State of Tennessee
Department of Health

Medical Laboratory Board

Metro Center Complex
665 Mainstream Drive, 2nd Floor
Nashville, TN 37243
(615) 532-3202
1-800-778-4123 Ext. 5325128
tennessee.gov/health

Medical Laboratory Board
Procedures for Application & Licensure

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I. APPLICATION PROCEDURES

Fees (Rule 1200-6-1-.06)

The following fees are required for licensure:

$ 50 (application fee) - nonrefundable
$ 10 (regulatory fee) - nonrefundable
$ 60 TOTAL

Checks or money orders must be made to the State of Tennessee.

Application Acknowledgment

A postcard was enclosed in your application packet (this service not available on-line). If you return the postcard with your application and it is addressed and stamped, the postcard will be returned upon receipt of your application. **The postcard will not be returned unless the applicant affixes the proper postage to the card.**

Converting Quarter Hours to Semester Hours:

$$\frac{\text{Total Quarter Hours}}{3} \times 2 = \text{Total Semester Hours}$$

Converting CEUs to Clock Hours:

Total CEUs x 10 = Total Clock Hours

Converting Semester Hours to Clock Hours:

Total Semester Hours x 15 = Total Clock Hours

II. TRAINEE PERMITS (1200-6-1-.14)

Registration of the Laboratory Trainee

A qualified laboratory trainee may be registered at no cost. Registration is valid for a period of two (2) years or less. Each training program must submit their trainee applications before the trainees begin practical training in a medical laboratory (permits will not be post dated). **The trainee work permit is only valid in the facility(ies) approved for practice training.** The facility(ies) must be approved prior to internship. A trainee may work in a department after completion of the classroom requirements, along with the clinical rotation period for that department, provided he/she is under the direct supervision of licensed medical laboratory personnel at the technologist level or higher. Documentation that the trainee has demonstrated acceptable competence levels in all procedures routinely performed in that clinical area must become part of that trainee's file.

The trainee permit shall be on file in the training program location and on-site during each clinical training program rotation.

III. LICENSURE INFORMATION

Processing Time: Each application is unique, however be prepared for a minimum of eight (8) to ten (10) weeks administrative processing time. Some applications will require more or less time depending upon complexity and circumstances.

Temporary License (Rule 1200-6-1-.13)

A temporary license may be issued by the Board for an applicant who has successfully completed the academic work, clinical training, and all Board designated requirements for the license sought, and is scheduled to take the next available Board approved examination. Individuals working with this temporary license may work under the supervision of a licensed laboratory professional at the supervisory level or a preceptor assigned by the laboratory supervisor. The preceptor will hold a license equal to or higher than the temporary licensee's level of licensure.

If the applicant fails the examination or does not sit for the scheduled examination, the temporary license shall become null and void on that date.

Renewals (Rule 1200-6-1-.09)

Licenses are renewed every other year based on the licensee's birthday. A penalty fee is due if your renewal is postmarked past the deadline. The licensee is responsible for notifying the administrative office in writing when there is an address or name change. (See Continuing Education Information, page 12). License renewal on-line: https://www.tennesseeanytime.org/hlrs .

Retirement/Reactivation of License (Rule 1200-6-1-.11)

A licensee who holds a current license and does not intend to practice as a medical laboratory professional in Tennessee may retire his/her license. The licensee must complete the Affidavit of Retirement from Practice in Tennessee Form and twenty-four (24) hours of continuing education and have it notarized. The licensee will be notified in writing about any change of status of his/her license. Renewal fees will not be required until the license is reactivated. The completion of a Reactivation Form and approval by the administrative office will allow the licensee to return to work. This document may be obtained from the Board's administrative office or from the Board's internet page indexed as Forms and Applications.

Change of Name or Address (Rule 1200-6-1-.17)

A change in name or address requires **prompt** notification to the Administrative office.
You may fax this information to the Administrative office: 615-741-7698.

