



ALASKA STATE MEDICAL BOARD

Department of Commerce, Community, and Economic Development
Division of Corporations, Business, and Professional Licensing
(333 Willoughby Avenue - Ninth Floor)
Post Office Box 110806, Juneau Alaska 99811-0806
A – K: 907/465-2756 L – Z : 907/465-2541
E-Mail: license@commerce.state.ak.us

APPLICATION FOR A LICENSE TO PRACTICE MOBILE INTENSIVE CARE PARAMEDIC

This packet contains all the documents you will need to apply for a permanent license to practice as a mobile intensive care paramedic in Alaska.

Please read all instructions and information carefully and complete all documents as requested. Please note the following:

- **Average processing time for a permanent license is from four to six weeks.**
Start the process far enough in advance to allow this process to occur. Applications are reviewed in order of receipt in our office. If there are items in the application about which the board requires additional information, or if there is any adverse or derogatory information that comes to light, the review process may take longer.
- Appropriate fees must accompany applications before initial screening can begin.
- An incomplete application or any unusual circumstances noted in the application may require additional processing time.
- While we understand your desire to conclude this process as quickly as possible, our licensing staff is responsible for reviewing many files and cannot complete the application process if required documents are missing. It is your responsibility to insure those documents are received by our office.
- The application review process is defined by the requirements set forth in state law. The board and its staff must comply with those laws in processing applications.
- The Alaska State Medical Board conducts a thorough evaluation of education, training, employment or work history, malpractice history, and any criminal or disciplinary history. We recommend you do not make commitments for loans, practice start dates, home purchases, etc., based on the expectation of licensure. The board will not accelerate one application over others nor will it forego any elements of its screening process.

PLEASE DO NOT MOVE TO ALASKA WITHOUT A LICENSE OR PERMIT IN HAND.

Please contact our offices or visit our website for forms or additional information.

907/269-8163 – Anchorage

907/465-2756 or 907/465-2541 – Juneau

www.commerce.state.ak.us/occ/pmed.htm

**ALASKA STATE MEDICAL BOARD
APPLICATION FOR LICENSE
MOBILE INTENSIVE CARE PARAMEDIC
IMPORTANT INFORMATION – PLEASE READ CAREFULLY**

APPLICATION REQUIREMENTS FOR LICENSURE

1. Must be at least 19 years of age or older
2. Must be a high school graduate
3. Complete Application (form 08-4004)
With Notary Seal and Passport type Photograph
4. Authorization for Release of Records
5. Paramedic Training Certificate, certified true copy
(may substitute an original letter from the program director)
6. National Registry Examination Score Report, certified true copy
(may use a certified true copy of the wall certificate or wallet card)
7. Verification of Paramedic Internship Training*
8. Physician Sponsor Statement of Responsibility

If you are licensed in another state, you will need the following:

9. Past Physician Sponsor's Declaration of Competence
10. Verification of Licensure from all states and provinces where applicant
has even been licensed

* Not required if currently licensed in another state.

It is your responsibility to submit the proper forms to the appropriate other agencies and to pay any fees required by those agencies.

GENERAL INFORMATION

ADDRESS OF RECORD

The application asks for your preferred address of record. This is the address to which you would like us to send all communications to you including your permit or license. Please do not use third party addresses, telephone numbers, or email addresses as this creates difficulties when we are trying to reach you.

APPLICATION STATUS UPDATES

Our licensing examiner will send you a written status update upon the initial screening of the application and every 30 days thereafter.

CERTIFIED TRUE COPIES

To obtain a certified true copy, take the original document to a notary public so he/she may compare the original to the photocopy of the document. **The notary must write "I certify this to be a true copy of the original document." on the photocopy and attest to the fact by signing and notarizing the document.**

COMPLETION OF THE APPLICATION FORMS

Help us do a good job processing your application: type or print legibly all application documents. Please read the instructions and give careful thought before answering the questions in the application - remember - you are certifying that the information is truthful and correct. Make sure all notary seals are properly affixed on the application and all documentation has been properly certified as required. Provide all documents requested in the application; incomplete applications will delay processing.

Each question in the application must be answered. Attach separate sheets of paper, labeled with your name and signed by you, for any question for which you have provided a YES response.

Failure to answer all questions completely and accurately, or the omission or falsification of information may be cause for denial of your application or disciplinary action if you are subsequently permitted by the board. WHEN IN DOUBT, DISCLOSE ALL INFORMATION OR CALL OUR OFFICE.

CONFIDENTIALITY

The contents of licensing files are generally considered public records. If you believe that the additional information you are attaching to explain a "yes" answer should be considered confidential, state that in the attachment. A request for confidentiality may or may not be granted.

CONTINUING MEDICAL EDUCATION REQUIREMENT

Alaska law requires an average of 60 hours of continuing medical education hours for each year of the licensing period (two-year licensing cycle). At the time of renewal, the licensee must attest to compliance with the CME requirements. After renewal is completed, the division will perform a computer-generated random audit of licensees who will be required to provide proof of CME courses. Please see regulations 12 AAC 40.350.

DENIAL OF LICENSE

The denial of an application for licensure may be reported to any person, professional licensing board, federal, state, or local government agency, or other entity making a relevant inquiry or as may be required by law.

EXAMINATION INFORMATION

Examinations for certification for the Mobile Intensive Care Paramedic are coordinated by:
Southern Region Emergency Medical Services Council, Inc.
6130 Tuttle Place
Anchorage AK 99507
907/562-6449

FAX DOCUMENTS

Fax copies of documents are **NOT** accepted for documentation or verification in our licensing process.

