ALABAMA STATE BOARD OF MEDICAL EXAMINERS

REINSTATEMENT APPLICATION

1. NAME _____
2. ADDRESS _____
3. INITIAL LICENSE NUMBER _____ ISSUED _____
4. INITIAL CERTIFICATE NUMBER _____ ISSUED _____
5. DATE OF REVOCATION/SUSPENSION/SURRENDER OF LICENSE _____
6. REASONS FOR REVOCATION/SUSPENSION/VOLUNTARY SURRENDER OF CERTIFICATE OR LICENSE (Please give detailed reasons — if necessary you may use an additional sheet of paper and attach to this application): _____

		YES	NO
7.	Have you ever been convicted of a felony?		
8.	Have you ever been convicted of a crime or offense, felony or misdemeanor related to the practice of medicine?		
9.	Have you ever been denied a state or federal controlled substances certificate?		
10.	Has your certificate of qualification or license to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation?		
11.	Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice?		
12.	Have you been denied a certificate of qualification or a license to practice medicine in any state or has your application for a certificate of qualification or license to practice medicine been withdrawn under threat of denial?		
13.	Have you ever had a judgement rendered against you, or action settled relating to the performance of your professional service?		
14.	Within the past two years, have you been diagnosed with or have you been treated for bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder?		
15.	Do you currently have any mental or physical condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or mental, emotional, or nervous disorder or condition) which in any way currently affects, or if untreated could affect your ability to practice in a competent and professional manner?[1]		
16.	Within the past five years, have you ever raised the issue of consumption of drugs or alcohol or the issue of a mental, emotional, nervous, or behavioral disorder or condition as a defense, mitigation, or explanation for your actions in the course of any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination by an educational institution; employer; government agency, professional organization or licensing authority?		
17.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or any sexual boundary violation?		
18.	Are you currently engaged in the illegal use of controlled dangerous substances?[1]		
19.	If your answer to the preceding question is yes, are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances?		
20.	Have you been within the past five years, convicted of driving under the influence (DUI) or have you been charged with DUI and been convicted of a lesser offense such as reckless driving?		
21.	Has your medical training or medical practice been interrupted or suspended for a period longer than 60 days for any reason other than a vacation?		

[1]The term "currently" does not mean on the day of , or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the condition referred to may have an ongoing impact on one's functioning as a physician within the past two years.

(If the answer to any of these questions is YES give complete detailed and/or current status of charges on separate attachment.)

I hereby authorize the release of any information, favorable or otherwise concerning me, in your files to the Alabama Board of Medical Examiners. A photostat copy of this authorization shall be as valid as the original.

_____
Applicant's Signature

Applicant's Social Security Number: _____

Pursuant to Ala. Code § 30-3-194, it is mandatory that we request and that you provide your social security number (SSN) on this application. The uses of your SSN are limited to the purpose of administering the state child support program and intra-agency for identification purposes. If your SSN is not provided, your application is not complete, and no license will be issued.

Please list below all states in which you have applied for licensure.

_____	_____	_____
_____	_____	_____
_____	_____	_____

I hereby certify that the information contained herein is true and accurate to the best of my ability.

_____
Date

_____
Applicant's Signature

SWORN to and subscribed before me this _____ day of _____, 20 _____.

_____
Notary Public
My Commission Expires: _____