Verification of License Status

The status of an individual's license is a matter of public record. Anyone inquiring about an individual's license will be given the licensure category, date of certification and if licensee is in good standing. This information may be obtained through the Tennessee Department of Health automated phone system, (615) 532-3202 (local), and following each prompt. Licensure information is also available from the Department's website, http://health.state.tn.us/licensure/default.aspx

Criminal Background Check (Rule 1200-6-3-1.05 (m))

Effective June 1, 2006 applicants for **initial** licensure in Tennessee (not applicable to the renewal or reinstatement or upgrade) **must** obtain a criminal background check. This rule affects all individuals required by statute to be licensed by the Tennessee Medical Laboratory Board to include: Technologists, Technicians, Cytologists, Special Analysts and Directors. For further information and instructions follow this link to the provided directions, http://health.state.tn.us/CBC/index.htm .

IV.

General Requirements- Mandatory

ALL APPLICANTS

___ Completed application
___ Notarized application
___ Complete fees
___ Photograph (signed on back of photo, passport size)
___ Official transcript which indicates that a degree was conferred. (sent directly from the University to this administrative office) See Attachment 1.
___ Graduation from a formal laboratory training program (NAACLS, CAHEA, CAAHEP) See Attachment 2.
___ Proof of National Certification (sent directly from the agency or its designee). See Attachment 3.
___ Completed Criminal Background Check
___ Completed Practitioner Profile
___ Declaration of Citizenship

All Applicants

Must submit a letter of completion from their laboratory training program in addition to the preceding requirements. This letter must be sent directly from the Program Director to the Board's administrative office.

Military Trained Applicants/Medical Laboratory Technician (Rule 1200-6-1-..22((2)(b)(2)

The applicant must have an associate degree in a laboratory science and successful completion of an official military medical laboratory procedures course of at least fifty (50) weeks duration in residence and have held the military enlisted occupational specialty of Medical Laboratory Specialist (Medical Laboratory Technician). This information will be referenced on form DD214, a copy of which must be included. National certification by examination is also required.

Military Trained Applicants/Medical Laboratory Technologist (Rule 1200-6-1-.22 (1) (a) (3)

Must have a baccalaureate degree, completion of the fifty (50) week military laboratory training program, three (3) years of full time clinical laboratory work experience as defined in (1)(j) of this rule; the individual must have completed science coursework equivalent to that required in a laboratory science education program as defined by (1)(h) of this rule. The military training program will be referenced on form DD214, a copy of which must be included. National certification by examination is required.

New Emerging Technology Applicants (Rule 1200-6-1-.22)

An individual may be issued a special analyst license to perform tests in a limited range (as listed on the license), if the procedure(s) for which licensure is requested is a new, emerging technology in the clinical laboratory or represents a subspecialty not otherwise regulated. The procedure(s) must not be a component of the traditional clinical laboratory science Body of Knowledge.

Internationally Trained Applicants (Rule 1200-6-1.05(2))

An **evaluation of a foreign transcript** is required to determine the applicant's eligibility in addition to the general requirements. The evaluation must be obtained from one of the following agencies.

Center for Applied Research
Evaluation & Education, Inc.
P.O. Box 18358
Anaheim, CA 92817-8358
Phone:
(714) 237-9272
(714) 237-9276
FAX:
(714) 237-9279
Email: eval_career@yahoo.com

Educational Evaluators International, Inc.
11 S. Angell St. #348
Providence, RI 02906
Phone:
(401) 521-5340
FAX:
(401) 437-6474
WEB:
www.educei.com

International Consultants of Delaware, Inc
625 Barksdale Professional Center, Suite 109
Newark, DE 19711-3258
Phone:
(302) 737-8715
FAX:
(302) 737-8756
Email: icd@icdel.com

Josef Silny and Associates, Inc.
International Education Consultants,
P.O. Box 248233
Coral Gables, FL 33124
Phone:
(305) 273-1616
FAX:
(305) 273-1338
Email: info@silny.com

