# 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 A LICENSE TO PRACTICE PODIATRIC MEDICINE

This packet contains all the documents you will need to apply for a permanent license to practice podiatric medicine in Alaska.

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

- ***Average processing time for a temporary permit is from twelve to fourteen weeks.*** Start the process far enough in advance to allow this process 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 any adverse or derogatory information that comes to light, the review process may take longer.
- Appropriate fees must accompany applications before initial screening can begin.
- 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 Alaska State Medical Board conducts a thorough evaluation of education, training, employment or work history, malpractice history, and any criminal or disciplinary history. We recommend you do not make commitments for loans, practice start dates, home purchases, etc., based on the expectation of licensure. The board will not accelerate one application over others nor will it forego any elements of its screening process.
- If you received this application from a source other than directly from the Division or its official website, the application maybe outdated or not an official version.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 PRACTIVE MEDICINE IN ALLASKA WITHOUT A VALID LICENSE – PLEASE PLAN AHEAD**

If you have questions please feel free to contact us:
(907)269-8163

PLEASE DO NOT MOVE TO ALASKA WITHOUT A LICENSE OR PERMIT IN HAND.

# ALASKA STATE MEDICAL BOARD
# APPLICATION FOR PODIATRIC MEDICINE LICENSE
# IMPORTANT INFORMATION – PLEASE READ CAREFULLY

## QUALIFICATIONS FOR LICENSURE

**THRESHOLD QUALIFICATIONS FOR LICENSURE**

- Successful graduation from a school of podiatry accredited by the Council of Podiatric Medical Education
- Successful completion of post-graduate training in a program accredited by the Council of Podiatric Medical Education to include:
  - One year of internship training in podiatric medicine and
  - One year of podiatric surgical training
- Completion of an acceptable 2-hour education course in pain management and opioid use and addiction
- Successful completion of the National Boards examination or the PMLexis examination

**CONTENTS OF A COMPLETE APPLICATION BY CREDENTIALS or EXAMINATION INCLUDES:**

- ❑ Application, notarized with recent passport-style photograph
- ❑ Appropriate fees, $825 total
  ($400 nonrefundable application fee, $425 license fee)
  You may remit a minimum of $600 (nonrefundable application fee and $200 temporary permit fee) at the time of application so that a temporary permit may be issued. However, the balance of $225 must be paid before the permanent license is issued. All applications must be accompanied by the appropriate fee. 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.
- ❑ Authorization for Release of Records
- ❑ Appropriate examination scores as required
- ❑ Podiatric Medicine School Diploma, certified true copy of original document Postgraduate Training
- ❑ Program Certificates, certified true copies of original documents
- ❑ Certificate of Completion for at least 2 hours of acceptable CME in pain management and opioid use and addiction
- ❑ Verifications of Licensure from all licensing jurisdictions, both U.S. and International, in which you have ever been licensed as any health care professional
- ❑ A listing of all hospitals where you have held privileges in the five years preceding your application in Alaska
- ❑ Verifications of hospital privileges from all hospitals in which you have held privileges in the five years preceding your application in Alaska
- ❑ Clearance report from the Drug Enforcement Administration
- ❑ Clearance report from the Federation of Podiatric Medical Boards' Disciplinary Data Bank
- ❑ Verification of medical school education
- ❑ Verification(s) of postgraduate training
- ❑ National Practitioner Data Bank report – requested by our licensing examiner

It is your responsibility to submit the proper forms to the appropriate boards, hospitals, and other agencies and to pay any fees required by those agencies.

## GENERAL INFORMATION

**ADDRESS OF RECORD**
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. Please do not use third party addresses, telephone numbers, or email addresses as this creates difficulties when we are trying to reach you.

**APPLICATION FOR LICENSURE BY CREDENTIALS**
The Alaska State Medical Board may waive the written examination requirement and license an applicant by credentials if you hold an active license issued after written examination in another state or territory or the United States or province of Canada. Such examination must be equivalent to the National Boards or the PMLexis examination series and have passed those examinations with at least the minimum passing score as defined by regulation.