FEES

Fees for a permanent paramedic application are:	\$100	Nonrefundable Application Fee
	\$100	License Fee
	\$ 50	Temporary or Provisional Permit Fee

All applications must be accompanied by the appropriate fee. Personal checks, cashier's checks, or money orders must be made payable to the State of Alaska. Incorrect fees will delay processing of your application.

LICENSING PROCESS

Submit your complete application to the board with fees and pertinent documents. The licensing examiner assembles the documents for your file and advises the applicant of the application status.

Upon the completion of the application file when all documents have been received from other organizations, the file is forwarded to the board's administrator who reviews the entire file. At the discretion of the administrator, a temporary permit may be issued (see information under Temporary Permit on page 5).

The complete application file is presented to the board at its next meeting. The board meets four times each year. Following the board's review and approval, the licensing examiner will issue the permanent license.

Applications will be processed in the order in which they are received in the board's office. Please insure that you apply well in advance of your need for the permit or license. Board staff will not expedite one application before another.

LICENSE APPLICATION PROCESSING STAFF

If your last name begins with the letters A through K, you may contact your licensing examiner at 907/465-2756.

If your last name begins with the letters L through Z, you may contact your licensing examiner at 907/465-2541.

LICENSE RENEWAL

All medical board licenses in Alaska are on a two-year cycle, with all licenses expiring December 31 of even-numbered years. Notification for license renewal is mailed out to license holders of record at least 30 days prior to expiration, usually in late October. You are required by law to keep your current address on file with the division (12 AAC 02.900).

Failure to receive a renewal notice is not considered an excuse for nonrenewal. A physician not intending to practice medicine in Alaska may renew their license in an inactive status. If you practice in the state occasionally, you must renew your license in active status. An inactive status license prohibits you from practicing; however, if you wish to reactivate your inactive license, contact the licensing examiner for instructions.

It is illegal to practice medicine in Alaska with an inactive or lapsed license or permit.

PAYMENT OF CHILD SUPPORT AND STUDENT LOANS

If the Alaska Commission on Postsecondary Education has determined you are in loan default or if the Alaska Child Support Enforcement Division has determined you are in arrears on child support, you will be issued a nonrenewable temporary license valid for 150 days. Contact Postsecondary Education at 1-800-441-2962 or (907) 465-2962 or Child Support Services at (907) 269-6657 if your last name begins with A – M; Contact (907) 269-6845 if your last name begins with N – Z; or 1-800-478-3300 to resolve payment issues.

PERSONAL INTERVIEWS

Applicants for medical licensure in Alaska may be required to have a personal interview either with an individual board member or with the full board. Should an interview be required, you will be notified and an interview scheduled. An interview may be required if, during the processing of your application, a question arises for which the board determines it requires additional information from you.

PROCESSING TIME

In general, average processing time for a permanent license is four to six weeks. PLEASE PLAN ACCORDINGLY. Application processing time depends to a large extent on the response time from other organizations and individuals. Time required also depends upon our workload and the volume of applications being processed. Because the length of processing time for your application may vary considerably, we urge you to be patient until our processing is complete and the permit is issued.

If there are any “Yes” responses or if adverse information is received, it will typically take longer to gather and evaluate additional data. If the application is referred to the Investigations Unit for investigation of a particular issue, processing time is extended by the time required to complete an investigation. Since investigations must be prioritized, it may take longer to complete the file.

PROVISIONAL LICENSE

A provisional license will, in the board’s discretion, be issued to an individual who has met all the requirements of 12 AAC 40.310 except for passing the National Registry/EMT examination. The applicant shall submit written verification from the National Registry of Emergency Medical Technicians that he or she is awaiting examination results or is scheduled to take the next examination.

A provisional license is valid until the first meeting of the board after the results of the exam have been issued or until the physician sponsor withdraws sponsorship, or until the board is notified that the applicant has failed the examination, which ever occurs first. A provisional license is not renewable.

SOCIAL SECURITY REQUIREMENT

Alaska Statute 08.01.060(b) requires an applicant for an occupational license to provide a United States social security number. Applicants who are foreign citizens and are unable to obtain a social security number must contact the division office for instructions. Social security numbers are required by federal law to be held confidential; we do not release these numbers to the public.

STALE DOCUMENTS

If during the license application process certain documents become older than six months from the date the document was received in our office, that document is considered to be stale and must be resubmitted. Affected documents include the application and verifications of licensure from other licensing jurisdictions.

TELEPHONE QUERIES

We have a very small staff and work hard to process applications as quickly as possible. Unnecessary telephone calls to our offices delay processing. If the licensing examiner must spend time answering numerous telephone queries, application processing time is affected. Because of the huge volume of telephone calls regarding the status of applications and because of privacy issues, **we must restrict our telephone responses to the applicant only.** We will not discuss your application with others. If you are concerned about your application being received in our office, mail it "certified – return receipt requested." You will have a verification of delivery returned to you by the post office.

TEMPORARY PERMIT

After your application for a permanent license is complete, it is forwarded to the board's executive administrator. Following her review, she may authorize the issuance of a temporary permit. Since the board only meets four times each year, the temporary permit is a courtesy to you to allow you to practice until the next board meeting when your file will be considered. The permit will be mailed to you at the address you specify in your application. Should a personal interview be required, the temporary permit may be issued at the conclusion of the interview.

