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*

Medical or Osteopathy License Application Instructions

This packet contains all the documents you will need to apply for a permanent license to practice medicine or osteopathy in Alaska.

Read all instructions and information carefully and complete all documents as requested.

- Average processing time for a temporary license is from six to eight weeks. Full licensure can take twelve to fourteen weeks or longer. Start the process far enough in advance to allow this process to occur. Applications are reviewed in order of receipt in our office. If there are items in the application about which the board requires additional information, or if there is any adverse or derogatory information that comes to light, the review process may take longer.
- Appropriate fees must accompany applications before initial screening can begin.
- While we understand your desire to conclude this process as quickly as possible, our licensing staff is responsible for reviewing many files and cannot complete the application process if required documents are missing. It is your responsibility to ensure those documents are received by our office.
- The application review process is defined by the requirements set forth in state law. The Board and its staff must comply with those laws in processing applications.
- The Alaska State Medical Board conducts a thorough evaluation of education, training, employment or work history, malpractice history and any criminal or disciplinary history. We recommend you do not make commitments for loans, practice start dates, home purchases, etc., based on the expectation of licensure. The Board will not accelerate one application over others, nor will it forego any elements of its screening process.
- If you received this application from a source other than directly from the Division or its official website, the application may be outdated or not an official version. To ensure you have the official version, please contact the Division. Application forms will be rejected if not on the current version.
- If you have a current DEA registration, you must register with the prescription drug monitoring program (PDMP) within 30 days of obtaining a permit or license. Application instructions at: *PDMP.Alaska.Gov*

THRESHOLD QUALIFICATIONS FOR LICENSURE - U.S.

- Successful graduation from an AAMC- or AOA-accredited medical school.
- Successful completion of post-graduate training in accredited programs in recognized hospitals.
- If graduated from medical school prior to 01/01/1995 – 1 year of postgraduate training.
- If graduated from medical school on or after 01/01/1995 – 2 years of postgraduate training.
- Successful passage of an acceptable licensing examination as defined by regulation.
- Completion of education in pain management and opioid use and addiction.
- Submit a complete application (contents listed below).
- Submit a list of malpractice settlements/claims with an explanation of the basis for each claim or settlement.
- NOT have a license to practice medicine in another state, territory, province, or international licensing jurisdiction suspended or revoked or otherwise disciplined.

THRESHOLD QUALIFICATIONS FOR LICENSURE - International Graduates

- Successful graduation from a medical school listed in the World Directory of Medical schools.
- Successful completion of three (3) years of postgraduate training in accredited programs in recognized hospitals in the United States or Canada.
- Completion of education in pain management and opioid use and addiction.
- Submit a complete application.
- ECFMG Certificate.
- Successful passage of appropriate examinations as defined by regulation.
- Submit a list of malpractice settlements/claims with an explanation of the basis for each claim or settlement.
- NOT have a license to practice medicine in another state, territory, or province suspended or revoked or otherwise disciplined.

The following must be received by the division before your application for Medical or Osteopathy License can be reviewed:

1. APPLICATION
A completed application, signed and notarized (#08-4105, pages 1-10).

2. FEES
Fees made payable to "State of Alaska."

Nonrefundable Application Fee:	$400.00
License Fee:	$425.00
Prescription Drug Monitoring Program (PDMP):	$ 0.00
Total Fees Due:	$825.00

3. AUTHORIZATION FOR RELEASE OF RECORDS
A completed Authorization for Release of Records form (#08-4105a).

4. EXAM SCORES
Appropriate examination scores as required by 12 AAC 40.020 and 12 AAC 40.021.

5. VERIFICATION OF LICENSURE
A completed Verification of Licensure form (#08-4105b) from all licensing jurisdictions, both U.S. and International, in which you have ever been licensed.

6. HOSPITAL PRIVILEGES
A listing of all hospitals where you have held privileges in the five years preceding your application in Alaska (#08-4105c).

7. VERIFICATION OF HOSPITAL PRIVILEGES
A completed Verification of Hospital Privileges form (#08-4105d).

8. VERIFICATION OF MEDICAL SCHOOL EDUCATION
A completed verification of medical school education form (#08-4105e).

9. CLEARANCE REPORT – DEA
A completed Clearance Report form (#08-4105f) from the Drug Enforcement Agency.

10. CLEARANCE REPORT – FSMB
A completed Clearance Report form (#08-4105g) from the Federation of State Medical Boards.

11. VERIFICATION OF POSTGRADUATE TRAINING
A completed verification of Postgraduate Training form (#08-4105h).

12. AMA/AOA PROFILE
AMA or AOA Physician Profile (required even if not a member).

13. NPDB REPORT
Division staff will obtain a clearance report directly from the National Practitioner Data Bank.

Application for Licensure Checklist

Checklist	Document	Provided By
☐	Completed application, signed and notarized (#08-4105, pages 1-10).	You provide
☐	Authorization for Release of Records form (#08-4105a).	You provide
☐	Examination Scores	Exam Agency or FCVS
☐	Verification of Medical School Education (#08-4105e).	Medical School or FCVS
☐	Post-Graduate Verifications of Training (#08-4105h)	PG Programs or FCVS
☐	Attestation of education in pain management and opioid use and addiction.	You provide
☐	Verifications of Licensure in Other Jurisdictions (#08-4105b).	Licensing Board or Veridoc
☐	Hospital Privileges List (#08-4105c).	You provide
☐	Hospital Privileges Verifications (#08-4105d).	Hospitals
☐	DEA Clearance Report (#08-4105f)	DEA
☐	FSMB Board Action Data Bank Report: *fsmb.org* (#08-4105g)	FSMB
☐	AMA Profile: *www.ama-assn.org* AOA Profile: *www.osteopathic.org*	AMA or AOA
☐	NPDB Report	Alaska Board will obtain
☐	Explanation and documentation of any “yes” responses in application	You provide
☐	Fees Enclosed with Application	You provide
☐	ECFMG, if international medical school graduate	ECFMG or FCVS

Each question in the application must be answered. Be sure to also include required documentation for each “yes” response.

Failure to answer all questions completely and accurately, or the omission or falsification of information may be cause for denial of your application or disciplinary action by the board. When in doubt, disclose all information and provide an explanation and documentation.

ADDRESS OF RECORD
The first page of the application asks for your preferred address of record. This is the address to which you would like us to send all communications to you including your permit or license. Please do not use third party addresses, telephone numbers, or email addresses as this creates difficulties when we are trying to reach you.

