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*

# Resident Permit Application Instructions

**Sec. 08.64.272. Residency and internship permits.**
(a) A person may not serve as a resident or intern without a permit issued under this section.
(b) For the limited purpose of residency or internship, the board may issue a permit to an applicant without examination if the applicant meets the requirements of AS 08.64.200(a)(1) and applicable regulations of the board, meets the requirements of AS 08.64.279, pays the required fee, and has been accepted by an eligible institution in the state for the purpose of residency or internship.
(c) A permit issued under this section is valid for the period specified by the board, but not to exceed 36 months after the date of issue. Upon application by a person who pays the required fee and has been accepted by an eligible institution in the state for the purpose of residency or internship, the board may renew a permit issued under this section for a period specified by the board, but not to exceed 36 months after the date of renewal.

***The following must be received by the division before your application for Resident Permit can be reviewed:***

1. **APPLICATION**
   A completed application, signed and notarized (#08-4022, pages 1-8).

2. **FEES**
   Fees made payable to "State of Alaska" in accordance with 12 AAC 02.250.

| | |
|---|---|
| Nonrefundable Application/Resident Permit Fee: | $100.00 |
| Prescription Drug Monitoring Program (PDMP): | $ 0.00 |
| Total Fees Due: | $100.00 |

3. **AUTHORIZATION FOR RELEASE OF RECORDS**
   A completed Authorization for Release of Records form (#08-4022a).

4. **MEDICAL SCHOOL DIPLOMA**
   A certified true copy of the medical school diploma.

5. **VERIFICATION OF MEDICAL EDUCATION**
   A completed Verification of Medical/Osteopath School Education form (#08-4022b).

6. **VERIFICATION OF GOOD STANDING FROM RESIDENCY PROGRAM**
   A completed Verification of Good Standing from Residency Training Program form (#08-4022c).

7. **ACCEPTANCE OF RESPONSIBILITY**
   A completed Acceptance of Responsibility by Alaska Facility, Hospital, Clinic form (#08-4022d).

8. **CLEARANCE REPORT – FSMB**
   A completed Clearance Report form (#08-4022e) from the Federation of State Medical Boards.

9. **VERIFICATION OF LICENSURE**
   A Verification of Licensure form (#08-4022f) from all licensing jurisdictions where the applicant holds or has ever held a license as any health care professional (e.g., physician assistant, nurse, MICP, dentist, optometrist, etc.).

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.

**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.

**FAX DOCUMENTS**

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

**FOREIGN LANGUAGE DOCUMENTS**

All foreign language documents must be certified true copies and must be accompanied by a certified translation into English by a recognized translator.

**LICENSE APPLICATION PROCESSING STAFF**

Please visit our website to find the contact information for your Licensing Examiner:
*ProfessionalLicense.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 resident permit 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.

**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.

**PRESCRIPTION DRUG MONITORING PROGRAM (PDMP)**

A licensee may not prescribe or dispense a controlled substance until registration with the PMDP is complete. All actively licensed practitioners with a DEA registration number valid in any state or practice location must register with the Alaska Prescription Drug Monitoring Program (PDMP) within 30 days of initial licensure and use the PDMP to review a patient's prescription history each time before prescribing, administering, or dispensing a federally scheduled II or III controlled substance. For more information, please visit *PDMP.Alaska.Gov*

**PROCESSING TIME**

In general, average processing time for a resident permit is six to eight weeks. PLEASE PLAN ACCORDINGLY. Application processing time depends to a large extent on the response time from other organizations. Time required also depends upon our workload and the volume of applications being processed. Because the length of processing time for your application may vary considerably, we urge you to be patient until our processing is complete and the permit is issued.

If there are any "yes" responses or if adverse information is received, it will typically take longer to gather and evaluate additional data. If the application is referred to the Investigations Unit for investigation of a particular issue, processing time is extended by the time required to complete an investigation. Since investigations must be prioritized, it may take longer to complete the file.

**SOCIAL SECURITY REQUIREMENT**

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

**STALE DOCUMENTS**

If during the license application process certain documents become older than 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, verifications of licensure from other licensing jurisdictions, the DEA clearance report and the FSMB Board Action Data Bank report.

