ALASKA STATE MEDICAL BOARD

Department of Community and Economic Development
Division of Occupational Licensing
(333 Willoughby Avenue - Ninth Floor)
Post Office Box 110806
Juneau Alaska 99811-0806
A – K: 907/465-2756 L – Z : 907/465-2541
E-Mail: medicalboard@alaska.gov

APPLICATION FOR A LICENSE TO PRACTICE MEDICINE OR OSTEOPATHY

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

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

- ***Average processing time for a permanent license is from eight to twelve 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this application from a source other than directly from the Division or its official website, the application may be outdated or not an official version. To ensure you have the official version, please contact the division. Application forms will be rejected if not on the current version.

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

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

907/269-8163 – Anchorage *907/465-2756 or 907/465-2541 – Juneau*

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

QUALIFICATIONS FOR LICENSURE

THRESHOLD QUALIFICATIONS FOR LICENSURE – United States Graduates

- Successful graduation from an accredited medical school
- Successful completion of post-graduate training in accredited programs in recognized hospitals:
  - If graduated from medical school prior to 01/01/1995 – 1 year of postgraduate training
  - If graduated from medical school on or after 01/01/1995 – 2 years of postgraduate training
- Submit a complete application (contents listed below)
- Submit a list of malpractice settlements/claims with an explanation of the basis for each claim or settlement
- NOT have a license to practice medicine in another state, territory, province, or international licensing jurisdiction suspended or revoked or otherwise disciplined

THRESHOLD QUALIFICATIONS FOR LICENSURE – International Graduates

- Successful graduation from a medical school listed in the Medical Board of California's List of Approved Schools (you may see the list at http://www.medbd.ca.gov/applicant/schools_recognized.html).
- Successful completion of three (3) years of postgraduate training in accredited programs in recognized hospitals in the United States or Canada
- Submit a complete application
- ECFMG Certificate
- Successful passage of appropriate examinations as defined by regulation
- Submit a list of malpractice settlements/claims with an explanation of the basis for each claim or settlement
- NOT have a license to practice medicine in another state, territory, or province suspended or revoked or otherwise disciplined

CONTENTS OF A COMPLETE APPLICATION BY CREDENTIALS or EXAMINATION

1 Application (9 pages), notarized with recent passport-style photograph
2 Authorization for Release of Records
3 Appropriate examination scores as required by regulation (12 AAC 40.020 and 021)
4 Medical School Diploma, certified true copy of original document
5 Postgraduate Training Program Certificates, certified true copies of original documents
6 Verifications of Licensure from all licensing jurisdictions, both U.S. and International, in which you have ever been licensed
7 A listing of all hospitals where you have held privileges in the five years preceding your application in Alaska
8 Verifications of hospital privileges from all hospitals in which you have held privileges in the five years preceding your application in Alaska
9 Clearance report from the Drug Enforcement Administration
10 Clearance report from the Federation of State Medical Boards Disciplinary Data Bank
11 AMA or AOA Physician Profile (required even if not a member)
12 Verification of medical school education
13 Verification of postgraduate training
14 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.

APPLICATION FOR LICENSURE
CHECKLIST

(Use this checklist to help complete the application for a license in Alaska.)

Document	You Provide Document	You Request; Other Agency Provides Document
Application, 9 pages, with recent photo and notarized	❑	
Authorization for Release of Records	❑	
Examination Scores	❑	❑ FCVS can provide
Medical School Diploma, certified true copy	❑	
Verification of Medical School Education		❑ Medical School or FCVS can provide
Post-Graduate Training Certificates, certified true copies	❑	
Post-Graduate Verifications of Training		❑ Programs or FCVS can provide
Verifications of Licensure in Other Jurisdictions		❑ States or Veridoc can provide
Hospital Privileges List	❑	
Hospital Privileges Verifications		❑ Hospitals provide
DEA Clearance report		❑ DEA provides
FSMB Board Action Data Bank		❑ FSMB provides
AMA/AOA Profile		❑ AMA/AOA provides
NPDB Report		❑ Alaska board will obtain
Explanations for any ‘yes’ responses in application	❑	
Fees Enclosed with Application	❑	
ECFMG, if international medical school graduate	❑	❑ FCVS can provide

GENERAL INFORMATION ABOUT APPLYING FOR A LICENSE IN ALASKA

ADDRESS OF RECORD
Item 8 of the application asks for your preferred address of record. This is the address to which you would like us to send all communications to you including your permit or license. 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 USMLE examination series or have passed the following examinations with at least a minimum passing score as defined by regulation (12 AAC 40.020): the National Board of Medical Examiners (NBME), the Federation Licensing Examination (FLEX), or the National Board of Osteopathic Medical Examiners (NBOME).

