



# ALABAMA STATE BOARD OF MEDICAL EXAMINERS

848 Washington Ave, Montgomery, AL 36104-0946 / (334) 242-4116



## Retired Senior Volunteer Program Certificate of Qualification Renewal Application

Ala. Code § 34-24-75.1 requires that all physicians holding limited licenses under the retired senior volunteer program apply to the Board of Medical Examiners for renewal of the certificate of qualification prior to renewal of the license. In accordance with this section, you are required to accurately complete this application. Once the application has been completed, please return it to the institution to obtain the certification of the qualified clinic or nonprofit organization.

Name in Full: \_\_\_\_\_ MD \_\_\_\_ DO \_\_\_\_  
(First) (Middle) (Last)

Alternate name(s) used: \_\_\_\_\_

Name of Qualified Clinic or Nonprofit Organization: \_\_\_\_\_

License Number: \_\_\_\_\_ Date Issued: \_\_\_\_\_

Please answer **Yes** or **No** to the following questions (if any below answers are in the affirmative, please explain in detail and provide the complete name and address of any psychiatrist/psychologist, state board, hospital, etc.):

- |    |                                                                                                                                                                                                                                                                                                                                                                                       |     |                          |    |                          |
|----|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|--------------------------|----|--------------------------|
| 1. | Do you limit your practice to the confines of the institution?                                                                                                                                                                                                                                                                                                                        | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 2. | Have you ever been convicted of a felony?                                                                                                                                                                                                                                                                                                                                             | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 3. | Have you ever been convicted of a crime or offense (felony or misdemeanor) related to the practice of medicine?                                                                                                                                                                                                                                                                       | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 4. | Have you ever been convicted of any violation of a state or federal law relating to controlled substances?                                                                                                                                                                                                                                                                            | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 5. | Has your DEA registration or any state controlled substance certificate been denied or subject to any discipline, including but not limited to the following: revocation; suspension; probation; restriction(s); condition(s); reprimand or fine; or has your DEA registration or any state controlled substance certificate been voluntarily surrendered while under investigation ? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |

6. Has your certificate of qualification or license to practice medicine in any state ever been denied or subject to any discipline, including but not limited to the following: revocation; suspension; probation; restriction(s); condition(s); reprimand or fine; or has your certificate of qualification or license to practice medicine in any state been voluntarily surrendered while under investigation or under threat of discipline? Yes  No
7. Have your staff privileges at any hospital or health care facility ever been revoked, suspended, curtailed, limited or placed under conditions restricting your practice? Yes  No
8. Have you ever 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? Yes  No
9. Have you ever had a judgment rendered against you or action settled relating to the performance of your professional service? Yes  No
10. 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? Yes  No
11. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, or voyeurism? Yes  No
12. Are you currently\* engaged in the excessive use of alcohol, controlled substances, or the use of illegal drugs, or received any therapy or treatment for alcohol or drug use, sexual boundary issues or mental health issues? (If you are an anonymous participant in the Alabama Professionals Health Program and are in compliance with your contract, you may answer "No" to this question. Such answer for this purpose will not be deemed upon certification as providing false information to the Alabama Board of Medical Examiners or the Medical Licensure Commission of Alabama). If you answered Yes to #12, a description is required. Yes  No

**IMPORTANT:** The Board recognizes that licensees encounter health conditions, including those involving mental health and substance use disorders, just as their patients and other health care providers do. The Board expects its licensees to address their health concerns and ensure patient safety. Options include anonymously self-referring to the Alabama Professionals 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.

\_\_\_\_\_ Please initial certifying that you understand and acknowledge your duty as a licensee to address any such condition as stated above.

*\*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.*

13. 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?

Yes  No

14. Has your medical education, training or 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?

Yes  No

Applicant's [typed] Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*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 8-1A-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.*

Clinic or Facility Administrator's [typed] Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*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 8-1A-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.*