**TELEPHONE QUERIES**

We have a very small staff and work hard to process applications as quickly as possible. Unnecessary telephone calls to our offices delay processing. If the licensing examiner must spend time answering numerous telephone queries, application processing time is affected. Because of the huge volume of telephone calls regarding the status of applications and because of privacy issues, **we must restrict our telephone responses to the applicant only**. We will not discuss your application with others. If you are concerned about your application being received in our office, mail it "certified – return receipt requested." You will have a verification of delivery returned to you by the post office.

**WEBSITE ADDRESS**

The Division of Corporations, Business and Professional Licensing maintains a website where you may check to see if your license or permit has been issued. The address is *ProfessionalLicense.Alaska.Gov*

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

**PROFESSIONAL FITNESS QUESTIONS**

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**

FOR DIVISION USE ONLY

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# Resident Permit Application

## PART I Professional Designation

| | |
|---|---|
| **Profession:** | ☐ Allopathic Physician (MD) ☐ Osteopathic Physician |

## PART II Payment of Fees

| | | |
|---|---|---|
| **Required Fees:** | ☐ Nonrefundable Application Fee/Resident Permit Fee | **$100.00** |
| **PDMP Fees:** | ☐ I have an active DEA registration number valid in any state or practice location. | **$ 0.00** |
| | ☐ I do not have an active DEA registration number valid in any state or practice location. | **$ 0.00** |

## PART III Personal Information

| | | | | |
|---|---|---|---|---|
| **Full Legal Name:** | | | | |
| **Provide all other names used (maiden, nicknames, aliases).** If any documentation will be received in a prior name, you must provide a certified true copy of the documentation showing proof of legal name change(s).<br>☐ Not Applicable<br>☐ Other Names Used: _____ | | | | |
| **Residence Address:** | Street | City | State | Zip |
| **Practice Address:** | Street | City | State | Zip |
| **Which address do you want to use for your mailing address and for the public record?** | ☐ Residence Address<br>☐ Practice Address | | | |

## PART III Personal Information (continued)

| | | | |
|---|---|---|---|
| **Contact Phone:** | | **Date of Birth:** | |
| **Place of Birth:** | | **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:** | | **Select One:** | ☐ Send my Correspondence by Email<br>☐ Send my Correspondence by 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 IV Alaska License or Permit

Complete the following if you have previously held a license or permit in Alaska.

| | | | |
|---|---|---|---|
| **Previous License or Permit Type:** | ☐ Permanent ☐ Resident ☐ Locum Tenens ☐ Temporary | | |
| **Previous AK License or Permit Number:** | | **Date Issued:** | |

## PART V Resident Rotation Assignment

Identify the Alaska facility where you will be serving your rotation.

| | | | |
|---|---|---|---|
| **Name of Facility or Institution:** | | | |
| **Location:** (City, State) | | **Dates of Rotation:** | |

## PART VI Medical School Education Information

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

| Name of Institution | Location (City, State) | Date Graduated |
|---|---|---|
| | | |
| | | |

## PART VII Post-Graduate Training Information

List internship, residency, or fellowship training programs chronologically.

| Name of Institution | Address | Date(s) Attended | Completed? |
|---|---|---|---|
| | | | ☐ Yes<br>☐ No |
| | | | ☐ Yes<br>☐ No |
| | | | ☐ Yes<br>☐ No |
| | | | ☐ Yes<br>☐ No |

## PART VIII ECFMG Certification

(Foreign Graduates Only)

If you graduated from an International Medical School, have you taken the ECFMG Exam?

☐ No

☐ Yes, and I have attached a certified true copy of my ECFMG certificate to this application.

| **ECFMG Certificate Number:** | |
|---|---|

## PART IX Self-Designated Specialty

You may designate a specialty area of practice, whether you hold a specialty board certification or not. If you are board certified, attach a certified true copy of the board certificate.

☐ I do not wish to designate a specialty area of practice.

