

Jorge A. Alsip, M.D.
Chairman/Executive Officer

Rebecca Robbins
Director of Operations



STATE of ALABAMA
MEDICAL LICENSURE COMMISSION

*Post Office Box 887
Montgomery, Alabama 36101*

*Phone: (334)242-4153
Email: mlc@almlc.gov*

Dear Physician:

Since your license to practice medicine in the State of Alabama has expired, you must complete the reinstatement process in order to obtain an active license status and practice medicine in the State of Alabama. Applicants for reinstatement must complete the reinstatement application and pay a prorated reinstatement fee. If your license expired prior to December 31, 2025, your reinstatement fee will be \$850.00. If your license expired on December 31, 2025, your reinstatement fee will be \$550.00 until the end the current calendar year.

According to 545-X-5-.13 of the Administrative Code of Alabama, applicants for reinstatement are required to submit 25 AMA PRA Category 1 continuing medical education credits from the previous 12 months of application.

In addition to the above requirements, applicants for reinstatement must complete a criminal background check and pay the associated \$65.00 fee. To complete the criminal background check, applicants must submit two standard issue FBI fingerprint cards and valid photo identification. Should fingerprint cards not be available to the applicant, fingerprint cards can be requested by emailing fingerprints@albme.gov with your mailing address. Once you have completed the fingerprinting process, cards, release form, and valid photo identification should be mailed to the Medical Licensure Commission at Post Office Box 887, Montgomery, Alabama 36101.

Once your reinstatement application is complete, it will be submitted to the Alabama Board of Medical Examiners for review. Should the Board identify grounds for denial, they may file a Notice of Intent to Contest Reinstatement with the Medical Licensure Commission. If the Board does not find grounds for denial, your license will be reinstated. Please note that incomplete applications for reinstatement expire six months from the date the application was received.

To check the status of your reinstatement application, you may log on to our website at albme.gov and click the "Check Pending Application" heading. You will be asked to provide your last name and the last five digits of your social security number. Once you click "Submit" you will be redirected to your online checklist. Application deficiencies will be listed here for your review.

If you have any questions regarding the reinstatement process, please contact Heather Lindemann at hlindemann@almlc.gov or by telephone at (334) 604-4954.

Thank you,

Medical Licensure Commission of Alabama

Administrative Code of Alabama, 545-X-2-.03, Subsections (6) – (9)

(6) If a licensee fails to register and pay the registration fee and late fee if applicable, within thirty-one (31) days after registration becomes due, the license shall automatically become inactive, provided that any person whose license shall become inactive in this way may make application in writing for the reinstatement of such license.

(7) When any physician licensed by this Commission shall have such license become inactive for nonpayment of the annual registration fee required under Code of Ala. 1975, §34-24-337, such physician may apply to the Commission in writing for reinstatement of such license by filing with the Commission an application together with the payment of all past due renewal fees for up to two years and the additional sum of \$250.00 dollars.

(8) Upon receipt of a properly completed application, criminal background check, the payment to the Commission of all required past due renewal fees plus the additional sum of \$250.00 dollars, subject to the maximums set out in subsection (7) Immediately above, proof of completion of twenty-five credits of AMA PRA/AOA category I continue medical education units within the last twelve months, and proof of citizenship, then the Commission shall reinstate the license of the application. In the event that the answers provided by the applicant to any question on the application form or from any other source indicates that the applicant has committed any act or undergone any change of circumstance which would constitute grounds for the revoking of a license to practice medicine in the State of Alabama under Code of Ala. 1975, §34-24-360, then the Commission shall refer the application to the State Board of Medical Examiners for investigation into all of the facts and circumstances surrounding such acts or circumstances in order to determine if a complaint for revocation or suspension of that physician's license should or should not be initiated.

(9) Before denying an application submitted under this section the Commission shall comply with all of the requirements of a contested case under the Alabama Administrative Procedure Act and the rules of this Commission.



STATE of ALABAMA
MEDICAL LICENSURE COMMISSION

Applicant Reinstatement Checklist

- _____ Completed/Notarized Application
- _____ Application Fee
- _____ Criminal Background Check Fee
- _____ Malpractice Claims Form
- _____ Malpractice Court Documents
- _____ 25 AMA PRA Category 1 CMEs
- _____ Declaration of Citizenship Form
- _____ Proof of Citizenship
- _____ Criminal History Release Form
- _____ Two Standard Issue FBI Fingerprint Cards

Please note that this list is not inclusive, and you may be required to provide additional information upon Commission request.

