



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 PODIATRIC MEDICINE

This packet contains all the documents you will need to apply for a permanent license to practice podiatric medicine 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 eight to twelve 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 PODIATRIC MEDICINE LICENSE
IMPORTANT INFORMATION – PLEASE READ CAREFULLY**

QUALIFICATIONS FOR LICENSURE

THRESHOLD QUALIFICATIONS FOR LICENSURE

- Successful graduation from a school of podiatry accredited by the Council of Podiatric Medical Education
- Successful completion of post-graduate training in a program accredited by the Council of Podiatric Medical Education to include:
 - One year of internship training in podiatric medicine and
 - One year of podiatric surgical training
- Successful completion of the National Boards examination or the PMLexis examination

CONTENTS OF A COMPLETE APPLICATION BY CREDENTIALS or EXAMINATION INCLUDES:

- | | | |
|----|--|--------------------------|
| 1 | Application (pages), notarized with recent passport-style photograph | <input type="checkbox"/> |
| 2 | Appropriate fees (\$250 non-refundable application fee; \$590 license fee) | <input type="checkbox"/> |
| 3 | Authorization for Release of Records | <input type="checkbox"/> |
| 4 | Appropriate examination scores as required | <input type="checkbox"/> |
| 5 | Podiatric Medicine School Diploma, certified true copy of original document | <input type="checkbox"/> |
| 6 | Postgraduate Training Program Certificates, certified true copies of original documents | <input type="checkbox"/> |
| 7 | Verifications of Licensure from all licensing jurisdictions, both U.S. and International, in which you have ever been licensed as any health care professional | <input type="checkbox"/> |
| 8 | A listing of all hospitals where you have held privileges in the five years preceding your application in Alaska | <input type="checkbox"/> |
| 9 | Verifications of hospital privileges from all hospitals in which you have held privileges in the five years preceding your application in Alaska | <input type="checkbox"/> |
| 10 | Clearance report from the Drug Enforcement Administration | <input type="checkbox"/> |
| 11 | Clearance report from the Federation of Podiatric Medical Boards' Disciplinary Data Bank | <input type="checkbox"/> |
| 12 | Verification of medical school education | <input type="checkbox"/> |
| 13 | Verification(s) of postgraduate training | <input type="checkbox"/> |
| 14 | National Practitioner Data Bank report – requested by our licensing examiner | <input type="checkbox"/> |

It is your responsibility to submit the proper forms to the appropriate boards, hospitals, and 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 FOR LICENSURE BY CREDENTIALS

The Alaska State Medical Board may waive the written examination requirement and license an applicant by credentials if you hold an active license issued after written examination in another state or territory or the United States or province of Canada. Such examination must be equivalent to the National Boards or the PMLexis examination series and have passed those examinations with at least the minimum passing score as defined by regulation.

APPLICATION STATUS UPDATES

Our licensing examiner will send you a written status update upon the initial screening of the application and monthly 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 FOR ASSISTANCE.

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 25 hours of Category I AMA- or AOA-approved continuing 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 40.200, 210, and 220.

DEA CLEARANCE REPORT

You are required to request a clearance report from the Drug Enforcement Administration for your DEA registration. Use the form provided in this packet and send your request to:

Drug Enforcement Administration
400 Second Avenue West
Seattle, WA 98119-4013

DENIAL OF LICENSE

The denial of an application for licensure is a public action and may be reported or disclosed 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 SCORES

Regardless of your application, whether by credentials or examination, Alaska requires that you must pass each component of your examinations with a minimum two-digit score of 75. If you are applying for licensure by examination and fail any component more than once, you will be required to complete a supervised course of study acceptable to the board before permission to retake the step will be given. You must request exam scores be sent to the board from the appropriate organization.