Education Credential Evaluators, Inc.
P.O. Box 514070
Milwaukee, WI 53203-3470
Phone:
(414) 289-3400
FAX:
(414) 289-3411
Email: eval@ece.org
Web: www.ECE.org

World Education Services, Inc
P.O. Box 745, Old Chelsea Station
New York, NY 10113-0745
Phone:
(212) 966-6311
FAX:
(212) 739-6100
Email: info@wes.org

Education International, Inc.
29 Denton Road
Wellesley, MA 02482
Phone:
(781) 235-7425
FAX:
(781) 235-6831
Email: edint@gis.net

Foundation for International Services, Inc
2150 30th Drive SE, Suite 320
Bothell, WA 98021
Phone:
(425) 487-2245
FAX:
(425) 487-1989
Email: info@fis-web.com

Foreign Academic Credentials Services, Inc
P.O. Box 400
Glen Carbon, IL 62034
Phone:
(618) 656-5291
FAX:
(618) 656-5292
Email: fasc@aol.com

International Education Research Foundation, Inc.
P.O. Box 3665
Culver City, CA 90231-3665
Phone:
(310) 258-9451
FAX:
(310) 342-7086
Email: info@ierf.org
WEB: www.ierf.org

Revised (08/26/11)

The evaluation must be submitted by the evaluating agency. This document must be in the Board's administrative office to determine your eligibility for licensure. The evaluation needs to be a general statement of equivalency. A course by course comparison is not necessary.

All internationally trained applicants must submit a notarized photocopy of their foreign college transcript to the Board's administrative office.

All non-U.S. citizens must submit current documentation of legal entry into the United States. All documents submitted must be unexpired.

V. CHECKLISTS

LABORATORY DIRECTOR CHECKLIST (Rule 1200-6-1-.20)

A check or money order in the amount of sixty ($60) dollars, payable to the State of Tennessee must accompany this form. All applications for director are presented for review and approval by Medical Laboratory Board members during their quarterly meeting.

A pathologist and any other person recognized by the Board as having special qualifications and who is duly licensed and registered to practice medicine in the State of Tennessee will not be required to obtain medical laboratory licensure in addition to his/her medical license. Individuals possessing an earned doctoral degree (non-medical degree) are required to obtain a license as a laboratory director from the Board.

A medical laboratory director must meet one of the following requirements:

Be a physician licensed in Tennessee, certified in clinical pathology by the American Board of Pathology or the American Osteopathic Board of Pathology or possess qualifications which are equivalent to those required for such certification (Board eligible).

Meet <u>one of the following</u> requirements to qualify as a director of a laboratory in one or more specialties:

__ Is a physician licensed in Tennessee, certified by the American Board of Medical Microbiology, the American Board of Clinical Chemistry, or other boards acceptable to the Board in one or more of the laboratory specialties.

__ Hold an earned doctoral degree in a chemical, physical, biological or clinical laboratory science, and certified by the American Board of Medical Microbiology, American Board of Clinical Chemistry, American Board of Bioanalysis, American Board of Medical Laboratory Immunology or other certifying boards acceptable to the Board in one or more laboratory specialties.

__ Is a physician licensed in Tennessee, who subsequent to graduation has four (4) years or more experience in pulmonary function. The directorship is limited to blood gas analysis (pH, pO_2, pCO_2).

__ Is a physician licensed in Tennessee, certified by a national board acceptable to the Board (not in

traditional laboratory specialty) in the specialty for which approval for directorship is being sought.

__ Holds an earned doctoral degree and has, in the opinion of the Board, appropriate work experience in a subspecialty for which there is no national certification. These individuals must obtain national boarding in the subspecialty when it becomes available.

Director Level Credentialing Agencies
Accepted by the Tennessee Medical Laboratory Board

Medical Doctors, who are duly licensed and registered to practice medicine in the State of Tennessee and are boarded by an acceptable credentialing agency, will not be required to obtain a medical laboratory director's license. Those who hold an earned non-medical doctoral degree are required to obtain a director's license from the Medical Laboratory Board.