**APPLICATION STATUS UPDATES**
Our licensing examiner will send you a written status update upon the initial screening of the application and monthly thereafter. 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 FOR ASSISTANCE.**

**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.

**CONTINUING MEDICAL EDUCATION REQUIREMENT**
Alaska law requires an average of 25 hours of Category I AMA- or AOA-approved continuing education hours for each year of the licensing period (two-year licensing cycle). At the time of renewal, the licensee must attest to compliance with the CME requirements. After renewal is completed, the division will perform a computer-generated random audit of licensees who will be required to provide proof of CME courses. Please see regulations 12 AAC 40.200, 210, and 220.

**DEA CLEARANCE REPORT**
You are required to request a clearance report from the Drug Enforcement Administration for your DEA registration. Use the form provided in this packet and send your request to:

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

**DENIAL OF LICENSE**
The denial of an application for licensure is a public action and may be reported or disclosed 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.

**EXAMINATION SCORES**
Regardless of your application, whether by credentials or examination, Alaska requires that you must pass each component of your examinations with a minimum two-digit score of 75. If you are applying for licensure by examination and fail any component more than once, you will be required to complete a supervised course of study acceptable to the board before permission to retake the step will be given.

You must request exam scores be sent to the board from the appropriate organization.

To request Part I/II scores from the National Board of Podiatric Medical Examiners: complete the form provided in this application packet, and mail it with your check or money order to: Prometric/NBPME, 1260 Energy Lane, St.Paul, MN 55108. If paying by **credit card**: Complete the form and FAX to 800.813.6670.

To request Part III (PMLexis) examination scores: Score requests are available for online ordering with payment by credit card at the Federation of Podiatric Medical Board's (FPMB) web site www.fpmb.org. Alternatively, requests maybe printed and mailed to the Federation with a check for the $45 fee. You may contact FPMB at: Federation of Podiatric Medical Boards, 6551 Malta Drive, Boynton Beach, FL 33437 (561) 752-3735.

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

**FEES**
Fees for a permanent physician application are:

| | |
|---|---|
| $400 | Nonrefundable Application Fee |
| $425 | License Fee |
| **$825** | **Total Due** |

You may remit a minimum of $600 (nonrefundable application fee and temporary permit fee) at the time of application so that a temporary permit may be issued; however, the $225 must be paid before the permanent license is issued. All applications must be accompanied by the appropriate fee. Please make personal checks, cashiers' checks, or money orders payable to the State of Alaska. Incorrect fees will delay processing of your application.

**INITIAL LICENSURE IN SECOND YEAR OF TWO-YEAR CYCLE**
If you were initially licensed in the second year of the two-year licensure period, within 12 months of the date of expiration (December 31, even-number years), the applicant will pay the entire license fee. Upon renewal, the applicant will receive a renewal form that pro-rates the licensure fee for the coming licensure period. The applicant will pay one-half of the required license renewal fee at the time of renewal.

If your permanent license was first issued to you after October 1 of the second year of the licensing period, you will pay the initial full license fee; however, your license will be issued showing the expiration date of the next biennial licensing period. (For example, if your initial license was issued October 18, 2002, the expiration date will automatically be entered as December 31, 2004.)

**LICENSING PROCESS**
Your application is received by the administrative services staff where the fees are received and receipted. The application is then forwarded to the medical board's licensing examiners. During especially busy times like renewal periods, this receipting process may take as long as a week.

Once the licensing examiner receives your application, a file and checklist will be created for you that will track all the documents required to complete the application. The licensing examiner will send you a status letter upon the initial review of the application and monthly thereafter until the file is complete.

When the application is complete and all documents have been received, the file is forwarded to the board's executive administrator who reviews the application file. At the discretion of the administrator, a temporary permit may be issued (see information under Temporary Permit on page 5).

The complete application file is presented to the board at its next scheduled meeting. The board meets four times each year. The board's annual meeting schedule may be obtained from its website.

Following the board's review and approval, the licensing examiner will issue the permanent license.

Applications will be processed in the date order in which they are received. 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.

**LICENSE APPLICATION PROCESSING STAFF**
Please visit our website to find the contact information for your Licensing Examiner:
ProfessionalLicense.Aslaska.Gov/StateMedicalBoard or call (907)269-3861

**LICENSE RENEWAL**
All medical licenses in Alaska are on a two-year cycle, with all licenses expiring December 31 of even-numbered years. Notification for license renewal is mailed out to license holders of record at least 60 days prior to expiration, usually in late October. You are required by law to keep your current address on file with the division (12 AAC 02.900).

Failure to receive a renewal notice is not considered an excuse for non-renewal. A physician not intending to practice medicine in Alaska may renew their license in an inactive status. If you practice in the state occasionally, you must renew your license in active status. An inactive status license prohibits you from practicing; however, if you wish to reactivate your inactive license, contact the licensing examiner for instructions.

It is illegal to practice medicine in Alaska with an inactive or lapsed license or permit.

**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 NCCPA-approved education, or Category 1 of AMA-approved education, or Category 1 or 2 of AOA-approved education. 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 managing, 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 permanent license is eight to twelve weeks***. PLEASE PLAN ACCORDINGLY. Application processing time depends to a large extent on the response time from other organizations. Time required also depends upon numerous factors out of our control. Because the length of processing time for applications varies considerably, we urge you apply well in advance of your intended practice date. Please 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.

Please do not move to Alaska without a permit in hand.

**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, verifications of licensure from other licensing jurisdictions, the DEA clearance report, and the FPMB's Board Action Data Bank report.

**STATE BUSINESS LICENSES**
Physicians who are employees do not need to obtain an Alaska state business license; physicians who are independent contractors must obtain a state business license. You may obtain a business license by contacting:

Division of Corporations, Business, and Professional Licensing
Business Licensing Section
Post Office Box 110806
Juneau AK 99811-0806
(907) 465-2550
www.commerce.alaska.gov/cbpl/bl

**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.

**TEMPORARY PERMIT**
After your application for a permanent license is complete, it is forwarded to the board's executive administrator. Following her review, she may authorize the issuance of a temporary permit. Since the board only meets four times each year, the temporary permit is a courtesy to you to allow you to practice until the next board meeting when your file will be considered. The permit will be mailed to you at the address you specify in your application.

**WEBSITE ADDRESS**
The Division of Corporations, Business, and Professional 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.commerce.state.ak.us/occ/pmed.htm.*

**WITHDRAWAL OF APPLICATIONS**
The board permits the withdrawal of an application that it has not yet considered at a board meeting. Should you wish to withdraw your application, please submit a request for withdrawal in writing stating the reason for the withdrawal. Such a request for withdrawal must be received before the first time the board reviews and considers the application. All withdrawals are reported to the Federation of State Medical Boards stating the reason for the withdrawal.

**"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 Whenever available use on-line resources to request verification documents such as the AMA Physician Profile.
5 Insure the application is complete when you submit it and provide any necessary explanations with the application. Print legibly or type your application.
6 Provide complete explanations for any "Yes" responses; it saves time if we don't have to request such information.
7 Provide a brief description for any malpractice claims describing what the allegation was, the nature of the case, your level of involvement, and the resolution of the case.

*Please – do not sell your house and move to Alaska until you have a permit or license in hand.*

QUESTIONS? CALL
**(907)269-8163**

# ALASKA STATE MEDICAL BOARD

Post Office Box 110806
Juneau AK 99811-0806
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Website: ProfessionalLicense.Alaska.Gov/StateMedicalBoard

**MED**

Office Use Only

## APPLICATION FOR A LICENSE TO **PRACTICE PODIATRIC MEDICINE**

| | |
|---|---|
| Nonrefundable Application Fee | $400 |
| License Fee | $425 |
| Total Due | $825 |