APPLICATION FOR LICENSURE BY EXAMINATION
The Alaska State Medical Board offers the USMLE Step 3 examination and has contracted with the Federation of State Medical Boards for the administration of the examination on our behalf. To request examination information, please call or write to the Federation at:

United States Medical Licensing Examination ™ (USMLE) Step 3
The Federation of State Medical Boards
400 Fuller Wiser Rd., Suite 300
Euless, TX 76039-3856
817/868-4000 or 817/868-4041

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

BOARD REVIEW OF APPLICATIONS
Only the board is authorized to grant licenses. Your application will, at some point, be presented to the board for review and approval. In most cases, you will be notified via a completion status letter from the licensing examiner that your file has been forwarded to the executive administrator for review and when the next scheduled board meeting will occur. In some cases, if there is an issue that requires resolution in your application, your file may be delayed for a period of time and your file may not be reviewed by the board immediately. If you wish to know when your application will be considered by the board, please contact the office and advise us as early as possible so that we may accommodate your request.

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

COMPLETION OF THE APPLICATION FORMS
Help us do a good job processing your application: type or print legibly all application documents. Please read the instructions and give careful thought before answering the questions in the application - remember - you are certifying that the information is truthful and correct. Make sure all notary seals are properly affixed on the application and all documentation has been properly certified as required. Provide all documents requested in the application; incomplete applications will delay processing.

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

Failure to answer all questions completely and accurately, or the omission or falsification of information may be cause for denial of your application or disciplinary action if you are subsequently permitted by the board. WHEN IN DOUBT, DISCLOSE ALL INFORMATION OR CALL OUR OFFICE.

CONFIDENTIALITY
The contents of licensing files are generally considered public 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.

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

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.

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 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 scores, send your full name, the name of your medical school, date of graduation, your birth date, and your social security number to the appropriate organization listed below. Each organization requires a fee of $65 accompany such requests (money order, personal check, or cashier's check).

For FLEX or USMLE examination scores, send your request to:

The Federation of State Medical Boards
Attn: FLEX/USMLE
Post Office Box 619850
Dallas TX 75261-9850

Telephone: (817) 868-4000
Fax: (817) 868-4099

For National Board of Medical Examiners, send your request to:

National Board of Medical Examiners
P.O. Box 48014
Newark, NJ 07101-4814

Overnight Delivery Service Requests:
c/o Image-Remit, Inc.
210 N. Center Drive, Commerce Center #210
North Brunswick, NJ 08902-4246

For the National Board of Osteopathic Medical Examiners, send your request to:

National Board of Osteopathic Medical Examiners
8765 W. Higgins Road, Suite 200
Chicago, IL 60631-4104

Telephone: (773) 714-0622

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

FEDERATION CREDENTIALS VERIFICATION SERVICE
The Federation of State Medical Boards offers a credentials verification service that is accepted by the Alaska board. This verification process is conducted separately and independently by the FCVS in accordance with established policies and procedures set forth by the board. By participation in the FCVS process, you will establish a permanent, lifetime portfolio of primary-source verified credentials allowing for quick and easy access to your important medical credentials.

To utilize this service, you must first enroll by submitting an application to the FCVS. For more information on this service, go to http://www.fsmb.org/fcvs.html or call toll free 1 888/275-3287. When the FCVS receives your information and documentation, a non-interpretive "Physician Information Profile" containing certified photocopies of your credentials is forwarded directly to the board. Please do not contact the Alaska State Medical Board regarding your FCVS application.

FEES

Fees for a permanent physician application are:

$200	Nonrefundable Application Fee
$300	Permanent License Fee
$500	**Total Due**

You may remit a minimum of $275 (nonrefundable application fee and $75 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.

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.

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

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 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 meeting. The board meets four times each year. Following the board's review and approval, the licensing examiner will issue the permanent license.

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

LICENSE APPLICATION PROCESSING STAFF

If your last name begins with the letters A through K, you may contact your licensing examiner at 907/465-2756.
If your last name begins with the letters L through Z, you may contact your licensing examiner at 907/465-2541.

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 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 nonrenewal. 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.

NAME CHANGES

If you have changed your name at any time during your life, you must submit a copy of the legal document (marriage certificate, divorce decree, etc.) supporting your name change.

PAYMENT OF CHILD SUPPORT
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.