WEBSITE ADDRESS

The Division of Corporations, Business, and Professional Licensing maintains a website with general information about the board or to check to see if your license or permit has been issued: www.commerce.state.ak.us/occ/pmed.htm.

WITHDRAWAL OF APPLICATIONS

The board permits the withdrawal of an application that it has not yet considered at a board meeting. Should you wish to withdraw your application, please submit a request for withdrawal in writing stating the reason for the withdrawal. Such request must be received before the first time the board reviews and considers the application.

"YES" RESPONSES

A "Yes" response in the application does not mean your application will be denied. If you have responded "Yes" to any question in the application, additional time will be required for the gathering and assessment of pertinent information. **You can expedite this process by providing complete explanations attached to your application for any "Yes" responses.**

HOW CAN YOU HELP?

1. First and foremost: apply far enough in advance to allow for application processing.
2. If you are concerned about your application being received in our office, mail it Certified - Return Receipt.
3. If you wish to expedite processing as much as you can, send all your verification request forms out via overnight mail and include a return overnight mail envelope addressed to the licensing examiner for the organization's use. This will help them to respond quickly.
4. Insure the application is complete when you submit it and provide any necessary explanations with the application. Print legibly or type your application.
5. Provide complete explanations for any "Yes" responses; it saves time if we don't have to request such information.

Please – do not sell your house and move to Alaska until you have a permit or license in hand.

QUESTIONS?

CALL

A – K: 907/465-2756

L – Z : 907/465-2541



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MED

For Office Use Only	
Receipt No.	Amount

APPLICATION FOR LICENSE – MOBILE INTENSIVE CARE PARAMEDIC

Nonrefundable Application Fee \$ 100
License Fee \$ 100
Temporary/Provisional Permit \$ 50

IDENTIFICATION (Please type or print legibly.)

Name (Last, Maiden) _____ First, _____ Middle, _____	Date of Birth MM / DD / YR
Address of Record	Gender <input type="checkbox"/> M <input type="checkbox"/> F
City, State, Zip	Email Address
Telephones Work: _____ Home: _____	Provisional Permit: <input type="checkbox"/> Yes <input type="checkbox"/> No Temporary Permit: <input type="checkbox"/> Yes <input type="checkbox"/> No

EDUCATION

High School	Yrs Attended	Year Graduated
College	Yrs Attended	Year Graduated
Paramedic Training Program	Yrs Attended	Year Graduated
Address – Paramedic Training Program		Telephone
City, State, Zip		

PHYSICIAN SPONSOR

Name	Alaska License No.
Address	Work Phone:
City, State, Zip	Email Address:

PREVIOUS LICENSE HISTORY – List all state, territories, or provinces of Canada in which you have EVER been licensed as a paramedic or any other health care provider.

State	Status	Expiration Date	State	Status	Expiration Date

APPLICANT: As required by state law, please provide your United States Social Security Number in the space below. It is considered **CONFIDENTIAL** information and is not for public disclosure.

Applicant's Social Security Number _____

PROFESSIONAL ACTIVITIES

Work History

Please provide a chronological listing of all medical and non-medical activities beginning with your graduation from high school, or college if appropriate, to the present date with no more than a 60-day gap in time. You may attach a detailed curriculum vitae as long as all information is included. **Please explain any gap in time from practice of more than sixty (60) days' duration.**

	Date (MM/YYYY)	Location (City, State, or Other Country)	Activity
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If necessary, continue to list on a separate sheet of paper labeled with your name and signed by you.

Applicant Name:	Date:
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SPECIAL INSTRUCTIONS FOR DISCIPLINARY HISTORY AND PERSONAL HISTORY

In responding to the questions in the Disciplinary History and Personal History portions of the application below, please check the appropriate box next to each question. A "Yes" response to a question does not automatically result in a denial of license application. **For each "Yes" response to any question, you must provide a separate, signed statement giving full details including dates, locations, type of action, organizations or parties involved, and specific circumstances.** When in doubt about your response, disclose and provide the explanation requested. Please answer parts A and B of each question.

CONFIDENTIALITY

The contents of licensing files are generally considered public records. If you believe that the additional information you are attaching to explain a "yes" answer should be considered confidential, state that in the attachment. A request for confidentiality may or may not be granted.

DISCIPLINARY HISTORY

**IMPORTANT! PLEASE READ
BEFORE ANSWERING THE DISCIPLINARY HISTORY QUESTIONS
24 through 36**

For the purposes of this application, the word "discipline" is used. There are many forms of disciplinary actions that may be imposed by organizations, schools, programs, licensing authorities, and other agencies. Such disciplinary actions may include but not be limited to: Suspension, Surrender, Revocation, Probation, Academic Probation, Reprimand, Censure, Restricted License, Limited License, Conditioned License, or Letters of Counseling, Concern, Advice, Warning, Caution, Admonishment, Reprimand, etc. Please include non-reported disciplinary actions.

WHEN IN DOUBT, DISCLOSE AND EXPLAIN.

24a. No Yes.Have you ever been convicted of a crime (felony or misdemeanor) in any jurisdiction of the United States, including military, or any international jurisdiction?

24b. No Yes.Is any such action pending?

25a. No Yes.Have you ever been charged with a crime (felony or misdemeanor) in any jurisdiction of the United States, including military, or any international jurisdiction that did not result in acquittal or dismissal?

25b. No Yes.Is any such action pending?

