



**ALABAMA STATE BOARD OF MEDICAL EXAMINERS
CONTINUING MEDICAL EDUCATION EXEMPTION DUE TO RETIREMENT**

CERTIFICATION

I, the undersigned _____, Alabama medical license number _____, state the following:

1. Effective _____, I am a fully retired physician licensed to practice medicine in the State of Alabama.
2. I do not and will not engage in the practice of medicine in any form, including the treatment of family members and the prescribing, to anyone, of controlled and/or legend drugs.
3. I submit this statement to the Alabama State Board of Medical Examiners for the purpose of claiming an exemption from the minimum continuing medical education requirement mandated by Ala. Code § 34-24-336 (1975) and Admin. R. 540-X-14.
4. I understand that, as a physician with an active license, my status will change from “active” to “active with restriction due to retirement.” This restriction is considered non-disciplinary, is not reportable to the National Practitioner Data Bank, and shall not be published in the Board of Medical Examiners’ Newsletter. I acknowledge that this restriction shall be a matter of public record and available to any person or organization requesting verification of my licensure status.
5. I have voluntarily surrendered my Alabama Controlled Substances Registration Certificate and have attached the original certificate to this application for Waiver.
6. I understand that, should I re-enter the practice of medicine in any form at a subsequent time, I must apply for the removal of waiver status and submit proof that I have satisfied the continuing medical education requirements of Ala. Admin. R. 540-X-14 of the Rules and Regulations of the Board of Medical Examiners. Additionally, I understand that if I apply to remove the waiver status after having been out of clinical practice for longer than two years, I may be subject to the provisions of Ala. Admin. R. 540-X-23 concerning physician reentry into practice, which may require me to complete a reentry plan prior to or concurrently with my return to the active practice of medicine.
7. I understand and agree that, if I currently have an Alabama Professionals Health Program (APHP) Assistance Agreement, and if I later decide to request removal of my waiver status by the Board, I will notify APHP of my request to remove my waiver simultaneously with the submission of my request to the Board.

I swear and affirm that the information set forth in this Certification is true and correct to the best of my knowledge, information and belief.

I acknowledge that providing false information to the Alabama Board of Medical Examiners or Medical Licensure Commission of Alabama could result in disciplinary action.

Date

Signature