To request scores, complete the form provided in this application packet, include a money order or check payable to NBPME for \$35, and mail it to:

Thomson Prometric-NBPME
2000 Lenox Drive – 3rd Flr
Lawrenceville NJ 08648
Phone: 877/302-8952

FAXED DOCUMENTS

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

FEES

Fees for a permanent physician application are:	\$250	Nonrefundable Application Fee
	\$590	License Fee
	\$840	Total Due

You may remit a minimum of \$145 of the license fee (along with the \$250 nonrefundable application fee) at the time of application so that a temporary permit may be issued; however, the balance of \$445 must be paid before the permanent license is issued. 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.

INITIAL LICENSURE IN SECOND YEAR OF TWO-YEAR CYCLE

If you were initially licensed in the second year of the two-year licensure period, within 12 months of the date of expiration (December 31, even-number years), the applicant will pay the entire license fee. Upon renewal, the applicant will receive a renewal form that pro-rates the licensure fee for the coming licensure period. The applicant will pay one-half of the required license renewal fee at the time of renewal.

If your permanent license was first issued to you after October 1 of the second year of the licensing period, you will pay the initial full license fee; however, your license will be issued showing the expiration date of the next biennial licensing period. (For example, if your initial license was issued October 18, 2002, the expiration date will automatically be entered as December 31, 2004.)

LICENSING PROCESS

Your application is received by the administrative services staff where the fees are received and receipted. The application is then forwarded to the medical board's licensing examiners. During especially busy times like renewal periods, this receipting process may take as long as a week.

Once the licensing examiner receives your application, a file and checklist will be created for you that will track all the documents required to complete the application. The licensing examiner will send you a status letter upon the initial review of the application and monthly thereafter until the file is complete.

When the application is complete and all documents have been received, the file is forwarded to the board's executive administrator who reviews the application 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 scheduled meeting. The board meets four times each year. The board's annual meeting schedule may be obtained from its website.

Following the board's review and approval, the licensing examiner will issue the permanent license.

Applications will be processed in the date order in which they are received. 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 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 60 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 non-renewal. 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

Alaska Statute 25.27.244 requires the Division of Corporations, Business, and Professional Licensing to deny issuance of the professional and occupational licenses of any person reported by the Alaska Child Support Services Division (CSSD) as not in substantial compliance with a child support order.

If this office is notified by the CSSD that you are not in substantial compliance with a child support order, you may be issued a nonrenewable, temporary license valid for 150 days. The 150-day temporary license period is your opportunity to work with CSSD to obtain a release. If you have questions regarding the status of your child support obligation, you may contact CSSD at 1-800-478-3300 or (907) 269-6900 to resolve payment issues. They may also be reached at: dor.cssd.customerservice.anchorage@alaska.gov

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 eight to twelve weeks. PLEASE PLAN ACCORDINGLY. Application processing time depends to a large extent on the response time from other organizations. Time required also depends upon numerous factors out of our control. Because the length of processing time for applications varies considerably, we urge you apply well in advance of your intended practice date. Please 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.

Please do not move to Alaska without a permit in hand.

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, verifications of licensure from other licensing jurisdictions, the DEA clearance report, and the FPMB's Board Action Data Bank report.

STATE BUSINESS LICENSES

Physicians who are employees do not need to obtain an Alaska state business license; physicians who are independent contractors must obtain a state business license. You may obtain a business license by contacting:

Division of Corporations, Business, and Professional Licensing
Business Licensing Section
Post Office Box 110806
Juneau AK 99811-0806
(907) 465-2550

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

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.

WEBSITE ADDRESS

The Division of Corporations, Business, and Professional Licensing maintains a website where you may obtain general information about the board or 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 a request for withdrawal must be received before the first time the board reviews and considers the application. All withdrawals are reported to the Federation of State Medical Boards stating the reason for the withdrawal.

"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 Whenever available use on-line resources to request verification documents such as the AMA Physician Profile.
- 5 Insure the application is complete when you submit it and provide any necessary explanations with the application. Print legibly or type your application.
- 6 Provide complete explanations for any "Yes" responses; it saves time if we don't have to request such information.
- 7 Provide a brief description for any malpractice claims describing what the allegation was, the nature of the case, your level of involvement, and the resolution of the case.

