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 99811-0806
(907) 269-8163
Email: *MedicalBoard@Alaska.Gov*
Website: *ProfessionalLicense.Alaska.Gov/StateMedicalBoard*

# Mobile Intensive Care Paramedic Emergency Courtesy License Application

**Only Mobile Intensive Care Paramedics 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.

***The following must be received by the division before your application can be reviewed:***

1. **APPLICATION**
   A completed application.

2. **FEES**
   Nonrefundable Application Fee: $50
   Emergency Courtesy License Fee: $20

3. **LICENSE VERIFICATION**
   Verification of a current license to practice medicine in good standing and not under investigation in the jurisdiction in which the applicant resides (form #08-4737a).

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

4. **PHYSICIAN SPONSOR'S STATEMENT OF SUPERVISION**
   A declaration of sponsorship form (#08-4737b) signed by a physician or osteopath who holds a license in this state, or an emergency courtesy license issued under this subsection, who will provide supervision as required by 12 AAC 40.310(a)(3).

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

**MED**

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# Mobile Intensive Care Paramedic Emergency Courtesy License

## PART I Payment of Fees

| | | |
|---|---|---|
| **Fees:** | ☐ Nonrefundable Application Fee | **$50.00** |
| | ☐ Emergency Courtesy License Fee | **$20.00** |

## PART II Personal Information

| | | | | |
|---|---|---|---|---|
| **Full Name:** This is a name change ☐ | | | | |
| *If you have had a legal name change since your last license was issued, you must complete a Change of Name form.* | | | | |
| **Mailing Address:** | Address/PO Box | City | State | ZIP Code |
| **Birthdate:** | | | | |
| **Contact Phone:** | | | | |

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

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

| | |
|---|---|
| **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 Professional Fitness Questions

**The following professional fitness questions must be answered in accordance with AS 08.64.331 and 12 AAC 40.045.**

"Yes" answers may not automatically result in license denial. If you answer "Yes" to any of the questions, please explain dates and specific circumstances (locations, type of action, organizations or parties involved) on a separate piece of paper, signed and dated, and send any supporting documents that are applicable (court records, judgments, charging documents, certificates of completion, board or license actions, investigative notices, etc.).

If you answer "Yes" to questions 4, 5, or 6, you must also submit a statement from your health care provider indicating your ability to safely practice as a mobile intensive care paramedic as applicable. as applicable. Applications submitted without the appropriate attachments will be considered incomplete and will not be processed.

***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 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**

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# Signature Page

| **Applicant Name:** | |
|---|---|

## PART IV 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's Signature:** | | **Date:** | |
|---|---|---|---|

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# Verification of Licensure

→ **Applicant**: Complete this top part and then forward a copy to all states, territories or other countries' licensing jurisdictions where you have ever been licensed. Make copies as needed.

| | | | |
|---|---|---|---|
| **Full Legal Name:** | | **Birth Date:** | |
| **Name of Training Program:** | | **Year Graduated:** | |
| **Applicant's Signature:** | | **Date:** | |

→ **Licensing Agency**: Complete this bottom part for the physician identified above and return the form directly to the Alaska State Medical Board.

| | | | |
|---|---|---|---|
| **State Board or Licensing Jurisdiction:** | | **License Number:** | |
| **Initial License Date:** | | **Expiration Date:** | |
| **Name of Training Program:** | | **Current License Status:** | |

| | | | |
|---|---|---|---|
| **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.** | Are you aware of any derogatory information regarding this applicant? | **Yes** ☐ | **No** ☐ |
| **5.** | Is any such investigation or action pending? | **Yes** ☐ | **No** ☐ |

| | | |
|---|---|---|
| Board Seal | **Signed by:** | **Date:** |
| | **Printed Name:** | **Title:** |

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# Physician Sponsor's Statement of Supervision

**Applicant**: →

Regulation 12 AAC 40.315 requires that you be under the supervision of a physician sponsor at all times. Please complete the top portion of this form and have your current physician sponsor complete the lower part.

| | | | |
|---|---|---|---|
| **Full Legal Name:** | | | |
| **Address:** | | | |
| **Applicant's Signature:** | | **Date:** | |

**Physician or Osteopath Sponsor:** →

Please complete the lower portion of this form and return it directly to the Alaska State Medical Board at the letterhead address above. All information requested below must be provided. If any space is left blank, the form will be returned to you for completion.

## Acknowledgement

I certify that I will be the supervising physician for the above named mobile intensive care paramedic applicant.

I further certify that the individual will, at all times, be under my supervision as required by 12 AAC 40.315. I understand that a change in sponsorship will automatically suspend the paramedic's license to practice until such time as a new physician sponsor is identified and provided to the board.

| | | | |
|---|---|---|---|
| **Sponsor Name:** | | **License Number:** | |
| **Sponsor Signature:** | | **Date:** | |

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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: _____

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. 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.