26a. No Yes.Relating to the practice of medicine, has there ever been a finding of, or have you ever been found guilty of, professional misconduct, unprofessional conduct, incompetence, or negligence, by any jurisdiction of the United States, including military, or any international jurisdiction?

26b. No Yes.Is any such action pending?

Applicant Name:

Date:

- 27a. No Yes.Relating to the practice of medicine, have you ever had charges filed against you alleging professional misconduct, unprofessional conduct, incompetence, or negligence, in any jurisdiction of the United States, including military, or any international jurisdiction?
- 27b. No Yes. Is any such action pending?
- 28a. No Yes.Has any hospital or other health care facility disciplined, restricted, or terminated your professional training, employment, or privileges (except for late medical records)?
- 28b. No Yes. Is any such action pending?
- 29a. No Yes.Have you ever voluntarily or involuntarily resigned or withdrawn from professional training, from employment, or your privileges from any hospital or other health care facility to avoid the imposition of disciplinary sanction, restriction, or termination?
- 29b. No Yes.Is any such action pending?
- 30a. No Yes.Have you ever had a paramedic/EMT license to practice medicine disciplined by any authority including a state medical board or a military authority?
- 30b. No Yes.Is any such action pending?
- 31a. No Yes.Have you ever been under investigation by any medical licensing jurisdiction or authority?
- 31b. No Yes.Is any such action pending?
- 32a. No Yes.Have you ever had a paramedic/EMT license application denied by any medical licensing jurisdiction or authority?
- 32b. No Yes. Is any such action pending?
- 33a. No Yes.Have you ever voluntarily or involuntarily withdrawn an application for a paramedic/EMT license in any jurisdiction?
- 33b. No Yes.Is any such action pending?
- 34a. No Yes.Have you ever voluntarily or involuntarily surrendered or suspended your paramedic/EMT license to practice medicine in any United States jurisdiction or any international jurisdiction?
- 34b. No Yes.Is any such action pending?
- 35a. No Yes.Have you ever voluntarily or involuntarily agreed to any limitations, restrictions, or conditions to your paramedic/EMT license to practice medicine?
- 35b. No Yes.Is any such action pending?

Applicant Name:	Date:
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- 36a No Yes.Has your employment by a clinic, hospital, or other health care organization ever been terminated involuntarily or voluntarily as a result of an actual or potential investigation or as grounds for disciplinary proceedings?
- 36b No Yes. Is any such action pending?

PLEASE READ THESE QUESTIONS CAREFULLY BEFORE YOU RESPOND.

If you respond 'yes' to any question, please attach a complete explanation to your application. If you are in doubt about your response to a question, please call our office to discuss.

WHEN IN DOUBT, DISCLOSE AND EXPLAIN.

PERSONAL HISTORY

Please refer to Special Instructions on page 6 before answering the questions below. For the purposes of the questions in this section, the following words or phrases are defined:

“Ability to Practice Medicine”

Includes, but is not limited to, the cognitive capacity to make appropriate clinical diagnoses and exercise reasonable medical judgments and to learn and keep abreast of medical developments; 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 the physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

“Medical Condition”

Includes physiological, mental, or psychological conditions or disorders, such as, but not limited to, orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

“Chemical Substance(s)”

Any natural or synthetic chemical substance, alcohol, drugs, or medications, including those chemical substances taken pursuant to a valid prescription for legitimate medical purpose and in accordance with the direction(s) of the prescribing physician, as well as those used illegally.

“Controlled Substances”

Means any substance as defined in either Alaska Statute 11.71.900 or the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C.A. Section 801 et seq. (Public Law 91-513) and any subsequent amendment(s).

“Currently”

Does not mean on the day of, or even in the weeks or months preceding the completion of this application; rather, “currently” means recently enough so that the event, condition, behavior, impairment, limitation, etc., may have an ongoing impact on the applicant’s ability to practice medicine in a competent manner.

“Illegal Drug Use”

Means the use of an illegally obtained controlled substance or dangerous drug; the term “illegal drug use” also means the use of a legally obtained controlled substance or dangerous drug which is not taken in accordance with the directions of the licensed physician who prescribed the controlled substance or dangerous drug.

37. No Yes.Has your ability to practice medicine in a competent and safe manner ever been impaired or limited by any condition, behavior, impairment, or limitation of a physical, mental, or emotional nature?
38. No Yes.Are you currently experiencing any medical condition or disorder that impairs your judgment or that otherwise affects your ability to practice medicine in a safe and competent manner?

Applicant Name:	Date:
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39. No Yes. Since completing your postgraduate training, have you ever been physically or mentally unable to practice medicine for a period of sixty (60) days or more?
40. No Yes. Are you currently the subject of any civil investigation or court process relating to your ability to practice in a safe and competent manner?
41. No Yes. Have you ever been diagnosed with, been treated for, or do you currently have voyeurism, pedophilia, exhibitionism, or any other sexual behavior disorder?
(Please note that "sexual behavior disorder" does **not** include sexual preference.)
42. No Yes. Are you currently engaged in the illegal use of any drug, whether by ingestion, injection, inhalation, or any other method?
43. No Yes. Have you used or are you currently using any chemical substance(s), legal or illegal, that in any way impaired or limited, or is currently impairing or limiting, your ability to practice medicine in a safe and competent manner?
44. No Yes. Have you ever been voluntarily or involuntarily committed or confined to any facility for mental health care?
45. No Yes. Have you ever been diagnosed with, treated for, or do you currently have (check the appropriate condition):
- | | | |
|--|--|--------------------------------------|
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Depressive Neurosis | <input type="checkbox"/> Kleptomania |
| <input type="checkbox"/> Hypomania | <input type="checkbox"/> Any Dissociative Disorder | <input type="checkbox"/> Pyromania |
| <input type="checkbox"/> Schizophrenia | <input type="checkbox"/> Any Psychotic Disorder | <input type="checkbox"/> Delirium |
| <input type="checkbox"/> Major Depression | <input type="checkbox"/> Any Organic Mental Disorder | <input type="checkbox"/> Paranoia |
| <input type="checkbox"/> Seasonal Affective Disorder | | |
46. No Yes. Have you ever taken, or are you currently taking, any controlled substance for any of the disorders listed in question 46 above?
If you responded 'Yes' to question 46, on a separate sheet of paper signed and dated by you, please list all medications you are taking, the dosage, frequency, and who is prescribing the medications for you.
47. No Yes. Have you ever been adjudicated or declared incompetent or been the subject of an incompetency proceeding?