PRACTICING IN ALASKA
For information on practice opportunities, please contact:

Alaska State Medical Association
4107 Laurel Street
Anchorage, AK 99508-5334
(907) 562-0304

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 our workload and the volume of applications being processed. Because the length of processing time for your application may vary considerably, we urge you to be patient until our processing is complete and the permit is issued

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

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

STALE DOCUMENTS
If during the license application process certain documents become older than six months from the date the document was received in our office, that document is considered to be stale and must be resubmitted. Affected documents include the application, verifications of licensure from other licensing jurisdictions, the DEA clearance report, and the FSMB 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.state.ak.us/occ

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.

VERIDOC – License Verification Service
You may wish to utilize the services of Veridoc, Inc. for the purpose of expediting your verifications of licensure from other states to the Alaska board for your application. To use this system, log on to their website at www.veridoc.org for more information. The use of Veridoc eliminates the time delay often experienced when relying on post office mail to receive license verifications. We recommend the use of Veridoc to expedite processing.

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 request 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.**

WHEN IN DOUBT, DISCLOSE AND EXPLAIN.

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.
8 Use VeriDoc for your license verifications; it speeds the process greatly.
9 We recommend the use of the FCVS; it also speeds the process.

Please – DO NOT come to Alaska until you have a permit or license in hand.

QUESTIONS? CALL

A – K: 907/465-2756 L – Z : 907/465-2541

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Department of Commerce, Community, and Economic Development
Division of Corporations, Business, and Professional Licensing
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For Office Use Only

APPLICATION FOR LICENSE TO PRACTICE MEDICINE OR OSTEOPATHY

Nonrefundable Application Fee	$200
Permanent License Fee	$300
Total Due	$500

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)		
		City	State	Zip Code
6	**Full Residence Address**	Mailing Address (Include street address if using post office box) →		**Duration at this address:** Yrs: Mos:
		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**			Do you wish to be included on an email emergency notification list? ❑ Yes ❑ No
10	**Professional Designation**	☐ MD ☐ DO		Application Based on: ☐ Credentials (Licensed in other state) ☐ Examination (Not licensed in other state)
11	**Previous License or Permit In ALASKA?**	☐ NO ☐ YES →		If YES, when and what type: Year:_____ ☐ 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 _____

12. **Military Service**

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

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

Date and Type of Discharge:_____

Locations where you served:_____

PART II EDUCATION

13. **Medical School Education** 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.

SCHOOL	MAILING ADDRESS		(MM/YYYY)	Completed Yes/No
		From		
		To		
		From		
		To		

13 a. If your medical school is an international one, is it listed on the Medical Board of California's List of Approved Schools? ☐ Yes ☐ No – If you check 'no', please call our office immediately.

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

Yr	HOSPITAL	MAILING ADDRESS		(MM/YYYY)	Completed Yes/No
1			From		
			To		
2			From		
			To		
3			From		
			To		
4			From		
			To		
5			From		
			To		
6			From		
			To		

15. **Examination History** Please specify National Boards, FLEX, LMCC, USMLE, or a state written examination.

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

Applicant Name: **Date:**

16. **ECFMG Certification - International Graduates Only** Attach a certified true copy of your certificate to this application.
If you are an international medical graduate, have you taken the ECFMG exam? ☐ Yes ☐ No

If Yes, ECFMG Certificate No. | Date Issued (MM/YYYY)

17. **Self-Designated Specialty** If you are board certified, attach a certified true copy of board certificate.

Specialty/Subspecialty	Board Certified? Yes/No/Date	What Board?	Recertification Date

PART III PROFESSIONAL ACTIVITIES

18. **Professional Licensure** Please list **all states, territories, provinces, or foreign countries** in which you hold or have **ever held a license to practice medicine**. Include 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				

Residency Licenses, Instructional or Training Permits

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

19. **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 19, 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.

20. **Medical Societies and Professional Organizations**

Name of Organization	Address	Date From/To - YYYY

Applicant Name: **Date:**

21. **Hospital Affiliations**

Have you ever held hospital privileges? ☐ Yes ☐ No

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)
1			From	
			To	
2			From	
			To	
3			From	
			To	
4			From	
			To	
5			From	
			To	
6			From	
			To	

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

22. **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. Please do not attach a CV; we require the use of this form. If needed, you may make additional copies of this page.

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
Fr			
To			

Fr			
To			

Fr			
To			

Fr			
To			

Continued on next page

Applicant Name: **Date:**

Medical Work History continued:

Fr			
To			

Fr			
To			

Fr			
To			

Fr			
To			

Fr			
To			

Fr			
To			

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

23. **Medical Malpractice History**

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

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

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

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

Applicant Name:	**Date:**

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.