STATE OF ALABAMA MEDICAL LICENSURE COMMISSION
POST OFFICE BOX 887
MONTGOMERY, ALABAMA 36101-0887

TELEPHONE
334-242-4153

E-MAIL
MLC@ALMLC.GOV



APPLICATION FOR REINSTATEMENT

LICENSE NUMBER (IF KNOWN): _____

DATE ISSUED: _____

DATE EXPIRED: _____

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:	<input type="checkbox"/> Home Address	<input type="checkbox"/> Practice Address
Mailing Address:	<input type="checkbox"/> Home Address	<input type="checkbox"/> Practice Address

Reinstatement & Criminal Background Check Fee \$ _____

MAKE 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 of 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 Physician 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 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 Physician 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 Medical Licensure Commission of Alabama 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

My Commission Expires: _____

ALABAMA BOARD OF MEDICAL EXAMINERS

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

DECLARATION OF CITIZENSHIP AND LAWFUL PRESENCE OF AN ALIEN FOR PUBLIC BENEFITS AND LICENSING/PERMITTING PROGRAMS

Title IV of the federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 8 U.S.C. § 1621, provides that, with certain exceptions, only United States citizens, United States non-citizen nationals, non-exempt “qualified aliens” (and sometimes only particular categories of qualified aliens), nonimmigrants, and certain aliens paroled into the United States are eligible to receive covered state or local public benefits.

With certain exceptions, Ala. Code § 31-13-1, *et. seq.* prohibits aliens unlawfully present in the U.S. from receiving state or local benefits. Every U.S. Citizen applying for a state or local public benefit must sign a Declaration of Citizenship, and the lawful presence of an alien in the U.S. must be verified by the Federal Government.

Ala. Code § 31-13-1, *et. seq.* also requires every individual applying for a permit or license to demonstrate his/her U.S. citizenship or if the applicant is an alien, he/she must demonstrate his/her lawful presence in the United States.

Directions: This form must be completed and submitted by individuals applying for licenses or permits.

SECTION 1 --- APPLICANT INFORMATION

NAME: _____
(Print or Type) (Last) (First) (M.I.)

MD / DO / PA License Number: _____ DATE OF BIRTH: _____

SECTION II --- U.S. CITIZENSHIP OR NATIONAL STATUS

Are you a citizen or national of the United States (check one) ____ Yes ____ No

If you answered **YES**: (1) Provide an original (only in person at agency office) or legible copy of document from attached List A or other document that demonstrates U.S. citizenship or nationality and (2) Complete Section IV.

If you answered **No**: Complete Sections III and IV.

Name of document provided: _____

SECTION III – ALIEN STATUS

Are you an alien lawfully present in the United States? ____ Yes ____ No

If you answered **Yes**: (1) Provide an original (only in person at agency office) or legible copy of the front and back (if any) of a document from attached List B or other document that demonstrates lawful presence in the United States. (2) Complete Section IV. Information from the documentation provided will be used to verify lawful presence through the United States Government.

Name of document provided: _____

If you answered **No**: Complete Section IV.

_____.

SECTION IV -- DECLARATION

I declare under penalty of perjury under the laws of the State of Alabama that the answers and evidence I provided are true and correct to the best of my knowledge.

APPLICANT'S SIGNATURE

DATE

ALABAMA BOARD OF MEDICAL EXAMINERS

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

LIST A

DOCUMENTS DEMONSTRATING U.S. CITIZENSHIP

1. The applicant's driver's license or nondriver's identification card issued by the division of motor vehicles or the equivalent governmental agency of another state within the United States if the agency indicates on the applicant's driver's license or nondriver's identification card that the person has provided satisfactory proof of United States citizenship.
2. The applicant's birth certificate that satisfactorily verifies United States citizenship.
3. Pertinent pages of the applicant's United States valid or expired passport identifying the applicant and the applicant's passport number.
4. The applicant's United States naturalization documents or the number of the certificate of naturalization.
5. Other documents or methods or proof of United States citizenship issued by the federal government pursuant to the Immigration and Nationality Act of 1952, and amendments thereto.
6. The applicant's Bureau of Indian Affairs card number, tribal treaty card number, or tribal enrollment number.
7. The applicant's consular report of birth abroad of a citizen of the United States of America.
8. The applicant's certificate of citizenship issued by the United States Citizenship and Immigration Services.
9. The applicant's certification of report of birth issued by the United States Department of State.
10. The applicant's American Indian card, with KIC classification, issued by the United States Department of Homeland Security.
11. The applicant's final adoption decree showing the applicant's name and United States birthplace.
12. The applicant's official United States military record of service showing the applicant's place of birth in the United States.
13. An extract from a United States hospital record of birth created at the time of the applicant's birth indicating the applicant's place of birth in the United States.

