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

Alaska State Medical Board
PO Box 110806, Juneau, AK 99811-0806
Phone: (907) 465-2550
Email: MedicalBoard@Alaska.Gov
Website: *ProfessionalLicense.Alaska.Gov/StateMedicalBoard*

Application for Mobile Intensive Care Paramedic (MICP)

An applicant for a mobile intensive care paramedic license must be at least 19 years of age or older and be a high school graduate, in accordance with 12 AAC 40.310(a)(1) and (2).

The following documents must be on file with our office before the Board will consider your application for Mobile Intensive Care Paramedic License:

1. **APPLICATION**
   A completed, signed application (pages 1-7).
2. **FEES**
   Fees made payable to "State of Alaska" in accordance with 12 AAC 02.250.

Nonrefundable application Fee:	$100.00
License Fee:	$ 75.00
Temporary/Provisional Permit fee:	$ 75.00

3. **AUTHORIZATION FOR RELEASE OF RECORDS**
   A completed Authorization for Release of Records form (#08-4004a).
4. **PARAMEDIC TRAINING CERTIFICATE**
   A certified true copy of the paramedic training certificate, or you may substitute an original letter from the program director.
5. **NATIONAL REGISTRY EXAMINATION SCORE REPORT**
   A certified true copy of the National Registry Examination Score Report. You may also use a certified true copy of the wall certificate or wallet card.
6. **VERIFICATION OF PARAMEDIC TRAINING PROGRAM**
   A completed Verification of Paramedic Training Program form (#08-4004b).
7. **VERIFICATION OF PARAMEDIC INTERNSHIP TRAINING**
   A completed Verification of Paramedic Internship Training form (#08-4004c), if not currently licensed in another state.
8. **PHYSICIAN SPONSOR STATEMENT OF SUPERVISION**
   A completed Physician Sponsor Statement of Supervision form (#08-4004d).
9. **VERIFICATION OF LICENSURE**
   Verification of Licensure form (#08-4004e) from All Licensing Jurisdictions Where You Have Ever Been Licensed as Any Health Care Professional (e.g., physician assistant, nurse, MICP, dentist, optometrist, etc.).

If you are licensed in another state, you will also need the following:

10. **PAST PHYSICIAN SPONSOR'S DECLARATION OF COMPETENCE**
    A completed Past Physician Sponsor's Declaration of Competence form (#08-4004f).

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.

APPLICATION STATUS UPDATES
Our licensing examiner will send you a written status update upon the initial screening of the application.

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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.

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 issued a license or permit by the board. WHEN IN DOUBT, DISCLOSE ALL INFORMATION OR CALL OUR OFFICE.

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.**

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.

CONTINUING MEDICAL EDUCATION REQUIREMENT
Alaska law requires an average of 60 hours of continuing medical 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 40.350.

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

EXAMINATION INFORMATION
Examinations for certification for the Mobile Intensive Care Paramedic are coordinated by:

Southern Region Emergency Medical Services Council, Inc.
6130 Tuttle Place
Anchorage, AK 99507
(907)562-6449

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

LICENSE APPLICATION PROCESSING STAFF
Please visit our website to find the contact information for your Licensing Examiner:
ProfessionalLicense.Alaska.Gov/StateMedicalBoard or call (907)465-2550.

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 mobile intensive care paramedic license may be issued.

Applications will be processed in the order in which they are received in the board's office. Please ensure that you apply well in advance of your need for the permit or license. Board staff will not expedite one application before another.

LICENSE RENEWAL
All medical board 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 30 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. 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. Courses must be NREMT-accepted education, education offered by a Board-approved paramedic training program, 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 management, opioid use, addiction.

PAYMENT OF CHILD SUPPORT
If the Alaska Child Support Enforcement Division has determined that you are in arrears on child support, you may be issued a nonrenewable temporary license valid for 150 days. Contact Child Support Services at (907)269-6900 to resolve payment issues.

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.

PROCESSING TIME
In general, average processing time for a mobile intensive care paramedic license 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 license 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.

