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*

Reinstatement of Medical License Application Instructions

Use this application if your Medical, Osteopath or Podiatrist license has been lapsed for at least 1 (ONE) year but less than 5 (FIVE) years or if you are reactivating an inactive license. If your license has been lapsed for less than 1 (ONE) year, complete and submit the Medical License Renewal Application (form #08-0077).

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

- 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.
- 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this application from a source other than directly from the division or its official website, the application may be outdated or not an official version.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, 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.*

The following must be received by the division before your Reinstatement of Medical License Application can be reviewed:

1. APPLICATION
A signed, completed application (#08-4974, pages 1-6).

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

Reinstatement
License Fee: $350.00

Reactivation*
Biennial License Renewal Fee – Inactive License Fees (previously paid in same licensing period) = $ _____
**Contact board staff to determine the appropriate fees*

3. VERIFICATION OF LICENSURE
Verification of Licensure sent directly from all licensing jurisdictions, both U.S. and International, in which you have ever been licensed as any health professional. You must arrange submission directly from licensing board, obtain from primary source website (if available) or Veridoc.

4. CLEARANCE REPORT – FSMB
Division staff will obtain a clearance report directly from the Federation of State Medical Boards.

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

6. VERIFICATION OF CME COMPLIANCE
Submit proof of completing the continuing medical education requirements, in accordance with 12 AAC 40.200 - .240.

General Information

APPLICATION PROCESSING:
The average processing time varies by program. When the application is complete and correct, all supporting documents have been received and all fees have been paid, the license may be issued. Start the process far enough in advance to allow for processing time. Applications are reviewed in order of receipt in our office, and walk-in customers should not expect immediate review.

LICENSE TERM:
Licenses are issued for a two-year period and expire on December 31 of even-numbered years, regardless of the date of issuance, except licenses issued within 90 days of the expiration date which are issued to the next biennial expiration date. One renewal notice will be sent via email or mail at least 30 days before license expiration to the last known email or mailing address of record. Failure to receive a renewal notice does not relieve a licensee from the responsibility of renewing a license on time.

PROFESSIONAL FITNESS QUESTIONS:
A "yes" response in the application does not mean your application will be denied. If you have responded "yes" to any professional fitness questions, submit an explanation with the charging and closing court documentation showing final disposition of charge(s) (e.g. court records, fitness letters, etc.).

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

CHANGES TO LEGAL NAMES, EMAIL ADDRESSES AND/OR MAILING ADDRESSES:
It is the applicant's responsibility to notify the division of any changes to legal names, email addresses and/or mailing addresses. The email or mailing address of record will be used to send all official notifications. The name appearing on the license must be your current legal name. The name change notification form is available on the division's website. Changes to email and/or mailing addresses can be submitted through MY LICENSE. (12 AAC 02.900)

CERTIFIED TRUE COPIES:
If any of the required documents will be issued under a former name, indicate on the application and submit marriage license and/or court documents that are notarized as a "certified true copy of the original document". To obtain a certified true copy, you must present the notary with the original document along with the photocopy. You must write, "I certify this is a true copy of the original document" and sign your name. The notary will compare the original document with the copy and then notarize your signature.

SOCIAL SECURITY NUMBERS:
A U.S. Social Security Number must be on file with the division before a professional license is issued. If you do not have a U.S. Social Security Number, complete the Request for Exemption from Social Security Number Requirement form located at *ProfessionalLicense.Alaska.Gov*, and include required supporting documents as noted on the form. (AS 08.01.060)

PUBLIC INFORMATION:
All information on the application will be available as public record, unless required to be kept confidential by state or federal law.

ABANDONED APPLICATIONS:
An application is considered abandoned when 12 months have elapsed since correspondence was last received from or on behalf of the applicant. An abandoned application is denied without prejudice. At the time of abandonment, the division will send notification to the last known email or mailing address of the applicant, who then has 30 days to submit a written request for a refund of biennial license and other fees paid, if applicable. The application fee will not be refunded. If no request for a refund is received within that timeframe, no refund will be issued, and all fees will be forfeited. (12 AAC 02.910)

STALE DOCUMENTS:
Application forms, authorizations and verifications older than 12 months from the date the document was received by the division will be considered stale; the document must be resubmitted as appropriate before the application will be considered by the division or a licensing board. Application documents include the application documents and verifications of licensure from other licensing jurisdictions. (12 AAC 02.915)

BUSINESS LICENSES:
The status of a professional license will directly impact the status of an associated business license. Renewal applications for business licenses are mailed separately. A professional license does not bypass the need for a business license; if a business license is required, it must be obtained after an initial professional license is issued. For more information about business licenses, visit *BusinessLicense.Alaska.Gov.*

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.