This concludes the questions portion of the application.

Applicant Name:	Date:
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SWORN STATEMENT

I hereby certify that I am the person herein named subscribing to this application. I have read the complete application, and I know the full content thereof.

I declare, under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct.

I am the lawful holder of the designation of Mobile Intensive Care Paramedic as prescribed by this application, and that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted were procured without fraud or misrepresentation or any mistake of which I am aware and that I am the lawful holder thereof.

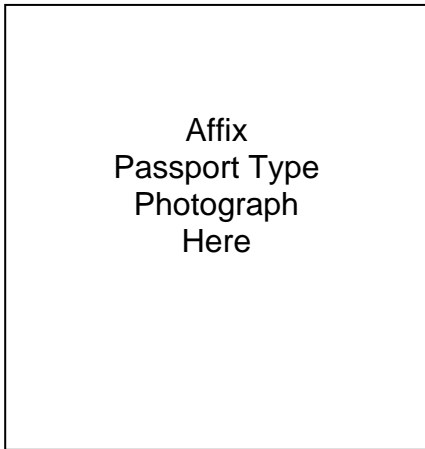
I further certify that the photograph that appears below is a true likeness of myself taken within the past 60 days.

I understand that any falsification or misrepresentation of any item or response in this application, or any attachment hereto or falsification or misrepresentation of credentials to support this application, is sufficient grounds for denying, revoking, or otherwise disciplining a license or permit to practice medicine in the state of Alaska.

I carefully read all the instructions in the application including the instructions under Disciplinary History on page 3 and Personal History on page 5. Yes

Applicant Signature _____ Date _____

The applicant signature date and the notary public date must be the same.



SUBSCRIBED AND SWORN TO before me, a Notary Public,
in and for the State of _____.

this _____ day of _____, _____.

Notary Signature _____

My commission expires: _____

NOTE: Notary Seal Must Overlie A Portion of the Photograph.

WARNING: Alaska Statute 11.56.210 states that any person who knowingly or intentionally furnishes false or fraudulent information in this application is subject to imprisonment for not more than one year, a fine of not more than \$5,000, or both.



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MICP

For Office Use Only

AUTHORIZATION FOR RELEASE OF RECORDS

TO WHOM IT MAY CONCERN:

I, _____, residing at
(Please print full name)

_____, hereby authorize the Alaska
(Please print full address)

Division of Corporations, Business, and Professional Licensing and its investigators to examine my medical and dental records, employment and education records including all training which pertains to my medical practice, and any records pertaining to litigation, judgments, suits, and/or settlements, and any law enforcement records pertaining to me and discuss them with persons having possession of them. I also expressly permit and authorize the release of any and all such records pertaining to me to the Alaska Division of Corporations, Business, and Professional Licensing and its investigators. This release also applies to all records that pertain to credentialing records at facilities at which I have applied for or held privileges to practice medicine.

I authorize the Division to discuss my records with persons or organizations that are considered appropriate by the Division in connection with an official investigation, and to provide copies of my records to those persons or organizations deemed appropriate by the Division.

This release also applies to any documents or records which contain information pertaining to psychiatric, psychological, drug, or alcohol evaluation, counseling, diagnosis or treatment received by me and which were prepared or made in conjunction with, or under the authority or guidance of any local, state, or federal law which relates to psychiatric, drug or alcohol evaluation, diagnosis or treatment, including all information previously identified, collected, or stored under the authority of any state or federal law, including 42 CFR Part 2.

I request that upon presentation of this release, or a Certified True Copy thereof, that you provide copies of those records to the Division and/or its investigators, and/or representatives of the Office of the Attorney General of the State of Alaska.

This authorization expires one (1) year from the date of my signature below.

Signature of Applicant

Date

Home Phone Number

Work Phone Number



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E-mail: license@commerce.state.ak.us

MICP

For Office Use Only

VERIFICATION OF PARAMEDIC INTERNSHIP TRAINING

Instructions to Applicant: Type or print legibly. This form is required to verify that you have completed a minimum of 480 hours of field internship training required by regulation. Mail this form to the appropriate physician for completion of the verification. PLEASE NOTE: . If you are already licensed in another jurisdiction, this document is not required. *Applicable Regulations on Back of Form*

Applicant Name _____

Address _____

Signature _____

City, State, Zip _____

Date _____

Doctor: Please complete and return this verification directly to the Alaska State Medical Board at the letterhead address. All information requested below must be provided – if any space is left blank, the document will be returned to you for completion.