PROVISIONAL LICENSE
A provisional license will, at the board's discretion, be issued to an individual who has met all the requirements of 12 AAC 40.310 except for passing the National Registry/EMT examination. The applicant shall submit written verification from the National Registry of Emergency Medical Technicians that he or she is awaiting examination results or is scheduled to take the next examination.

A provisional license is valid until the first meeting of the board after the results of the exam have been issued or until the physician sponsor withdraws sponsorship, or until the board is notified that the applicant has failed the examination, whichever occurs first. A provisional license is not renewable.

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 twelve 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, and verifications of licensure from other licensing jurisdictions.

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. Should a personal interview be required, the temporary permit may be issued at the conclusion of the interview.

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 *ProfessionalLicense.Alaska.Gov*

The medical board's website is *ProfessionalLicense.Alaska.Gov/StateMedicalBoard*

WITHDRAWAL OF APPLICATIONS
The board permits the withdrawal of an application that has not yet been 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 requests must be received before the first time the board reviews and considers the application.

"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. Ensure the application is complete when you submit it and provide any necessary explanations with the application. Print legibly or type your application.
4. Provide complete explanations for any "Yes" responses. It saves time if we don't have to contact you and request such information.
5. 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.

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MED

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Mobile Intensive Care Paramedic License Application

PART I Payment of Fees

Required Fees:	☐ Nonrefundable Application Fee	**$100.00**
	☐ License Fee	**$ 75.00**
	☐ Temporary/Provisional Permit Fee	**$ 75.00**

PART II Applicant Information

Full Legal Name:			
Provide all other names used (maiden, nicknames, aliases). Attach documentation of all legal name changes. ☐ Not Applicable ☐ Other Names Used:			
Address of Record:			
Birth Date: (mm/dd/yyyy)		**Birthplace:**	
Phone:		**Gender:**	

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

Email Address:		☐ Send my Correspondence by Email ☐ Send my Correspondence by US Mail
SOCIAL SECURITY NUMBER: AS 08.01.060 requires you to provide your United States Social Security Number. It is considered confidential information and will not be publicly disclosed; it may be used to verify inter-state licensure.		

PART III Alaska License or Permit

Complete the following if you have previously held a license or permit in Alaska.			
Previous License or Permit Type:			
Previous AK license or Permit Number:		**Date Issued:**	

PART IV Physician Sponsor

Name:		**License Number:**	
Address:			
Email Address:		**Work Phone:**	

PART V Education

High School Education

Name of School:			
Years Attended:		**Year Graduated:**	

College Education

Name of School:			
Years Attended:		**Year Graduated:**	

Paramedic Training Program

Name of Program:			
Address:			
Years Attended:		**Year Graduated:**	

Opioid Education Program

Name of Program:		**Hours Earned:**	
Sponsor:			

PART VI Professional Licensure

Professional Licensure: Please list all states, territories, provinces, or foreign countries in which you hold or have ever held a license as a paramedic, emergency medical technician, or any other health care professional. Failure to list all licenses 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.

Location	License Number	Issue Date	Current Status

PART VII Work History

Please provide a chronological listing of all medical and non-medical activities beginning with your graduation from high school or college, if appropriate, to the present date with no more than a 60-day gap in time. If necessary, make additional copies of this page, or continue to list your work history on a separate sheet labeled with your name and signed by you.

Please explain any gap in time of more than sixty (60) days' duration.

Dates (from/to)		Facility/Location	Activity

PART VIII Professional Fitness Questions – Disciplinary History

The following questions must be answered. "Yes" answers may not automatically result in license denial. You must answer both parts of each multi-part question**.**

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. Documentation includes copies of court orders, charging documents, board, or license actions, etc. When in doubt about your response, disclose and provide the required explanation and documents. Applications submitted without the required attachments will be considered incomplete and will not be processed.

The contents of licensing files are generally considered public records. 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.

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

When in doubt, disclose and explain.