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LIST B

DOCUMENT INDICATING STATUS OF QUALIFIED ALIENS, NONIMMIGRANTS, AND ALIENS PAROLED INTO U.S. FOR LESS THAN ONE YEAR

The documents listed below that are registration documents are indicated with an asterisk (*).

Qualified Aliens

Evidence of "Qualified Alien" status includes the following:

- Alien lawfully admitted for permanent residence
- Form I-551 (Alien Registration Receipt Card, commonly known as a "green card"); or unexpired temporary I-51 stamp in foreign passport or on *Form I-94

Asylee

- *Form I-94 annotated with stamp showing grant of asylum under section 208 of the INA
- *Form I-688B (Employment Authorization Card) annotated "274.a12(a)(50)"
- *Form I-766 (Employment Authorization Document) annotated "A5"; grant letter from the Asylum Office of the U.S. Citizenship and Immigration Service; or Order of an immigration judge granting asylum.

Refugee

- *Form I-94 annotated with stamp showing admission under § 207 of the INA
- *Form I-688B (Employment Authorization Card) annotated "274a.12(a)(3)"
- *Form I-766 (Employment Authorization Document) annotated "A3"

Alien Paroled Into the U.S. for at Least One Year

- *Form I-94 with stamp showing admission for at least one year under section 212(d)(5) of the INA. (Applicant cannot aggregate periods of admission for less than one year to meet the one year requirement.)

Alien Whose Deportation or Removal Was Withheld

- *Form I-688B (Employment Authorization Card) annotated "274.12(a)(10)"
- *Form I-766 (Employment Authorization Document) annotated "A10"; or Order from an immigration judge showing deportation withheld under §243(h) of the INA as in effect prior to April 1, 1997, or removal withheld under § 241(b)(3) of the INA.

Alien Granted Conditional Entry

- *Form I-94 with stamp showing admission under § 203(a)(7) of the INA
- *Form I-688B (Employment Authorization Document) annotated "274a.12(a)(3)"
- *Form I-766 (Employment Authorization Document) annotated "A3"

Cuban/Haitian Entrant

- *Form I-551 (Alien Registration Receipt Card, commonly known as a "green card") with the code CU6, CU7, or CH6
- Unexpired temporary I-551 stamp in foreign passport or on *Form I-94 with the code CU6 or CU7
- Form I-94 with stamp showing parole as "Cuba/Haitian Entrant" under Section 212(d)(5) of the INA

Alien Who Has Been Declared a Battered Alien Subjected to Extreme Cruelty

- U.S. Citizenship and Immigration Service petition and supporting documentation

FBI PRIVACY ACT STATEMENT

Authority: The FBI's acquisition, preservation, and exchange of fingerprints and associated information is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include Federal statutes, State statutes pursuant to Pub. L. 92-544, Presidential Executive Orders, and federal regulations. Providing your fingerprints and associated information is voluntary; however, failure to do so may affect completion or approval of your application.

Principal Purpose: Certain determinations, such as employment, licensing, and security clearances, may be predicted on fingerprint-based background checks. Your fingerprints and associated information/biometrics may be provided to the employing, investigating, or otherwise responsible agency, and/or the FBI for the purpose of comparing your fingerprints to other fingerprints in the FBI's Next Generation Identification (NGI) system or its successor systems (including civil, criminal, and latent fingerprint repositories) or other available records of the employing, investigating, or otherwise responsible agency. The FBI may retain your fingerprints and associated information/biometrics in NGI after the completion of this application and, while retained, your fingerprints may continue to be compared against other fingerprints submitted to or retained by NGI.

Routine Uses: During the processing of this application and for as long thereafter as your fingerprints and associated information/biometrics are retained in NGI, your information may be disclosed pursuant to your consent, and may be disclosed without your consent as permitted by the Privacy Act of 1974 and all applicable Routine Uses as may be published at any time in the Federal Register, including the Routine Uses for the NGI system and the FBI's Blanket Routine Uses. Routine uses include, but are not limited to, disclosures to: employing, governmental or authorized non-governmental agencies responsible for employment, contracting, licensing, security clearances, and other suitability determinations; local, state, tribal, or federal law enforcement agencies; criminal justice agencies; and agencies responsible for national security or public safety.