I verify that I was the supervising physician for the paramedic named above during his/her paramedic internship located in:

(Location of Training)

From _____ To _____
(Dates of Training)

I certify that the paramedic named above successfully completed a 480-hour field internship in which all procedures performed by the intern were under my direct supervision, or the supervision of another physician, physician assistant, registered nurse, or mobile intensive care paramedic license or certified in the state in which the internship occurred and who had been designated the responsibility of supervision by me.

I certify that the above named paramedic has been trained to and is capable of performing the following tasks:

- 1 – electrocardiographic monitoring and defibrillation;
- 2 – initiating and maintaining intravenous routes using approved intravenous techniques and solution;
- 3 – performing endotracheal intubation and pulmonary ventilation by approved methods;
- 4 – performing gastric suction by intubation;
- 5 – obtaining blood for laboratory analysis;
- 6 – administering parenterally, orally, or topically and approved agents of solutions;
- 7 – use of pneumatic anti-shock devices;
- 8 – other emergency procedures listed below which I authorized as sponsoring physician:

Signature, Supervising Physician

NOTARY:

Printed Name

SUBSCRIBED AND SWORN before me, a Notary Public, in and for the state of _____

Physician License:
State _____ License Number _____

this _____ day of _____, 20____.

Mailing Address :

Notary Public
My commission expires: _____

Street/PO Box

City _____ State _____ Zip _____

(Notary Seal)

12 AAC 40.310. QUALIFICATIONS FOR INITIAL LICENSE. (a) An applicant for a mobile intensive care paramedic license must

- (1) be 19 years of age or older;
 - (2) be a high school graduate;
 - (3) provide a letter from the applicant's physician sponsor verifying that the applicant will, at all times, be under the supervision of a physician sponsor approved by the board, as required by 12 AAC 40.315;
 - (4) submit a certified copy of the applicant's paramedic education program certificate or an original letter, signed by the education program director and sent directly to the division from the program director, verifying completion of a training program that meets the requirements of 12 AAC 40.320;
 - (5) following the successful completion of the classroom and clinical portions of the board approved curriculum, have satisfactorily completed a 480-hour internship that meets the requirements of 12 AAC 40.325;
 - (6) pass the written and practical examination for emergency medical technician-paramedic administered by the National Registry of Emergency Medical Technicians; and
 - (7) submit verification of licensure from the appropriate licensing authority in each state, territory, or province where the applicant holds or has ever held a license as a paramedic or other health care professional; and
 - (8) submit the applicable fees established in 12 AAC 02.250.
- (b) An applicant for licensure as a mobile intensive care paramedic who is currently licensed in another state must fulfill the requirements of (a)(1) – (4) and (6) – (8) of this section and
- (1) may not be currently under suspension or revocation as a mobile intensive care paramedic, or emergency medical technician-paramedic, or the equivalent, and may not be the subject of an unresolved investigation, complaint review procedure, or disciplinary proceeding undertaken by a certifying or licensing agency in another state; and
 - (2) must submit written verification from the applicant's previous physician sponsor, on a form approved by the department, attesting that the applicant is capable of performing the activities listed in 12 AAC 40.370(a) plus any other specific emergency procedures authorized by the physician sponsor.
 - (c) The board will, in its discretion, require an applicant to provide additional documentation necessary to verify the applicant's education or experience.

Authority: AS 08.64.100 AS 08.64.107 AS 08.64.240

12 AAC 40.325. INTERNSHIP REQUIREMENTS. An internship for a mobile intensive care paramedic must meet the following requirements:

- (1) all procedures performed by an intern must be under the direct supervision of a physician sponsor or another physician, physician assistant, registered nurse, or mobile intensive care paramedic, licensed or certified in the state where the internship takes place, who has been designated the responsibility of supervision by the physician sponsor;
- (2) the successful completion of the internship must be verified, on a form approved by the board, by the physician sponsor, attesting that the mobile intensive care paramedic intern is capable of performing the activities listed in 12 AAC 40.370(a) including any other specific emergency procedures authorized by the physician sponsor under 12 AAC 40.370(a)(8); and
- (3) verification from the supervising physician of the successful completion of 20 twenty-four hour shifts, or the equivalent number of hours, completed at a location approved in advance by the board.

Authority: AS 08.64.100 AS 08.64.107

12 AAC 40.370. SCOPE OF AUTHORIZED ACTIVITIES. (a) A licensed mobile intensive care paramedic, when under the supervision of a sponsor physician, may perform the activities listed in this subsection. The direct supervision of an activity may be delegated to another physician when the mobile intensive care paramedic is caring for a patient in a hospital, at the scene of a medical emergency when voice contact is monitored by a physician and direct communication is maintained, or when under the specific written standing order of a physician. The activities are

- (1) electrocardiographic monitoring and defibrillation;
 - (2) initiating and maintaining intravenous routes using approved intravenous techniques and solutions;
 - (3) performing endotracheal intubation and pulmonary ventilation by approved methods;
 - (4) performing gastric suction by intubation;
 - (5) obtaining blood for laboratory analysis;
 - (6) administering parenterally, orally, or topically any approved agents or solutions;
 - (7) use of pneumatic antishock devices; and
 - (8) performing other emergency procedures authorized by a sponsoring physician.
- (b) A person enrolled in a mobile intensive care paramedic training program may perform the activities set out in (a) of this section insofar as:
- (1) the activities are required as part of the training program;
 - (2) the activities that take place in a hospital are supervised by a physician, physician assistant, or nurse; and
 - (3) the activities that take place outside a hospital are supervised by a licensed mobile intensive care paramedic, or a physician sponsor, or the physician sponsor's designee.
- (c) While functioning as an intern in Alaska, a person may not perform the activities listed in (a) of this section for more than 480 hours, or for more than six calendar months, without becoming licensed as a mobile intensive care paramedic by the board.
- (d) The scope of authorized activities for a mobile intensive care paramedic does not include primary patient care, such as dispensing nonemergency medications, performing physical examinations for nonemergency purposes, and treatment of nonemergency medical conditions included in the scope of practice for a physician, physician assistant, or nurse, unless specifically authorized by the board.