1.	Have you ever been convicted of a crime (felony or misdemeanor) in any jurisdiction of the United States, including military, or any international jurisdiction?	**Yes** ☐	**No** ☐
	Is any such action pending?	**Yes** ☐	**No** ☐
2.	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?	**Yes** ☐	**No** ☐
	Is any such action pending?	**Yes** ☐	**No** ☐
3.	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?	**Yes** ☐	**No** ☐
	Is any such action pending?	**Yes** ☐	**No** ☐
4.	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?	**Yes** ☐	**No** ☐
	Is any such action pending?	**Yes** ☐	**No** ☐
5.	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)?	**Yes** ☐	**No** ☐
	Is any such action pending?	**Yes** ☐	**No** ☐
6.	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?	**Yes** ☐	**No** ☐
	Is any such action pending?	**Yes** ☐	**No** ☐
7.	Have you ever had a paramedic/EMT license to practice medicine disciplined by any authority including a state medical board or a military authority?	**Yes** ☐	**No** ☐
	Is any such action pending?	**Yes** ☐	**No** ☐

PART VIII Professional Fitness Questions (Disciplinary History - Continued)

8.	Have you ever been under investigation or inquiry by any medical licensing jurisdiction or authority?	**Yes** ☐	**No** ☐
	Is any such action pending?	**Yes** ☐	**No** ☐
9.	Have you ever had a paramedic/EMT license application denied by any medical licensing jurisdiction or authority?	**Yes** ☐	**No** ☐
	Is any such action pending?	**Yes** ☐	**No** ☐
10.	Have you ever voluntarily or involuntarily withdrawn an application for a paramedic/EMT license in any jurisdiction?	**Yes** ☐	**No** ☐
	Is any such action pending?	**Yes** ☐	**No** ☐
11.	Have you voluntarily or involuntarily surrendered or suspended your paramedic/EMT license to practice medicine in any United States jurisdiction or any international jurisdiction?	**Yes** ☐	**No** ☐
	Is any such action pending?	**Yes** ☐	**No** ☐
12.	Have you ever voluntarily or involuntarily agreed to any limitations, restrictions, or conditions to your paramedic/EMT license to practice medicine?	**Yes** ☐	**No** ☐
	Is any such action pending?	**Yes** ☐	**No** ☐
13.	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?	**Yes** ☐	**No** ☐
	Is any such action pending?	**Yes** ☐	**No** ☐

PART IX Professional Fitness Questions – Personal History

The following questions must be answered. "Yes" answers may not automatically result in license denial.

For each "Yes" response to any question, you must provide an explanation and documentation. 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. Documentation includes copies of court records, judgments, charging documents, etc. You must also have your treating physician submit a letter directly to the Board; the letter must include the following information:

- Summary of your diagnoses (including explanation, dates of onset and significant events, and frequency of contact with you)
- Medication history
- Impact on your ability to practice safely and competently

When in doubt about your response, disclose and provide the required explanation and documents. Applications submitted without the required attachments will be considered incomplete and will not be processed.

The contents of licensing files are generally considered public records. 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 IX Professional Fitness Questions (Personal History - Continued)

For the purposes of the questions in this section:

"Medical Condition" includes physiological, mental, or psychological conditions or disorders such as, but not limited to, orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

"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.	In the past two years, have you been diagnosed as having, or been hospitalized for, a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety?	**Yes** ☐	**No** ☐
15.	Do you currently have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety?	**Yes** ☐	**No** ☐
16.	In the past two years, have you been the subject of any civil investigation or court process relating to your ability to practice in a safe and competent manner?	**Yes** ☐	**No** ☐
17.	Are you currently engaged in the illegal use of drugs, or the use of illegal drugs?	**Yes** ☐	**No** ☐
18.	In the past two years, 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?	**Yes** ☐	**No** ☐
19.	Are you currently taking a controlled substance that limits your ability to practice medicine in a fully competent and professional manner with safety to patients?	**Yes** ☐	**No** ☐
20.	Have you had or do you now have any disease or condition that interferes with your ability to perform the essential functions of your profession, including any disease or condition generally regarded as chronic by the medical community, i.e., (1) mental or emotional disease or condition; (2) alcohol or other substance abuse; (3) physical disease or condition, that presently interferes with your ability to practice your profession?	**Yes** ☐	**No** ☐