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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For Office Use Only	
Receipt No.	Amount

APPLICATION FOR A LICENSE TO PRACTICE PODIATRIC MEDICINE

Nonrefundable Application Fee \$250
 License Fee +\$590
 Total Due \$840

PART I PERSONAL IDENTIFICATION INFORMATION

(Type or Print Legibly)

1	Full Legal Name (Last, First, Middle)	Last	First	Middle
2	Other Names Used (Incl. Maiden Name)			
3	Legal Name Changes (Provide copy of documents)			
4	Date of Birth	Mo / Day / Year	Place of Birth (City, State/Country):	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
5	Full Practice Address	Mailing Address (Include street address if using post office box)		
		City	State	Zip Code
6	Full Residence Address	Mailing Address (Include street address if using post office box) →		Duration at this address: Yrs: _____ Mos: _____
		City	State	Zip Code
7	Telephones	Work: _____ Area Code/Phone	Home: _____ Area Code/Phone	
8	Preferred Address of Record (See Address of Record information.)	<input type="checkbox"/> Use Practice Address Send my mail to this address.	<input type="checkbox"/> Use Residence Address Send my mail to this address.	
9	E-Mail Address	emergency	Do you wish to be included on an email notification list? <input type="checkbox"/> Yes <input type="checkbox"/> No	
10	Application Based on:	<input type="checkbox"/> Credentials _____ (Upon what state license do you base this application?)		
		<input type="checkbox"/> Examination (Not licensed in other state)		
11	Previous License or Permit In ALASKA?	<input type="checkbox"/> NO <input type="checkbox"/> YES →		If YES, when and what type: Year: _____ <input type="checkbox"/> Resident <input type="checkbox"/> Locum Tenens <input type="checkbox"/> Permanent License

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 _____

12. Military Service

Have you ever been in the armed forces?

Yes

No

If YES, branch of service: _____ Date of commission: _____

Date and Type of Discharge: _____

Locations where you served: _____

PART II EDUCATION

13. Podiatric Medical School Education

List the podiatric medical school(s) you attended and from which you graduated. If you attended more than one school, provide your reason for changing schools on a separate sheet of paper signed and dated by you.

Yr	SCHOOL	MAILING ADDRESS	Completed	
			(MM/YYYY)	Yes/No
1			From	
			To	
2			From	
			To	
3			From	
			To	
4			From	
			To	

14. Postgraduate Training

List internship, residency, or fellowship training programs chronologically. You must have at least one year of surgical post-graduate training.

Yr	HOSPITAL	MAILING ADDRESS	Completed	
			(MM/YYYY)	Yes/No
1			From	
			To	
2			From	
			To	
3			From	
			To	
4			From	
			To	

15. Examination History

Please specify National Boards or PMLexis, or a state written examination.

Exam Series	Location	Date Taken (MM-YYYY)	Result
			<input type="checkbox"/> Pass <input type="checkbox"/> Fail
			<input type="checkbox"/> Pass <input type="checkbox"/> Fail
			<input type="checkbox"/> Pass <input type="checkbox"/> Fail

Applicant Name:	Date:
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16. Self-Designated Specialty

If you are board certified, attach a certified true copy of board certificate.

Specialty/Subspecialty	Board Certified? Yes/No/Year	What Board?	Recert. Date -Year

PART III PROFESSIONAL ACTIVITIES

17. Professional Licensure

Please list all states or territories of the United States, provinces of Canada, or other countries in which you hold or have **ever** held a license as a doctor of podiatric medicine. Include instructional or training permits. **Failure to disclose all licenses may result in disciplinary sanctions or denial.**

	Location (State, territory, etc.)	License Number	Date Issued	Current Status
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				

If necessary, continue to list on a separate sheet of paper labeled with your name and signed by you.

18. Other Professional Licensure

Other than as a physician, have you **ever** been licensed in any jurisdiction in any other profession of the healing arts?

