ALASKA STATE MEDICAL BOARD
Post Office Box 110806 Juneau Alaska 99811-0806
Phone: (907)269-8163
E-Mail: medicalboard@alaska.gov
Website: ProfessionalLicense.Alaska.Gov/StateMedicalBoard

APPLICATION FOR LOCUM TENENS PERMIT

This packet contains all the documents you will need to apply for a locum tenens permit to practice medicine in Alaska.

Please read all instructions carefully and complete all documents as requested. Please note the following points:

- The appropriate fees must accompany applications before initial screening can begin.
- Locum tenens application processing time is typically eight weeks after receipt by the board. Start the process far enough in advance to allow processing 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 adverse or derogatory information that comes to light; the review process may take longer.
- An incomplete application or any unusual circumstances noted in the application may require additional processing time.
- 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 insure 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 locum tenens permit is a specific purpose permit set by law. Please ensure that your need for the permit meets the requirements of law for this type of permit. If your need does not meet one of the three purposes for a locum tenens permit, please do not use this application. Contact our office if you have questions about which application packet to use.
- The duration of the permit is 90 days. A one-time extension of 60 days may be obtained. Please refer to the page entitled “Requirements for Extension of Locum Tenens Permit” in this application packet (page 16 of 17 in packet).
- 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this application from a source other than directly from the Division or its official website, the application may be outdated or not an official version.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.

IT IS ILLEGAL TO PRACTICE MEDICINE OR OSTEOPATHY IN ALASKA WITHOUT A VALID LICENSE - PLEASE PLAN AHEAD

LOCUM TENENS PERMIT APPLICATION
IMPORTANT INFORMATION - PLEASE READ CAREFULLY

PURPOSE OF A LOCUM TENENS PERMIT

There are three purposes specified by law for a locum tenens permit. They are:

1. To substitute for a physician or osteopath licensed in Alaska who is temporarily absent from their practice;
2. To be temporarily employed by a physician or osteopath licensed in Alaska who is evaluating the permittee for permanent employment; or
3. To be temporarily employed by a hospital or community mental health center while the facility attempts to fill a vacant permanent physician or osteopath staff position with a physician or osteopath licensed in this state.

If one of these circumstances does not apply to your specific situation, please use the application for a permanent license or the application for a resident permit, as appropriate.

THRESHOLD QUALIFICATIONS FOR LICENSURE - United States Graduates

- Successful graduation from an AAMC- or AOA- accredited medical school
- Successful completion of post-graduate training in an accredited program in a recognized hospital:

  1 Year - If graduated from medical school prior to 01/01/95
  2 Years - If graduated from medical school 01/01/95 or later
- Successful passage of an acceptable licensing examination as defined by regulation
- Completion of an acceptable 2-hour education course in pain management and opioid use and addiction.
- Must be actively licensed in at least one other state
- Submit a list of malpractice settlements/claims
- NOT have a license to practice medicine in another state, province, or territory suspended or revoked

THRESHOLD QUALIFICATIONS FOR LICENSURE - International Graduates

- Successful graduation from a medical school listed in the *Medical Board of California 2006 List of Approved Medical Schools*
- Successful completion of three years of post-graduate training at an accredited program in a recognized hospital in the U.S. or Canada
- Successful passage of an acceptable licensing examination as defined by regulation
- Completion of an acceptable 2-hour education course in pain management and opioid use and addiction.
- ECFMG Certificate
- Must be actively licensed in at least one other state
- Submit a list of malpractice settlements/claims
- NOT have a license to practice medicine in another state, province, or territory suspended or revoked

CONTENTS OF A COMPLETE APPLICATION

- Complete Application Form and Fees
- Statement of Purpose
- Authorization for Release of Records
- Verifications of Licensure from all states, territories, or provinces of Canada in which you have ever been licensed
- Certified True Copy of Medical School Diploma
- Certified True Copy of postgraduate training program certificates
- Clearance report from the Federation of State Medical Boards Disciplinary Data Bank
- Appropriate examination scores as required by regulation

General Information

ADDRESS OF RECORD
Item 8 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. This is also the address that is available to the public. If you choose to use a third party address such as an employment or staffing agency, we are not responsible for mail reaching you directly.

APPLICATION STATUS UPDATES
Our licensing examiner will send you a written status update upon the initial screening of the application. Use our convenient online services by registering with MyLicense. The online features will help you 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

APPLICATION SUBMITTAL
Submit application forms and supporting documents by U.S. Mail to:
Alaska State Medical Board
PO Box 110806
Juneau, AK 99811-0806

If you are using a courier delivery service, the physical delivery address is: 333 Willoughby Ave.-Ninth Floor, Juneau, Alaska. The U.S. Post Office will not deliver to the physical address.

CERTIFIED TRUE COPIES
To obtain a certified true copy, take the original document to a notary public so he/she may compare the original to the photocopy of the document. The notary must write “I certify this to be a true copy of the original" on the photocopy and attest to the fact by signing and notarizing the document.

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 you are providing in your application 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.

Each question in the application must be answered. Attach separate sheets of paper, labeled with your name and signed by you, for any question for which you have provided a 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 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 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.

DENIAL OF APPLICATION
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.

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

FEES
Fees for a locum tenens physician application are:

$150	Nonrefundable Application Fee
$150	Locum Tenens Permit Fee
$300	**Total Due**

The appropriate fees must accompany all applications. Personal checks, cashier’s checks, or money orders must be made payable to the State of Alaska. Incorrect fees will delay processing of your application.

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.

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 board’s administrator reviews the file. At the discretion of the administrator, a locum tenens permit may be issued.
Following the authorization from the board’s administrator, the licensing examiner will issue the locum tenens permit and mail it to the address indicated in the application.
Applications will be processed in the order in which they are received in the board’s office. Please insure that you apply well in advance of your need for the permit. Board staff will not expedite one application before another.

LICENSE APPLICATION PROCESSING STAFF
All inquires should be directed to the State Medical Board - 907-269- 8163 or medicalboard@alaska.gov

OPIOID EDUCATION
A two-hour education course (equivalent to a continuing medical education program) is required to qualify for a new license in the State of Alaska, unless you do not hold a valid DEA registration. Courses must be Category 1 of AMA-approved education, or Category 1 or 2 of AOA-approved education. For a podiatrist, it may instead be earned in a continuing medical education program from a provider that is approved by the Council on Podiatric Medical Education (CPME). To document compliance with the opioid education requirement, the title/description of the program on your Certificate of Completion should specifically reference all three areas of the required subject matter: pain management, opioid use, addiction.

PAYMENT OF CHILD SUPPORT AND STUDENT LOANS
If the Alaska Child Support Enforcement Division has determined that you are in arrears on child support, or if the Alaska Commission on Post-Secondary Education has determined you are in loan default, you may be issued a nonrenewable temporary license valid for 150 days. Contact Child Support Services at (907) 269-6900 or the Post-Secondary Education office at (907) 465-2962 or 1-800-441-2962 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.

Prescription Drug Monitoring Program (PDMP)

All Alaska-licensed practitioners with a DEA registration must register with the Alaska Prescription Drug Monitoring Program (PDMP) and use the PDMP to review a patient's prescription history each time before prescribing a federally scheduled II or III controlled substance. pdmp.alaska.gov

PROCESSING TIME
In general, average processing time for a locum tenens permit is eight 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 permit is issued.

If there are any "Yes" responses or if adverse information is received, it may 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 six 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.

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.

WEBSITE ADDRESSES
The Division of Occupational Licensing maintains a website where you may obtain general information about the board or check to see if your license or permit has been issued: www.dced.state.ak.us/occ/pmed.htm.

"YES" RESPONSES
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. If you wish to expedite processing as much as you can, send all your verification request forms out via overnight mail and include a return overnight mail envelope addressed to the licensing examiner for the organization's use. This will help them to respond quickly.
4. Insure the application is complete when you submit it and provide any necessary explanations with the application. Print legibly or type your application.
5. Provide complete explanations for any "Yes" responses. It saves time if we don't have to contact you and request such information.
6. 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.

QUESTIONS? CALL 907-269-8163

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For Office Use Only

APPLICATION FOR LOCUM TENENS PERMIT

Nonrefundable Application Fee	$150
Locum Tenens Permit Fee	$150
Total Due	**$300**

PART I PERSONAL IDENTIFICATION INFORMATION

(Type or Print Legibly)

1	Full Legal Name (Last, First, Middle)	Last	First	Middle	
2	Other Names Used (Incl. Maiden Name)				
3	Legal Name Changes (Provide copies)				
4	Date of Birth	Mo Day Year / /	Place of Birth (City, State/Country):		Sex: ☐ M ☐ F
5	Full Practice Address	Mailing Address (Include street address if using post office box)			
		City	State	Zip Code	
6	Full Residence Address	Mailing Address (Include street address if using post office box)			
		City	State	Zip Code	
7	Telephone	Work	Area Code/Phone	Home	Area Code/Phone
8	Preferred Address of Record (See Address of Record information.)	☐ Use Practice Address		☐ Use Residence Address	
9	E-Mail Address			☐ Send my correspondence by email ☐ Send my correspondence by US Mail	
10	Professional Designation	☐ MD	☐ DO	☐ DPM	
11	Previous License/Permit In ALASKA?	☐ NO ☐ YES		If YES, what type and when: Type: _____ Year: _____	

APPLICANT: As required by state law, please provide your Social Security Number in the space below. It is considered CONFIDENTIAL information and is not for public disclosure.

Applicant's Social Security Number _____

PART II EDUCATION

1. **Medical School Education** List all medical schools you have attended. 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	Year Graduated

If you graduated from an International Medical School:

[ ] My school is listed on the 2006 Medical Board of California's list of approved schools; and

[ ] I have attached a certified true copy of my ECFMG certificate

ECFMG Certificate Number _____ Issue Date: _____

2. **Postgraduate Training** List internship, residency, or fellowship training programs chronologically.

Yr	Hospital	Mailing Address		(MM/YYYY)	Completed Yes/No
1			From		
			To		
2			From		
			To		
3			From		
			To		

3. **Examination History:** 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
			Pass Fail

4. **Opioid Education**

[ ] I have earned at least two hours of education in pain management, opioid use, and addiction; the course is AMA category 1, or AOA category 1 or 2, or CPME-approved. I will provide a Certificate of Completion that confirms as least two hour 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 addition until I apply for a DEA registration number.

5. DEA Registration and Alaska Prescription Drug Monitoring Program (PDMP)

[ ] I have a valid DEA registration, and have registered with the Alaska PDMP
DEA Registration Number: _____
PDMP Registration Number: _____

[ ] I do not have a DEA Registration. I understand that if I obtain a DEA registration I must register with the Alaska PDMP and use it to review a patient's prescription history, as required by Alaska law.

6. **Self-Designated Specialty**

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

[ ] I do not wish to designate a specialty area of practical.

[ ] I wish to designate the following specialty area(s) of practice.

Specialty/subspecialty	Specialty Board (if applicable)	Date (if Board certified)	Recertification date (if Board certified

PART III PROFESSIONAL ACTIVITIES

1. Other than as a physician, have you ever been licensed in any jurisdiction in any other professions of the healing arts? ☐ No ☐ Yes

If Yes, please complete the following:

Profession (DDS, DC, RN, PA-C, DC, etc.)	Jurisdiction (State, territory, country, etc.)	Date Licensed	Subject to Discipline?
			☐ No ☐ Yes
			☐ No ☐ Yes

If you have responded 'yes' to question 18, verifications of good standing for each license must be submitted for all other health care professions under which you have been licensed by those jurisdictions.

2. **Professional Licensure** Please list **all states, territories, provinces, or foreign countries** in which you hold or have **ever held a license to practice medicine**. Include instructional or training permits. ***Failure to list all jurisdictions may result in disciplinary sanctions or denial.***

	Location (State, territory, etc.)	Date Issued		Location (State, territory, etc.)	Date Issued
1			7		
2			8		
3			9		
4			10		
5			11		
6			12		

If necessary, continue to list on a separate sheet of paper labeled with your name and signed by you.

3. **Medical Malpractice History**

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

If Yes, please list all claims of malpractice filed against you below. Include all settlements, judgments, awards, and claims, even if no money was paid. For each case listed below, provide an explanation and documentation. Provide your explanation on a separate sheet of paper labeled with your name, and signed by you; include a brief description regarding the nature of the case, the allegations, and your response to the allegations. *Letters from attorneys or insurance carriers **may not** be substituted for this required explanation*. Documentation includes a copy of the order for settlement, dismissal, or removal from the case, or other documentation to support your explanation. Please do not send all of the motions or filings for the case.

Case Number	Date of Case (Mo/Yr)	Jurisdiction (State, etc.)	Nature of Allegation	Amount of Settlement Paid on Your Behalf
1				
2				
3				
4				
5				

If necessary, continue to list on a separate sheet of paper labeled with your name and signed by you.

Applicant Name:	Date of Birth:

6. Medical Work History

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.

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.

Dates	Facility/Location	Activity

→ Signature: Date:

SPECIAL INSTRUCTIONS FOR PARTS IV AND V

In responding to the questions in Parts IV and V below, please check the appropriate box next to each question. A "Yes" response to a question does not automatically result in a denial of license application. **For each "Yes" response to any question, you must provide an explanation and documentation.** Provide your explanation on a separate sheet of paper labeled with your name, and signed by you; include full details, dates, locations, type of action, organizations or parties involved, and specific circumstances. When in doubt about your response, disclose and provide the explanation requested. Please answer parts A and B of each question. Documentation includes copies of court orders, charging documents, board or license actions, etc.

CONFIDENTIALITY

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.

PART IV DISCIPLINARY HISTORY

IMPORTANT! ***PLEASE READ BEFORE ANSWERING THE DISCIPLINARY HISTORY QUESTIONS***

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. Please include non-reported disciplinary actions. Failure to disclose past history may be grounds for disciplinary sanctions.

WHEN IN DOUBT, DISCLOSE AND EXPLAIN.

1 a.	☐ No	☐ Yes	Have you ever been convicted of a crime (felony or misdemeanor) in any jurisdiction of the United States, including military, or any international jurisdiction?
1 b.	☐ No	☐ Yes	Is any such action pending?
2 a.	☐ No	☐ Yes	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?
2 b.	☐ No	☐ Yes	Is any such action pending?
3 a.	☐ No	☐ Yes	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?
3 b.	☐ No	☐ Yes	Is any such action pending?
4 a.	☐ No	☐ Yes	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 jurisdictions?
4 b.	☐ No	☐ Yes	Is any such action pending?

Continued on next page

5 a. ☐ No ☐ Yes Has any hospital or other health care facility denied, disciplined, restricted, or terminated your professional training, employment, or privileges, or investigated a complaint or accusation regarding your practice (except for late medical records)?

5 b. ☐ No ☐ Yes Is any such action pending?

6 a. ☐ No ☐ Yes 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?

6 b. ☐ No ☐ Yes Is any such action pending?

7 a. ☐ No ☐ Yes Have you ever been denied privileges or voluntarily or involuntarily resigned, restricted, or withdrawn your privileges from any hospital, clinic, health management organization or other health care facility to avoid the imposition of disciplinary sanction, restriction, or termination?

7 b. ☐ No ☐ Yes Is any such action pending?

8 a. ☐ No ☐ Yes Have you ever been disciplined by a medical school or post-graduate training program?

8 b. ☐ No ☐ Yes Is any such action pending?

9 a. ☐ No ☐ Yes 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)?

9 b. ☐ No ☐ Yes Is any such action pending?

10 a. ☐ No ☐ Yes Have you ever been under investigation by any medical licensing jurisdiction or authority or contacted by a medical board investigator regarding a complaint filed against you?

10 b. ☐ No ☐ Yes Is any such action pending?

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

11 b. ☐ No ☐ Yes Is any such action pending?

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

12 b. ☐ No ☐ Yes Is any such action pending?

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

13 b. ☐ No ☐ Yes Is any such action pending?

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

14 b. ☐ No ☐ Yes Is any such action pending?

Applicant Name:	Date of Birth:

PLEASE READ THESE QUESTIONS CAREFULLY BEFORE YOU RESPOND.

If you respond 'yes' to any question, please attach a complete explanation to your application. Failure to disclose past history may be grounds for disciplinary sanctions.

WHEN IN DOUBT, DISCLOSE AND EXPLAIN.

PART V PERSONAL HISTORY

Please refer to Special Instructions on page 4. For the purposes of the questions in this section, the following phrases or words are defined:

"Ability to Practice Medicine" includes, but is not limited to, the cognitive capacity to make appropriate clinical diagnoses and exercise reasonable medical judgments and to learn and keep abreast of medical developments; the ability to communicate those judgments and medical information to patients and other health care providers with or without the use of aids or devices, such as voice amplifiers; and the physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids of devices, such as corrective lenses or hearing aids.

"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.

"*Chemical Substance(s)"* any natural or synthetic chemical substance, alcohol, drugs, or medications, including those chemical substances taken pursuant to a valid prescription for legitimate medical purpose and in accordance with the direction(s) of the prescribing physician, as well as those used illegally.

"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.

15. ☐ No ☐ Yes — Has your ability to practice medicine in a competent and safe manner ever been impaired or limited by any condition, behavior, impairment, or limitation of a physical, mental, or emotional nature?

16. ☐ No ☐ Yes — Are you currently experiencing any medical condition or disorder that impairs your judgment or that otherwise affects your ability to practice medicine in a safe and competent manner?

17. ☐ No ☐ Yes — Since completing your postgraduate training, have you ever been physically or mentally unable to practice medicine for a period of sixty (60) days or more?

18. ☐ No ☐ Yes — Are you currently the subject of any civil investigation or court process relating to your ability to practice in a safe and competent manner?

19. ☐ No ☐ Yes — Have you ever been diagnosed with, been treated for, or do you currently have pedophilia, exhibitionism, or voyeurism, or any other sexual behavior disorder? (Please note that "sexual behavior disorder" does **not** include sexual preference.)

20. ☐ No ☐ Yes — Are you currently engaged in the illegal use of any drug, whether by ingestion, inhalation, injection, or any other method?

21. ☐ No ☐ Yes — 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?

Continued on next page

Applicant Name: Date of Birth:

22. ☐ No ☐ Yes Have you ever been voluntarily or involuntarily committed or confined to any facility for mental health care?

23. ☐ No ☐ Yes Have you ever been diagnosed with, treated for, or do you currently have (check the appropriate condition):

☐ Bipolar Disorder ☐ Depressive Neurosis ☐ Kleptomania
☐ Hypomania ☐ Any Dissociative Disorder ☐ Pyromania
☐ Schizophrenia ☐ Any Psychotic Disorder ☐ Delirium
☐ Depression ☐ Any Organic Mental Disorder ☐ Paranoia
☐ Seasonal Affective Disorder
☐ Any condition requiring chronic medical or behavioral treatment

24. ☐ No ☐ Yes Have you ever taken, or are you currently taking, any chemical substance for any of the disorders listed in question 41 above?

25. ☐ No ☐ Yes Have you ever been adjudicated or declared incompetent or been the subject of an incompetency proceeding?

! If you have checked "Yes" to any of the questions above, please attach a detailed explanation. You must also have your treating physician submit a letter directly to the Board regarding your ability to practice safely and competently. (See complete instructions on page 5. and 7.)

PART VI SWORN STATEMENT

I hereby certify that I am the person herein named subscribing to this application. I have read the complete application, and I know the full content thereof. **I declare, under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct.** I am the lawful holder of the degree of Doctor of Medicine or Doctor of Osteopathy as prescribed by this application, and that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted were procured without fraud or misrepresentation or any mistake of which I am aware and that I am the lawful holder thereof. I further certify that the photograph that appears below is a true likeness of myself taken within the past 60 days.

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

Applicant Signature_____ Date_____

You must sign and date this application in front of the notary public.
Applicant signature date and notary public date must be the same.

Affix a ***Recent*** Passport Type Photograph Here

NOTE: Notary Seal Must Overlie A Portion of the Photograph.

SUBSCRIBED AND SWORN TO before me, a Notary Public, in and for the State of _____.
this _____day of _____, 20____.

Notary Signature_____
My commission expires:_____

WARNING: Alaska Statute 11.56.210 states that any person who knowingly or intentionally furnishes false or fraudulent information in this application is subject to imprisonment for not more than one year, a fine of not more than $5,000, or both.

MED

ALASKA STATE MEDICAL BOARD

Post Office Box 110806
Juneau AK 99811-0806
Phone:907-269-8163
Email: medicalboard@alaska.gov
Website:ProfessionalLicense.Alaska.Gov/StateMedicalBoard

Office Use Only

LOCUM TENENS PERMIT
STATEMENT OF PURPOSE

APPLICANT (please type or print legibly) _____
(Last Name, First, Middle) MD/DO/DPM

START DATE _____ DURATION OF ASSIGNMENT_____

WORK LOCATION _____

Please have the appropriate physician or administrator sign below the purpose for which you intend to use the locum tenens permit in Alaska.

1 Substituting for a physician or osteopath licensed in Alaska for that physician's temporary absence from practice.

Name of Alaska Physician _____

Signature _____ AK License No._____

2 Temporarily employed by a physician or osteopath licensed in Alaska while that physician or osteopath evaluates the applicant for permanent employment.

Name of Alaska Physician _____

Signature _____ AK License No._____

3 Temporarily employed by a hospital or community mental health center while the facility attempts to fill a vacant permanent physician or osteopath staff position with a physician or osteopath licensed in this state.

Name of Facility _____

Signature of Director or Hospital Administrator _____ Date_____

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AUTHORIZATION FOR RELEASE OF RECORDS

TO WHOM IT MAY CONCERN:

I, _____, residing at
(Please print full name)

_____, hereby authorize the
(Please print full address)

Alaska Division of Occupational 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 Occupational 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.

_____ _____
Signature of Applicant Date

_____
Printed Name of Applicant

_____ _____
Home Phone Number Work Phone Number

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Office Use Only

VERIFICATION OF LICENSURE

Instructions to the Applicant: Please complete Part I below and forward a copy of this form to **all** states, territories, or other countries' licensing jurisdictions where you have **ever** been licensed – including as other health care professionals. Copy this form as needed. Please type or print legibly.

PART I

Full Name (Last, First, Middle)	Maiden or Other Names Used:		Date of Birth (MM/DD/YYYY)
Mailing Address	City	State	Zip
Medical/Osteopathic School Attended	Location		Year of Graduation
Signature of Applicant			Date of Signature

FOLLOWING TO BE COMPLETED BY STATE BOARD OR OTHER LICENSING JURISDICTION ONLY

Instructions to the licensing agency: Please complete Part II below for the physician identified above and return this document directly to the Alaska State Medical Board.

PART II

LICENSING JURISDICTION		**LICENSE NUMBER**	
INITIAL ISSUE DATE		**EXPIRATION DATE**	
BASIS OF LICENSURE (FLEX, USMLE, etc.)		**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?	☐ No	☐ Yes
2	Is any such investigation pending?	☐ No	☐ Yes
3	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?	☐ No	☐ Yes
4	Is any such action pending?	☐ No	☐ Yes
5	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?	☐ No	☐ Yes
6	To your knowledge, is there any derogatory information regarding this applicant?	☐ No	☐ Yes

Signed by _____ Date _____

(Board Seal)

Printed Name _____ Title _____

MED

ALASKA STATE MEDICAL BOARD

Post Office Box 110806
Juneau Alaska 99811-0806
Phone: 907-269-8163
E-Mail: medicalboard@alaska.gov
Website: ProfessionalLicense.Alaska.Gov/StateMedicalBoard

Office Use Only

PHYSICIAN
BOARD ACTION DATA BANK INQUIRY

Applicant: Please complete the identifying information below. Type or print legibly.

YOU MUST MAIL THIS REQUEST FORM TO:

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

NAME _____ DATE OF BIRTH _____ (MM/DD/YYYY)

CURRENT ADDRESS _____

_____

MEDICAL OR OSTEOPATHIC SCHOOL ATTENDED _____ YEAR OF GRADUATION_____

IF INTERNATIONAL MEDICAL SCHOOL GRADUATE, ECFMG NO. _____ YEAR OBTAINED_____

FOLLOWING TO BE COMPLETED BY THE FEDERATION OF STATE MEDICAL BOARDS

Board Action 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.

FOR FEDERATION USE ONLY

ALASKA STATE MEDICAL BOARD

Post Office Box 110806
Juneau Alaska 99811-0806
Phone: 907-629-8163

E-Mail: medicalboard@alaska.gov
Website: ProfessionalLicense.Alaska.Gov/StateMedicalBoard

REQUIREMENTS FOR EXTENSION OF LOCUM TENENS PERMIT

Alaska Statute 08.64.275 (e) provides that the permit holder may request a one-time extension of the locum tenens permit of 60 days. There are several qualifications that must be met before a permit can be extended.

A The following **must be submitted to the board before** the expiration of the initial 90-day permit.

1. Request for Extension of Locum Tenens Permit (form 08-4021f)
2. Application for permanent licensure (form 08-4105 – 10 pages)
3. Authorization for Release of Records (form 08-4105a)
4. List of Hospitals Where Privileged (form 08-4105c)
5. A new Statement of Purpose (form 08-4021 a)
6. Fees: $ **150** extended locum tenens permit fee
   $ **400** nonrefundable application fee
   $ **200** temporary permit fee
   $ 750 total due (This is the minimum amount due upon application; however, the remaining $225 permanent license fee must be paid before the permanent license is issued.)

Please allow a minimum of two weeks prior to the expiration of the locum tenens permit for processing. These documents must be on file with the board before the permit can be extended.

B The documents listed below **must be requested by you** but are not required to be on file before the extension may be granted. You must request these documents be sent to the board to become part of your permanent application:

1 Verifications of licensure from all jurisdictions in which you have ever been licensed
2 Verifications of hospital privileges from all hospitals in which you have been privileged in the past five years
3 Verification of the status of your DEA registration
4 Board Action Data Bank report from the Federation of State Medical Boards
5 American Medical Association's or American Osteopathic Association's Physician Profile
6 National Practitioners Data Bank Report

C If you are requesting the extension based on AS 08.64.275(f) "…the extension is necessary in order to provide essential medical services for the protection of public health and safety… ," you must submit the documents listed in paragraphs 1 and 2 above; however, in addition to the documents listed in paragraph 1 above, the following documents must be **on file with the board before** the extension will be granted:

1 Verification of the status of your DEA registration
2 American Medical Association's or American Osteopathic Association's Physician Profile
3 National Practitioners Data Bank Report

Please contact our office or visit our website for forms or additional information.

907-269-8163 or via email at medicalboard@alaska.gov

www.commerce.state.ak.us/occ/pmed.htm

MED

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REQUEST FOR EXTENSION
LOCUM TENENS PERMIT

Extension Fee: $150

Instructions: State law provides for the initial issuance of a locum tenens permit with one extension of 60 days. Extensions must be specifically requested in advance and must be processed prior to the expiration of the original permit. Check the appropriate use of the locum tenens permit, complete the applicable portions of this form and submit it at least two weeks prior to the expiration of the original permit along with the other documents necessary for an extension of the permit. (See Requirements for Extension of Locum Tenens Permit, form 08-4021e.) **YOU MUST INCLUDE EXTENSION FEE OF $150 WITH THIS REQUEST**. You must also submit the permanent license application along with those required minimum fees of $750. Type or print legibly. Faxed documents are not accepted.

Locum Tenens
Physician Name _____ LT Permit No. _____
(Print Last, First, Middle)

☐ **PART I** **Purpose:** **Locum Tenens Physician Substituting for Absent Alaska Physician**

Alaska Physician for Whom Working Locum Tenens _____

☐ **PART II** **Purpose:** **Locum Tenens Physician Temporarily Employed For Evaluation Purposes for Permanent Employment**

Alaska Physician Employer _____

☐ **PART III** **Purpose:** **Temporarily Employed by Hospital or Community Mental Health Center while Facility is Recruiting for Permanent Physician**

Hospital/Community Mental Health Center _____

Administrator/Director of Facility _____

☐ **PART IV** **Request for Exception to 60-day Extension**

Extension of locum tenens permit necessary to provide essential medical services for the protection of public health and safety.

If you check Part IV above, attach a separate sheet of paper, and provide details for the board to support this request. Your explanation should include the location where you will be providing medical services, the patient population you are serving, the type of practice you are conducting, and why this practice is essential and necessary for the public health and safety. This information will be reviewed by the board and a decision made following that review.

Signature,
Locum Tenens Physician_____ Date _____

THE STATE of ALASKA

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

FOR DIVISION USE ONLY

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: _____

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.