I. American Board of Pathology **(813) 286-2444**

A Anatomical Pathology and Clinical Pathology

Qualifies as Director General – Clinical and Anatomical Laboratory

B Anatomical Pathology only

Qualifies as Director General – Anatomical Laboratory

C Clinical Pathology Only

Qualifies as Director General – Clinical Laboratory

D Anatomical Pathology or Oral Pathology

MD or Dentist Qualifies as a Director – Oral Pathology Laboratory

II American Board of Bioanalysis **(314) 241-1445**

A Bioanalyst Clinical Laboratory Director (BCLD)

Qualifies as Public Health Lab Director and Director General – Clinical Laboratory

B High Complexity Clinical Laboratory Director (HCLD)

Qualifies as a Director in the subspecialty in which they are boarded.

With applicable work experience, qualifies as a Public Health Lab Director.

Those subspecialties are:
- Bacteriology (including mycobacteriology)
- Mycology
- Parasitology
- Virology
- Immunology
- Hematology (Including flow cytometry)
- Chemistry (including urinalysis)
- Endocrinology
- Toxicology
- Andrology
- Embryology
- Clinical Molecular Biology

C Public Health Laboratory Director (PHLD)

With applicable work experience, qualifies as a Public Health Lab Director.

III American Board of Clinical Chemistry (202) 835-8727

A Clinical Chemistry

Qualifies as a Director of Chemistry

B Toxicological Chemistry

Qualifies as a Director of Toxicology

C Clinical Molecular Genetics

Qualifies as a Director of Molecular Diagnostics

IV American Board of Forensic Toxicology Laboratory (719) 636-1100

A Qualifies as a Director of Toxicology Laboratory

V American Board of Internal Medicine (215) 446-3500

A Endocrinology

Qualifies as a Director of Endocrinology

B Hematology

Qualifies as a Director of Hematology

C Gastroenterology

Qualifies as a Director of a Nutritional Lab

D Infectious Diseases

Qualifies as a Director of an Infectious Disease Laboratory

VI Board of Medical Microbiology (202) 942-9281

A Qualifies as a Director of Microbiology

With applicable work experience, qualifies as a Public Health Lab Director

VII American Osteopathic Board of Pathology (800) 621-1773 ext. 7445

A Qualifies as a Director General

VIII American Board of Medical Genetics (301) 634-7315

A Clinical Molecular Genetics

Qualifies as a Director of Molecular Diagnostics

IX American Board of Medical Laboratory Immunology (202) 942-9281

A Qualifies as a Director of Immunology and Director of Flow Cytometry

X American Board of Histocompatability and Immunogenetics (913) 541-0009 ex 476

A Qualifies as a Director of Histocompatibility and Immunogenetics

XI American Board of Pediatrics (919) 929-0461

A Infectious Diseases

Qualifies as a Director of a Direct Virology Laboratory

B Gastroenterology

Qualifies as a Director of a Direct Nutrition Laboratory

XII American Board of Obstetrics and Gynecology (214) 871-1619

A Reproductive Endocrinology

Qualifies as a Director of a Direct Andrology Laboratory

XIII American Board of Oral and Maxillofacial Pathology (813) 286-2444

A Qualifies as a Director of Oral and Maxillofacial Pathology Laboratory

XIV National Registry of Certified Chemists (703) 979-9001

A Chemistry

Qualifies as a Director of Chemistry

B Toxicology

Qualifies as a Director of Toxicology

MEDICAL LABORATORY DIRECTOR APPLICATION SUMMARY

General Requirements-Mandatory

___ Completed application
___ Notarized application
___ Complete fees
___ Photograph (signed on back, passport size)
___ Official transcript which indicates that a degree was conferred. (sent directly from the University to this administrative office) See Attachment 1
___ Proof of National Boarding (sent directly from the agency to this administrative office) See Attachment 3
___ Declaration of Citizenship See Attachment 4
___ Completed Criminal Background Check-Initial Applicants Only, Effective June 1, 2006
___ Completed Practitioner Profile

LABORATORY SUPERVISOR CHECKLIST (Rule 1200-6-1-.21)

A check or money order in amount of sixty ($60) dollars, payable to the State of Tennessee must accompany this form.