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Notary Signature Page

PART X Notarized Signature

I certify that the information in this application is true and correct to the best of my knowledge. I understand that if information is provided in the Criminal History Report from the State of Alaska, or FBI, that I did not report, the issuance of my license may be delayed or denied. I further certify that all credentials and supporting documents supplied by me are true and correct and that the photograph 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 documents to support this application, is sufficient grounds for denying, revoking, or otherwise disciplining a license or permit to practice in the state of Alaska.

I further understand that it is a Class A misdemeanor under Alaska Statute 11.56.210 to falsify an application and commit the crime of unsworn falsification.

A person who makes a false statement on this application may be subject to civil and criminal penalties, including prosecution for perjury (AS 11.56.200 & AS 11.56.230).

Current Passport-Type Photo				
	Applicant's Printed Name:			
	Applicant's Signature:			
	Notary Public for State of:		**Subscribed and Sworn to Before me on this Day:**	
	Notary's Signature:		**My Commission Expires:**	

NOTARY SEAL

THE STATE of ALASKA
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State Office Building, 333 Willoughby Avenue, 9th Floor
PO Box 110806, Juneau, AK 99811-0806
Phone: (907) 465-2550
Email: *License@Alaska.Gov*

Letter of Explanation for a Professional Fitness "Yes" Answer

Use this form **only** to explain and document any professional fitness "Yes" answers. A "Yes" answer is not necessarily disqualifying, but concealing one may be.

Each "Yes" answer requires a separate explanation and associated documentation. Submit all relevant documentation with this form, even if you have previously provided it.

- **Explanations** include full details, dates, locations, type of action, organizations or parties involved, and specific circumstances. If the space provided is insufficient, make additional copies as needed.
- **Documentation** includes copies of court orders, charging documents, board or license actions, decisions against your professional certification, satisfaction of consent agreements (fines paid, community service completed, off probation, etc.), and fitness to practice letters (statement from your provider that you are safe to practice if you check "Yes" to any of the questions regarding mental or physical health, or drug or alcohol abuse or addiction).
- **Disciplinary actions** may include but not be limited to; suspension, surrender, revocation, probation, academic probation, reprimand, censure, restricted license, limited license, conditioned license, or letters of counseling, concern, advice, warning, caution, admonishment, or reprimand.

If you have multiple "Yes" answers or multiple incidents for any professional fitness question, you must use a separate copy of this form and provide a full explanation and documentation for each incident.

The contents of licensing files are 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 according to state law.

	Write the professional fitness question number you are answering "Yes" to in the box.

Location of Incident:		**Date of Incident:**	
Explanation of Incident:			
When in doubt, disclose and explain. **Make copies as necessary.**			

Did you attach all applicable documents associated with this incident?

- ☐ Court orders
- ☐ Consent agreements
- ☐ Disciplinary actions
- ☐ Charging documents
- ☐ Court records
- ☐ Fitness to practice
- ☐ All other documentation related to this incident
- ☐ I have additional incidents for this "Yes" answer, or "Yes" answers to other Professional Fitness questions and have attached a separate copy of this form for each incident.

Full Name:		**PL Code:**	
Signature:		**Date:**	

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Authorization for Release of Records

I hereby authorize the 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.

Name:	First	Middle	Last	
Full Address:	Street or PO Box	City	State	Zip
Phone:		**Birth Date:** (mm/dd/yyyy)		
Email:				
Signature:		**Date:**		

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Verification of Paramedic Training Program

→ Applicant: This form is required to verify that you have completed the approved curriculum for mobile intensive care paramedic. Mail this form to the program or school from which you received your paramedic training.