**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 copy of documents) | | |
| 4 | **Date of Birth** | Mo Day Year / / | **Place of Birth (City, State/Country):** Sex: ☐ M ☐ F |
| 5 | **Full Practice Address** | Facility Name and Mailing Address (Include street address if using post office box)<br>City State Zip Code | |
| 6 | **Full Residence Address** | Mailing Address (Include street address if using post office box)<br>City State Zip Code | |
| 7 | **Telephones** | Area Code/Phone Work: | Area Code/Phone Home: |
| 8 | **Preferred Address of Record** (See Address of Record information.) | ☐ Use **Practice** Address Send my mail to this address. | ☐ Use **Residence** Address Send my mail to this address. |
| 9 | **E-Mail Address** | ☐ Send my correspondence by email<br>☐ Send my correspondence by US Mail | |
| 10 | **Application Based on:** | ☐ Credentials _____ (Upon what state license do you base this application?) | ☐ Examination (Not licensed in other state) |
| 11 | **Previous License or Permit In ALASKA?** | ☐ NO ☐ YES → | If YES, when and what type: Year:_____<br>☐ Resident ☐ Locum Tenens ☐ Permanent License |

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

**Applicant's Social Security Number _____**

1. **Military Service**

Have you ever been in the armed forces? ❑ No ❑ Yes

If YES, branch of service:_____ Date of commission:_____

Date and Type of Discharge:_____

Locations where you served:_____

## PART II EDUCATION

1. **Podiatric Medical School Education** List the podiatric medical school(s) you attended and from which you graduated. If you attended more than one school, provide your reason for changing schools on a separate sheet of paper signed and dated by you.

| Yr | SCHOOL | MAILING ADDRESS | | (MM/YYYY) | Completed Yes/No |
|---|---|---|---|---|---|
| 1 | | | From | | |
| | | | To | | |
| 2 | | | From | | |
| | | | To | | |
| 3 | | | From | | |
| | | | To | | |

2. **Postgraduate Training** List internship, residency, or fellowship training programs chronologically. You must have at least one year of surgical post-graduate training.

| Yr | HOSPITAL | MAILING ADDRESS | | (MM/YYYY) | Completed Yes/No |
|---|---|---|---|---|---|
| 1 | | | From | | |
| | | | To | | |
| 2 | | | From | | |
| | | | To | | |
| 3 | | | From | | |
| | | | To | | |

3. **Examination History** Please specify National Boards or PMLexis, or a state written examination.

| Exam Series | Location | Date Taken (MM-YYYY) | Result |
|---|---|---|---|
| | | | ☐ Pass ☐ Fail |
| | | | ☐ Pass ☐ Fail |
| | | | ☐ Pass ☐ Fail |

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

## 4. Opioid Education

☐ I have earned at least two hours of education in pain management, opioid use and addiction; the course is NCCPA approved, or AMA category 1, or AOA category 1 or 2. I will provide 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

## 5. 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.

## 6. 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) |
|---|---|---|---|
| | | | |
| | | | |

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

## PART III PROFESSIONAL ACTIVITIES

1. **Professional Licensure**

Please list **all states, territories, provinces, or foreign countries** in which you hold or have **ever held a license as a doctor of podiatric medicine**. Include temporary, courtesy, and locum tenens licenses, and instructional or training permits. ***Failure to list all jurisdictions may result in disciplinary sanctions or denial.*** If necessary, continue to list on a separate sheet of paper labeled with your name and signed by you.

***Physician Licenses***

| | Location (state, territory, etc.) | License Number | Date Issued | Current Status (Active, Lapsed, etc.) |
|---|---|---|---|---|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |

**2. Residency Licenses, Instructional or Training Permits**

| | Location (state, territory, etc.) | License Number | Date Issued | Current Status (Active, Lapsed, etc.) |
|---|---|---|---|---|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |

**3. Other Professional Licensure**

Other than as a physician, have you ever been licensed in any jurisdiction in any other profession 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 | Was License Disciplined? |
|---|---|---|---|
| | | | ☐ 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.

4. **Medical Societies and Professional Organizations**

| Name of Organization | Address | Date From/To - YYYY |
|---|---|---|
| | | |
| | | |
| | | |

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

5. **Hospital Affiliations** Have you ever held hospital privileges? ❑ No ❑ Yes

If Yes, please list all hospitals in which you have been credentialed within the immediate past five years.

| | HOSPITAL | MAILING ADDRESS | | WHEN PRIVILEGED (MM/YYYY) |
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| 13 | | | From | |
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| 14 | | | From | |
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| 15 | | | From | |
| | | | To | |

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

**Applicant Name:** **Date:**

6. **Medical Work History**

Please 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. You may attach a detailed curriculum vitae as long as all information is included. **Please explain any gap in time from practice of more than sixty (60) days' duration.**

| | Date (MM/YYYY ) | Location (City, State, or Other Country) | Activity |
|---|---|---|---|
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If necessary, continue to list on a separate sheet of paper labeled with your name and signed by you.

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

7. **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 No. | Date of Case (Mo/Yr) | Jurisdiction (State, etc.) | Nature of Allegation | Amount of Settlement Paid on Your Behalf |
|---|---|---|---|---|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |
| 6 | | | | |

## 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?

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? (*See 'Important Information' block on discipline on page 6.)

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)?
*(If you are unsure about your response to this question, please refer to the instructions and definitions for this section on page 6 of this application above. When in doubt, disclose and explain.)*

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

9a. ❑ No ❑ Yes. . . . . Have you ever been under investigation, notified of an investigation, or contacted by a board investigator or enforcement officer for any medical licensing jurisdiction or authority?
*(If you are unsure about your response to this question, please refer to the instructions and definitions for this section on page 6 of this application above. When in doubt, disclose and explain.)*

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

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

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?

14a. ❑ No ❑ Yes. . . . . Has your employment by a clinic, hospital, or other health care organization ever been terminated involuntarily or voluntarily as a result of an actual or potential investigation or as grounds for disciplinary proceedings?

14b. ❑ 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.

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

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 voyeurism, pedophilia, exhibitionism, 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, injection, inhalation, 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?

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 pages 7 and 9.)

## PART VIII Notarized Signature with Photograph

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 me taken within the past 60 days.

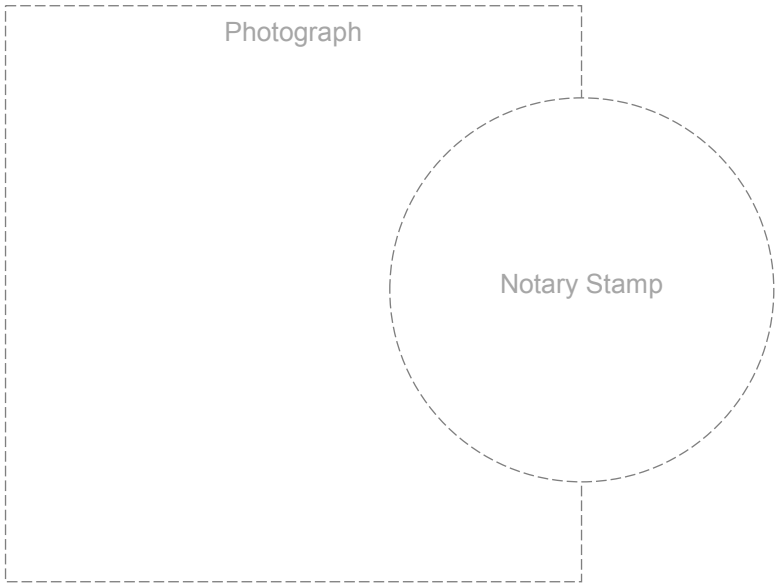
I understand that any falsification or misrepresentation of any item or response in this application, or any attachment hereto or falsification or misrepresentation of credentials to support this application, is sufficient grounds for denying, revoking, or otherwise disciplining a license or permit to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

**I have read all of the instructions in the application, including the instructions under Part VI, Professional Fitness.**

You must sign and date this application before a notary public on the same day.