A laboratory supervisor must meet one of the requirements in Section I and Section II:

SECTION I

____ Be a physician licensed in Tennessee or possess a doctoral degree with a chemical, physical or biological science as his/her major subject. The applicant must have at least two (2) years of experience in one of the laboratory specialties in a clinical laboratory and with a director at the doctoral level subsequent to graduation.

____ Possess a valid general medical laboratory technologist license in Tennessee. Must have at least four (4) years of full time (30 hours per week), clinical laboratory experience, or its equivalent, subsequent to qualifying as a technologist.

____ Possess a valid medical laboratory technologist license in Tennessee limited to one of the categories of chemistry, hematology, immunohematology or microbiology. The applicant must have at least four (4) years of full time (30 hours per week), clinical laboratory experience, or its equivalent, subsequent to qualifying as a technologist. The license shall be limited to the category in which the current medical laboratory technologist license is held.

____ Possess a valid special analyst license in Tennessee limited to one subspecialty and have at least four (4) years of full time (30 hours per week) clinical laboratory experience, or its equivalent, subsequent to qualifying as a technologist. The license shall be limited to the subspecialty in which the current special analyst license is held.

SECTION II

____ Documentation of sixty (60) clock hours of continuing education to include forty-five (45) clock hours of management and fifteen (15) clock hours of technical courses. **At least eight (8) clock hours of management courses must be in a classroom or workshop setting.** Please refer to the calculation conversions section to determine eligibility. An individual that qualifies as a medical laboratory director does not have to meet the continuing education requirements.

DOCUMENTATION INFORMATION

The management courses must either have "management" in their title or be specifically designated or designed for managers or supervisors.

Course documentation may be in the form of diplomas, certificates and letters of verification from employers, professional groups or agencies which conduct the training. All handwritten documents must be signed by the applicant's supervisor(s) to verify attendance.

An official transcript is necessary if the applicant is using college courses for continuing education credit. The transcript must be sent directly from the school to the administrative office of the Medical Laboratory Board.

Work experience must be verified in writing on hospital letterhead. The letters must include: job title, dates of employment and full or part-time employment status. If work experience was part-time, the verification letters must indicate the number of hours worked per week. Work experience letters must be sent directly from the employer to the administrative office of the Medical Laboratory Board.

CONTINUING EDUCATION-ALL LICENSEES

(CANNOT BE USED FOR UPGRADE TO SUPERVISOR)

All individuals in Tennessee, licensed as Medical Laboratory Professionals by the Tennessee Medical Laboratory Board, are required to fulfill twenty-four (24) yours of Board approved Continuing Education (CE) course/requirements during the two (2) calendar year cycle previous to the renewal of the individual's license.

These requirements also pertain to those individuals that have retired their license and wish to reinstate the license, those individuals whose licenses have been revoked, and those individuals whose licenses have expired.

Renewals are based on a two (2) year cycle. Every CE cycle will run from January 1 one calendar year to December 31 of the following calendar year.

For example: January 1, 2006-December 31, 2007 (even year issued licenses) or January 1, 2007 – December 31, 2008 (odd year issued licenses).

Courses accepted and/or sponsored by the Tennessee Medical Laboratory Board may be found on the Board's website, http://health.state.tn.us/boards/MedLab/education.htm then click on educational programs.

Management Continuing Education Subject Areas For Supervisor License
Adapted from ASCP Board of Registry DLM Certification

Subject Materials Approved by Tennessee Medical Laboratory Board

1. Financial Management

Budgets
Equipment Acquisition
Cost Analysis
Financial Accounting
Reimbursement
Materials Management
Contract Negotiation
Billing and Collections

2. Operations Management

Quality Assurance/Total Quality Management
Licensure
Safety
Medical-Legal/Risk Management
Flow Charting
Productivity

3. Personnel Management

Motivation
Staffing
Performance Standards/Evaluation
Counseling/Discipline
Education and Training
Wage and Salary Administration
Conflict Resolution

4. Marketing Management

Product Development
Consumer Relations
Market Research
Managed Care

CYTOLOGY GENERAL SUPERVISOR CHECKLIST (Rule 1200-6-1-.23)

A check or money order in the amount of sixty ($60) dollars payable to the State of Tennessee must accompany this form.

A cytology general supervisor must meet the following requirements:

__ Possess a current license as a cytotechnologist from the State of Tennessee.

__ Have at least three (3) years of full-time (2080 hours per year) experience as a cytotechnologist within the preceding ten (10) years.

CONTINUING EDUCATION REQUIREMENTS FOR SUPERVISOR-CYTOLOGY

SEE PAGE SECTION II FOR INFORMATION

SUBJECT MATERIALS MUST BE IN CYTOLOGY

Work experience must be verified in writing on facility letterhead. The letter must include: job title, dates of employment, and full or part-time employment status. If work experience was part-time, the verification letters must indicate the number of hours worked per week. Work experience letters must be sent directly from the employer to the administrative office of the Medical Laboratory Board.

MEDICAL LABORATORY CYTOLOGIST APPLICATION SUMMARY

General Requirements-Mandatory

____ Completed application
___ Notarized application
___ Complete fees
___ Photograph (signed on back, passport size)
___ Official transcript which indicates that a degree was conferred, if a transcript is not on file (sent directly from the University to this administrative office) See Attachment 1
___ Declaration of Citizenship See Attachment 4
___ Completion of required continuing education for upgrade to supervisory level Do not send originals.
___ Verification of work experience
___ Completed Criminal Background Check (Only if this is an initial application)
___ Completed Practitioner Profile (Updated profile upgrading to supervisory level)

MEDICAL LABORATORY TECHNOLOGIST CHECKLIST (Rule 1200-6-1.22)

A check or money order in the amount of sixty ($60) dollars payable to the State of Tennessee must accompany this form.

A medical laboratory technologist shall meet one of the following requirements, in addition to possessing national certification by exam at the technologist level:

__ A baccalaureate degree in medical technology or in one of the biological, chemical or physical sciences, and with the completion of a medical laboratory technologist training program.

__ A baccalaureate degree, MLT/CLT certification, three (3) years of full time clinical laboratory work experience and completion of science coursework equivalent to that required in a laboratory science education program.

__ A baccalaureate degree, completion of the fifty (50) week military laboratory training program, three (3) years of full time clinical laboratory work experience and completion of science coursework equivalent to that required in a laboratory science education program.

__ A baccalaureate degree, five (5) years of full time clinical laboratory work experience and completion of science coursework equivalent to that required in a laboratory science education program.

__ For those individuals obtaining national certification by examination or recognition at the technologist level prior to September 1, 1997:

1. Having received a passing grade on a Health and Human Services proficiency examination in clinical laboratory science and completion of five (5) years of full time clinical laboratory work experience; or

2. A minimum of ninety (90) semester hours including science coursework equivalent to that required in a laboratory science education program and with the completion of a medical laboratory technologist training program that was approved at the time of graduation by National Accrediting Agency for Clinical Laboratory Sciences (NAACLS) or a national accrediting agency acceptable to the Board.

NOTE: For all licensing categories, courses completed in a laboratory training program do not count toward the course hours required in chemistry, biological science or math. College courses must be acceptable toward a major in those fields of study. Survey, audit, remedial, college level examination program and advanced placement do not qualify as fulfillment of the chemistry, biology, or mathematics requirements. Core curriculum courses in chemistry, biological science or math are not acceptable when completed on-line.

