



STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TENNESSEE 37243
www.tn.gov/health

TENNESSEE BOARD OF MEDICAL EXAMINERS

APPLICATION INSTRUCTIONS FOR LICENSURE AS A TEMPORARY INTERNATIONAL MEDICAL SCHOOL GRADUATE

Provided below is a checklist for your personal use and convenience containing all items that must be completed before your application for a Tennessee medical license will be considered.

ALL APPLICATION FEES ARE NON-REFUNDABLE

1. Complete and submit application pages 1 through 6. _____
2. Transcripts sent directly from your Medical School or through FCVS Profile. Transcripts sent in by the applicant will not be accepted. Documentation must be submitted in English. _____
3. Complete and mail Attachment 1 to each institution in the at which you received postgraduate medical training. This form must be notarized or contain the institution's seal. _____
4. Offer of employment letter on employer's letterhead. The letter must include an ACGME accreditation code of an accredited post-graduate training program in place at the facility. _____
5. Submit a clear and recognizable recently taken bust photograph of yourself that shows the full head, face forward from at least the shoulders up. _____
6. Submit proof of citizenship in the United States or Canada or evidence of being lawfully present in the United States. (Notarized copies of birth certificates, naturalization papers, H-1 visas, or current passports are acceptable.) _____
7. Submit two (2) original letters of recommendation from an MD or DO. All letters must be on signatory's letterhead, attest to your good moral character, signed and dated within the last six (6) months. _____
8. Exam scores for any licensing exam taken submitted to the administrative office directly from the exam institution. _____
9. If ECFMG certified, submit ECFMG Certification Status report directly to the Board. _____
10. If applying pursuant to T.C.A. § 63-6-207(g)(1)(C) – Complete and email Attachment 2-Verification of employment for the last five years. Verification must include details of the duties performed. _____
11. Complete and submit along with your application the *Practitioner Profile Questionnaire* which is online at <https://www.tn.gov/content/dam/tn/health/healthprofboards/PH-3585.pdf>. You are required by law update your profile within 30 days of any change as long as you have an active license. Failure to do so may subject you to disciplinary action. _____

12. **Attach to the application and submit a check or money order in U.S. funds in the amount of \$510, made payable to the Tennessee Board of Medical Examiners.**

13. Pursuant to T.C.A. § 63-6-221, physicians who perform Level II office based surgery must so report at the time of initial application, reinstatement, or renewal of a medical license. Level II office based surgery means “level II surgery, as defined by the board of medical examiners in its rules and regulations, that is performed outside of a hospital, an ambulatory surgical treatment center, or other medical facility licensed by the Department of Health.” The Board of Medical Examiners’ rules regarding office based surgery, including definitions of Level II and Level III surgery, can be found at: <https://publications.tnsosfiles.com/rules/0880/0880-02.20220606.pdf>. Please review these rules carefully if you perform level II procedures in your office. Under T.C.A. § 63-6-221, you are further required to report certain “unanticipated events” to the board of medical examiners within mandated time frames of the occurrence.

14. A criminal background check is required. For instructions to obtain a criminal background check, go to <http://tn.gov/health/article/CBC-instructions>

15. All applicants must complete, sign and have notarized the Declaration of Citizenship form and submit the documents required by the Declaration of Citizenship form, The Declaration of Citizenship is available online at <https://www.tn.gov/content/dam/tn/health/healthprofboards/PH-41833.pdf>.

UNDERSTANDING THE APPLICATION PROCESS

1. **All application fees are non-refundable. Accordingly, please familiarize yourself with the laws, rules and requirements for licensure prior to submitting your application.**
2. All documents and fees required to be submitted by you or which must be requested from the appropriate institutions in this application process must be mailed directly to:

**Tennessee Board of Medical Examiners
665 Mainstream Drive
Nashville, TN 37243 (37228 for courier service only)**
3. **Allow fourteen (14) working days** for information mailed to our office to be received and placed in your file. Federal Express or special courier services will not appreciably reduce the processing time. Additionally, if Federal Express or special courier services are used, you will be responsible for the charges incurred. The Board's Administrative Office asks that you please give the Board office every consideration in this matter.
4. If necessary documentation has not been received when your application has been received by the Board office, an initial deficiency letter will be sent to you. The supporting documentation requested in the letter must be received in the Board office ninety (90) days from the date of the initial deficiency letter. **(Files not completed within ninety (90) days may be closed.)**
5. Absent any complicating factors, the average application processing time is eight (8) weeks. Once the application is completed, your file will be reviewed and an initial licensure determination made. You will be notified by letter of the initial determination.
6. If an address change occurs at any time during the application process, you must notify the Board office, in writing, immediately.
7. You have the option to receive all correspondence from the Department of Health electronically. Should you "opt in," you will no longer receive physical mail from this office. Opting in does not discharge your obligation to provide the Department with a current physical address and email address. You are required by statute and rule to notify the Department of an address change within thirty (30) days of any such change.
8. It is strongly recommended that you do not make arrangements to accept employment as a physician in Tennessee until you are granted a license number by the Board of Medical Examiners.
9. All documents which are provided to this office in conjunction with your request for a medical license becomes part of the public record and must be released pursuant to a public records request.

Thank you for your cooperation. We will make every effort to process your application in an efficient manner.



**FOR OFFICIAL USE
ONLY**

**1606-001 \$500.00
1606-006 \$ 10.00**

**ATTACH A
CURRENT FULL-
FACE
PHOTOGRAPH**

**STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH-RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243**

**BOARD OF MEDICAL EXAMINERS
(800) 778-4123, ext. 532-4384 or Local (615) 532-3202, ext. 532-4384**

www.tennessee.gov

APPLICATION FOR LICENSURE AS A TEMPORARY INTERNATIONAL MEDICAL SCHOOL GRADUATE

Please **check** the appropriate qualification category:

- T.C.A. § 63-6-207(g)(1)(B)-Completed a three-year post-graduate training program in the graduate's licensing country.
- T.C.A. § 63-6-207(g)(1)(C)-Practiced as a medical professional performing the duties of a physician for at least 3 of the last 5 years outside of the United States.

PERSONAL INFORMATION

Name as it will appear on license: _____
(First) (Middle) (Last)

Have you been known by any other name? Y N If yes, list names: _____

Date of Birth: Mo. ____ Day ____ Yr. ____ Social Security Number: _____ - _____ - _____

Are you a U.S. Citizen? Y N Gender: M F Race: _____

Are you entitled to Live and Work in U.S.? Y N

Are you a member of the U.S. armed forces who has, within the preceding 180 days, retired from the armed forces, received any discharge other than a dishonorable discharge from the armed forces, or been released from active duty to a reserve component of the armed forces? Y N (If yes, please provide a copy of DD214.)

Are you the spouse of a member of the armed forces who has been transferred by the military to Tennessee or who has, within the preceding 180 days, retired from the armed forces, received a discharge other than a dishonorable discharge from the armed forces or been released from active duty to a reserve component? Y N (If yes, please provide proof of same.)

Present Mailing Address: _____ Home Phone: (____) _____ - _____

Work Phone: (____) _____ - _____

Email address: _____

Do you wish to receive notification, including renewal notification, from the Department of Health via email? Y N
Please note, by opting in, all correspondence from the Department of Health will be delivered to the email address on file for you. You will no longer receive physical mail from our office.

Type of intended primary specialty practice in Tennessee _____

EDUCATIONAL AND EXAMINATION INFORMATION

MEDICAL EDUCATION

I have spent _____ years in the study of medicine in the medical educational institutions below:

From: _____ To: _____
MM/YY MM/YY Educational Institution Location

From: _____ To: _____
MM/YY MM/YY Educational Institution Location

POSTGRADUATE TRAINING

I have spent _____ years in medical training in the medical educational institutions below:

From: _____ To: _____
MM/YY MM/YY Educational Institution Location

From: _____ To: _____
MM/YY MM/YY Educational Institution Location

From: _____ To: _____
MM/YY MM/YY Educational Institution Location

I have taken the following medical licensure examinations: (Check all applicable)

- 1. ___ USMLE
- 2. ___ NBME - Please Note: This exam has not been administered since 1996.
- 3. ___ FLEX examination administered by the State of _____ on _____
(Date(s))
- 4. ___ Licensure by the Medical Council of Canada (LMCC)
- 5. ___ State Board administered by _____ prior to 1972.
(State)
- 6. ___ Other _____

