THE STATE of ALASKA
*Department of Commerce, Community, and Economic Development*
*Division of Corporations, Business and Professional Licensing*

**Telemedicine Business Registry**
PO Box 110806, Juneau, AK 99811-0806
Phone: (907) 465-2550 • Fax: (907) 465-2974
Email: *TelemedicineBusinessRegistry@Alaska.Gov*
Website: *ProfessionalLicense.Alaska.Gov/TelemedicineBusinessRegistry*

# Telemedicine Business Registry Application Instructions

**Please read the application and instructions carefully.**
**Failure to do so may cause additional correspondence and delay in the processing of your application**.

**INITIAL APPLICATION**
To be included on the telemedicine business registry established and maintained under AS 44.33.381, and before providing telemedicine services to a recipient located in this state, a business performing telemedicine services must submit to the Division a complete registration on a form provided by the Division; the registration must include the business's name, active Alaska business license number, address, and contact information.

Appropriate fees must accompany applications before initial screening can begin. All fees may be paid with check or money order made payable to the State of Alaska or by credit card. To pay by credit card, use the attached credit card payment form.

A business performing telemedicine services must register with the name it is using to perform telemedicine services in this state. A business operating under multiple names to perform telemedicine services shall file a separate registration for each name.

**BUSINESS REGISTRY CHANGES**
If the name, address, or contact information of a business on the telemedicine business registry changes, the business performing telemedicine services must submit to the Division, not later than 30 days after the change or termination, a Business Registry Change Form (08-4722). A business that fails to comply timely may not perform telemedicine services in this state and must submit a new application before resuming telemedicine services to a recipient located in this state.

**TERMINATION OF TELEMEDICINE SERVICES**
If a business terminates the performance of telemedicine services in this state, the business shall notify the department by submitting form #08-4727. The business must submit a new application before resuming the provision of telemedicine services to a recipient located in this state.

**OTHER INFORMATION**
Please be aware that all information on the application form will be available to the public, unless required to be kept confidential by state or federal law. Information about current licensees, including mailing addresses, is available on the Division's website at *ProfessionalLicense.Alaska.gov* under License Search.

The complete set of statutes and regulations for this program are available by written request or online at the Division's website: *ProfessionalLicense.Alaska.Gov*. If you would like to receive notice of all proposed regulation changes for your program, email your request to *RegulationsAndPublicComment@Alaska.Gov* with your name, preferred contact method (mail or email), and the program you want to be updated on.

***IT IS ILLEGAL TO DELIVER TELEMEDICINE SERVICES IN ALASKA WITHOUT AN ACTIVE AND VALID ALASKA BUSINESS LICENSE AND REGISTRATION***

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**TBR**

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# Telemedicine Business Registry Application

| | | |
|---|---|---|
| **Required Fee:** | ☐ Registration Fee | **$50.00** |

| | |
|---|---|
| **Enter the three-letter program code of the primary health care profession delivered by telemedicine. Enter only <u>one</u> of the codes listed below:** | ☐☐☐ |

**ACU** · Acupuncture
**ATH** · Athletic Training
**AUD** · Audiology and Speech
**BEV** · Behavioral Analysis
**CHI** · Chiropractic
**CSW** · Social Work
**DEN** · Dental
**DTN** · Dietetics and Nutrition
**MED** · Medical
**MFT** · Marital and Family Therapy
**MID** · Midwifery
**NAT** · Naturopathy
**NHA** · Nursing Home Administrators
**NUR** · Nursing
**OPT** · Optometry
**PCO** · Professional Counseling
**PHA** · Pharmacy
**PHY** · Physical and Occupational Therapy
**PSY** · Psychology
**VET** · Veterinary

***List your business name <u>exactly</u> as it appears on your current Alaska business license:***

| | | | | |
|---|---|---|---|---|
| **Alaska Business Name:** | | | | |
| **Alaska Business License #:** | | | | |
| **Mailing Address:** | Street/PO Box: | City: | State: | Zip Code: |

| | | | |
|---|---|---|---|
| **Representative's Name:** | | **Title:** | |
| **Representative's Phone #:** | | | |
| **Representative's Signature:** | | **Date:** | |

**EMAIL AGREEMENT:** By choosing to receive correspondence on any matter affecting my license or other business with the Alaska Division of Corporations, Business and Professional Licensing, I agree to maintain an accurate email address through the MY LICENSE web page. I understand that failure to check my email account or to keep the email address in good standing may result in an inability to receive crucial information, potentially resulting in my inability to obtain or maintain licensure.

| | | |
|---|---|---|
| **Email Address:** | | ☐ Send my Correspondence by Email<br>☐ Send my Correspondence by US Mail |

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# Credit Card Payment Form

All major credit cards are accepted. For security purposes, do not email credit card information. Include this credit card payment form with your application.

Name of Applicant or Licensee: _____

Program Type: _____ License Number *(if applicable)*: _____

I wish to make payment by credit card for the following *(check all that apply)*: **AMOUNT**

- ☐ Application Fee: _____ _____
- ☐ License or Renewal Fee: _____ _____
- ☐ Other *(name change, wall certificate, fine, duplicate license, exam, etc.)*:
  1. _____ _____
  2. _____ _____

**TOTAL:** 0

Name *(as shown on credit card)*: _____

Mailing Address: _____

Phone Number: _____ Email *(optional)*: _____

**Signature of Credit Card Holder:** _____

08-4438 Rev 12/26/18 Credit Card Payment Form (all major cards accepted)

**CREDIT CARD INFO: Your payment cannot be processed unless all fields are completed!**

1. Account Number: _____
2. Expiration Date: _____
3. Billing ZIP Code: _____
4. Security Code: _____

All four fields **MUST** be completed!

This section will be destroyed after the payment is processed.