No

Yes

If Yes, please complete the following:

Profession (DDS, DC, RN, PA-C, DC, etc.)	Jurisdiction (State, territory, country, etc.)	Date Licensed	Was License Disciplined?
			<input type="checkbox"/> No <input type="checkbox"/> Yes
			<input type="checkbox"/> No <input type="checkbox"/> Yes

If you have responded 'yes' to question 18, verifications of good standing for each license must be submitted for all other health care professions under which you have been licensed by those jurisdictions.

Applicant Name:	Date:
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19. Medical Societies and Professional Organizations

Name of Organization	Address	Date From/To - YYYY

20. Hospital Affiliations

Have you ever held hospital privileges? Yes No

If Yes, please list all hospitals in which you have been credentialed within the immediate past five years.

	HOSPITAL	MAILING ADDRESS	WHEN PRIVILEGED (MM/YYYY)	
			From	
1			From	
			To	
2			From	
			To	
3			From	
			To	
4			From	
			To	
5			From	
			To	

If necessary, continue to list of a separate sheet of paper labeled with your name and signed by you.

21. Medical Work History

Please provide a chronological listing of all medical and non-medical activities beginning with your graduation from medical school 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
Fr			
To			
Fr			
To			
Fr			
To			

(Continued on next page)

Applicant Name: _____	Date: _____
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Fr			
To			

Fr			
To			

Fr			
To			

Fr			
To			

Fr			
To			

Fr			
To			

If necessary, continue to list on a separate sheet of paper labeled with your name and signed by you.

22. Medical Malpractice History

Have you ever had any claims of malpractice filed against you? No Yes

If Yes, please list all claims of malpractice filed against you below. Include all settlements, judgements, awards, and claims for which no money was paid. For each case listed below, provide a brief description on a separate sheet of paper labeled with your name and signed by you. Include the nature of the case, the allegations, and your response to the allegations. Please do not send letters from attorneys or insurance carriers.

Case No.	Date of Case (Mo/Yr)	Jurisdiction (State, etc.)	Nature of Allegation	Amount of Settlement Paid on Your Behalf
1				
2				
3				
4				
5				
6				

Applicant Name:	Date:
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SPECIAL INSTRUCTIONS FOR PARTS IV AND V

In responding to the questions in Parts IV and V 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.

PART IV DISCIPLINARY HISTORY

IMPORTANT! PLEASE READ BEFORE ANSWERING THE DISCIPLINARY HISTORY QUESTIONS 24 through 37.

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?

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?

Applicant Name: _____ **Date:** _____

- 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 been disciplined* by a medical school or post-graduate training program? (*See 'Important Information' block on discipline on page 6.)
- 30b. No Yes Is any such action pending?
-
- 31a. No Yes Have you ever had a license to practice medicine disciplined by any authority including a state medical board or a military authority (except for late medical records)?
- 31b. No Yes Is any such action pending?
-
- 32a. No Yes Have you ever been under investigation, notified of an investigation, or contacted by a board investigator or enforcement officer for any medical licensing jurisdiction or authority?
- 32b. No Yes Is any such action pending?
-
- 33a. No Yes Have you ever had a medical license application denied by any medical licensing jurisdiction or authority?
- 33b. No Yes Is any such action pending?
-
- 34a. No Yes Have you ever voluntarily or involuntarily withdrawn an application for a 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 surrendered or suspended your license to practice medicine in any United States jurisdiction or any international jurisdiction?
- 35b. No Yes Is any such action pending?
-
- 36a. No Yes Have you ever voluntarily or involuntarily agreed to any limitations, restrictions, or conditions to your license to practice medicine?
- 36b. No Yes Is any such action pending?
-
- 37a. 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?
- 37b. No Yes Is any such action pending?

Applicant Name:	Date:
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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.

PART V PERSONAL HISTORY

Please refer to Special Instructions on page 6 before answering these questions. 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 of 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.

Part V Personal History Questions Continued

- 38. 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?
- 39. 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:** _____

40. 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?

41. 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?

42. 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.)

43. No Yes Are you currently engaged in the illegal use of any drug, whether by ingestion, injection, inhalation, or any other method?

44. 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?

45. No Yes Have you ever been voluntarily or involuntarily committed or confined to any facility for mental health care?

46. 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 | | |

47. 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.

48. No Yes Have you ever been adjudicated or declared incompetent or been the subject of an incompetency proceeding?

Applicant Name:	Date:
------------------------	--------------

PART VI 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 degree of Doctor of Podiatric Medicine 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.

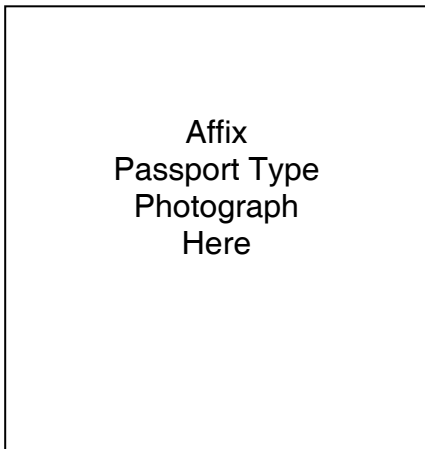
I further certify that the photograph that appears below is a true likeness of myself taken within the past 60 days.

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 have carefully read all the instructions in the application including the instructions under Part IV, Disciplinary History, on page 6. Yes

Applicant Signature _____ Date _____

(Applicant signature date and 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.



ALASKA STATE MEDICAL BOARD

Department of Commerce, Community, and Economic Development
Division of Corporations, Business, and Professional Licensing
(333 Willoughby Avenue – Ninth Floor)
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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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VERIFICATION OF LICENSURE

Instructions to the Applicant: Please complete Part I below and forward a copy of this form to **all** states, territories, or other countries' licensing jurisdictions where you have **ever** been licensed. Copy this form as needed. Please type or print legibly.

PART I

Full Name (Last, First, Middle)	Maiden or Other Names Used:	Date of Birth (MM/DD/YYYY)
Mailing Address	City	State Zip
Medical/Osteopathic School Attended	Location	Year of Graduation
Signature of Applicant	Date of Signature	

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

Instructions to the licensing agency: Please complete Part II below for the physician identified above and return this document directly to the Alaska State Medical Board.

PART II

LICENSING JURISDICTION		LICENSE NUMBER	
INITIAL ISSUE DATE		EXPIRATION DATE	
BASIS OF LICENSURE (FLEX, USMLE, etc.)		CURRENT LICENSE STATUS	

- 1 Has this applicant ever been the subject of an investigation by a licensing or disciplinary authority in your state or jurisdiction? No Yes
- 2 Is any such investigation pending? No Yes
- 3 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
- 4 Is any such action pending? No Yes
- 5 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
- 6 To your knowledge, is there any derogatory information regarding this applicant? No Yes

(Board Seal)

Signed by _____

Date _____

Printed Name _____

Title _____



ALASKA STATE MEDICAL BOARD

Department of Commerce, Community, and Economic Development
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LIST OF HOSPITALS WHERE PRIVILEGED

Instructions to the Applicant:

Type or print legibly. List below all hospitals where you currently hold or have held privileges in the last five years. If you have not held privileges within the past five years or never held privileges, please write "None" on this form, sign it, and submit this form as part of your application. Please include residency privileges if appropriate.

HOSPITAL	MAILING ADDRESS	WHEN PRIVILEGED (MM/YYYY)	
		From	To
1		From	
		To	
2		From	
		To	
3		From	
		To	
4		From	
		To	
5		From	
		To	
6		From	
		To	
7		From	
		To	
8		From	
		To	

I certify that listed above are all hospitals where I hold or have held privileges in the past five years. I understand it is my responsibility to request these hospitals submit a letter to the board to complete my application for licensure. I certify under penalty of unsworn falsification that the above information is true and correct.

Signature _____

Date _____

Warning: Alaska Statute 11.56.210 states that any person who knowingly or intentionally furnishes false or fraudulent information in this application has committed a Class A misdemeanor.



