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 Emergency Courtesy License Application Instructions

Only Physicians (MD) and Osteopathic Physicians (DO) may use this form to apply for an Emergency Courtesy License.

If approved, an Emergency Courtesy License authorizes an individual to practice in Alaska during the period in which the Medical Board has determined an urgent health crisis exits. Emergency Courtesy licenses are issued for six months and may be extended for one additional six-month period if the board has determined the urgent situation still exists.

All actively licensed practitioners with a DEA registration number valid to use 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, please visit *PDMP.Alaska.Gov*

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

1. APPLICATION
A signed, completed application (#08-4735, pages 1-4).

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

Nonrefundable Application Fee:	$100.00
Emergency Courtesy License Fee:	$150.00
Prescription Drug Monitoring Program (PDMP):	$ 0.00
Total Fees Due:	$250.00

3. AUTHORIZATION FOR RELEASE OF RECORDS
A completed Authorization for Release of Records form (#08-4735a).

4. VERIFICATION OF LICENSURE
A completed Verification of Licensure form (#08-4735b) showing current license to practice medicine or osteopathy in good standing and not under investigation in the jurisdiction in which the applicant resides, OR verification of a retired license issued under AS 08.64.296.

This license must be current at the time the board issues the courtesy license. An inactive status is not a current license.

5. CLEARANCE REPORT - DEA
A completed Clearance Report form (#08-4735c) from the Drug Enforcement Administration.

6. CLEARANCE REPORT - FSMB
A completed Clearance Report form (#08-4735d) from the Federation of State Medical Boards.

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

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Medical Emergency Courtesy License Application

PART I Payment of Fees

Required Fees:	☐ Nonrefundable Application Fee	**$100.00**
	☐ Emergency Courtesy License Fee	**$150.00**
PDMP Fees:	☐ I have an active DEA registration number valid in any state or practice location.	**$ 0.00**
	☐ I do not have an active DEA registration number valid in any state or practice location.	**$ 0.00**

PART II 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: _____			
Mailing Address:	P.O. Box or Street / City / State / Zip		
Contact Phone:		**Date of Birth:**	
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 by Email ☐ Send my Correspondence by Mail
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 III Retired License

Do you currently hold a retired license issued under AS 08.64.296 within the past two years?		☐ No	☐ Yes
***If Yes,* License Number:**			

PART IV 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 V)

☐ **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 courtesy 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 a 3-day supply or less, or 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 V 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 VI Scope of Practice

Provide a description of the scope of practice below. Attach an additional document if necessary.

PART VII Professional Fitness Questions

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.

If you answer "yes" to questions 4, 5, or 6, in addition to your personal statement, you must also 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. When in doubt about your response, disclose and provide the required explanation and documents.

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.

When in doubt, disclose and explain.

1.	Has your professional license in any state or country ever been denied, revoked, suspended, stipulated, on probation, or been subject to any other restriction or disciplinary action?	☐ **Yes**	☐ **No**
2.	Have you ever been convicted of any misdemeanors or felonies (convictions include "suspended impositions of sentence")?	☐ **Yes**	☐ **No**
3.	Have you ever been or are you currently the subject of an inquiry or under investigation by any state board or other licensing agency concerning a violation or alleged violation of any state regulation, statute, or for any violation or alleged violation relating to the practice of medicine or osteopathy or unprofessional or unethical conduct?	☐ **Yes**	☐ **No**
4.	Within the past five years, have you been or are you currently being treated or on medication for any mental or emotional illness which may impair or interfere with your ability to practice safely and in a competent and professional manner?	☐ **Yes**	☐ **No**
5.	Are you currently participating in a substance abuse and/or alcohol or drug treatment program or been diagnosed with a substance abuse disorder which in any way currently affects or limits your ability to practice safely and in a competent manner?	☐ **Yes**	☐ **No**
6.	Do you have a physical disability or physical illness which may impair or interfere with your ability to practice safely and in a competent and professional manner?	☐ **Yes**	☐ **No**
7.	Have you ever had any claims of medical malpractice filed against you?	☐ **Yes**	☐ **No**

"Yes" Answers

If you answered "yes" to questions 4, 5, or 6, in addition to your personal statement, you must submit a personal statement from yourself and 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.

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Signature Page

Applicant Name:	

PART VIII Agreement

I hereby certify that I am the person herein named and subscribing to this application and that I have read the complete application, and I know the full content thereof. I declare that all of the information contained herein, and evidence or other documents submitted herewith are true and correct.

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, certificate, 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.

Applicant Signature:		**Date Signed:**	

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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:**	

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Verification of Licensure

→ Applicant:

Please complete the identifying information below and forward a copy of this form to all states, territories, or jurisdictions where you currently are or have ever been licensed. *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, or is any such investigation or action pending?	☐ 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, or is any such investigation or action pending?	☐ 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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DEA Clearance Report

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

Drug Enforcement Administration
300 5th Avenue, Suite 1300
Seattle, WA 98104

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 physician. Please return this form directly to the Alaska State Medical Board at the letterhead address.

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

2. Is any such investigation pending? ☐ Yes ☐ No

Comments:

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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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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:		**PL Code:**	
Signature:		**Date:**	

You must submit one form for each "Yes" answer. Make copies of this form as necessary.

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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.