



ALABAMA BOARD OF MEDICAL EXAMINERS

P.O. Box 946 / Montgomery, AL 36101-0946 / (334) 242-4116

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

Limited License Application Application for Certificate of Qualification to Practice Medicine in Alabama Without Examination

Instructions for Limited License Application

- Include with this application:
 - A copy of your Medical School Diploma
 - A cover letter from program/institution
 - A completed Declaration of Citizenship form with attached proof
 - A copy of your ECFMG (if applicable)
 - Application fee of \$175.00
- All portions of the application must be completed. If a question does not apply to you, the answer N/A is acceptable.
- The Limited License, or Certificate of Qualification Issued without Examination, may only be issued at the Board's discretion for a period of up to one calendar year.
- The Limited License may only be issued to an applicant who does not qualify for a full license and is a resident, fellow, medical school professor, or practices full-time at certain State of Alabama institutions.
- The application must be certified by an institution's Dean, Program Director, Chief Medical Officer, Warden, or Medical Director.
- For complete rules, please see Board Rules, Chapter 540-X-3
- Once the application has been received by our agency and processing has begun, you will receive an email with instructions to check the status of your application online by following these steps:
 - Log on to our website at albme.gov
 - Click the CHECK APPLICATION STATUS heading
 - Create a username and password to log into your Licensee Gateway
 - Click the Application Status box to view your checklist
- Pursuant to Ala. Code § 30-3-194, it is mandatory that we request and that you provide your social security number (SSN) on this application. The uses of your SSN are limited to the purpose of administering the state child support program and intra-agency for identification purposes. If your SSN is not provided, your application is not complete, and no license will be issued.

Name in Full (First, Middle, Last) _____ MD DO

Alternate Name(s) used _____

Current Address _____

City _____ State _____ Zip _____

Birthplace: City _____ State _____ Country _____

Date of Birth _____ Sex _____ Social Security Number _____

Email Address _____

Phone Number (Home or Cell) _____ Phone Number (Work) _____

Name of Institution _____

Type of License (Check one)

Resident

Distinguished Professor

State Institution

Specialty Professor

Visiting Professor

Fellow

Required background information

If your answer is "yes," please attach a detailed explanation.

Legal:

Yes No

1. Have you ever been arrested for, cited for, charged with, or convicted of any crime, offense, or violation of any law, felony, or misdemeanor, including, but not limited to, offenses related to the practice of medicine or state or federal controlled substances laws, or driving under the influence?

*This question excludes minor traffic violations such as speeding and parking tickets but includes felony and misdemeanor criminal matters that have been dismissed, expunged, sealed, subject to a diversion or deferred prosecution program, or otherwise set aside.

2. Have you ever been arrested for, cited for, charged with, or convicted of any sex offender laws or required to register as a sex offender for any reason?
3. Have you ever had a judgment rendered against you or action settled relating to an action for injury, damages, or wrongful death for breach of the standard of care in the performance of your professional service ("malpractice")?
4. To your knowledge, as of the date of this application, are you the subject of an investigation or proposed action by any law enforcement agency?

Administrative/Regulatory:

Yes No

5. Have you ever had any Drug Enforcement Administration registration and/or state controlled substances registration denied, voluntarily surrendered while under investigation, or subject to any discipline, including, but not limited to revocation, suspension, probation, restriction, conditions, reprimand, or fine?
6. Have you ever been denied a license to practice medicine in any state or jurisdiction or has your application for a license to practice medicine been withdrawn under threat of denial?
7. Has your certificate of qualification or license to practice medicine in any state or jurisdiction ever been subject to any discipline, including but not limited to revocation,

suspension, probation, restrictions, conditions, reprimand, or fine?

8. Have your staff privileges at any hospital or health care facility ever been revoked, suspended, curtailed, limited, or placed under conditions restricting your practice?
9. To your knowledge, as of the date of this application, are you the subject of an investigation or proposed action by any federal agency, any licensing board/agency, or any hospital or health care facility?

Fitness to Practice:

Yes No

10. Are you currently suffering from any condition that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical, and professional manner?
11. Within the past five years, have you raised the issue of any physical or psychiatric health disorder as a defense, mitigation, or explanation for your actions during any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination by an educational institution; employer; government agency; professional organization; or licensing authority?
12. The Board recognizes that licensees encounter potentially impairing health conditions just as their patients and other health care providers do, including psychiatric or physical illnesses which may impact cognition, as well as substance use disorders. The Board expects its licensees to address their health concerns, both mental and physical, in a timely manner to ensure patient safety. Licensees should seek appropriate medical care and should limit their medical practice when appropriate and as needed. The Board encourages licensees to utilize the services of the Alabama Professionals Health Program, a physician advocacy organization dedicated to improving the health and wellness of medical professionals in a confidential manner. The failure to adequately address a health condition, where the licensee is unable to practice medicine with reasonable skill and safety to patients, can result in the Board taking action against the license to practice medicine.

I have read and understand the statements above.

Physician Initials

Education/Training/Experience:

Yes No

13. As of the date of this application, has it been more than two years since the last time you were actively engaged in clinical practice or direct patient care?
14. Has your medical education, training, or medical practice been interrupted or suspended, or have you ceased to engage in direct patient care, for a period longer than 60 days for any reason other than a vacation or for the birth or adoption of a child? If yes, please provide a brief explanation.?

15. Have you ever been placed on academic or disciplinary probation by, or been required to remediate any portion of, a medical school or postgraduate program?
16. Were limitations or special requirements imposed on you because of questions of academic, clinical, or disciplinary problems, or any other reason during your medical education or postgraduate training, such as repeating a class or classes or taking time off from school to study for an examination?
17. Have you ever been disciplined for unprofessional conduct/behavior reasons by a medical school or postgraduate program?
18. Pre-Medical education: List all schools attended, undergraduate and post-graduate work other than medical school, dates attended, and degree conferred.

Start Date	End Date	Name of School	Degree

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

Start Date	End Date	Name & Address of Institution

20. Post-Graduate medical education training: List all post-graduate medical education training since graduation from medical school, dates, and complete addresses of institutions. Do not list practice experience.

Start Date	End Date	Name & Address of Institution

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

I understand and agree that by typing my name, I am providing an electronic signature that has the same legal effect as a written signature pursuant to Ala. Code § 8-1A-2 and 8-14-7. I attest that the foregoing information has been provided by me and is true and correct to the best of my knowledge, information, and belief.

Name of Dean-School of Medicine OR Director-Residency
Training Program OR Warden/Medical Director OR Chief Medical Officer

Signature of Dean-School of Medicine OR Director-Residency
Training Program OR Warden/Medical Director OR Chief Medical Officer

Date

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

Please submit a completed application to:

Credentialing@albme.gov

OR mail to:

Alabama Board of Medical Examiners
ATTN: Credentialing Specialist
848 Washington Avenue
Montgomery, AL 36104