ALASKA STATE MEDICAL BOARD

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VERIFICATION OF HOSPITAL PRIVILEGES

Instructions to the Applicant:

Please complete Part I below. Forward a copy of this form to each hospital where you have held privileges in the immediate past five years. Include privileges held during residency. Copy this form as needed. Please type or print legibly. Part II is to be completed by the hospital staff office.

PART I

Full Name (Last, First, Middle)	Maiden or Other Names Used:	Date of Birth (MM/DD/YYYY)
Mailing Address	City	State Zip
Signature of Applicant	Date of Signature	

Name of Hospital _____

Mailing Address _____

City/State/Zip _____

FOLLOWING TO BE COMPLETED BY HOSPITAL STAFF ONLY

PART II

Instructions to the Hospital: I am applying for a license to practice medicine in Alaska. The Alaska board requires this form to be completed by each hospital where I have held privileges in the past five years. Please complete this form by answering the questions below and return this form **directly** back to the Alaska board at the letterhead address.

- 1 Dates of Hospital Privileges: From _____ To _____
- 2 Has your hospital ever taken any disciplinary action against this physician? No Yes
- 3 Have there ever been limitations or restrictions on this physician's privileges? No Yes
- 4 Are any disciplinary actions pending against this physician? No Yes
- 5 Is there any derogatory information on file regarding this physician? No Yes
- 6 Is there any reason you would not readmit this physician to your medical staff? No Yes

If you answer "Yes" to any question above, please attach a detailed explanation signed and dated by the person whose signature appears below.

Signature _____ Printed Name _____

Title _____ Date _____

Telephone _____



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VERIFICATION OF STATUS OF DEA REGISTRATION

Instructions to the Applicant: Type or print legibly. Complete Part I below and mail this form to the DEA.

PART I

Full Name (Last, First, Middle)	Maiden or Other Names Used:	Date of Birth (MM/DD/YYYY)
Mailing Address	City	State Zip
Address Where DEA Registered	DEA Registration No.	
Signature of Applicant	Date of Signature	

YOU MUST MAIL THIS REQUEST FORM TO:

Drug Enforcement Administration
Attn: Diversion Unit
400 Second Avenue West
Seattle, WA 98119-4013

FOLLOWING TO BE COMPLETED BY DEA STAFF ONLY

PART II

Instructions to the DEA staff: Please search your records and advise if there is any derogatory information on file against this physician. Please return this form directly to the State Medical Board at the letterhead address.

Comments: _____

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BOARD ACTION DATA BANK INQUIRY

Instructions to the Applicant: Type or print legibly. Complete Part I below. Mail this form to the Federation at the address below.

PART I

Full Name (Last, First, Middle)	Maiden or Other Names Used:	Date of Birth (MM/DD/YYYY)
Mailing Address (Street)		Place of Birth
City/State/Zip		If International Grad., ECFMG No.
Medical/Osteopathic School (Name and Location)		Year of Graduation

YOU MUST MAIL THIS FORM TO:

Federation of Podiatric Medical Boards
6551 Malta Drive
Boynton Beach FL 33437

FOLLOWING TO BE COMPLETED BY DATA BANK STAFF ONLY

PART II

Instructions to the Data Bank Staff: Please search the data bank for any record of this practitioner. Please forward your report to the medical board at the letterhead address.

FOR FEDERATION USE ONLY



ALASKA STATE MEDICAL BOARD

DPM

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VERIFICATION OF PODIATRIC MEDICAL SCHOOL EDUCATION

Instructions to the Applicant: Type or print legibly. Complete Part I below and send to the medical school from which you received your diploma.

PART I

Full Name (Last, First, Middle)		Maiden or Other Names Used:		Date of Birth (MM/DD/YYYY)	
Mailing Address		City		State Zip	
Signature of Applicant				Date of Signature	

Full School Name _____

Location _____

FOLLOWING TO BE COMPLETED BY MEDICAL SCHOOL STAFF ONLY

PART II

Instructions to the Medical School: Please complete the information below and return this document **directly** to the Alaska board at the letterhead address.