Full Legal Name: (Last, First, Middle)			
Mailing Address:			
Full Program/School Name:		**Location:**	
Applicant Signature:		**Date of Signature:**	

→ Program/School Staff: Please complete and return this verification directly to the Alaska State Medical Board at the letterhead address. All information requested below must be provided; if any space is left blank, the document will be returned to you for completion.

Exact Date on Diploma or Certificate:	

1.	At the time this individual completed training in your program, did the curriculum meet the U.S. Department of Transportation national training requirements for Emergency Medical Technician Paramedics?	**Yes** ☐	**No** ☐
2.	Was the training in your program completed under the direction of a physician licensed in the state where the program is located?	**Yes** ☐	**No** ☐
3.	Did the paramedic training program include at least two hours of education in pain management and opioid use and addiction?	**Yes** ☐	**No** ☐
4.	During this individual's participation in your program, was he/she ever investigated or disciplined by the program/school for any reason? Disciplinary actions include but are not 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 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.	**Yes** ☐	**No** ☐
5.	Is there anything in this individual's training records that would indicate he/she would be unable to practice as a paramedic competently and safely? If "yes," please attach a detailed explanation.	**Yes** ☐	**No** ☐

Board Seal	**Signature:**		**Date:**	
	Printed Name:		**Title:**	

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

Alaska State Medical Board
PO Box 110806, Juneau, AK 99811-0806
Phone: (907) 465-2550
Email: MedicalBoard@Alaska.Gov
Website: *ProfessionalLicense.Alaska.Gov/StateMedicalBoard*

Verification of Paramedic Internship

→ Applicant: This form is required to verify that you have completed a minimum of 480 hours of field internship training required by regulation. Mail this form to the appropriate physician for completion of the verification. **PLEASE NOTE: If you are already licensed in another jurisdiction, this document is not required.**

Full Legal Name: (Last, First, Middle)			
Mailing Address:			
Applicant Signature:		**Date of Signature:**	

→ Supervising Physician: Please complete and return this verification directly to the Alaska State Medical Board at the letterhead address. All information requested below must be provided – if any space is left blank, the document will be returned to you for completion.

I verify that I was the supervising physician for the paramedic named above during his/her paramedic internship located in:		
Location of Training:		
Dates of Training:	From: _____	To: _____

I certify that the paramedic named above successfully completed a 480-hour field internship in which all procedures performed by the intern were under my direct supervision, or the supervision of another physician, physician assistant, registered nurse, or mobile intensive care paramedic licensed or certified in the state in which the internship occurred and who had been designated the responsibility of supervision by me.

I certify that the above-named paramedic has been trained and is capable of performing the following tasks:

1 – electrocardiographic monitoring and defibrillation;
2 – initiating and maintaining intravenous routes using approved intravenous techniques and solutions;
3 – performing endotracheal intubation and pulmonary ventilation by approved methods;
4 – performing gastric suction by intubation;
5 – obtaining blood for laboratory analysis;
6 – administering parenterally, orally, or topically and approved agents of solutions;
7 – use of pneumatic anti-shock devices;
8 – other emergency procedures listed below which I authorized as sponsoring physician:

_____

Seal (if applicable)	**Signature:**		**Date:**	
	Printed Name:		**Title:**	

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Physician Sponsor's Statement of Supervision

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

Applicant Name:			
Address:			
Applicant's Signature:		**Date of Signature:**	

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

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

Sponsor's Printed Name:		**AK License Number:**	
Sponsor's Signature:		**Date of Signature:**	

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Verification of Licensure, Authorization or Certification

→ 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 Legal Name: (Last, First, Middle)		**Birth Date:** (mm/dd/yyyy)	
License/Certificate Number:			
Mailing Address:			
Applicant Signature:		**Date of Signature:**	