AMA OR AOA PROFILES
All applicants must have a copy of their individual Physician Profile Report sent directly to the Board by the American Medical Association (AMA) or the American Osteopathic Association (AOA), even if you are not a member of these organizations. You must contact the organizations directly to order the profile: AMA Profile: *www.ama-assn.org* AOA Profile: *www.osteopathic.org*

APPLICATION FOR LICENSURE BY CREDENTIALS
The Alaska State Medical Board may waive the written examination requirement and license an applicant by credentials if you hold an active license issued after written examination in another state or territory of the United States or province of Canada. Such examination must be equivalent to the USMLE examination series or must include passing the following examinations with at least a minimum passing score as defined by regulation (12 AAC 40.020): the National Board of Medical Examiners (NBME), the Federation Licensing Examination (FLEX), or the National Board of Osteopathic Medical Examiners (NBOME).

APPLICATION FOR LICENSURE BY EXAMINATION
The Alaska State Medical Board requires the USMLE examination series and has contracted with the Federation of State Medical Board for administration of the examination. To request examination information, please contact the Federation at:

United States Medical Licensing Examination (USMLE) Step 3
The Federation of State Medical Boards
400 Fuller Wiser Rd., Suite 300
Euless, TX 76039-3856
817/868-4000 or 817/868-4041

APPLICATION STATUS UPDATES
Our licensing examiner will send you a written status update upon the initial screening of the application.

APPLICATION SUBMITTAL
- Use our convenient online services by registering with MYLICENSE. The online features will help you apply for a new license, renew an existing license, update your email and mailing address, and receive electronic communication about application status, licensure, regulations changes, and other important news. *ProfessionalLicense.Alaska.Gov/MYLICENSE*
- Use the Uniform Application (UA) for initial licensure offered through the Federation of State Medical Boards (FSMB). This application process may benefit physicians applying for licensure in multiple states. *FSMB.org/uniform-application*
- Use a traditional paper application. You may still opt-in to receive electronic communication about application status. Visit our website for additional information: *ProfessionalLicense.Alaska.Gov/StateMedicalBoard*

BOARD REVIEW OF APPLICATIONS
Only the board is authorized to grant full licenses. Your application will be presented to the board for review and approval of your license at a regularly-scheduled board meeting. In most cases, you will be notified via a completion status letter from the licensing examiner that your file has been forwarded to the executive administrator for review and when the next scheduled board meeting will occur. In some cases, if there is an issue that requires resolution in your application, your file may be delayed for a period and your file may not be reviewed by the board immediately. If you wish to know when your application will be considered by the board, please contact the office and advise us as early as possible so that we may accommodate your request.

COMPLETION OF THE APPLICATION FORMS
Help us do a good job processing your application: type or print legibly all application documents. Please read the instructions and give careful thought before answering the questions in the application - remember - you are certifying that the information is truthful and correct.

Make sure all notary seals are properly affixed on the application and all documentation has been properly certified as required. Provide all documents requested in the application; incomplete applications will delay processing.

Failure to answer all questions completely and accurately, or the omission or falsification of information may be cause for denial of your application or disciplinary action if you are subsequently permitted by the board.
WHEN IN DOUBT, DISCLOSE ALL INFORMATION OR CALL OUR OFFICE.

CONFIDENTIALITY
The contents of licensing files are generally considered public. If you believe the additional information you are attaching to explain a "yes" answer should be held confidential, so state in the attachment. A request for confidentiality may or may not be granted.

CONTINUING MEDICAL EDUCATION REQUIREMENT

Alaska law requires an average of 25 hours of Category I AMA- or AOA-approved continuing education hours for each year of the licensing period (two-year licensing cycle) of which 2 hours must be in education related to pain management and opioid use and addiction. At the time of renewal, the licensee must attest to compliance with the CME requirements. After renewal is completed, the division will perform a computer-generated random audit of licensees who will be required to provide proof of CME courses. Please see regulations 12 AAC 40.200, 210, and 220.

DEA CLEARANCE REPORT

You are required to request a clearance report from the Drug Enforcement Administration for your DEA Registration. Use the form provided in this packet and send your request to:

DEA Diversion, Registration
1630 East Tudor Road
Anchorage, AK 99507

DENIAL OF LICENSE

The denial of an application for licensure may be reported to any person, professional licensing board, federal, state, or local government agency, or other entity making a relevant inquiry or as may be required by law.

EXAMINATION SCORES

Regardless of your application, whether by credentials or examination, Alaska requires that you must pass each component of your examinations with a minimum two-digit score of 75. If you are applying for licensure by examination and fail any component more than once, you will be required to complete a supervised course of study acceptable to the board before permission to retake the step will be given. You must request exam scores be sent to the board from the appropriate organization.

To request scores, send your full name, the name of your medical school, date of graduation, your birth date, and your social security number to the appropriate organization listed below. Each organization requires a fee of $65 accompany such requests (money order, personal check, or cashier's check).

For FLEX or USMLE examination scores, send your request to:

The Federation of State Medical Boards
Attn: FLEX/USMLE
Post Office Box 619850
Dallas TX 75261-9850

Telephone: (817) 868-4000
Fax: (817) 868-4099

For National Board of Medical Examiners, send your request to:

National Board of Medical Examiners
P.O. Box 48014
Newark, NJ 07101-4814

Overnight Delivery Service Requests:
c/o Image-Remit, Inc.
210 N. Center Drive, Commerce Center #210
North Brunswick, NJ 08902-4246

For the National Board of Osteopathic Medical Examiners, send your request to:

National Board of Osteopathic Medical Examiners
8765 W. Higgins Road, Suite 200
Chicago, IL 60631-4104

Telephone: (773) 714-0622

FAX DOCUMENTS

Fax copies of documents are **NOT** accepted for documentation or verification in our licensing process.

FEDERATION CREDENTIALS VERIFICATION SERVICE

The Federation of State Medical Boards offers a credentials verification service that is accepted by the Alaska board. This verification process is conducted separately and independently by the FCVS in accordance with established policies and procedures set forth by the board. By participation in the FCVS process, you will establish a permanent, lifetime portfolio of primary-source verified credentials allowing for quick and easy access to your important medical credentials.

To utilize this service, you must first enroll by submitting an application to the FCVS. For more information on this service, go to www.fsmb.org/fcvs.html or call toll free 1-888-275-3287. When the FCVS receives your information and documentation, a non-interpretive "Physician Information Profile" containing certified photocopies of your credentials is forwarded directly to the board. Please do not contact the Alaska State Medical Board regarding your FCVS application.

FSMB BOARD ACTION DATABANK REPORT

The Alaska State Medical Board requires all applicants to have a copy of their individual Board Action Databank Report sent directly to the Board by the Federation of State Medical Boards (FSMB). You must contact them directly to order the report: *www.fsmb.org*

FOREIGN LANGUAGE DOCUMENTS
All foreign language documents must be certified true copies and must be accompanied by a certified translation into English by a recognized translator.

LICENSE APPLICATION PROCESSING STAFF
Please visit our website to find the contact information for your Licensing Examiner:
ProfessionalLicense.Alaska.Gov/StateMedicalBoard or call (907)465-2550

INITIAL LICENSURE IN SECOND YEAR OF TWO-YEAR CYCLE
If you were initially licensed in the second year of the two-year licensure period, within 12 months of the date of expiration (December 31, even-number years), the applicant will pay the entire license fee. Upon renewal, the applicant will receive a renewal form that pro-rates the licensure fee for the coming licensure period. The applicant will pay one-half of the required license renewal fee at the time of renewal.

If your permanent license was first issued to you after October 1 of the second year of the licensing period, you will pay the initial full license fee; however, your license will be issued showing the expiration date of the next biennial licensing period. (For example, if your initial license was issued October 18, 2002, the expiration date will automatically be entered as December 31, 2004.)

LICENSING PROCESS
Submit your complete application to the board with fees and pertinent documents. The licensing examiner assembles the documents for your file and advises the applicant of the application status. Upon the completion of the application file when all documents have been received from other organizations, the file is forwarded to the board's administrator who reviews the entire file. At the discretion of the administrator, a Medical or Osteopathic license may be issued.

Applications will be processed in the order in which they are received in the board's office. Please ensure that you apply well in advance of your need for the permit or license. Board staff will not expedite one application before another.

LICENSE RENEWAL
All medical licenses in Alaska are on a two-year cycle, with all licenses expiring December 31 of even-numbered years. Notification for license renewal is mailed out to license holders of record at least 30 days prior to expiration, usually in late October. You are required by law to keep your current address on file with the division (12 AAC 02.900).

Failure to receive a renewal notice is not considered an excuse for nonrenewal. A physician who is not intending to practice medicine in Alaska may renew their license in an inactive status. If you practice in the state occasionally, you must renew your license in active status. An inactive status license prohibits you from practicing; however, if you wish to reactivate your inactive license, contact the licensing examiner for instructions. It is illegal to practice medicine in Alaska with an inactive or lapsed license or permit.

NAME CHANGES
If you have changed your name at any time during your life, you must submit a copy of the legal document (marriage certificate, divorce decree, etc.) supporting your name change.

OPIOID EDUCATION
Attestation of opioid education related to pain management, opioid use and addiction is required to qualify for a new license in the State of Alaska, unless you do not hold a valid DEA registration. You must document compliance with the opioid education requirement on your application.

PAYMENT OF CHILD SUPPORT
If the Alaska Child Support Enforcement Division has determined that you are in arrears on child support, you may be issued a nonrenewable temporary license valid for 150 days. Contact Child Support Services at (907) 269-6900 to resolve payment issues.

PERSONAL INTERVIEWS
Applicants for medical licensure in Alaska may be required to have a personal interview either with an individual board member or with the full board. Should an interview be required, you will be notified and an interview scheduled. An interview may be required if, during the processing of your application, a question arises for which the board determines it requires additional information from you.

PRACTICING IN ALASKA
For information on practice opportunities, please contact:
Alaska State Medical Association
4107 Laurel Street
Anchorage, AK 99508-5334
(907) 562-0304

PRESCRIPTION DRUG MONITORING PROGRAM (PDMP)
A licensee may not prescribe or dispense a controlled substance in Alaska or to Alaskan residents until registration with the PMDP is complete. All actively licensed practitioners with a DEA registration valid in any state or practice location must register with the Alaska Prescription Drug Monitoring Program (PDMP) within 30 days of initial licensure and use the PDMP to review a patient's prescription history each time before prescribing, administering, or dispensing a federally scheduled II or III controlled substance. For more information go to: *PDMP.Alaska.Gov*

PROCESSING TIME
In general, average processing time for a temporary license is from six to eight weeks. Full licensure may take up to twelve to fourteen weeks. Please plan accordingly. Application processing time depends to a large extent on the response time from other organizations. Time required also depends upon our workload and the volume of applications being processed. Because the length of processing time for your application may vary considerably, we urge you to be patient until our processing is complete and the license is issued.

If there are any "yes" responses or if adverse information is received, it will typically take longer to gather and evaluate additional data. If the application is referred to the Investigations Unit for investigation of a particular issue, processing time is extended by the time required to complete an investigation. Since investigations must be prioritized, it may take longer to complete the file.

SOCIAL SECURITY REQUIREMENT
Alaska Statute 08.01.060(b) requires an applicant for an occupational license to provide a United States social security number. Applicants who are foreign citizens and are unable to obtain a social security number must contact the division office for instructions. Social security numbers are required by federal law to be held confidential; we do not release these numbers to the public.

STALE DOCUMENTS
If during the license application process certain documents become older than twelve months from the date the document was received in our office, that document is considered to be stale and must be resubmitted. Affected documents include the application document, verifications of licensure from other licensing jurisdictions, the DEA clearance report and the FSMB Board Action Data Bank report.

STATE BUSINESS LICENSES
Physicians who are employees do not need to obtain an Alaska state business license; physicians who are independent contractors must obtain a state business license. You may obtain a business license by contacting: *BusinessLicense.Alaska.Gov or* (907) 465-2550

TELEPHONE QUERIES
We have a very small staff and work hard to process applications as quickly as possible. Unnecessary telephone calls to our offices delay processing. If the licensing examiner must spend time answering numerous telephone queries, application processing time is affected. Because of the huge volume of telephone calls regarding the status of applications and because of privacy issues, **we must restrict our telephone responses to the applicant only**. We will not discuss your application with others. If you are concerned about your application being received in our office, mail it "certified – return receipt requested." You will have a verification of delivery returned to you by the post office.

TEMPORARY LICENSE
Upon receipt of your initial application with payment and minimum required documents, your application will be forwarded to the board's executive administrator. Following her review, she may authorize the issuance of a temporary license. Since the Board only meets four times each year, the temporary license allows you to practice until your application is considered complete and eligible to be reviewed for full licensure at the next board meeting.

VERIDOC – LICENSE VERIFICATION SERVICE
You may wish to utilize the services of Veridoc, Inc. for the purpose of expediting your verifications of licensure from other states to the Alaska board for your application. To use this system, log on to their website at *www.veridoc.org* for more information. The use of Veridoc eliminates the time delay often experienced when relying on post office mail to receive license verifications. We recommend the use of Veridoc to expedite processing.

WITHDRAWAL OF APPLICATIONS
The board permits the withdrawal of an application that it has not yet considered at a board meeting. Should you wish to withdraw your application, please submit a request in writing stating the reason for the withdrawal. Requests must be received before the first time the Board reviews and considers the application. All withdrawals are reported to the Federation of State Medical Boards stating the reason for the withdrawal.

WEBSITE ADDRESS
The Division of Corporations, Business and Professional Licensing maintains a website where you may check to see if your license or permit has been issued. The address is *https://www.commerce.alaska.gov/cbp/main/Search/Professional.*

The medical board's website is *ProfessionalLicense.Alaska.Gov/StateMedicalBoard.*

PROFESSIONAL FITNESS QUESTIONS

A "yes" response in the application does not mean your application will be denied. If you have responded "yes" to any question in the application, additional time will be required for the gathering and assessment of pertinent information. **You can expedite this process by providing with your application complete explanations and documentation for any "yes" responses.**

HOW CAN YOU HELP?

1. First and foremost: apply far enough in advance to allow for application processing.
2. If you are concerned about your application being received in our office, mail it Certified - Return Receipt.
3. Ensure the application is complete when you submit it and provide any necessary explanations with the application. Print legibly or type your application.
4. Provide complete explanations for any "yes" responses. It saves time if we don't have to contact you and request such information.
5. Provide a brief description for any malpractice claims describing the allegation, the nature of the case, your level of involvement, and the resolution of the case.

WHEN IN DOUBT, DISCLOSE AND EXPLAIN.

THE STATE of ALASKA

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

MED

FOR DIVISION USE ONLY

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

Medical or Osteopathy License Application

PART I Professional Designation

Applying By:	☐ Examination (Not licensed in another state) ☐ Credentials (Licensed in another state)
Profession:	☐ Allopathic Physician (MD) ☐ Osteopathic Physician (DO)

PART II Payment of Fees

Required Fees:	☐ Nonrefundable Application Fee	**$400.00**
	☐ License Fee	**$425.00**
PDMP Fees:	☐ I have an active DEA registration number valid in any state or practice location.	**$ 0.00**
	☐ I do not have an active DEA registration number valid in any state or practice location.	**$ 0.00**

PART III Personal Information

Full Legal Name:	

Provide all other names used (maiden, nicknames, aliases). If any documentation will be received in a prior name, you must provide a certified true copy of the documentation showing proof of legal name change(s).

☐ Not Applicable
☐ Other Names Used: _____

Residence Address:	Street	City	State	Zip
Practice Address:	Street	City	State	Zip

Which address do you want to use for your mailing address and for the public record?
☐ Residence Address
☐ Practice Address

PART III Personal Information (continued)

Contact Phone:		**Date of Birth:**	
Place of Birth:		**Gender:**	

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.

SOCIAL SECURITY NUMBER: AS 08.01.060 requires you to provide your United States Social Security Number. It is considered confidential information and will not be publicly disclosed; it may be used to verify inter-state licensure.	

PART IV Alaska License or Permit

Complete the following if you have previously held a license or permit in Alaska.

Previous License or Permit Type:	☐ Permanent ☐ Resident ☐ Locum Tenens ☐ Temporary		
Previous AK License or Permit Number:		**Date Issued:**	

PART V Military Service

Have you ever been in the armed forces?	☐ Yes ☐ No		
Branch of Service:		**Date of Commission:**	
Location(s) Where You Served:			
Type of Discharge:		**Date of Discharge:**	

PART VI Medical School Education Information

List the medical school(s) you attended and from which you graduated. If you attended more than one medical school, provide your reason for changing medical schools on a separate sheet of paper signed and dated by you.

Name of Institution	Location (City, State)	Date Graduated

PART VII ECFMG Certification (Foreign Graduates Only)

If you graduated from an International Medical School:

- ☐ My school is listed in the World Directory of Medical Schools, and
- ☐ I have attached a certified true copy of my ECFMG certificate.

ECFMG Certificate Number:		Issue Date:	

PART VIII Post-Graduate Training Information

List internship, residency, or fellowship training programs chronologically.

Name of Institution	Address	Date(s) Attended	Completed?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

PART IX Opioid Education

- ☐ I have received education in pain management, opioid use, and addiction. Upon renewal of my Alaska license, I will provide a Certificate of Completion that confirms at least two hours of credit covering all three areas of the required subject matter: pain management, opioid use, addiction.
- ☐ I request a waiver of the requirement for two hours of education in pain management, opioid use, and addiction until I apply for a DEA registration number.

PART X Examination History

Please specify National Boards, FLEX, LMCC, USMLE or a state-administered medical licensing examination.

Exam Series	Location	Date Administered	Result
			☐ Pass ☐ Fail
			☐ Pass ☐ Fail
			☐ Pass ☐ Fail

PART XI Self-Designated Specialty

You may designate a specialty area of practice, whether you hold a specialty board certification or not. If you are board certified, attach a certified true copy of the board certificate.

☐ I do not wish to designate a specialty area of practice.

☐ I wish to designate the following specialty area(s) of practice:

Specialty / Subspecialty	Certification Date	Specialty Board	Recertification Date

PART XII DEA Registration and PDMP Acknowledgment

1. **Providers with a DEA registration number valid to use in any state or practice location must register with the PDMP. Do you have a DEA Registration number?**

☐ **a.** **NO**, I do not have an active DEA registration number valid to use in any state or practice location. I understand if I obtain a DEA registration number, I must register with the Alaska PDMP within 30 days as required by the board. I will comply with mandatory use and refer to all applicable authorizing statutes and regulations. (Skip to Part XIII)

☐ **b.** **YES,** I have an active DEA registration number valid to use in any state or practice location. I understand I must register with the Alaska PDMP within 30 days of receiving this license, as required by the board, and will comply with mandatory use as required by AS 17.30.200 and 12 AAC 40.967.

☐ I acknowledge I must review a patient's prescription history prior to prescribing, administering, or dispensing a federally scheduled II or III controlled substance. I understand that I must also review the patient's history once every 30 days for up to 90 days, and at least once every three months if treatment continues for more than 90 days.

If I have a change in DEA registration number or status, I also understand I must promptly submit the DEA Registration Status Change Form (#08-4763).

If you're unsure of the DEA issue date, indicate January 1st of the estimated year.

DEA Registration Number:		Issue Date:		Expiration Date:	

2. **Providers who directly dispense a federally scheduled II - IV controlled substance are required to report daily. Do you plan to directly dispense?** Directly dispense means you deliver the substance directly to the user. Writing a prescription for a patient to fill at a pharmacy is NOT direct dispensing.

Reporting does not apply to you if you directly dispense an outpatient supply of 24-hours or less in practice locations exempt under AS 17.30.200(t). Exempted facilities include health care facilities (defined in AS 18.07.111 or AS 18.20.499), correctional facilities, inpatient pharmacies, and emergency departments.

Per AS 11.71.900(8) "dispense" means to deliver a controlled substance to an ultimate user or research subject by or under the lawful order of a practitioner, including the prescribing, administering, packaging, labeling, or compounding necessary to prepare the substance for that delivery; "dispenser" means a practitioner who dispenses.

☐ **a.** **YES**, I plan to directly dispense and acknowledge I must report daily per AS 17.30.200 and 12 AAC 52.865.

☐ **b.** **NO**, I do not plan to directly dispense and acknowledge that if I begin directly dispensing, I must report daily. (If you are not directly dispensing, the reporting criteria do not apply to you.)

PART XIII Professional License(s)

Please list all states, territories, provinces, or foreign countries in which you currently are or have ever been licensed as any health care professional. Include instructional and training permits.

State or Jurisdiction	License Number	Issue Date	License Status (Active, Lapsed)

PART XIV Other Professional License(s)

Other than as a physician, have you ever been licensed in any jurisdiction in any other profession of the healing arts?	☐ Yes ☐ No		
License Number	**State or Jurisdiction**	**Issue Date**	**License Status** (Active, Lapsed)

PART XV Medical Societies and Professional Organizations

Please list all medical society memberships and professional organizations.

Name of Organization	Address	From Date	To Date

PART XVI Hospital Affiliations

Have you held hospital privileges within the immediate past five years?	☐ Yes ☐ No

If yes, please list all hospitals in which you have been credentialed within the **immediate past five years.**

Hospital Name	Mailing Address	From Date	To Date

PART XVII Work History

Please provide a chronological listing of all medical and non-medical activities beginning with your graduation from medical school to the present date with no more than a 60-day gap in time. Please do not attach a CV; we require the use of this form. If necessary, make additional copies of this page, or continue to list your work history on a separate sheet labeled with your name and signed by you.

Please explain any gap in time from practice of more than sixty (60) days' duration. If you have retired from practice, provide the dates. If you have been inactive from practice for two years or more, provide the dates and include documentation of your recent continuing medical education.

Start Date	End Date	Facility / Location	Activity

PART XVIII Medical Malpractice History

Have you ever had any claims of malpractice filed against you?	☐ Yes ☐ No

If "yes," you must provide an explanation and support document for each case. Use the Medical Malpractice History Explanation Form (#08-4869) appended to this application.

PART XIX Professional Fitness Questions – Disciplinary History

The following questions must be answered. "Yes" answers may not automatically result in license denial.

For each "yes" response to any question, you must provide an explanation and documentation. Use the letter of explanation form (#08-4752) appended to this application; include full details, dates, locations, type of action, organizations or parties involved, and specific circumstances. A separate letter of explanation form must be provided for each "yes" answer documented below. Documentation includes copies of court orders, charging documents, board, or license actions, etc.

The contents of licensing files are generally considered public records. If you believe that the additional information you are attaching to explain a "yes" answer should be considered confidential, state that in the attachment. A request for confidentiality may or may not be granted.

For the purposes of this application, the word "discipline" is used. There are many forms of disciplinary actions that may be imposed by organizations, schools, programs, licensing authorities, and other agencies. Such disciplinary actions may include but not be limited to: Suspension, Surrender, Revocation, Probation, Academic Probation, Reprimand, Censure, Restricted License, Limited License, Conditioned License, or Letters of Counseling, Concern, Advice, Warning, Caution, Admonishment, Reprimand, etc. You must include non-reported disciplinary actions. Failure to disclose past history may be grounds for disciplinary sanctions.

When in doubt, disclose and explain.

1.	Have you ever been convicted of a crime (felony or misdemeanor) in any jurisdiction of the United States, including military, or any international jurisdiction?	☐ **Yes** ☐ **No**
	Is any such action pending?	☐ **Yes** ☐ **No**
2.	Have you ever been charged with a crime (felony or misdemeanor) in any jurisdiction of the United States, including military, or any international jurisdiction that did not result in acquittal or dismissal?	☐ **Yes** ☐ **No**
	Is any such action pending?	☐ **Yes** ☐ **No**
3.	Relating to the practice of medicine, has there ever been a finding of, or have you ever been found guilty of, professional misconduct, unprofessional conduct, incompetence, or negligence, by any jurisdiction of the United States, including military, or any international jurisdiction?	☐ **Yes** ☐ **No**
	Is any such action pending?	☐ **Yes** ☐ **No**
4.	Relating to the practice of medicine, have you ever had charges filed against you alleging professional misconduct, unprofessional conduct, incompetence, or negligence, in any jurisdiction of the United States, including military, or any international jurisdiction?	☐ **Yes** ☐ **No**
	Is any such action pending?	☐ **Yes** ☐ **No**
5.	Has any hospital or other health care facility disciplined, restricted, or terminated your professional training, employment, or privileges, or investigated a complaint or accusation regarding your practice (except for late medical records)?	☐ **Yes** ☐ **No**
	Is any such action pending?	☐ **Yes** ☐ **No**
6.	Have you ever voluntarily or involuntarily resigned or withdrawn from professional training, from employment, or your privileges from any hospital or other health care facility to avoid the imposition of disciplinary sanction, restriction or termination?	☐ **Yes** ☐ **No**
	Is any such action pending?	☐ **Yes** ☐ **No**

PART XIX Professional Fitness Questions – Disciplinary History (continued)

7. Have you ever been disciplined by a medical school or post-graduate training program, including academic probation? ☐ **Yes** ☐ **No**

Is any such action pending? ☐ **Yes** ☐ **No**

8. Have you ever had a license to practice medicine disciplined by any authority including a state medical board or a military authority (except for late medical records)? (If you are unsure about your response to this question, please refer to the instructions and definitions for this section on page 7 of this application above. When in doubt, disclose and explain.) ☐ **Yes** ☐ **No**

Is any such action pending? ☐ **Yes** ☐ **No**

9. Have you ever been under investigation by any medical licensing jurisdiction or authority? (If you are unsure about your response to this question, please refer to the instructions and definitions for this section on page 7 of this application. When in doubt, disclose and explain.) ☐ **Yes** ☐ **No**

Is any such action pending? ☐ **Yes** ☐ **No**

10. Have you ever had a medical license application denied by any medical licensing jurisdiction or authority? ☐ **Yes** ☐ **No**

Is any such action pending? ☐ **Yes** ☐ **No**

11. Have you ever voluntarily or involuntarily withdrawn an application for a license to practice medicine in any United States jurisdiction or any international jurisdiction? ☐ **Yes** ☐ **No**

Is any such action pending? ☐ **Yes** ☐ **No**

12. Have you ever voluntarily or involuntarily surrendered or suspended your license to practice medicine in any United States jurisdiction or any international jurisdiction? ☐ **Yes** ☐ **No**

Is any such action pending? ☐ **Yes** ☐ **No**

13. Have you ever voluntarily or involuntarily agreed to any limitations, restrictions, or conditions to your license to practice medicine? ☐ **Yes** ☐ **No**

Is any such action pending? ☐ **Yes** ☐ **No**

14. Has your employment by a clinic, hospital, or other health care organization ever been terminated involuntarily or voluntarily as a result of an actual or potential investigation or as grounds for disciplinary proceedings? ☐ **Yes** ☐ **No**

Is any such action pending? ☐ **Yes** ☐ **No**

"Yes" Answers

If you answered "yes" to any of the above questions, you must submit signed and dated documentation explaining the specific circumstance(s) of the incident(s).

PART XX Professional Fitness Questions – Personal History

The following questions must be answered. "Yes" answers may not automatically result in license denial.

For each "yes" response to any question, you must provide an explanation and documentation. Use the letter of explanation form (#08-4752) appended to this application; include full details, dates, locations, type of action, organizations or parties involved, and specific circumstances. A separate letter of explanation form must be provided for each "yes" answer documented below. Documentation includes copies of court orders, charging documents, board, or license actions, etc.

You must also have your treating physician submit a letter directly to the Board; the letter must include the following information:

- Summary of your diagnoses (including explanation, dates of onset and significant events, and frequency of contact with you)
- Medication history
- Impact on your ability to practice safely and competently

When in doubt about your response, disclose and provide the required explanation and documents. Applications submitted without the required attachments will be considered incomplete and will not be processed.

The contents of licensing files are generally considered public records. If you believe that the additional information you are attaching to explain a "yes" answer should be considered confidential, state that in the attachment. A request for confidentiality may or may not be granted.

For the purposes of the questions in this section:

"Medical Condition" includes physiological, mental, or psychological conditions or disorders such as, but not limited to, orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

"Controlled Substances" means any substance as defined in either Alaska Statute 11.71.900 or the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C.A. Section 801 et seq. (Public Law 91-513) and any subsequent amendment(s).

"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application; rather, "currently" means recently enough so that the event, condition, behavior, impairment, limitation, etc., may have an ongoing impact on the applicant's ability to practice medicine in a competent manner.

"Illegal Drug Use" means the use of an illegally obtained controlled substance or dangerous drug; the term "illegal drug use" also means the use of a legally obtained controlled substance or dangerous drug which is not taken in accordance with the directions of the licensed physician who prescribed the controlled substance or dangerous drug.

1.	In the past two years, have you been diagnosed as having, or been hospitalized for, a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety?	☐ **Yes**	☐ **No**
2.	Do you currently have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety?	☐ **Yes**	☐ **No**
3.	In the past two years, have you been the subject of any civil investigation or court process relating to your ability to practice in a safe and competent manner?	☐ **Yes**	☐ **No**
4.	Are you currently engaged in the illegal use of drugs, or the use of illegal drugs?	☐ **Yes**	☐ **No**
5.	In the past two years, have you used or are you currently using any chemical substance(s), legal or illegal, that in any way impaired or limited, or is currently impairing or limiting, your ability to practice medicine in a safe and competent manner?	☐ **Yes**	☐ **No**
6.	Are you currently taking a controlled substance that limits your ability to practice medicine in a fully competent and professional manner with safety to patients?	☐ **Yes**	☐ **No**
7.	Have you had or do you now have any disease or condition that interferes with your ability to perform the essential functions of your profession, including any disease or condition generally regarded as chronic by the medical community, i.e., (1) mental or emotional disease or condition; (2) alcohol or other substance abuse; (3) physical disease or condition, that presently interferes with your ability to practice your profession?	☐ **Yes**	☐ **No**

"Yes" Answers

If you answered "yes" to any of the above questions, in addition to your personal statement, you must submit a statement from your health care provider indicating your ability to safely practice medicine. Applications submitted without the appropriate attachments will be considered incomplete and will not be processed.

THE STATE of ALASKA

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Division of Corporations, Business and Professional Licensing

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Email: *MedicalBoard@Alaska.Gov*
Website: *ProfessionalLicense.Alaska.Gov/StateMedicalBoard*

Notary Signature Page

PART XXI Notarized Signature

I certify that the information in this application is true and correct to the best of my knowledge. I understand that if information is provided in the Criminal History Report from the State of Alaska, or FBI, that I did not report, the issuance of my license may be delayed or denied. I further certify that all credentials and supporting documents supplied by me are true and correct and that the photograph below is a true likeness of me taken within the past 60 days. I understand that any false or misleading information or falsification of documents may result in failure to obtain, or subsequent revocation of, a license to practice medicine in Alaska.

I agree to inform the Alaska State Medical Board within 30 days of any change in my credentialing or privilege status in any hospital or other health care facility, any disciplinary actions or restrictions, or investigation of a complaint or accusation regarding my practice (except for late medical records).

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).

Current Passport-Type Photo	**Applicant Printed Name:**			
	Applicant Signature:			
	Notary Public for State of:		**Subscribed and Sworn to Before me on this Day:**	
Notary Seal	**Notary Signature:**		**My Commission Expires:**	

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Website: *ProfessionalLicense.Alaska.Gov/StateMedicalBoard*

Authorization for Release of Records

I hereby authorize the Alaska Division of Corporations, Business, and Professional Licensing and its investigators to examine my medical and dental records, employment and education records including all training which pertains to my medical practice, and any records pertaining to litigation, judgments, suits, and/or settlements, and any law enforcement records pertaining to me and discuss them with persons having possession of them. I also expressly permit and authorize the release of any and all such records pertaining to me to the Alaska Division of Corporations, Business, and Professional Licensing and its investigators. This release also applies to all records that pertain to credentialing records at facilities at which I have applied for or held privileges to practice medicine.

I authorize the division to discuss my records with persons or organizations that are considered appropriate by the division in connection with an official investigation, and to provide copies of my records to those persons or organizations deemed appropriate by the division.

This release also applies to any documents or records which contain information pertaining to psychiatric, psychological, drug, or alcohol evaluation, counseling, diagnosis or treatment received by me and which were prepared or made in conjunction with, or under the authority or guidance of any local, state, or federal law which relates to psychiatric, drug or alcohol evaluation, diagnosis or treatment, including all information previously identified, collected, or stored under the authority of any state or federal law, including 42 CFR Part 2.

I request that upon presentation of this release, or a Certified True Copy thereof, that you provide copies of those records to the division and/or its investigators, and/or representatives of the Office of the Attorney General of the State of Alaska.

This authorization expires one (1) year from the date of my signature below.

Name:	First Middle Last		
Full Address:	P.O. Box or Street City State Zip		
Phone:		**Date of Birth:**	
Email:			
Signature:		**Date Signed:**	

THE STATE of ALASKA
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Website: *ProfessionalLicense.Alaska.Gov/StateMedicalBoard*

Verification of Licensure

→ Applicant:

Please complete the identifying information below and forward a copy of this form to all states, territories, or other countries' licensing jurisdictions where you have ever been licensed as any health care professional. *Make additional copies of this form, as needed.*

Applicant Name:		**Date of Birth:**	
Medical or Osteopathic School Attended:		**Year of Graduation:**	
Applicant Signature:		**Date Signed:**	

→ Licensing Agency or State Board:

Please complete this bottom part for the applicant identified above and return the form directly to the Alaska State Medical Board at the letterhead address.

License Number:		**State or Jurisdiction:**	
Basis of Licensure: (FLEX, USMLE, Etc.)		**License Status:**	
Original Issue Date:		**Expiration Date:**	

1.	Has this applicant ever been the subject of an investigation by a licensing or disciplinary authority in your state or jurisdiction?	☐ Yes	☐ No
2.	Have formal disciplinary proceedings been initiated against this applicant or the applicant's license by a licensing or disciplinary authority in your state or jurisdiction?	☐ Yes	☐ No
3.	Has this applicant's license ever been suspended, revoked, disciplined, restricted, warned, placed on probation, or in any other manner limited by a licensing or disciplinary authority in your state?	☐ Yes	☐ No
4.	Is any such investigation or action pending?	☐ Yes	☐ No
5.	Are you aware of any derogatory information regarding this applicant?	☐ Yes	☐ No

"Yes" Answers

If you answered "yes" to any question above, please attach a detailed explanation or documentation signed and dated by the person whose signature appears below.

Board Seal	**Signature:**		**Date Signed:**	
	Printed Name:		**Title:**	
	Email:		**Phone:**	

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List of Hospitals Where Privileged

Type or print legibly. List below all hospitals where you currently hold or have held privileges in the last five years. If you have not held privileges within the past five years or never held privileges, please write "None" on this form, sign it, and submit this form as part of your application. Please include residency privileges, if appropriate.

PART I Hospital Information

Hospital	Mailing Address	From Date	To Date

PART II Signature

I certify that listed above are all hospitals where I hold or have held privileges in the past five years. I understand it is my responsibility to request these hospitals submit a letter to the board to complete my application for licensure. I certify under penalty of unsworn falsification that the above information is true and correct.

Applicant Signature:		**Date Signed:**	

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Verification of Hospital Privileges

→ Applicant: Please complete the identifying information below and forward a copy of this form to each hospital where you have held privileges in the immediate past five years. Include privileges held during residency. *Make additional copies of this form, as needed.*

Applicant Name:		**Date of Birth:**	
Applicant Signature:		**Date Signed:**	

→ Hospital: Please complete this bottom part for the applicant identified above and return the form directly to the Alaska State Medical Board at the letterhead address.

Hospital Name:				
Mailing Address:	P.O. Box or Street	City	State	Zip
Dates of Hospital Privileges:				

- THE FOLLOWING SECTION IS TO BE COMPLETED BY HOSPITAL STAFF ONLY -

1.	Has your hospital ever taken any disciplinary action against this physician?	☐ Yes	☐ No
2.	Have there ever been limitations or restrictions on this physician's privileges?	☐ Yes	☐ No
3.	Are any disciplinary actions pending against this physician?	☐ Yes	☐ No
4.	Is there any derogatory information on file regarding this physician?	☐ Yes	☐ No
5.	Is there any reason you would not readmit this physician to your medical staff?	☐ Yes	☐ No

"Yes" Answers

If you answered "yes" to any question above, please attach a detailed explanation or documentation signed and dated by the person whose signature appears below.

Board Seal	**Signature:**		**Date Signed:**	
	Printed Name:		**Title:**	
	Email:		**Phone:**	

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Verification of Medical or Osteopathic School Education

→ Applicant: Please complete the identifying information below and forward a copy of this form to the medical school which awarded your diploma.

Applicant Name:		**Date of Birth:**	
Applicant Signature:		**Date Signed:**	

→ Medical School Staff: Please complete this bottom part for the applicant identified above and return the form directly to the Alaska State Medical Board at the letterhead address.

- THE FOLLOWING SECTION IS TO BE COMPLETED BY MEDICAL SCHOOL STAFF ONLY -

Medical School Name:		**Exact Date on Diploma:**	
Medical School Address:	Street City State Zip		

1. During this physician's medical school education, was he/she ever investigated by the school or disciplined by the school for any reason? Disciplinary actions include but are not limited to being placed on probation, issued a letter of reprimand, censured, suspended, restricted, or otherwise disciplined. ☐ Yes ☐ No

"Yes" Answers

If you answered "yes" to the question above, please attach a detailed explanation or documentation signed and dated by the person whose signature appears below.

Seal (If Applicable)	**Signature:**		**Date Signed:**	
	Printed Name:		**Title:**	
	Email:		**Phone:**	

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DEA Clearance Report

→ Applicant: Please complete this top section, then mail to the Drug Enforcement Administration (DEA):

DEA Diversion, Registration
1630 East Tudor Road
Anchorage, AK 99507

Full Legal Name:					
Other Names Used:					
Date of Birth:		**DEA Registration Number:**			
Mailing Address:	P.O. Box or Street	City		State	Zip
Address of DEA Registration:	P.O. Box or Street	City		State	Zip
Applicant Signature:			**Date Signed:**		

→ DEA Use Only: Please search your records and advise if there is any derogatory information on file against this applicant. Please return this form directly to the Alaska State Medical Board at the letterhead address.

Has this applicant ever surrendered (for cause) or had a federal controlled substance registration revoked, suspended, restricted or denied? ☐ Yes ☐ No

Comments: _____

_____

_____

_____

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Verification of Postgraduate Training

→ **Applicant:** Please complete the identifying information below and forward a copy of this form to the post-graduate training program(s) you attended.

Full Legal Name:		**Date of Birth:**	
Maiden or Other Names Used:			
Medical School Name:		**Year of Graduation:**	
Medical School Location:		**If international graduate, ECFMG No.:**	
Name of Post-Graduate Program:			

→ **Postgraduate Program Staff:** Please complete this bottom part for the applicant identified above and return the form directly to the Alaska State Medical Board at the letterhead address.

- THE FOLLOWING SECTION IS TO BE COMPLETED BY POSTGRADUATE PROGRAM STAFF ONLY -

Verification for Postgraduate Year:	Year 1 ☐ Year 2 ☐ Year 3 ☐ Year 4 ☐ Year 5 ☐ Year 6 ☐
Dates of Training:	

1. At the time this individual completed training in your program, the program was accredited through:

☐ Accreditation Council for Graduate Medical Education ☐ American Osteopathic Association
☐ Royal College of Physicians and Surgeons of Canada ☐ None of These

2. During the physician's participation in your program, was he/she ever investigated or disciplined by the program, such disciplinary actions to include but not be limited to: being placed on probation, issued a letter of reprimand or warning, censured, suspended from the program, restricted, or otherwise disciplined? ☐ Yes ☐ No

3. Is there anything in this physician's postgraduate training records that would indicate he/she would be unable to practice medicine competently and safely? ☐ Yes ☐ No

4. Was a certificate of completion issued to this physician upon completion of the program? ☐ Yes ☐ No

"Yes" Answers

If you answered "yes" to question 2 or 3, please attach a detailed explanation or documentation signed and dated by the person whose signature appears below.

