Alabama Board of Medical Examiners
PO Box 946
Montgomery AL 36101
848 Washington Avenue – 36104
(334) 242-4116

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, and submit the following statement concerning my age, moral character, preliminary and medical education and practice:

Type in the following:
Name in full (First, Middle, Last, M.D./D.O.)
Alternate name(s) used
Home Address (Street, City, State, Zip)
Email address
Place of birth
Date of birth
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)

Name of Institution
Type of license (check one): Resident Fellow Distinguished Professor Specialty Professor Visiting Professor State Institution

Answer yes or no. If any below answers are in the affirmative, please explain in detail and provide the complete name and address of any state board, hospital, psychiatrist/psychologist, etc.

1.Have you ever been convicted of a felony? (If yes, please provide the name of the court of record or a copy of the record of conviction)
2.Have you ever been convicted of a crime or offense (felony or misdemeanor) related to the practice of medicine? (If yes, please provide the name of the court of record or a copy of the record of conviction)
3.Have you ever been convicted of any violation of a state or federal law relating to controlled substances? (If yes, please provide the name of the court of record or a copy of the record of conviction)
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?
5.Has your certificate of qualification or license to practice medicine in any state 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?
6.Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited, or placed under conditions restricting your practice?
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 a license to practice medicine in any state been withdrawn under threat of denial?
8.Have you ever had a judgment rendered against you or action settled relating to performance of your professional service?
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?
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?
11.Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, or voyeurism?
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 answer "Yes," then a description is required.
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?
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?

Pre-medical education: List all schools attended, undergraduate and post-graduate work (other than medical school), dates attended, and degree conferred.

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

List all activities following medical school excluding the post-graduate medical training provided above

Have you taken and passed a written licensing examination?
You answered yes, please choose: ABMS or AOA board certification exam USMLE COMLEX Other
Date

Release:

I, [name prints here], certify , that all of the information supplied in the foregoing 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 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.

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.

Date_____

Applicant's typed name_____

Attach or upload Photograph

Certification: This is to certify that the aforementioned individual is making application for a limited certificate of qualification at this institution.

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.

Date_____

_____

Type name of Dean-School of Medicine, Director-Residency Training Program, Warden/Medical Director

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

Print application, attach a recent photograph of yourself, have Dean-Medical School, Director-Residency Training Program, or Warden/Medical Director sign, and return original to the Alabama Board of Medical Examiners.