Authority: AS 08.64.100 AS 08.64.107



ALASKA STATE MEDICAL BOARD

Department of Commerce, Community, and Economic Development
Division of Corporations, Business, and Professional Licensing
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Post Office Box 110806 Juneau AK 99811-0806
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E-mail: license@commerce.state.ak.us

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PHYSICIAN SPONSOR'S STATEMENT OF SUPERVISION

Instructions to the Applicant: Regulation 12 AAC 40.315 requires that you be under the supervision of a physician sponsor at all times. Please complete the top portion of this form and have your current physician sponsor complete the lower part.

Applicant Name _____

Address _____

City, State, Zip _____

Signature _____

Instructions to the Physician Sponsor: Please complete the lower portion of this form and return it directly to the Alaska State Medical Board at the letterhead address above. All information requested below must be provided. If any space is left blank, the form will be returned to you for completion.

I certify that I will be the supervising physician for the above named mobile intensive care paramedic applicant. I further certify that the individual will, at all times, be under my supervision as required by 12 AAC 40.315. I understand that a change in sponsorship will automatically suspend the paramedic's license to practice until such time as a new physician sponsor is identified and provided to the board.

Signature, Sponsor Physician _____

Alaska License No. _____

Printed Name _____

Date _____

SUBSCRIBED AND SWORN before me, a Notary Public, in and for the State of _____, this _____ day of _____, 20____.

(Notary Seal)

Signature, Notary Public _____

My commission expires: _____

Applicable Regulations on Back of Form

12 AAC 40.315. SPONSORSHIP. (a) A person licensed as a mobile intensive care paramedic shall immediately report to the board, in writing, any change of sponsorship.

(b) When a sponsor withdraws sponsorship of a mobile intensive care paramedic, the paramedic is not authorized to practice until a new physician sponsor is approved by the board.

Authority: AS 08.64.100

AS 08.64.107

12 AAC 40.370. SCOPE OF AUTHORIZED ACTIVITIES. (a) A licensed mobile intensive care paramedic, when under the supervision of a sponsor physician, may perform the activities listed in this subsection. The direct supervision of an activity may be delegated to another physician when the mobile intensive care paramedic is caring for a patient in a hospital, at the scene of a medical emergency when voice contact is monitored by a physician and direct communication is maintained, or when under the specific written standing order of a physician.

The activities are

- (1) electrocardiographic monitoring and defibrillation;
- (2) initiating and maintaining intravenous routes using approved intravenous techniques and solutions;
- (3) performing endotracheal intubation and pulmonary ventilation by approved methods;
- (4) performing gastric suction by intubation;
- (5) obtaining blood for laboratory analysis;
- (6) administering parenterally, orally, or topically any approved agents or solutions;
- (7) use of pneumatic antishock devices; and
- (8) performing other emergency procedures authorized by a sponsoring physician.

(b) A person enrolled in a mobile intensive care paramedic training program may perform the activities set out in (a) of this section insofar as:

- (1) the activities are required as part of the training program;
- (2) the activities that take place in a hospital are supervised by a physician, physician assistant, or nurse; and
- (3) the activities that take place outside a hospital are supervised by a licensed mobile intensive care paramedic, or a physician sponsor, or the physician sponsor's designee.

(c) While functioning as an intern in Alaska, a person may not perform the activities listed in (a) of this section for more than 480 hours, or for more than six calendar months, without becoming licensed as a mobile intensive care paramedic by the board.

(d) The scope of authorized activities for a mobile intensive care paramedic does not include primary patient care, such as dispensing nonemergency medications, performing physical examinations for nonemergency purposes, and treatment of nonemergency medical conditions included in the scope of practice for a physician, physician assistant, or nurse, unless specifically authorized by the board.

Authority: AS 08.64.100

AS 08.64.107



ALASKA STATE MEDICAL BOARD

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VERIFICATION OF STATE LICENSURE, AUTHORIZATION, OR CERTIFICATION

Instructions to the Applicant: Please type or print legibly. This form is required if you have been licensed, certified, or registered in another state. Please complete the top portion of this form and forward it to each jurisdiction in which you currently hold or have ever held a license, authorization, or certification at a paramedic or other health care professional.

Applicant Name _____ Date of Birth: _____

Address _____ License/Certificate No.: _____

City, State, Zip _____

Signature

The information below must be completed by the state licensing board only.

FOLLOWING TO BE COMPLETED BY STATE BOARD OR OTHER LICENSING JURISDICTION ONLY

Instructions to the licensing agency: Please complete the below portion of this form for the paramedic identified above and return this document directly to the Alaska State Medical Board.