24a. ☐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?

24b. ☐No ☐Yes . . . . . Is any such action pending?

25a. ☐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?

25b. ☐No ☐Yes . . . . . Is any such action pending?

26a. ☐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?

26b. ☐No ☐Yes . . . . . Is any such action pending?

27a. ☐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?

27b. ☐No ☐Yes . . . . . Is any such action pending?

Continued on next page

28a. ☐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)?

28b. ☐No ☐Yes . . . . . Is any such action pending?

29a. ☐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?

29b. ☐No ☐Yes . . . . . Is any such action pending?

30a. ☐No ☐Yes . . . . . Have you ever been disciplined by a medical school or post-graduate training program? (Including Academic Probation) *See Important information block on discipline on page 6.*

30b. ☐No ☐Yes . . . . . Is any such action pending?

31a. ☐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.)

31b. ☐No ☐Yes . . . . . Is any such action pending?

32a. ☐No ☐Yes . . . . . Have you ever been under investigation by 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.)

32b. ☐No ☐Yes . . . . . Is any such action pending?

33a. ☐No ☐Yes . . . . . Have you ever had a medical license application denied by any medical licensing jurisdiction or authority?

33b. ☐No ☐Yes . . . . . Is any such action pending?

34a. ☐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?

34b. ☐No ☐Yes . . . . . Is any such action pending?

35a. ☐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?

35b. ☐No ☐Yes . . . . . Is any such action pending?

36a. ☐No ☐Yes . . . . . Have you ever voluntarily or involuntarily agreed to any limitations, restrictions, or conditions to your license to practice medicine?

36b. ☐No ☐Yes . . . . . Is any such action pending?

37a ☐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?

37b ☐No ☐Yes . . . . . Is any such action pending?

Applicant Name:	**Date:**

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.

38. ☐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?

39. ☐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?

40. ☐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?

41. ☐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?

42. ☐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.)

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

44. ☐No ☐Yes . . . . . Have you used or are you currently using any chemical substance(s), legal or illegal, that in any way impaired or limited, or is currently impairing or limiting, your ability to practice medicine in a safe and competent manner?

Continued on next page

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

46. ☐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

47. ☐No ☐Yes . . . . . Have you ever taken, or are you currently taking, any controlled substance for any of the disorders listed in question 46 above?

48. ☐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.

PART VI SWORN STATEMENT

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

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

I have carefully read all the instructions in the application including the instructions under Part IV, Disciplinary History, on page 6. ❑ ***Yes***

Applicant Signature_____ Date_____

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

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

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

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

Notary Signature_____
My commission expires:_____

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

ALASKA STATE MEDICAL BOARD

MED

Department of Commerce, Community, and Economic Development
Division of Corporations, Business, and Professional Licensing
(333 Willoughby Avenue – Ninth Floor)
Post Office Box 110806
Juneau AK 99811-0806
A – K: 907/465-2756 L – Z: 907/465-2541
E-Mail: medicalboard@alaska.gov

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

ALASKA STATE MEDICAL BOARD

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Juneau AK 99811-0806
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E-Mail: medicalboard@alaska.gov

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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

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E-mail: medicalboard@alaska.gov

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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

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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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E-mail: medicalboard@alaska.gov

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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

Department of Commerce, Community, and Economic Development
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(333 Willoughby Avenue - Ninth Floor)
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Juneau AK 99811-0806
A – K: 907/465-2756 L – Z : 907/465-2541
E-mail: medicalboard@commerce.state.ak.us

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BOARD ACTION DATA BANK INQUIRY

Instructions to the Applicant: Type or print legibly. Complete Part I below. Mail this form 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 State Medical Boards
400 Fuller Wiser Rd., Suite 300
Euless TX 76039-3855

FOLLOWING TO BE COMPLETED BY FSMB 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

American Medical Association

Physicians dedicated to the health of America

AMA Physician Profile Unit
515 North State St
Chicago IL 60610

Telephone: 312/ 464-5199
Fax: 312/464-5900

AMA Physician Profile Order Form – Physician Use Only

Complete and send this form to the American Medical Association (AMA) at the above address. Profiles also can be ordered online ***through AMA ePhysician Profiles*** located at http://www.ama-assn.org/AMAPhysicianProfiles. AMA Customer Service is available for ordering assistance at 800-665-2882 or 312-464-5199, Monday through Friday, 8:30 am – 4:45pm CT.