APPLICATION NOTIFICATION AND RECORD CHALLENGE

Your fingerprints will be used to check the criminal history records of the FBI. You have the opportunity to complete or challenge the accuracy of the information contained in the FBI identification record. The procedure for obtaining a change, correction, or updating an FBI identification record are set forth in Title 28, CFR, 16.34. You can find additional information on the FBI website at <https://www.fbi.gov/about-us/cjis/background-checks>.

APPLICATION TO REVIEW ALABAMA CRIMINAL HISTORY RECORD INFORMATION



PERSONAL INFORMATION

Full Name (First, Middle, Last, Suffix): _____ Sex/Gender: ☐ Male ☐ Female

Aliases/Nickname: _____

Applicant Current Address: _____

City: _____ State: _____ Zip Code: _____ SSN: _____

Date of Birth: _____ (MM/DD/YYYY) Driver's License Number: _____ Issuing State: _____

Race: ☐ White ☐ Black ☐ Asian ☐ Indian ☐ Other (please specify) _____

Home Phone: () _____ Mobile Phone: () _____ Work Phone: () _____

WORK INFORMATION

Employer Name: _____ Employer Phone: () _____

Contractor Name: _____ Contractor Phone: () _____

State Agency: _____ Agency Phone: () _____

Work Email Address: _____

Job Role/Classification: _____ Supervisor Name: _____

Included with my Release are the following items:

- ☐ Completed Application signed by applicant and **two witnesses** OR notarized.
- ☐ The required copy of my valid photo identification.
- ☐ A classifiable copy of my own fingerprints taken by an authorized law enforcement agency as required.
- ☐ **If applying for state employment/licensure/certification, reference that agency's fee requirements for a background check.**

AFFIDAVIT FOR RELEASE INFORMATION

I hereby authorize the Alabama Law Enforcement Agency to release any and all criminal history information to:

Name & Address of Requesting Agency or Authorized Agent*

I, the above referenced individual, hereby request to release any and all criminal history record information (CHRI) maintained by both the Alabama Law Enforcement Agency, the Federal Bureau of Investigation, and any information relating to my past record and character whether it be financial, academic, military, employment, judicial, or personal reference. I hereby release all parties contributing such information from any charges or liability whatsoever because of furnishing said information. By signing below and submitting this application, I hereby verify that the information listed in my application and in the attached documentation is correct. I also acknowledge that I understand that, in accordance with Section 41-9-601 of the Code of Alabama 1975, that any person who willfully requests, obtains or seeks to obtain criminal offender record information under false pretenses, or who willfully communicates or seeks to communicate criminal offender record information to any agency or person without authorization, may be guilty of a felony, and shall be fined not less than \$5,000 nor more than \$10,000 or imprisoned in the state penitentiary for not more than five years or both. § 41-9-601, Code of Ala. (1975). Furthermore, as set forth at Title 28, Code of Federal Regulations (CFR), Section 16.34 I have the right to challenge or appeal any portion of my state and/or federal CHRI that I believe to be inaccurate (see "Appendix A" for contact information).

Applicant Signature _____ Date _____

Name of Witness _____ Name of Witness _____

Address of Witness _____ Address of Witness _____

City, State and Zip _____ City, State and Zip _____

Sworn to and subscribed before me this ____ day of _____, 20__.

Notary Signature _____ My Commission Expires _____, 20__.

FOR ALEA OFFICIAL USE ONLY: TCN: _____ SID: AL _____

Received By (Initials): _____/Date: ____/____/____ Processed By (initials): _____/Date: ____/____/____

Walk-in/Hand Delivered _____ Mailed _____ Status: _____ Initials: _____ Date: ____/____/____

Billed: _____ Paid: _____ No Charge: _____

Check#: _____

Background Check Qty: ____ Total: \$ _____

Certified Letter Qty: ____ Total: \$ _____

Alabama Board of Medical Examiners

Malpractice Claims Information Form

Please attach a copy of the PLAINTIFF’S COMPLAINT AND SETTLEMENT, DISMISSAL, OR JUDGMENT, if applicable.

The applicant must complete this form for **each** liability or malpractice claim of which they are aware. Please use one form for each claim or suit.

1. In addition to copies of the complaint and settlement or order, if any, describe below the allegations against you. **A copy of the complaint will not replace a written description by you.** Include the patient's name, a brief history, and comments regarding the examination and care surrounding the allegations. If suits are pending, a brief summary of the allegations or charges must be included regardless of the litigation stage.

[illegible]

2. Date of claim: _____
3. Is the claim pending? Yes _____ No _____
4. Was there a judgment or settlement? Yes _____ No _____
5. What was the amount and date of the judgment or settlement?

6. Additional Comments:
