ALASKA STATE MEDICAL BOARD

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

APPLICATION FOR
RESIDENT PERMIT

IMPORTANT INSTRUCTIONS - PLEASE READ CAREFULLY

Sec. 08.64.272. Residency and internship permits. (a) A person may not serve as a resident or intern without a permit issued under this section.

(b) For the limited purpose of residency or internship, the board may issue a permit to an applicant without examination if the applicant meets the requirements of AS 08.64.200(a)(1) and applicable regulations of the board, meets the requirements of AS 08.64.279, pays the required fee, and has been accepted by an eligible institution in the state for the purpose of residency or internship.

(c) A permit issued under this section is valid for the period specified by the board, but not to exceed 36 months after the date of issue. Upon application by a person who pays the required fee and has been accepted by an eligible institution in the state for the purpose of residency or internship, the board may renew a permit issued under this section for a period specified by the board, but not to exceed 36 months after the date of renewal.

CONTENTS OF A COMPLETE APPLICATION

- Application (6 pages)
- Authorization for Release of Records
- Certified True Copy of Medical School Diploma
- Verification of Medical School Education
- Verification of Good Standing from Residency Program
- Acceptance of Responsibility by Alaska Facility, Hospital, Clinic
- Verifications of Licensure from All Licensing Jurisdictions Where You Have Ever Been Licensed as Any Health Care
- Professional (e.g., physician assistant, nurse, MICP, dentist, optometrist, etc.)
- Clearance Report from the Federation of State Medical Boards
- Fees

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, regulation 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 this 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 document." 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 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. If you believe the additional information you are attaching to explain a "yes" answer should be held confidential, so state in the attachment. A request for confidentiality may or may not be granted.

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

FEES
Fee for a resident application and permit: **$100**

All applications must be accompanied by the appropriate fees. 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.

LICENSE APPLICATION PROCESSING STAFF
Please visit our website to find the contact information for your Licensing Examiner:
ProfessionalLicense.Aslaska.Gov/StateMedicalBoard or call (907)269-8163

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

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 or license. Board staff will not expedite one application before another.

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 resident permit is six to 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 will typically take longer to gather and evaluate additional data. If the application is referred to the Investigations Unit for investigation of a particular issue, processing time is extended by the time required to complete an investigation. Since investigations must be prioritized, it may take longer to complete the file.

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

STALE DOCUMENTS
If during the license application process certain documents become older than 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 ADDRESS
The Division of Corporations, Business and Professional Licensing maintains a website where you may check to see if your license or permit has been issued. The address is www.dced.state.ak.us/occ/Search3.htm.

The medical board's website is *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.

WHEN IN DOUBT, DISCLOSE AND EXPLAIN.

QUESTIONS? CALL (907)269-8163

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MED

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APPLICATION FOR RESIDENT PERMIT

Non-refundable Resident Permit Fee $100

PART I PERSONAL IDENTIFICATION INFORMATION

(Type or Print Legibly)

1	Full Legal Name (Last, First, Middle)				☐ Jr. ☐ Sr.
2	Other Names Used (Incl. Maiden Name)				
3	Legal Name Changes (Provide copies)				
4	Social Security Number		Date of Birth		
5	Place of Birth (City, State, Country)				
6	Full Practice Address	Mailing Address (Include street address if using post office box) City State Zip Code			
7	Full Residence Address	Mailing Address (Include street address if using post office box) City State Zip Code			
8	Telephones	Work		Home	
9	E-Mail Address (Optional)			☐ Send my correspondence by email ☐ Send my correspondence by US Mail	
10	Preferred Address of Public Record	☐ Use Practice Address		☐ Use Residence Address	
11	Professional Designation	☐ Allopathic Physician (MD)		☐ Osteopathic Physician (DO)	
12	Previous License or Permit In ALASKA?	☐ NO	☐ YES	If YES, what type and when: Type: _____ Year: _____	

RESIDENT ROTATION ASSIGNMENT (Identify the Alaska facility where you will be serving your rotation.)

Name of Institution	Location	Dates of Rotation
		From: To:

PART II EDUCATION

1. **Medical School Education**

Name of Institution	Location	Date Graduated

2. **Postgraduate Training** (List Internship, Residency, or Fellowship Training Programs Chronologically)

	Name of Institution	Address	Dates From/To	Compl? Yes/No
1				
2				
3				
4				

3. **ECFMG Certification - International Graduates Only**

Have you taken the ECFMG exam? ☐ Yes Certificate No._____ ☐ No
Attach a certified true copy of the certificate to this application.

4. DEA Registration and 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.

5. 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	Specialty Board (if applicable)	Date (if Board certified)	Recertification date (if Board certified)

PART III PROFESSIONAL ACTIVITIES

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

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

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

2. **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.

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.

1a.	☐ 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?
1b.	☐ No	☐ Yes	Is any such action pending?
2a.	☐ 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?
2b.	☐ No	☐ Yes	Is any such action pending?
3a.	☐ 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?
3b.	☐ No	☐ Yes	Is any such action pending?

Continued on next page

Part IV Disciplinary History continued

4a. ☐ 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 jurisdiction?

4b. ☐ No ☐ Yes Is any such action pending?

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

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

6a. ☐ 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?

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

7a. ☐ No ☐ Yes Have you ever been disciplined by a medical school or post-graduate training program, including academic probation? (Please read definition of “discipline” on page 3).

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

8a. ☐ 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)? (Please read definition of “discipline” on page 3.)

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

9a. ☐ No ☐ Yes Have you ever been under investigation or inquiry by any medical licensing jurisdiction or authority?

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

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

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

11a. ☐ 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?

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

12a. ☐ 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?

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

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

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

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.

14. ☐ 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?

15. ☐ 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?

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

17. ☐ 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?

18. ☐ 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.)*

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

20. ☐ 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?

Part V Personal History continued

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

22. ☐ 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

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

24. ☐ 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 pages 3 and 5.)

PART VI SWORN STATEMENT

I hereby certify that the information contained in this application is true and correct to the best of my knowledge. I further certify that all credentials supplied by me are true and correct and that the photograph that appears below is a true likeness of myself taken within the past 60 days. I understand that any false information or falsification or credentials may result in the denial of 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

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

Notary Signature_____
My commission expires:_____

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

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.

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MED

Office Use Only

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 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.

_____ _____
Signature of Applicant Date

_____ _____
Home Phone Number Work Phone Number

_____ _____
Date of Birth Social Security Number

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VERIFICATION OF MEDICAL/OSTEOPATHIC SCHOOL EDUCATION RESIDENT APPLICATION

Instructions to the Applicant: Type or print legibly. Complete the identification portion of this form below and send to the medical school from which you received your diploma.

NAME (Last, First, Middle)	Date of Birth (MM-DD-YYYY)	Social Security Number

ADDRESS	CITY	STATE	ZIP CODE

SIGNATURE	DATE SIGNED

Applicant: Do not detach – do not write below this line.

MEDICAL SCHOOL

Please complete the information below and return this document **directly** to the Alaska board at the letterhead address.

Full Medical School Name _____

Location _____

Exact Date on School Diploma _____

During this physician's medical school education, was he/she ever investigated by the school or disciplined by the school for any reason? Disciplinary actions include but are not limited to being placed on probation, issued a letter of reprimand, censured, suspended, restricted, or otherwise disciplined.

☐ No ☐ Yes

If you responded "Yes" to this question, please provide a detailed explanation of the action and the reason for the action.

_____

_____

_____

Signed _____

(SEAL, If Applicable)

Printed Name _____

Title _____

Date _____

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VERIFICATION OF GOOD STANDING FROM RESIDENCY TRAINING PROGRAM

Instructions to the Resident Applicant: Complete Parts I, II, and III below. Type or print legibly. Submit the form to your residency program director for completion.

PART I RESIDENT APPLICANT

Name (Last, First, Middle)	Maiden or Other Names Used	Date of Birth	MD/DO

PART II RESIDENCY PROGRAM

Name of Program	
Mailing Address	
Telephone	

PART III ROTATION AUTHORIZED FOR

Name of Alaska Facility, Hospital, Clinic	Location	Dates of Rotation From	To

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

Instructions to Program Director: Please complete Part IV below. Mail this form to the board at the letterhead address.

PART IV CERTIFICATION OF GOOD STANDING

I HEREBY CERTIFY that the resident physician named above is a resident in good standing at the residency program shown above. There have been no disciplinary sanctions against this resident during his/her training in this program. This physician will be serving a portion of his/her clinical training at the Alaska institution named above. This program is approved by the Accreditation Council on Graduate Medical Education of the American Medical Association or the Royal College of Physicians and Surgeons of Canada.

_____ _____

Signature, Physician Program Director Printed Name

Date Signed_____ Telephone_____

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ACCEPTANCE OF RESPONSIBILITY BY ALASKA FACILITY, HOSPITAL, OR CLINIC

Instructions to the Resident Applicant: Complete the information in Parts I and II below. Type or print legibly. Mail the form to the Alaska facility, hospital, or clinic where you intend to serve your residency rotation.

PART I RESIDENT APPLICANT

Name (Last, First, Middle)	Maiden or Other Names Used	Date of Birth	MD/DO

PART II RESIDENCY PROGRAM

Name of Program	
Mailing Address	
Telephone	

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

Instructions to the Alaska Facility: Please complete Part III below, sign Part IV, and return this document directly to the board at the letterhead address.

PART III ROTATION AUTHORIZED FOR:

Name of Alaska Facility, Hospital, or Clinic		Dates of Rotation--From/To	
Address			

Alaska Physician Primarily Responsible for Training/Supervision:

_____ Printed Name_____ Date_____
Signature

PART IV VERTIFICATION OF ACCEPTANCE OF RESPONSIBILITY

I CERTIFY THAT the Resident Physician named above has been accepted by this institution to serve as a resident. This physician will be serving a portion of his/her clinical training at the Alaska institution named above. This institution accepts responsibility for this physician's training and supervision while he/she is located at this institution.

_____ _____
Signature, Physician Clinical Director Date Printed Title

_____ _____
Printed Name Telephone

08-4022 d (Rev. 02/01/19)

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

MED

Office Use Only

PHYSICIAN BOARD ACTION DATA BANK INQUIRY

Instructions to the 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 Name (Last, First, Middle)	Maiden or Other Names Used:	Date of Birth (MM/DD/YYYY)
Mailing Address (Street)		Place of Birth
City/State/Zip		Social Security Number
Medical/Osteopathic School (Name and Location)	Year of Graduation	If International Grad., 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.

FOR FEDERATION USE ONLY

ALASKA STATE MEDICAL BOARD

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VERIFICATION OF LICENSURE - Resident

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

Full Name (Last, First, Middle) Maiden or Other Names Used:	Date of Birth (MM/DD/YYYY)
Mailing Address (Street)	Place of Birth
City/State/Zip	Social Security Number
Signature of Applicant	Date of Signature

Applicant: Do not detach – do not write below this line.

Instructions to the licensing agency: Please provide the information requested below for the physician identified in this form and send document directly to the Alaska State Medical Board at the letterhead address.

STATE		**LICENSE NUMBER**	
INITIAL ISSUE DATE		**EXPIRATION DATE**	
TYPE OF LICENSE (MD/DO, PA, RN, 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, or in any other manner (including being placed on probation) 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

(Board Seal)

_____ Signed by

_____ Date

_____ Printed Name

_____ Title

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.