STATUTES AND REGULATIONS:

The complete set of statutes and regulations for this program are available by written request or online at the division's website: *ProfessionalLicense.Alaska.Gov*. Centralized statutes and regulations also apply to all professional licenses; those are also available on the division's website. To receive notifications of proposed regulation changes, send a request with your name, email, and the program you want to be updated on to the regulation specialist at the following email: *RegulationsAndPublicComment@Alaska.Gov.* Courtesy notifications of proposed program regulations changes will also be sent to the email address on record.

PRESCRIPTION DRUG MONITORING PROGRAM:

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. Providers 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. For more information, please visit *PDMP.Alaska.Gov.*

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Reinstatement of Medical License Application

PART I Professional Designation

Profession:	☐ Allopathic Physician (MD) ☐ Osteopathic Physician (DO) ☐ Podiatrist (DPM)
Alaska License Number:	

PART II Payment of Fees

Reinstatement Fees: (Lapsed at Least 1 Year but Less Than 5 Years)	☐ License Fee **$350.00**
Reactivation Fees:* (Inactive License to Active License)	☐ Biennial License Renewal - Inactive License Fees (previously paid in same licensing period) = ____

**Contact board staff to determine the appropriate fees.*

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: _____			
Mailing Address:	P.O. Box or Street	City	State Zip
Practice Address:	Street	City	State Zip
Which address do you want to use for important correspondence affecting your license?		**Select One:**	☐ Mailing Address ☐ Practice Address
Contact Phone:		**Date of Birth:**	
EMAIL AGREEMENT: Providing an email address authorizes the division to send you a web authorization code to register with the MY LICENSE self-service portal. If you have already registered with MY LICENSE, no action is needed. If you did not receive a code or the code you received has expired, contact the division. Once registered you may opt-in to receive all official correspondence electronically. Your account can be accessed at any time.			
Email Address:			
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 Self-Designated Specialty

You may designate a specialty area of practice, whether you hold a specialty board certification or not.

☐ 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 V Professional License(s)

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 VI Hospital Affiliations

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

If yes, list all hospitals in which you have been credentialed within the **immediate past five years.** Print additional pages as needed.

Hospital Name	Location (City and State)	From Date	To Date	Disciplinary Action at Facility?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

PART VII CME Verification of Compliance

Your license cannot be reinstated unless you have met and submitted the continuing medical education requirements, in accordance with 12 AAC 40.200 - .240.

You must provide verification that you have completed an average of 25 credit hours of continuing medical education during each year of the previous license. Of which, at least two of these hours must have been in pain management and opioid use and addiction. The division will use/accept the Accreditation Council for Continuing Medical Education's (ACCME) Program and Activity Reporting System (PARS) to verify that physicians have fulfilled their CME requirements. If you do not use PARS to document your CME activity, you must submit copies of your training certificates with this application.

Select ONE (1) of the following:

☐ I have completed and been awarded credit for at least 50 hours of Category 1 AMA-, AOA-, or CPME-approved education, within the two years immediately preceding the date of this application.

- ☐ I have attached copies of my CME certificates to this application.

  - OR -

- ☐ I use the Accreditation Council for Continuing Medical Education (ACCME) Program and Activity System (PARS). My continuing medical education hours may be verified through this system, and I do NOT need to attach copies of my CME certificates.

☐ I hold a current physician's recognition award from the AMA, AOA or APA, or a recognized subspeciality board.

☐ I obtained initial certification or recertification during the previous licensing period by a specialty board recognized by the AMA or AOA.

☐ I participated in a residency program during the concluding licensing period.

PART VIII Opioid Education

☐ I have provided 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 IX 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 XI)

☐ **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:**	

PART IX DEA Registration and PDMP Acknowledgment *(continued)*

2. **Providers who directly dispense a federally scheduled II - IV controlled substance are required to report the dispensation(s) daily.** 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.

Select ONE (1) of the following:

☐ **a. I send all of my controlled substance prescriptions to be filled at or through a pharmacy, including via a PickPoint system.**

☐ I acknowledge reporting does not apply to me, however if I begin directly dispensing, I must report daily per AS 17.30.200 and 12 AAC 52.865.