| | |
|---|---|
| **Applicant's Signature** | |
| **Date** | |
| **Printed Name** | |

| | |
|---|---|
| **Notary Public for State of:** | |
| **Subscribed and Sworn to Before me on this Day:** | |
| **Notary's Signature:** | |
| **My Commission Expires:** | |

| | |
|---|---|
| **Attach a recent photo that is no larger than 3" x 3".**<br><br>**The notary seal must overlie a portion of the photograph.** |  |

# 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/StateMedicalBoard


For Office Use Only

## AUTHORIZATION FOR RELEASE OF RECORDS

TO WHOM IT MAY CONCERN:

I, _____, residing at
(Please print full name)
_____, hereby authorize the Alaska
(Please print full address)
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

MED

# ALASKA STATE MEDICAL BOARD

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Juneau AK 99811-0806
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Website: ProfessionalLicense.Alaska.Gov/StateMedicalBoard

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# 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. 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

# ALASKA STATE MEDICAL BOARD

Post Office Box 110816
Juneau, AK 99811-0806
Phone: (907)269-8163
E-mail: medicalboard@alaska.gov
Website: ProfessionalLicense.Alaska.Gov/StateMedicalBoard

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## LIST OF HOSPITALS WHERE PRIVILEGED

**Instructions to the Applicant:** **Ty**pe or print legibly. List below all hospitals where you currently hold or have held privileges in the last five years. If you have not held privileges within the past five years or never held privileges, please write "None" on this form, sign it, and submit this form as part of your application. Please include residency privileges if appropriate.

| | **HOSPITAL** | **MAILING ADDRESS** | | **WHEN PRIVILEGED** (MM/YYYY) |
|---|---|---|---|---|
| 1 | | | From | |
| | | | To | |
| 2 | | | From | |
| | | | To | |
| 3 | | | From | |
| | | | To | |
| 4 | | | From | |
| | | | To | |
| 5 | | | From | |
| | | | To | |
| 6 | | | From | |
| | | | To | |
| 7 | | | From | |
| | | | To | |
| 8 | | | From | |
| | | | To | |

I certify that listed above are all hospitals where I hold or have held privileges in the past five years. I understand it is my responsibility to request these hospitals submit a letter to the board to complete my application for licensure. I certify under penalty of unsworn falsification that the above information is true and correct.

Signature _____

Date _____

*Warning: Alaska Statute 11.56.210 states that any person who knowingly or intentionally furnishes false or fraudulent information in this application has committed a Class A misdemeanor.*

# ALASKA STATE MEDICAL BOARD

**MED**

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# VERIFICATION OF HOSPITAL PRIVILEGES

**Instructions to the Applicant**: Please complete Part I below. Forward a copy of this form to each hospital where you have held privileges in the immediate past five years. Include privileges held during residency. Copy this form as needed. Please type or print legibly. Part II is to be completed by the hospital staff office.

**PART I**

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

Name of Hospital _____

Mailing Address _____

City/State/Zip _____

FOLLOWING TO BE COMPLETED BY HOSPITAL STAFF ONLY

**PART II**

Instructions to the Hospital: I am applying for a license to practice medicine in Alaska. The Alaska board requires this form to be completed by each hospital where I have held privileges in the past five years. Please complete this form by answering the questions below and mailing this form **directly** back to the Alaska board at the letterhead address.

1 Dates of Hospital Privileges: From_____ To_____

2 Has your hospital ever taken any disciplinary action against this physician? ❑ No ❑ Yes

3 Have there ever been limitations or restrictions on this physician's privileges? ❑ No ❑ Yes

4 Are any disciplinary actions pending against this physician? ❑ No ❑ Yes

5 Is there any derogatory information on file regarding this physician? ❑ No ❑ Yes

6 Is there any reason you would not readmit this physician to your medical staff? ❑ No ❑ Yes

If you answer "Yes" to any question above, please attach a detailed explanation signed and dated by the person whose signature appears below.

