. Failure to renew a special purpose license according to the renewal schedule shall result in the automatic revocation of the special purpose license. In the event of the automatic revocation of a special purpose license for failure to renew, the licensee must reapply for a new special purpose license.

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. I acknowledge that any false or untrue statement or representation made in this application may result in the revocation of the license 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 _____

Before me the undersigned authority, personally appeared _____, who is known to me and who being first duly sworn states that all of the information in the foregoing application is true and correct to the best of his/her knowledge.

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

Notary Public

My Commission Expires: _____

