APA-1
Revised 4/2018

TRANSMITTAL SHEET FOR
NOTICE OF INTENDED ACTION

Control 545 Department or Agency: Medical Licensure Commission of Alabama
Rule No. 545-X-2-Appendix C
Rule Title: Application for Reinstatement
X New ____ Amend X Repeal ____ Adopt by Reference

Would the absence of the proposed rule significantly harm or endanger the public health, welfare, or safety?	Yes
Is there a reasonable relationship between the state's police power and the protection of the public health, safety, or welfare?	Yes
Is there another, less restrictive method of regulation available that could adequately protect the public?	No
Does the proposed rule have the effect of directly or indirectly increasing the costs of any goods or services involved and, if so, to what degree?	No
Is the increase in cost, if any, more harmful to the public than the harm that might result from the absence of the proposed rule?	No
Are all facets of the rulemaking process designed solely for the purpose of, and so they have, as their primary effect, the protection of the public?	Yes
Does the proposed action relate to or affect in any manner any litigation which the agency is a party to concerning the subject matter of the proposed rule?	No

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Does the proposed rule have an economic impact? No

If the proposed rule has an economic impact, the proposed rule is required to be accompanied by a fiscal note prepared in accordance with subsection (f) of Section 41-22-23, Code of Alabama 1975.

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Certification of Authorized Official

I certify that the attached proposed rule has been proposed in full compliance with the requirements of Chapter 22, Title 41, Code of Alabama 1975, and that it conforms to all applicable filing requirements of the Administrative Procedure Division of the Legislative Services Agency.

Signature of certifying officer Craig H Christopher M.D.

Date March 18, 2022

APA-2

MEDICAL LICENSURE COMMISSION OF ALABAMA

NOTICE OF INTENDED ACTION

AGENCY NAME: Medical Licensure Commission of Alabama

RULE NO. & TITLE: 545-X-2-Appendix C, Application for Reinstatement

INTENDED ACTION: To repeal the current Application for Reinstatement of a medical license and replace with new version.

SUBSTANCE OF PROPOSED ACTION: To update the reinstatement application to remove outdated questions. To update substance abuse question and add mental health attestation and signature acknowledgement.

TIME, PLACE, MANNER OF PRESENTING VIEWS: All interested persons may submit views, comments, or arguments concerning the proposed rule in writing to: Karen Silas, Operations Director, 848 Washington Avenue Montgomery, AL 36104 by mail, or by email to ksilas@almlc.gov until and including Thursday,May 5, 2022. Persons wishing to obtain copies of the text of this rule should contact Ms. Karen Silas by email or telephone at ksilas@almlc.gov or (334)833-0174.

FINAL DATE FOR COMMENT AND COMPLETION OF NOTICE: May 5, 2022

CONTACT PERSON AT AGENCY: Karen Silas

Craig H Christopher M.D.

Craig H. Christopher, M.D., Chairman
Medical Licensure Commission of Alabama

CHAPTER 2--APPENDIX C - REPEALED

APPLICATION FOR REINSTATEMENT

LICENSE NUMBER: _____

DATE ISSUED: _____

NAME IN FULL: _____
(Last Name) (First Name) (Middle Name)

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

COUNTY: _____ TELEPHONE: (_____) _____

TYPE OF PRACTICE: _____

ALABAMA PRACTICE ADDRESS: _____

_____

CITY: _____ STATE: _____ ZIP CODE: _____

EMAIL ADDRESS _____

DATE: _____ SIGNATURE: _____

Please specify the following:

Public Address: ☐ Home Address ☐Practice Address
Mailing Address: ☐ Home Address ☐Practice Address

PLEASE ATTACH REINSTATEMENT FEE OF $_____

PLEASE ATTACH CRIMINAL BACKGROUND CHECK FEE OF $_____

MAKE SEPARATE CHECKS PAYABLE TO: MEDICAL LICENSURE COMMISSION OF ALABAMA

** YOU MUST SUBMIT PROOF (COPIES) OF HAVING OBTAINED TWENTY-FIVE (25) HOURS OF CONTINUING MEDICAL EDUCATION WITHIN THE PRECEDING (12) TWELVE MONTH PERIOD

**** ALL ACTIVE LICENSES EXPIRE DECEMBER 31 OF EACH YEAR****
APPLICATION FOR REINSTATEMENT OF LICENSE

To The Medical Licensure Commission of the State of Alabama

I hereby make application for reinstatement of my license to practice medicine/osteopathy in the State of Alabama, Certificate Number _____, which automatically became inactive on the 1st day of February 20___, for nonpayment of the annual registration fee as provided in §§ 34-24-337, Code of Alabama, 1975. The following information is submitted in connection with this application for reinstatement.