☐ I wish to designate the following specialty area(s) of practice:

| Specialty / Subspecialty | Certification Date | Specialty Board | Recertification Date |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## PART X DEA Registration and PDMP Acknowledgment

1. **Providers with a DEA registration number valid to use in any state or practice location must register with the PDMP. Do you have a DEA Registration number?**

☐ **a.** **NO**, I do not have an active DEA registration number valid to use in any state or practice location. I understand if I obtain a DEA registration number, I must register with the Alaska PDMP within 30 days as required by the board. I will comply with mandatory use and refer to all applicable authorizing statutes and regulations. (Skip to Part XI)

☐ **b.** **YES,** I have an active DEA registration number valid to use in any state or practice location. I understand I must register with the Alaska PDMP within 30 days of receiving this permit, as required by the board, and will comply with mandatory use as required by AS 17.30.200 and 12 AAC 40.967.

☐ I acknowledge I must review a patient's prescription history prior to prescribing, administering, or dispensing a federally scheduled II or III controlled substance. I understand that I must also review the patient's history once every 30 days for up to 90 days, and at least once every three months if treatment continues for more than 90 days.

If I have a change in DEA registration number or status, I also understand I must promptly submit the DEA Registration Status Change Form (#08-4763).

***If you're unsure of the DEA issue date, indicate January 1st of the estimated year.***

| **DEA Registration Number:** | | **Issue Date:** | | **Expiration Date:** | |
|---|---|---|---|---|---|

2. **Providers who directly dispense a federally scheduled II - IV controlled substance are required to report daily. Do you plan to directly dispense?** Directly dispense means you deliver the substance directly to the user. Writing a prescription for a patient to fill at a pharmacy is NOT direct dispensing.

*Reporting does not apply to you if you directly dispense a 3-day supply or less, or in practice locations exempt under AS 17.30.200(t). Exempted facilities include health care facilities (defined in AS 18.07.111 or AS 18.20.499), correctional facilities, inpatient pharmacies, and emergency departments.*

*Per AS 11.71.900(8) "dispense" means to deliver a controlled substance to an ultimate user or research subject by or under the lawful order of a practitioner, including the prescribing, administering, packaging, labeling, or compounding necessary to prepare the substance for that delivery; "dispenser" means a practitioner who dispenses.*

☐ **a.** **YES**, I plan to directly dispense and acknowledge I must report daily per AS 17.30.200 and 12 AAC 52.865.

☐ **b.** **NO**, I do not plan to directly dispense and acknowledge that if I begin directly dispensing, I must report daily. (If you are not directly dispensing, the reporting criteria do not apply to you.)

## PART XI Professional License(s)

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

| State or Jurisdiction | License Number | Issue Date | License Status (Active, Lapsed) |
|---|---|---|---|
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## PART XII 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.

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

| Date of Case (mm/yyyy) | State or Jurisdiction | Nature of Allegation | Amount of Award or Settlement |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

## PART XIII Professional Fitness Questions – Disciplinary History

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

**For each "yes" response to any question, you must provide an explanation and documentation.** Use the letter of explanation form (#08-4752) appended to this application; include full details, dates, locations, type of action, organizations or parties involved, and specific circumstances. A separate letter of explanation form must be provided for each "yes" answer documented below. Documentation includes copies of court orders, charging documents, board, or license actions, etc.

The contents of licensing files are generally considered public records. 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 been disciplined by a medical school or post-graduate training program, including academic probation? (Please read definition of "discipline" above.) ☐ **Yes** ☐ **No**

Is any such action pending? ☐ **Yes** ☐ **No**

## PART XIII Professional Fitness Questions – Disciplinary History (continued)

**8.** Have you ever had a license to practice medicine disciplined by any authority including a state medical board or a military authority (except for late medical records)? (Please read definition of "discipline" on page 5.) ☐ **Yes** ☐ **No**

Is any such action pending? ☐ **Yes** ☐ **No**

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

Is any such action pending? ☐ **Yes** ☐ **No**

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

Is any such action pending? ☐ **Yes** ☐ **No**

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

Is any such action pending? ☐ **Yes** ☐ **No**

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

Is any such action pending? ☐ **Yes** ☐ **No**

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

Is any such action pending? ☐ **Yes** ☐ **No**

"Yes" Answers

**If you answered "yes" to any of the above questions,** you must submit signed and dated documentation explaining the specific circumstance(s) of the incident(s).

## PART XIV 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.** Use the letter of explanation form (#08-4752) appended to this application; include full details, dates, locations, type of action, organizations or parties involved, and specific circumstances. A separate letter of explanation form must be provided for each "yes" answer documented below. Documentation includes copies of court orders, charging documents, board, or license actions, etc.

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 XIV 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.

| | | | |
|---|---|---|---|
| **1.** | 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** |
| **2.** | 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** |
| **3.** | 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** |
| **4.** | Are you currently engaged in the illegal use of drugs, or the use of illegal drugs? | ☐ **Yes** | ☐ **No** |
| **5.** | 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** |
| **6.** | 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** |
| **7.** | 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** |

"Yes" Answers

**If you answered "yes" to any of the above questions,** in addition to your personal statement, you must submit a personal statement from yourself and a statement from your health care provider indicating your ability to safely practice medicine. Applications submitted without the appropriate attachments will be considered incomplete and will not be processed.

THE STATE of ALASKA

*Department of Commerce, Community, and Economic Development*
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**MED**

FOR DIVISION USE ONLY

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# Notary Signature Page

## PART XV 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 Printed Name:** | | | |
| | **Applicant Signature:** | | | |
| | **Notary Public for State of:** | | **Subscribed and Sworn to Before me on this Day:** | |
| Notary Seal | **Notary Signature:** | | **My Commission Expires:** | |

THE STATE of ALASKA
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Website: *ProfessionalLicense.Alaska.Gov/StateMedicalBoard*

# 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:** | P.O. Box or Street City State Zip | | |
| **Phone:** | | **Date of Birth:** | |
| **Email:** | | | |
| **Signature:** | | **Date Signed:** | |

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

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

# Verification of Medical or Osteopathic School Education

→ **Applicant:** Please complete the identifying information below and forward a copy of this form to the medical school which awarded your diploma.

| | | | |
|---|---|---|---|
| **Applicant Name:** | | **Date of Birth:** | |
| **Applicant Signature:** | | **Date Signed:** | |

→ **Medical School Staff:** Please complete this bottom part for the applicant identified above and return the form directly to the Alaska State Medical Board at the letterhead address.

**- THE FOLLOWING SECTION IS TO BE COMPLETED BY MEDICAL SCHOOL STAFF ONLY -**

| | | | |
|---|---|---|---|
| **Medical School Name:** | | **Exact Date on Diploma:** | |
| **Medical School Address:** | Street City State Zip | | |

**1.** 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. ☐ Yes ☐ No

"Yes" Answers

**If you answered "yes" to the question above,** please attach a detailed explanation or documentation signed and dated by the person whose signature appears below.

| | | | | |
|---|---|---|---|---|
| Seal (If Applicable) | **Signature:** | | **Date Signed:** | |
| | **Printed Name:** | | **Title:** | |
| | **Email:** | | **Phone:** | |

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# Verification of Good Standing from Residency Training Program

→ **Applicant**: Please complete the identifying information below and forward a copy of this form to the post-graduate training program(s) you attended.

| | | | |
|---|---|---|---|
| **Applicant Name:** | | **Date of Birth:** | |
| **Profession:** | ☐ Allopathic Physician (MED) ☐ Osteopathic Physician (DO) | | |
| **Residency Program** | | | |
| **Name of Residency Program:** | | **Phone:** | |
| **Mailing Address:** | P.O. Box or Street City State Zip | | |
| **Rotation Authorized For** | | | |
| **Name of Alaska Facility, Hospital, Clinic:** | | | |
| **Location:** | | | |
| **Rotation Start Date:** | | **Rotation End Date:** | |
| **Applicant Signature:** | | **Date Signed:** | |

→ **Program Director**: Please complete this bottom part for the applicant identified above and return the form directly to the Alaska State Medical Board at the letterhead address.