LICENSING JURISDICTION		LICENSE NUMBER	
INITIAL ISSUE DATE		EXPIRATION DATE	
NAME OF TRAINING PROGRAM		CURRENT LICENSE STATUS	

- Has this individual ever been the subject of an investigation by a licensing or disciplinary authority in your state or jurisdiction? No Yes
- Is any such investigation pending? No Yes
- Have formal disciplinary proceedings been initiated against this applicant or the applicant's license by a licensing or disciplinary authority in your state or jurisdiction? No Yes
- Is any such action pending? No Yes
- Has this applicant's license ever been suspended, revoked, disciplined, restricted, warned, placed on probation, or in any other manner limited by a licensing or disciplinary authority in your state? No Yes
- To your knowledge, is there any derogatory information regarding this applicant? No Yes

Comments: _____

If any disciplinary action has been taken, please attach a certified true copy of the document and any other pertinent information.

(Board Seal)

Signed by _____

Date _____

Printed Name _____

Title _____

Telephone _____



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PAST PHYSICIAN SPONSOR'S DECLARATION OF COMPETENCE

Instructions to the Applicant: Please type or print legibly. This form is required if you have been licensed, certified, or registered in another state. Please complete the top portion of this form and forward it to a past physician sponsor for completion of the lower part. The past physician sponsor may be a physician with whom you trained during your internship training or a past employer physician sponsor who has worked with you and can attest to your competence. *Applicable Regulations on Back of Form*

Applicant Name _____

Address _____

City, State, Zip _____

Signature

Instructions to the Past Physician Sponsor: Please complete the lower portion of this form and return it directly to the Alaska State Medical Board at the letterhead address above. All information requested below must be provided. If any space is left blank, the form will be returned to you for completion.

I hereby certify that I was a past physician sponsor for the paramedic identified above during the time:

From _____ To _____ at _____
(Location)

I attest that this paramedic has been trained to and is capable of performing the following tasks:

- 1 - electrocardiographic monitoring and defibrillation;
 - 2 - initiating and maintaining intravenous routes using approved intravenous techniques and solution;
 - 3 - performing endotracheal intubation and pulmonary ventilation by approved methods;
 - 4 - performing gastric suction by intubation;
 - 5 - obtaining blood for laboratory analysis;
 - 6 - administering parenterally, orally, or topically and approved agents of solutions;
 - 7 - use of pneumatic anti-shock devices;
 - 8 - other emergency procedures listed below which I authorized as sponsoring physician:
- _____

Signature, Supervising Physician

Printed Name

Physician License:
State _____ License Number _____

Mailing Address :

Street/PO Box

City State Zip

NOTARY:

SUBSCRIBED AND SWORN before me, a Notary Public, in and for the state of _____

this _____ day of _____, 20_____.

Notary Public

My commission expires: _____

(Notary Seal)

12 AAC 40.370. SCOPE OF AUTHORIZED ACTIVITIES. (a) A licensed mobile intensive care paramedic, when under the supervision of a sponsor physician, may perform the activities listed in this subsection. The direct supervision of an activity may be delegated to another physician when the mobile intensive care paramedic is caring for a patient in a hospital, at the scene of a medical emergency when voice contact is monitored by a physician and direct communication is maintained, or when under the specific written standing order of a physician. The activities are

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- (5) obtaining blood for laboratory analysis;
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- (8) performing other emergency procedures authorized by a sponsoring physician.

(b) A person enrolled in a mobile intensive care paramedic training program may perform the activities set out in (a) of this section insofar as:

- (1) the activities are required as part of the training program;
- (2) the activities that take place in a hospital are supervised by a physician, physician assistant, or nurse; and
- (3) the activities that take place outside a hospital are supervised by a licensed mobile intensive care paramedic, or a physician sponsor, or the physician sponsor's designee.

(c) While functioning as an intern in Alaska, a person may not perform the activities listed in (a) of this section for more than 480 hours, or for more than six calendar months, without becoming licensed as a mobile intensive care paramedic by the board.

(d) The scope of authorized activities for a mobile intensive care paramedic does not include primary patient care, such as dispensing nonemergency medications, performing physical examinations for nonemergency purposes, and treatment of nonemergency medical conditions included in the scope of practice for a physician, physician assistant, or nurse, unless specifically authorized by the board.

Authority: AS 08.64.100 AS 08.64.107



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CHANGE or ADDITION OF PARAMEDIC PHYSICIAN SPONSOR

- Change of Sponsor Physician
- Addition of Sponsor Physician

12 AAC 40.315. SPONSORSHIP. (a) A person licensed as a mobile intensive care paramedic shall immediately report to the board, in writing, any change of sponsorship.
 (b) When a sponsor withdraws sponsorship of a mobile intensive care paramedic, the paramedic is not authorized to practice until a new physician sponsor is approved by the board.

Paramedic: Please type or print legibly. Please complete the upper portion of this form and forward to the new physician sponsor who is assuming the role of sponsorship for you.

Paramedic Name	Employer Name
Address	Work Address
City, State, Zip	City, State, Zip
Daytime Phone	Employer's Telephone
License No.	
Scope of Duties: _____	
✓ Paramedic Signature _____	Date _____

PHYSICIAN SPONSOR: As indicated by my signature below, I acknowledge and confirm that I am assuming responsibility as physician sponsor for the paramedic identified above in accordance with 12 AAC 40.315.

✓ _____
Signature, Supervising Physician

Printed Name

License Number

Mailing Address :

Street/PO Box

City State Zip

Daytime Telephone

NOTARY:

SUBSCRIBED AND SWORN before me, a Notary
Public, in and for the state of _____
this _____ day of _____, 20____.

Notary Public
My commission expires: _____

(Notary Seal)