Are you ABMS Board certified? **Y N** If yes, identify board of specialty: _____

Are you certified by another specialty board? **Y N** If yes, Identify: _____

Do you have a DEA Registration? **Y N** If yes, please provide: _____

Do you have an NPI Number? **Y N** If yes, please provide _____

I intend to perform Level II Office Based Surgery which is integral to a planned treatment regimen and not performed on an urgent or emergent basis. **Y N**

If you intend to perform Level III Office Based Surgery, you must apply for and obtain a permit prior to engaging in such practice. You may access the application by visiting: <https://tn.gov/assets/entities/health/attachments/PH-3963.pdf>

PRACTICE AND LICENSURE INFORMATION

YES NO

Are you or have you ever been licensed to practice medicine in Tennessee or another state? _____

Are you or have you ever been licensed in any other profession? _____

List below all states, countries or provinces in which you have ever been or currently are licensed, permitted or certified. Use the back of this page if you need additional space.

STATE	PROFESSION	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Intended practice location in Tennessee:

Name: _____

Address: _____

Please complete your employment history starting with the most current position first. You may use a separate sheet of paper if you need additional space.

<u>DATES</u>		<u>LOCATION</u>		<u>POSITION AND DUTIES</u>
From: _____ MM/YY	To: _____ MM/YY	_____	_____	_____
		(City)	(State)	_____
From: _____ MM/YY	To: _____ MM/YY	_____	_____	_____
		(City)	(State)	_____
From: _____ MM/YY	To: _____ MM/YY	_____	_____	_____
		(City)	(State)	_____
From: _____ MM/YY	To: _____ MM/YY	_____	_____	_____
		(City)	(State)	_____

COMPETENCY INFORMATION

For the purposes of the questions below, the following phrases or words have the following meanings:

1. **“Ability to practice your profession”** is to be construed to include all of the following:
 - a. The cognitive capacity to make appropriate clinical diagnoses, exercise reasoned medical judgments, to learn, and keep abreast of medical developments;
 - b. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
 - c. The physical capability to perform professional tasks and procedures required of your profession, with or without the use of aids or devices, such as corrective lenses or hearing aids.
2. **“Medical Condition”** includes physiological, mental or psychological conditions including, but not limited to: orthopedic, visual, speech and/or hearing impairments, emotional or mental illness, specific learning disabilities, drug addiction, and alcoholism.
3. **“Minor Traffic Offense”** generally means moving and non-moving violations punishable by fines only and does not include offenses such as driving under the influence or while intoxicated or reckless driving.
4. **“Chemical substances”** is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.
5. **“Currently”** does not mean on the day of or even in the weeks or months preceding the completion of the application; rather, it means within the past two years or recently enough so that the use of drugs or alcohol or other medical conditions may have an ongoing impact on one’s functioning as a physician.
6. **“Illegal use of illicit or controlled substances”** means the use of substances obtained illegally (e.g., heroin or cocaine) as well as the use of controlled substances that are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

Please respond to ALL questions. If you answer “YES” to any question, please attach a written explanation. Affirmative response requires final documents or orders from the issuing states, courts and/or agencies.

QUESTIONS:	YES	NO
1. The Board recognizes that licensees may suffer from potentially impairing health conditions, just like their patients, including psychiatric illnesses, physical illnesses which may impact cognition, and substance use disorders. The Board expects its licensees to properly address their health concerns, in order to ensure patient safety. Licensees should seek appropriate medical care and should limit their medical practice, when appropriate. The Board encourages licensees to utilize the services of the Tennessee Medical Foundation, a confidential resource which provides advocacy for licensees who may suffer from potentially impairing illnesses. (www.e-tmf.org) The failure of a licensee to adequately address any health condition which may impair their ability to practice medicine with reasonable skill and safety to patients, may result in the board taking action against the license to practice medicine. I have read and understand this statement.	_____	_____
2. Do you currently have any condition that is causing impairment that affects your ability to practice medicine with reasonable skill and safety in a competent, ethical and professional manner? (You may answer no if you are being appropriately treated and are not impaired.)	_____	_____