*** * * Join or renew your AMA membership today --- call 800-AMA-3211 * * ***

Indicate AMA Membership Status: ____Member Physician ____Nonmember Physician

Membership Type	**Standard Mail Service* (within 3-5 business days)**	**Express Service * (within 1 business day)**
AMA Member Physician	No charge	$6 per profile
Nonmember Physician	$35 per profile	Not available

* ***Prices are subject to change without advance notice.***

CREDIT CARE PAYMENT ONLY.

___ VISA ___ American Express ___MasterCard Charge Amount: $_____

Credit Care Number _____ Expiration Date: _____/ _____/ _____

Name on Credit Care: _____

Billing Address: _____

Approval Signature _____ Daytime Telephone: _____

Part I: AMA Physician Profile Delivery Information

Please send my profile to the following state licensing or medical specialty board:

Board Name: _____

NOTE: When requesting delivery to a state licensing board, indicate MD or DO profession type.

Part 2: Physician Information

_____
Physician Name (first, middle, last, suffix)

_____ _____/_____/_____ _____
Place of Birth Date of Birth Social Security Number

_____ _____
E-mail Address Medical Education Number (optional)

_____
Preferred Mailing Address

_____ (_____)_____-_____
City, State, Zip Code Telephone Number

The above address is my OFFICE___ HOME___ OTHER___

If address is home or other, please complete this section.

_____
Primary Office Address

_____ (_____)_____-_____
City State Zip Code Office Telephone Number

Part 3: Medical Education and Other Information

Medical School of Graduation _____ Year of Graduation _____

DEA Number _____ ECFMG Number _____

Residency Training

Residency Training (institution/hospital name, location, and years) _____

_____

_____

Hospital Admitting Privileges

Hospital Name _____ City/State _____

_____ _____

_____ _____

_____ _____

Group Practice Affiliation(s)

Group Practice Name _____ City/State _____

_____ _____

_____ _____

_____ _____

Physician Agreement

Agreement must be signed in order to process your request.
AMA endeavors to maintain its physicians' records with information that is complete, current, and timely; however, because of possible reporting and processing delays, no representations or warranties as to the accuracy or completeness can be or is made. In consideration of the receipt of your physician record provided by AMA, hereby release AMA, its agents and servants from any and all liability whatsoever for inaccurate or incomplete information in such physician record. Submission of this form and payment of fee (if applicable) shall be conclusive evidence of your understanding and agreement to the above stated terms and conditions.

X_____ _____/_____/_____
Signature Date

The state of Alaska requires all osteopathic physicians who are applying for a license to practice medicine have a copy of their individual "Official Osteopathic Physician Profile Report" sent directly to the board by the American Osteopathic Information Association.

There are two options in ordering your profile:

1 Order your official Osteopathic Physician report over the Internet at www.doprofiles.org and ask that it be sent to the Alaska board at:

Alaska State Medical Board
P O Box 110806
Juneau AK 99811-0806
Email: medicalbaord@alaska.gov

OR

2 Complete the bottom portion of this form (please print clearly) and send to:

The American Osteopathic Information Association
Credentials Services
142 E. Ontario Street
Chicago IL 60611

* * * * *

Please send my Official Osteopathic Physician Profile Report to:

Alaska State Medical Board

Physician Name _____
Last, First, Middle, Suffix

Medical School _____ Yr Grad _____

Date of Birth _____/_____/_____ AOA Number _____

Fee: AOA Members – No charge
Non-members - $20

- ❑ Check enclosed payable to AOIA for $20
- ❑ Credit Card
  - ❑ VISA ❑ Mastercard ❑ AMEX ❑ Discover

Card Number _____
Expiration Date Month_____ Year_____
Name on Card _____
(Print)
Amount $_____

Signature _____
Contact Phone _____

ALASKA STATE MEDICAL BOARD

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E-mail: medicalboard@alaska.gov

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VERIFICATION OF MEDICAL/ OSTEOPATHIC 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 Medical 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 _____

ALASKA STATE MEDICAL BOARD

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E-mail: medicalboard@alaska.gov

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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. NOTE: At least two years of postgraduate training must be verified if the physician graduated from medical school on or after January 1, 1995. Three years of postgraduate training must be verified for international medical school graduates.

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:

PG-Yr 1 ☐ PG-Yr 2 ☐ PG-Yr 3 ☐ PG- Yr 4 ☐ PG-Yr 5 ☐ PG-Yr 6 ☐

Exact Dates of Training _____

1 At the time this individual completed training in your program, was the program accredited through the Accreditation Council for Graduate Medical Education, the Royal College of Physicians and Surgeons of Canada, or the American Osteopathic Association?

☐ No ☐ Yes (please circle the accrediting agency above)

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