Signature

Board Seal				
	Signature:		**Date Signed:**	
	Printed Name:		**Title:**	
	Email:		**Phone:**	

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Physician Board Action Data Bank Inquiry

→ **Applicant**: Please complete the information below. Type or print legibly. **MAIL THIS REQUEST FORM TO:**

Federation of State Medical Boards
400 Fuller Wiser Rd., Suite 300
Euless, TX 76039-3855

Full Legal Name:			
Date of Birth:		**Social Security Number:**	
Mailing Address:	P.O. Box or Street / City / State / Zip		
Medical or Osteopathic School Name:		**Location:**	
Year of Graduation:		**If International Graduate, ECFMG No.:**	

→ **Applicant: Do Not Write Below This Line - Do Not Detach**

Instructions to the Data Bank Staff: Please search the data bank for any record of this practitioner. Please forward your report to the medical board at the letterhead address.

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Website: *ProfessionalLicense.Alaska.Gov/StateMedicalBoard*

Authorization to Discuss Professional License Application and Information

Medical Board staff is authorized to communicate only with the applicant. If the applicant is using a credentialing agency or is accepting assistance from a staffing or employment agency, division staff must have a signed release from the applicant to discuss the application and share information on file.

To authorize communication, please complete this form and file with your application.

PART I Applicant/Agency Information

Name of Applicant:			
Profession:	☐ Physician ☐ Physician Assistant		
Applicant Email:		**Applicant Phone:**	
Authorized Agency:		**Agency Phone:**	
Authorized Individual:		**Email Address:**	

PART II Signature

I hereby authorize staff of the Alaska State Medical Board to share and exchange information relating to my licensing application with the above-named authorized agency and individual.

This release applies to status updates, documents, and any other information required to complete my application for licensure in the State of Alaska.

☐ I give permission for you to discuss the contents of my license file with the above-named person until the date my license is issued.

☐ I give permission for you to discuss the contents of my license file with the above-named person until I withdraw permission.

Applicant Signature:		**Date:**	

Information for credentialing, staffing or employment agencies:

- Licensing staff will respond to no more than two inquiries from agencies each month. Every effort will be made to respond to inquiries quickly, please allow 10 business days for this request to be processed.
- Applicants are emailed with a status update and may contact staff to query application status at any time.
- The board will not accept applications that list an agency address as the practice address and will likewise not accept the telephone numbers or email addresses for such agencies as the applicant's own. The board may only accept those addresses, phone numbers, and email addresses if the applicant is actually practicing in that office. Alaska law requires the applicant to provide their information, not the agency information.

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Website: *ProfessionalLicense.Alaska.Gov/StateMedicalBoard*

Medical Malpractice History Explanation

Use this form to list and explain your history of malpractice claims filed against you. Include all settlements, judgements, award and claims, even if no money was paid.

Provide documents to corroborate your explanation, including a copy of the order for settlement, dismissal, or removal from the case.

Please do not send all of the motions or filings for a case.

Letters from attorneys or insurance carriers may be submitted to corroborate explanations but may not be substituted for this required explanation.

Location of Incident:		**Date of Occurrence:**	
Date of Case Closure:		**Amount of Settlement:**	
If there was a monetary settlement, upon what basis was it awarded ? (e.g., Attorney/Insurance Company recommended)			
Nature of Allegation and Description of the Case:			
Practitioner Explanation and Response to Allegation:			
What was the overall final injury to the patient? (e.g., disability or death)			

Full Name:			
Signature:		**Date Signed:**	

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Website: *ProfessionalLicense.Alaska.Gov*

Letter of Explanation for a Professional Fitness "Yes" Answer

Use this form only to explain and document any professional fitness "yes" answers. A "yes" answer is not necessarily disqualifying but concealing one may be.

Each "yes" answer requires a separate explanation and associated documentation. Submit all relevant documentation with this form, even if you have previously provided it.

- **Explanations** include full details, dates, locations, type of action, organizations or parties involved, and specific circumstances. If the space provided is insufficient, make additional copies as needed.
- **Documentation** includes copies of court orders, charging documents, board or license actions, decisions against your professional certification, satisfaction of consent agreements (fines paid, community service completed, off probation, etc.), and fitness to practice letters (statement from your provider that you are safe to practice if you check "yes" to any of the questions regarding mental or physical health, or drug or alcohol abuse or addiction).
- **Disciplinary actions** may include, but not be limited to, suspension, surrender, revocation, probation, academic probation, reprimand, censure, restricted license, limited license, conditioned license, or letters of counseling, concern, advice, warning, caution, admonishment, or reprimand.

If you have multiple "yes" answers or multiple incidents for any professional fitness question, you must use a separate copy of this form and provide a full explanation and documentation for each incident.

The contents of licensing files are public records. If you believe that the additional information you are attaching to explain a "yes" answer should be considered confidential, state that in the attachment. A request for confidentiality may or may not be granted according to state law.

☐ ⇦ **Write the professional fitness question number you are answering "yes" to in the box.**

Location of Incident:		**Date of Incident:**	
Explanation of Incident: When in doubt, disclose and explain. *Make copies as necessary.*			

Did you attach all applicable documents associated with this incident?

☐ Court Orders ☐ Consent Agreements ☐ Disciplinary Actions ☐ Charging Documents

☐ Court Records ☐ Fitness to Practice ☐ All Other Documentation Related to This Incident

☐ I have additional incidents for this "yes" answer, or "yes" answers to other Professional Fitness questions and have attached a separate copy of this form for each incident.

Full Name:		**Program:**	
Signature:		**Date Signed:**	

THE STATE of ALASKA

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

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State of Alaska
Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing
PO Box 110806, Juneau, AK 99811
Phone: (907) 465-2550

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: _____

Profession Type (e.g., Acupuncture):

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 *(fine, exam, etc.)*: _____ _____

1. _____ _____
2. _____ _____

TOTAL: _____

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

Mailing Address: _____

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

Signature of Credit Card Holder: X _____

08-4438 Rev 12/06/2022 Credit Card Payment Form (all major cards accepted)

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

1. Credit Card Number: -
2. Expiration Date: -
3. Security Code: -

All 3 fields **MUST** be completed!

This section will be destroyed after the payment is processed.