**CERTIFICATION OF GOOD STANDING**

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

| | | | |
|---|---|---|---|
| **Physician Program Director Signature:** | | **Date Signed:** | |
| **Printed Name:** | | **Phone:** | |

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# Acceptance of Responsibility by Alaska Facility, Hospital or Clinic

→ **Applicant**: Please complete the identifying information below and forward a copy of this form to the Alaska facility, hospital, or clinic where you intend to serve your residency rotation.

| | | | |
|---|---|---|---|
| **Applicant Name:** | | **Date of Birth:** | |
| **Profession:** | ☐ Allopathic Physician (MED) ☐ Osteopathic Physician (DO) | | |
| **Residency Program** | | | |
| **Name of Residency Program:** | | **Phone:** | |
| **Mailing Address:** | P.O. Box or Street City State Zip | | |
| **Applicant Signature:** | | **Date Signed:** | |

→ **Program Director**: Please complete this bottom part for the applicant identified above and return the form directly to the Alaska State Medical Board at the letterhead address.

| | | | |
|---|---|---|---|
| **Rotation Authorized For** | | | |
| **Name of Alaska Facility, Hospital or Clinic:** | | | |
| **Location:** | | | |
| **Rotation Start Date:** | | **Rotation End Date:** | |
| **Alaskan Physician Primarily Responsible for Training/Supervision** | | | |
| **Printed Name:** | | | |
| **Signature:** | | **Date Signed:** | |
| **VERIFICATION OF ACCEPTANCE OF RESPONSIBILITY**<br>I hereby certify the Resident Physician named above has been accepted by this institution to serve as a resident. This physician will be serving a portion of his/her clinical training at the Alaska institution named above. This institution accepts responsibility for this physician's training and supervision while he/she is located at this institution. | | | |
| **Physician Clinical Director Signature:** | | **Date Signed:** | |
| **Printed Name:** | | **Phone:** | |

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# Physician Board Action Data Bank Inquiry

→ **Applicant**: Please complete the information below. Type or print legibly. **MAIL THIS REQUEST FORM TO:**

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

| | | | |
|---|---|---|---|
| **Full Legal Name:** | | | |
| **Date of Birth:** | | **Social Security Number:** | |
| **Mailing Address:** | P.O. Box or Street City State Zip | | |
| **Medical or Osteopathic School Name:** | | **Location:** | |
| **Year of Graduation:** | | **If International Graduate, ECFMG No.:** | |

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

**Instructions to the Data Bank Staff:** Please search the data bank for any record of this practitioner. Please forward your report to the medical board at the letterhead address.

**FOR FEDERATION USE ONLY**

THE STATE of ALASKA

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# Verification of Licensure – Resident

**Applicant:** Please complete the identifying information below and forward a copy of this form to all states, territories, or jurisdictions where you currently are or have ever been licensed. *Make additional copies of this form, as needed.*

| | | | |
|---|---|---|---|
| **Applicant Name:** | | **Date of Birth:** | |
| **Maiden or Other Names Used:** | | | |
| **Mailing Address:** | P.O. Box or Street City State Zip | | |
| **Place of Birth:** | | **Social Security Number:** | |
| **Applicant Signature:** | | **Date Signed:** | |

**Licensing Agency or State Board:** Please complete this bottom part for the applicant identified above and return the form directly to the Alaska State Medical Board at the letterhead address.

| | | | |
|---|---|---|---|
| **License Number:** | | **State or Jurisdiction:** | |
| **Type of License:** (MD, DO, PA, RN, Etc.) | | **License Status:** | |
| **Original Issue Date:** | | **Expiration Date:** | |

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

"Yes" Answers

**If you answered "yes" to any question above,** please attach a detailed explanation or documentation signed and dated by the person whose signature appears below.

| | | | | |
|---|---|---|---|---|
| Board Seal | **Signature:** | | **Date Signed:** | |
| | **Printed Name:** | | **Title:** | |
| | **Email:** | | **Phone:** | |

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Website*: ProfessionalLicense.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.**<br>**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:** | |

***You must submit one form for each "Yes" answer. Make copies of this form as necessary.***

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# Credit Card Payment Form

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

Name of Applicant or Licensee: _____

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.