Exact Date on School Diploma _____

During this physician's medical school education, was he/she ever investigated by the school or disciplined by the school for any reason? Disciplinary actions include but are not limited to being placed on probation, issued a letter of reprimand, censured, suspended, restricted, or otherwise disciplined.

No Yes

If you responded "Yes" to this question, please provide a detailed explanation of the action and the reason for the action on a separate sheet of paper attached to this form signed and dated by the person whose signature appears below.

(SEAL, If Applicable) Signed _____

Printed Name _____

Title _____

Date _____



ALASKA STATE MEDICAL BOARD

PGY

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VERIFICATION OF POSTGRADUATE TRAINING

Instructions to the Applicant: Type or print legibly. Complete Part I below and send to the post-graduate training program(s) you attended.

PART I

Full Name (Last, First, Middle)	Maiden or Other Names Used:	Date of Birth (MM/DD/YYYY)	
Mailing Address	City	State	Zip
Medical/Osteopathic School (Name and Location)	Yr of Graduation	If IMG, ECFMG No.	
Signature of Applicant	Date		

NAME OF POSTGRADUATE PROGRAM _____
 ADDRESS _____

FOLLOWING TO BE COMPLETED BY POST-GRADUATE PROGRAM STAFF ONLY

PART II

Post-graduate Training Program: Please complete the information requested below and return this document directly to the Alaska board at the letterhead address.

VERIFICATION FOR:

PPMR PSR-12 PSR-24 PM&S-24 PM&S-36 POR

Exact Dates of Training _____

- At the time this individual completed training in your program, was the program accredited through the Council on Podiatric Medical Education?
 Yes No
- During the physician's participation in your program, was he/she ever investigated or disciplined by the program, such disciplinary actions to include but not be limited to, being placed on probation, issued a letter of reprimand or warning, censured, suspended from the program, restricted, or otherwise disciplined? If you respond "Yes" to this question, please attach a separate sheet providing a detailed explanation of the action and the reason for the action.
 No Yes
- Is there anything in this physician's postgraduate training records that would indicate he/she would be unable to practice medicine competently and safely? If "Yes", please attach a detailed explanation.
 No Yes

(SEAL, If Applicable) _____ Signature _____ Date _____
 _____ Printed Name _____ Title _____

REQUEST FOR NBPME SCORES

Please print clearly and complete all items. Mail this form to:

THOMSON PROMETRIC-NBPME
2000 Lenox Drive – 3rd Floor
Lawrenceville NJ 08648
Phone: 878-302-8952

Date: _____ Year of Graduation: _____ Social Security No.: _____
(Optional)
Phone: _____

Check scores to be sent: _____ Part I _____ Part II

_____ Name
_____ Address
_____ City, State, Zip

← This is a mailing label. Please
Print your full name and address.

FEE: \$35.00

The fee covers the transmittal of
Part I and Part II scores and must
Accompany each request.

Make check payable to NBPME.

Your Signature

A copy is forwarded to the address listed below with your NBPME scores.

A copy remains in our office file.

Please retain a copy for your file.

_____ Name
_____ Organization
_____ Address
_____ City, State, Zip

← This is a mailing label.
Please print the exact name,
office, and address to which
the scores are to be sent.

Date scores sent _____
(Board use only)

Filename: med4109.doc
Directory: C:\Documents and
Settings\dmsomers\Desktop\occ lic forms
Template: C:\Documents and
Settings\dmsomers\Application
Data\Microsoft\Templates\Normal.dot
Title: ALASKA STATE MEDICAL BOARD
Subject:
Author: LABEL
Keywords:
Comments:
Creation Date: 12/18/2007 3:02:00 PM
Change Number: 2
Last Saved On: 12/18/2007 3:02:00 PM
Last Saved By: Administrator
Total Editing Time: 5 Minutes
Last Printed On: 12/18/2007 3:02:00 PM
As of Last Complete Printing
Number of Pages: 25
Number of Words: 9,305 (approx.)
Number of Characters: 53,042
(approx.)