Signature_____ Printed Name_____

***Original signature only, signature stamps are not accepted.***

Title_____ Date_____

Telephone_____

# ALASKA STATE MEDICAL BOARD

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**MED**

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# VERIFICATION OF STATUS OF DEA REGISTRATION

**Instructions to the Applicant**: Type or print legibly. Please complete Part I below and mail to the DEA.

**PART I**

| Full Name (Last, First, Middle) | Maiden or Other Names Used: | | Date of Birth (MM/DD/YYYY) |
|---|---|---|---|
| Mailing Address | City | State | Zip |
| Address Where DEA Registered | | | DEA Registration No. |
| Signature of Applicant | | | Date of Signature |

MAIL THIS REQUEST FORM TO: Drug Enforcement Administration
Attn: Diversion Unit
300 5th Avenue, Suite 1300
Seattle, WA 98104

## FOR DEA USE ONLY

**Instructions to the DEA staff:** Complete Part II below. Please search your records and advise if there is any derogatory information on file against this physician. Please return this form directly to the State Medical Board at the letterhead address.

**PART II**

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

DEA Comments: _____

# ALASKA STATE MEDICAL BOARD

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Juneau AK 99811-0806
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E-mail: medicalboard@alaska.gov
Website: ProfessionalLicense.Alaska.Gov/StateMedicalBoard


**MED**

For Office Use Only

# BOARD ACTION DATA BANK INQUIRY

Instructions to the Applicant: Type or print legibly. Complete Part I below. Mail this form, along with a $50 fee, payable by check to the Federation at the address below.

**PART I**

| 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 | If International Grad., ECFMG No. |
| Medical/Osteopathic School (Name and Location) | Year of Graduation |
| | |

## YOU MUST MAIL THIS FORM TO:

Federation of Podiatric Medical Boards
12116 Flag Harbor Dr.
Germantown, MD 20874

FOLLOWING TO BE COMPLETED BY DATA BANK STAFF ONLY

**PART II**

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

MED

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


# VERIFICATION OF PODIATRIC MEDICAL SCHOOL EDUCATION

**Instructions to the Applicant:** **T**ype or print legibly. Complete Part I below and send to the medical school from which you received your diploma.

**PART I**

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

Full School Name _____

Location _____

**FOLLOWING TO BE COMPLETED BY MEDICAL SCHOOL STAFF ONLY**

**PART II**

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

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 on a separate sheet of paper attached to this form signed and dated by the person whose signature appears below.

Signed _____
***Original signature only, signature stamps are not accepted.***

(SEAL, If Applicable)

Printed Name _____

Title _____

Date _____

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## VERIFICATION OF POSTGRADUATE TRAINING

Instructions to the Applicant: Type or print legibly. Complete Part I below and send to the post-graduate training program(s) you attended.

**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 (Name and Location) | | Yr of Graduation | If IMG, ECFMG No. |
| Signature of Applicant | | Date | |

NAME OF POSTGRADUATE PROGRAM _____

ADDRESS _____

**FOLLOWING TO BE COMPLETED BY POST-GRADUATE PROGRAM STAFF ONLY**

**PART II**

**Post-graduate Training Program:** **Please complete the information requested below and return this document directly to the Alaska** board at the letterhead address.

VERIFICATION FOR: PPMR ☐ PSR-12 ☐ PSR-24 ☐ PM&S-24 ☐ PM&S-36 ☐ POR ☐

Exact Dates of Training _____

1 At the time this individual completed training in your program, was the program accredited through the Council on Podiatric Medical Education?

❑ Yes ❑ No

2 During the physician's participation in your program, was he/she ever investigated or disciplined by the program, such disciplinary actions to include but not be limited to, being placed on probation, issued a letter of reprimand or warning, censured, suspended from the program, restricted, or otherwise disciplined? If you respond "Yes" to this question, please attach a separate sheet providing a detailed explanation of the action and the reason for the action.

❑ No ❑ Yes

3 Is there anything in this physician's postgraduate training records that would indicate he/she would be unable to practice medicine competently and safely? If "Yes", please attach a detailed explanation.

❑ No ❑ Yes

(SEAL, If Applicable)

_____ Signature

_____ 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.