THE STATE of ALASKA

Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing

Alaska State Medical Board
PO Box 110806, Juneau, AK 99811
Phone: (907) 465-2550
Email: *MedicalBoard@Alaska.Gov*
Website: *ProfessionalLicense.Alaska.Gov/StateMedicalBoard*

IHS Provider State Licensure Exemption

A provider employed by a tribal health program in Alaska holding a license in another state in accordance with 25 U.S.C. 1621t are not required to become licensed by the Alaska State Medical Board, however, a notification of employment must be submitted to the board. The notification must be submitted no later than 30 days after the provider begins working at a tribal health program in this state as indicated in 12 AAC 40.981. Please use this form to notify the board of your employment and attach the documents as required below.

PART I Application Type

Applying As:	☐ Physician (MD, DO)	☐ Podiatrist	☐ Physician Assistant

PART II Provider Information

Provider Name:		**License Number:**	
State of Licensure:		**Contact Phone:**	
Mailing Address:	P.O. Box or Street / City / State / Zip		

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:		**Select One:**	☐ Send my Correspondence Electronically ☐ Send my Correspondence by Mail

Note: If both boxes are selected above, you will receive correspondence electronically.

PART III Tribal Health Information

Tribal Health Program Employer:		**Start Date:**	

PART IV Attachments

Please attach the following to this form:

☐ Certified true copy of the current, valid physician, physician assistant, or podiatrist license from another jurisdiction.

Note: *To obtain a "certified true copy," you must present the notary with the original document along with the photocopy. You must write, "I certify this is a true copy of the original document" and sign your name. The notary will compare the original document with the copy and then notarize your signature.*

- AND -

☐ Proof of employment by a tribal health program that is operating under an agreement with the federal Indian Health Service under 25 U.S.C. 450-458ddd-2 (Indian Self-Determination and Education Assistance Act).

- OR -

☐ Proof of status as an independent contractor, including a copy of the contract, if the out-of-state provider is working for the tribal health program as an independent contractor.

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MED

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Notary Signature Page

PART V Notarized Signature

I HEREBY CERTIFY that the information contained in this form is true and correct to the best of my knowledge. I further certify that all credentials supplied by me are true and correct and acknowledge that I must apply for licensure as a provider in accordance with AS 08.80 before practicing beyond the scope my contract with a tribal health organization.

I understand that any falsification or misrepresentation of any item or response in this application, or any attachment hereto, or falsification or misrepresentation of documents to support this application, is sufficient grounds for denying, revoking, or otherwise disciplining a license or permit to practice in the state of Alaska.

I further understand that it is a Class A misdemeanor under Alaska Statute 11.56.210 to falsify an application and commit the crime of unsworn falsification.

A person who makes a false statement on this application may be subject to civil and criminal penalties, including prosecution for perjury (AS 11.56.200 & AS 11.56.230).

Notary Stamp				
	Applicant Printed Name:			
	Applicant Signature:			
	Notary Public for State of:		**Subscribed and Sworn to Before me on this Day:**	
	Notary Signature:		**My Commission Expires:**	