**COMPETENCY INFORMATION
CONTINUED**

		YES	NO
3.	Do you currently use any medications or substances (legal, OTC, prescribed or illicit) which in any way impairs or limits your ability to practice medicine with reasonable skill and safety in a competent, ethical and professional manner?	_____	_____
	If so, please list: _____		
4.	During the past two years, did you engage in any activity involving substances, either alcohol or controlled/illicit drugs, that impaired or limited your ability to practice medicine with reasonable skill and safety in a competent, ethical and professional manner? You may answer "NO" if you are being appropriately treated and are not impaired).	_____	_____
	It should be noted, however, that if such activity is not revealed, but manifests at some later time in your career, the Board, in its role as the protector of the health, safety and welfare of people in the State of Tennessee, will be able to pursue a disciplinary action on your license.		
5.	Have you ever been diagnosed as having or have you ever been treated for a paraphilia or other type disease of a predatory nature such as, but not limited to pedophilia, exhibitionism, voyeurism, etc.	_____	_____
6.	Have you ever held or applied for a license or certificate in any state, country, or province, in any health care profession, that has been or was ever denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	_____	_____
7.	Have you ever had staff privileges at any hospital or health care facility that were ever revoked, suspended, curtailed, restricted, limited, otherwise disciplined, or voluntarily surrendered under threat of restriction or disciplinary action?	_____	_____
8.	Have you ever applied for or held a state or federal controlled substance certificate that was ever denied, revoked, suspended, restricted, voluntarily surrendered or otherwise disciplined or surrendered under threat of restriction or disciplinary action?	_____	_____
9.	Have you ever been convicted (including a nolo contendere plea or guilty plea) of a felony or misdemeanor (other than a minor traffic offense) whether or not sentence was imposed or suspended?	_____	_____
10.	Have you ever been rejected or censured by a medical society?	_____	_____
11.	In relation to the performance of your professional services in any profession:		
	a. Have you ever had a final judgment rendered against you;	_____	_____
	b. Have you ever entered into any settlement of any legal action; or	_____	_____
	c. Are there any legal actions pending against you or to which you are a party?	_____	_____
12.	Are you currently under investigation by a licensing board?	_____	_____
13.	My name has been placed on the registry of persons who have abused, neglected or misappropriated the property of vulnerable individuals (Tennessee abuse registry or an abuse registry in another state).	_____	_____

ATTACHMENT 1

TENNESSEE BOARD OF MEDICAL EXAMINERS
(800) 778-4123, ext. 532-4384 or (615) 532-3202, ext. 532-4384

VERIFICATION OF POSTGRADUATE MEDICAL TRAINING

APPLICANT: Provide the information requested in the top box and then mail this form to each institution in which you received any postgraduate medical training. If additional forms are required, copy this one.

Institution Administration: I am applying for a Tennessee medical license and hereby authorize you to release any and all information in your files concerning my medical training. I was in training at your institution as follows:

Applicant's name: _____
(Last) (First) (Middle/Maiden)

Name of Institution: _____ **Program Title:** _____

Applicant's Signature

Dates of Training

THIS PORTION IS TO BE COMPLETED BY THE TRAINING PROGRAM'S ADMINISTRATIVE OFFICE

Please complete (including questions) and return to: medical.health@tn.gov

CIRCLE ONE

1. Was the above program accredited at the time the applicant attended training? Yes No
2. If yes, please provide the accrediting body: _____
3. Were there any adverse charges or actions taken during the residency? Yes No
**If yes, please attach supporting information and/or documentation.*
4. The applicant has successfully completed _____ months of the program.
(# of Months)

I certify that the information on this form is true and correct.

Program Director's/Dean's Signature

Date

Subscribed and sworn before me this the ____ day of _____, _____.

Notary Public

(Affix Seal Here)

My Commission Expires: _____

ATTACHMENT 2

TENNESSEE BOARD OF MEDICAL EXAMINERS

Employment Verification

APPLICANT: Complete the top portion and submit this form to all hospitals or clinics you have practiced in the last five years.

Applicant's name: _____ (Last) (First) (Middle/Maiden)
Applicant's Date of Birth: _____
Applicant's Signature: _____

Employer/Hospital: Complete and send the form directly to the Tennessee Board of Medical Examiners by email to medical.health@tn.gov

It is hereby certified that _____
(Name of Applicant)

is/was employed at _____
(Name of Hospital/Clinic)

located at _____
(Address of Facility)

From _____ **To** _____
(Month/Day/Year) (Month/Day/Year)

Description of duties performed _____

Would you recommend the applicant for licensure? Yes _____ **No** _____

To be completed by Employer/Authorized Representative of Employer Print Name: _____ Signature: _____ Date _____ Email: _____	Institutional Seal
---	---------------------------

If seal is unavailable, form must be notarized.