Date: _____ DEA #: _____ License #: _____

Name: _____

Date of Birth: _____ Social Security Number: _____

Professional Address:

_____

_____

_____

Telephone: ( ) _____

Other States or Jurisdictions in which you are currently licensed:

_____

CURRENT PRACTICE

Specialty: _____

Board Certified: _____ Yes _____ No

Name of Board (if yes above): _____

Date of Certification and/or Re-certification (if yes above): _____

Practice Pattern:

Percentage of Professional Time/Office: _____

Percentage of Professional Time/Clinic: _____

Percentage of Professional Time/Hospital: _____

Percentage of Professional Time/Other: _____

CURRENT PROFESSIONAL CONNECTIONS

Specialty Society Member: _____ Yes _____ No

Name of Specialty Society (if yes above): _____

Name/Location of Hospital(s): _____

Hospital Staff Status (active, etc.): _____

Hospital Privileges (specify): _____

CERTIFICATION OF CME COMPLIANCE

_____ I hereby certify that I have met the annual minimum continuing medical education requirement of twenty-five 25 AMA PRA Category 1 Credits™ or equivalent continuing medical education within the preceding twelve (12) months.

Names/Results of Practice Related Examinations taken in the past year:

_____

Other (specify for the past year):

_____

1. Have you been charged with any offense (felony or misdemeanor) ? _____ Yes _____ No

2. Have you ever been convicted of a crime or offense (felony or misdemeanor) in the practice of medicine?

_____ Yes _____ No

3. Have you ever been convicted of any violation of a state or federal law relating to controlled substances?

_____ Yes _____ No

4. Have you ever been denied a state or federal controlled substances certificate? _____ Yes _____ No

5. 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?

_____ Yes _____ No

6. Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice? _____ Yes _____ No

7. 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? _____ Yes _____ No

8. Have you ever had a judgment rendered against you, or actions settled relating to the performance of your professional service? _____ Yes _____ No

9. To your knowledge, are you the subject of an investigation, or has a formal complaint against your license been filed by a licensing Board/Agency as of the date of this application since you were last licensed in this state? _____ Yes _____ No

10. Within the past two years, have you been diagnosed with or have you been treated for bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder? _____ Yes _____ No

11. 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, or within the past two (2) years have you

applied for and/or have you received any payment or other compensation for any mental or physical condition? _____ Yes _____ No

12. 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

13. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism? _____ Yes _____ No

14. Are you currently engaged in the illegal use of controlled dangerous substances? _____ Yes _____ No

15. 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?

_____ Yes _____ No

16. Have you been, within the past five (5) 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

17. 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 or maternity leave?

_____ Yes _____ No

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, or within the past two years.

If you have answered yes to any of the foregoing questions, please provide complete information.

RELEASE/CERTIFICATION

I certify that the above information is currently accurate and truly reflects my professional activities. I hereby release this information for internal use to those state authorities responsible for medical licensure and/or discipline.

_____

Signature

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

_____

Notary Public

My Commission Expires: _____

Author: Alabama Medical Licensure Commission
Statutory Authority: Code of Alabama 1975
History: New Forms: Filed November 25, 2003; effective December 30, 2003.
Amended: Approved for Publication January 28, 2004.
Filed: January 30, 2004
Approved for Adoption: April 21, 2004; **Effective Date:** May 28, 2004
Amended: Approved for Publication November 17, 2005; **Filed:** November 28, 2005
Approved for Adoption: February 22, 2006; **Filed:** February 27, 2006; **Effective Date:** April 3, 2006. **Amended/Approved:** August 22, 2007; Emergency Rule Effective September 4, 2007.
Approved: November 28, 2007; Effective January 4, 2008. **Amended/Approved:** July 23, 2008; Emergency Rule Effective October 1, 2008: **Approved for Adoption:** October 22, 2008; Filed October 29, 2008, Effective Date: December 3, 2008.
Approved for Adoption: January 27, 2010; **Filed:** January 5, 2011
Final File: April 5, 2011; Effective May 11, 2011.
Repealed:

545-X-2-APPENDIX C - NEW RULE

APPLICATION FOR REINSTATEMENT

LICENSE NUMBER (IF KNOWN): _____

NAME IN FULL:_____

(Last Name) (First Name) (Middle Name)

HOME ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

COUNTY:_____ HOME TELEPHONE:_____

HOME E-MAIL ADDRESS:_____

ARE YOU CURRENTLY IN ACTIVE CLINICAL PRACTICE IN ANY STATE? YES NO

TYPE OF PRACTICE:_____

PRACTICE ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

PRACTICE TELEPHONE:_____

PRACTICE E-MAIL ADDRESS:_____

Please specify the following:

Public Address: Home Address Practice Address

Mailing Address: Home Address Practice Address

Reinstatement & Criminal Background Check Fee $_____
MAKE ALL CHECKS PAYABLE TO MEDICAL LICENSURE COMMISSION OF ALABAMA or PAY ONLINE AT ALBME.GOV

****ALL ACTIVE LICENSES EXPIRE DECEMBER 31 OF EACH YEAR****

DATE OF BIRTH:_____

CURRENT PRACTICE

SPECIALTY: _____ BOARD CERTIFIED: YES NO

Name of Board (If yes above):_____

Date of Certification and/or Re-certification (if yes above):_____

Other states or jurisdictions in which you are currently licensed:_____

****CERTIFICATION OF CME COMPLIANCE**

☐ I hereby certify that I have met the annual minimum continuing medical education requirement of twenty-five (25) AMA PRA Category 1 Credits or equivalent continuing medical education within the preceding twelve (12) months.

SINCE YOUR LICENSE WAS LAST ACTIVE IN ALABAMA (Unless otherwise indicated):

1. Have you been charged with any criminal offense (felony or misdemeanor)? (This includes driving under the influence (DUI), even if you were convicted of a lesser offense). If yes, please include a detailed explanation.

   YES NO

2. Have you been convicted of a crime or offense (felony or misdemeanor) in the practice of medicine? If yes, please include a detailed explanation.

   YES NO

3. Have you been convicted of any violation of state or federal law relating to controlled substances? If yes, please include a detailed explanation.

   YES NO

4. Have you been denied a state or federal controlled substances certificate? If yes, please include a detailed explanation.

YES NO

5. Has your certificate of qualification or license to practice medicine in any state been suspended, revoked, restricted, curtailed, voluntarily surrendered, or disciplined in any manor? If yes, please include a detailed explanation.

   YES NO

6. Have your staff privileges at any hospital or healthcare facility been revoked, suspended, curtailed, limited, restricted, or voluntarily surrendered? If yes, please include a detailed explanation.

   YES NO

7. 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? If yes, please include a detailed explanation.

   YES NO

8. Have you had a judgement rendered against you, or an action settled relating to the performance of your professional service? If yes, please include a detailed explanation.

   YES NO

9. Are you the subject of an investigation, or has a formal complaint been filed against you or your license by any licensing board, state or federal, regulatory or law enforcement agency? If yes, please include a detailed explanation.

   YES NO

10. Have you 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 or sexual boundary issues? If you are a 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 Alabama Medical Licensure Commission.** If yes, please include a detailed explanation.

    YES NO

11. **IMPORTANT:** The Commission recognizes that licensees encounter health conditions, including those involving mental health and substance use disorders, just as their patients and other healthcare providers do. The Commission expects its licensees to address their health concerns and ensure patient safety. Options include anonymously self-referring to the Alabama Professionals Health Program (www.alabamaphp.weebly.com), 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 Commission 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.**

12. Has your medical training or medical practice been interrupted or suspended for a period longer than 60 days for any reason other than vacation, maternity leave, or retirement? If yes, please include a detailed explanation.

    YES NO

RELEASE/CERTIFICATION

I understand and agree that by signing my name, 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.

Knowingly providing false information to the Alabama Board of Medical Examiners or Alabama Medical Licensure Commission could result in disciplinary action.

I understand that the information contained herein may be subject to public inspection or disclosure, and I hereby release the Alabama Medical Licensure Commission and the Alabama Board of Medical Examiners from any and all claims or liability associated with the use or dissemination of the information contained herein.

_____

Physician Signature

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

_____

Notary Public Signature

My commission expires: _____

Author: Alabama Medical Licensure Commission
Statutory Authority: Code of Ala. 1975, §34-24-337.
History: New Rule: Filed for publication March 18,2022