☐ **b. I send some of my controlled substance prescriptions to a pharmacy and some I directly dispense to the patient myself.**

☐ I acknowledge I must report daily per AS 17.30.200 and 12 AAC 52.865.

☐ **c. I personally dispense all of my controlled substance prescriptions to my patients myself.**

☐ I acknowledge I must report daily per AS 17.30.200 and 12 AAC 52.865.

☐ **d. I only administer controlled substances to patients at a healthcare facility or correctional facility.**

PART X 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, unless required to be kept confidential by state or federal law.

When in doubt, disclose and explain.

Since the date your last Alaska license was issued or renewed:

1.	Has your professional license been denied, revoked, suspended, surrendered, fined, stipulated, placed on probation, reprimanded, or been otherwise restricted or disciplined in any jurisdiction (including Alaska), including military authorities, or is any such action pending?	☐ **Yes** ☐ **No**
2.	Have you voluntarily or involuntarily surrendered or restricted your professional license in any jurisdiction (including Alaska) for any reason or is any such action pending?	☐ **Yes** ☐ **No**
3.	Have your staff privileges been denied, reduced, restricted, removed, or otherwise disciplined by any hospital, clinic, or other health care organization (for other than late medical records), or is any such action pending?	☐ **Yes** ☐ **No**
4.	Have you been convicted of a crime or are you currently charged with committing a crime? For purposes of this question, "crime" includes a misdemeanor, felony, or a military offense, including but not limited to, driving under the influence (DUI) or driving while intoxicated (DWI), driving without a license, reckless driving, or driving with a suspended or revoked license. "Convicted" includes having been found guilty by verdict of a judge or jury, having entered a plea of guilty, nolo contendere or no contest, or having been given probation, a suspended imposition of sentence, or a fine.	☐ **Yes** ☐ **No**
5.	Have you been the subject of an investigation by any licensing jurisdiction (including Alaska) or are you currently under investigation by any licensing jurisdiction (including Alaska) or is any such action pending?	☐ **Yes** ☐ **No**

PART X Professional Fitness Questions – Disciplinary History *(continued)*

6.	Have you withdrawn an application for a license from a state licensing agency or for privileges from a hospital while under inquiry or investigation?	☐ **Yes** ☐ **No**
7.	Have you been notified of any complaint or allegations involving you filed with or by any licensing authority, including Alaska, which complaint or allegations remain open as of the date of this application?	☐ **Yes** ☐ **No**
8.	Have you been investigated or disciplined by the Drug Enforcement Administration or have you surrendered your federal or any state-controlled substance registration for any reason or is any such action pending?	☐ **Yes** ☐ **No**
9.	Has a medical malpractice claim been resolved or a civil action been terminated in which damages have been paid or are to be paid by you or on your behalf to a claimant or plaintiff, whether by judgment or under settlement?	☐ **Yes** ☐ **No**
10.	If you responded "yes" to question 9, has such settlement already been reported to the board?	☐ **Yes** ☐ **No** ☐ **N/A**

PART XI Professional Fitness Question – Personal History

The following question must be answered. **A "Yes" response requires an explanation and documentation.** Use the letter of explanation form (#08-4752) appended to this application; include full details, dates of onset, duration, prognosis, treatment.

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

- Summary of your condition (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, unless required to be kept confidential by state or federal law.

For the purposes of the question 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.

"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.

Are you currently suffering from any condition, mental or physical, that impairs your judgement or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner? ☐ **Yes** ☐ **No**

"Yes" Answer

If you answered "yes" to the above question, in addition to your personal statement, you must have your treating physician submit a statement indicating your ability to safely practice medicine. Applications submitted without the appropriate attachments will be considered incomplete and will not be processed.

PART XII Alaska Law

☐ I hereby certify I have reviewed, understand and will abide by the statutes and regulations applicable to my profession (AS 08.64 and 12 AAC 40).

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Signature Page

Applicant Name:	
Alaska License Number:	

PART XIII Agreement

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

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); or any criminal charge or conviction.

I understand 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, registration, certificate, or permit to practice in the state of Alaska.

I further understand 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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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 generally considered public records, unless required to be kept confidential by state or federal 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:**	

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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:			
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:	0

Name *(as shown on credit card)*:			
Mailing Address:			
Phone Number:		**Email *(Optional)*:**	
Signature of Credit Card Holder:	X		

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

1. Credit Card Number:		**All 3 fields MUST be completed.**
2. Expiration Date:		**This section will be destroyed after the payment is processed.**
3. Security Code:		