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

1.	Has this applicant ever been the subject of an investigation by a licensing or disciplinary authority in your state or jurisdiction?	**Yes** ☐	**No** ☐
2.	Have formal disciplinary proceedings been initiated against this applicant or the applicant's license by a licensing or disciplinary authority in your state or jurisdiction?	**Yes** ☐	**No** ☐
3.	Has this applicant's license ever been suspended, revoked, disciplined, restricted, warned, placed on probation, or in any other manner limited by a licensing or disciplinary authority in your state?	**Yes** ☐	**No** ☐
4.	Is any such investigation or action pending?	**Yes** ☐	**No** ☐
5.	Are you aware of any derogatory information regarding this applicant?	**Yes** ☐	**No** ☐

Board Seal	**Signature:**		**Date:**	
	Printed Name:		**Title:**	

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Past Physician Sponsor's Declaration of Competence

→ **Applicant**: This form is required if you have been licensed, certified, or registered in another state. Complete the top portion of this form and forward to a past physician sponsor for completion of the lower portion. The past physician may be a physician with whom you trained during your internship training, or another physician who has worked with you and can attest to your competence. This form must be submitted directly to this office from the past physician sponsor.

Applicant Name:			
Address:			
Applicant's Signature:		**Date of Signature:**	

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

I hereby certify that I was a past physician sponsor for the paramedic identified above during the time:

Dates:	From: _____	To: _____
Location:		

I attest that this paramedic has been trained to and is capable of performing the following tasks:

1 – electrocardiographic monitoring and defibrillation;
2 – initiating and maintaining intravenous routes using approved intravenous techniques and solutions;
3 – performing endotracheal intubation and pulmonary ventilation by approved methods;
4 – performing gastric suction by intubation;
5 – obtaining blood for laboratory analysis;
6 – administering parenterally, orally, or topically and approved agents of solutions;
7 – use of pneumatic anti-shock devices;
8 – other emergency procedures listed below which I authorized as sponsoring physician:

_____

Past Sponsor's Printed Name:		**AK License Number:**	
Past Sponsor's Signature:		**Date of Signature:**	

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CHANGE or ADDITION of Paramedic Physician Sponsor

12 AAC 40.315. SPONSORSHIP. (a) A person licensed as a mobile intensive care paramedic shall immediately report to the board, in writing, any change of sponsorship.
(b) When a sponsor withdraws sponsorship of a mobile intensive care paramedic, the paramedic is not authorized to practice until a new physician sponsor is approved by the board.

☐ Change ☐ Addition

→ **Paramedic**: Please type or print legibly. Please complete the upper portion of this form and forward to the new physician sponsor who is assuming the role of sponsorship for you.

Paramedic Name:		**License Number:**	
Address:		**Phone:**	
Employer Name:		**Employer Phone:**	
Work Address:			
Scope of Duties:			
Paramedic Signature:		**Date of Signature:**	

→ **Physician Sponsor**: Please complete the lower portion of this form and return it directly to the Alaska State Medical Board at the letterhead address above.

As indicated by my signature below, I acknowledge and confirm that I am assuming responsibility as physician sponsor for the paramedic identified above in accordance with 12 AAC 40.315.

Printed Name:		**License Number:**	
Mailing Address:		**Phone:**	
Physician Sponsor's Signature:		**Date of Signature:**	

THE STATE of ALASKA

Department of Commerce, Community, and Economic Development
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FOR DIVISION USE ONLY

State of Alaska
Department of Commerce, Community, and Economic Development
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Phone: (907) 465-2550

Credit Card Payment Form

All major credit cards are accepted. For security purposes, do not email credit card information. Include this credit card payment form with your application.

Name of Applicant or Licensee: _____

Program Type: _____ License Number *(if applicable)*: _____

I wish to make payment by credit card for the following *(check all that apply)*: **AMOUNT**

- ☐ Application Fee: _____ _____
- ☐ License or Renewal Fee: _____ _____
- ☐ Other *(name change, wall certificate, fine, duplicate license, exam, etc.)*:
  1. _____ _____
  2. _____ _____

TOTAL: 0

Name *(as shown on credit card)*: _____

Mailing Address: _____

Phone Number: _____ Email *(optional)*: _____

Signature of Credit Card Holder: _____

08-4438 Rev 12/26/18 Credit Card Payment Form (all major cards accepted)

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

1. 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.