Applicants seeking a **categorical technologist license** must to refer to the **Special Analyst Checklist**.

SCIENCE COURSEWORK REQUIRED IN LAB TRAINING PROGRAM

__ Sixteen (16) semester hours or twenty-four (24) quarter hours of chemistry which shall include one (1) full academic year of general chemistry courses (including lecture and laboratory) and one (1) course in organic chemistry or biochemistry (including lecture and laboratory). The other courses may be selected from qualitative or quantitative chemistry.

__ Sixteen (16) semester hours or twenty-four (24) quarter hours of biological sciences, including a course in microbiology (lecture and lab).

__ Three (3) semester hours or four and one half (4.5) quarter hours of pre-science mathematics.

Work experience must be verified in writing on hospital letterhead and must be submitted directly from the employer to the administrative office of the Medical Laboratory Board. The letters must include: job title, dates of employment, lab areas of employment and full (30 hours per week) or part-time employment status.

If your work experience was part-time, the verification letters must indicate the number of hours worked per week. Work experience letters must be sent directly from the employer to the administrative office for the Medical Laboratory Board.

MEDICAL TECHNOLOGIST–CATEGORICAL CHECKLIST (Rule 1200-6-1-.22)

A check or money order in the amount of sixty ($60) dollars payable to the State of Tennessee must accompany this form.

A medical laboratory technologist may obtain a license limited to one of the following categories:

__ Chemistry
__ Hematology
__ Immunohematology
__ Microbiology

The applicant must meet the following requirements:

__ Must present proof of national certification by certifying body acceptable to the Board in the laboratory specialty at which licensure is being sought at the technologist level, or present proof of national certification as a general technologist.

__ Must meet one of the qualification routes on the medical laboratory technologist checklist.

SPECIAL ANALYST CHECKLIST (Rule 1200-6-1-.22)

An individual may be issued a limited special analyst license to perform tests in only a limited range (as listed on the license) if the following criteria are met:

__ The individual is certified by a national certification body approved by the Board, where such certification exists, or

__ In the absence of national certification, the individual must possess at least a baccalaureate degree relevant to the subspecialty in which licensure is being sought. **All individuals qualifying in this manner shall be approved by the Board.** Individuals must obtain national certification for continued licensure at the time such certification becomes available.

MEDICAL TECHNOLOGIST GENERALIST OR CATEGORICAL APPLICATION SUMMARY

SPECIAL ANALYST APPLICATION SUMMARY

General Requirements

___ Completed application
___ Notarized application
___ Complete fees
___ Photograph (signed on back, passport size)
___ Official transcript which indicates that a degree was conferred (sent directly from the University to this administrative office) See Attachment 1
___ Graduation from a formal laboratory training program (NAACLS, ASCP, CAHEA, CAAHEP, ASHI, etc.) See Attachment 1
See Attachment 2
___ Proof of National Certification (sent directly from the agency or its designee)
See Attachment 3
___ Complete Declaration of Citizenship See Attachment 4
___ National certification (sent directly from the agency to this administrative office).
___ Completed Criminal Background Check-Initial Applicants Only, Effective June 1, 2006
___ Completed Practitioner Profile

The Board Approved Certifying Agencies are	
Chemistry	**ASCP or NCA or NRCC or AAB or AMT or ASCP BOC**
Hematology	**ASCP or NCA or AAB or AMT or ASCP BOC**
Immunohematology	**ASCP or NCA or AAB or AMT or ASCP BOC**
Microbiology	**ASCP or NCA or NRM or AAB or AMT or ASCP BOC**
Cytogenetics	**NCA or ASCP BOC**
Toxicology	**NRCC**
Histocompatibility/Immunogenetics	**ABHI**
Flow Cytometry	**ASCP or ASCP BOC**
Andrology	**ABB or AAB**
Embryology	**AAB**

NOTE: **The National Certification Agency or its designee must send a letter of verification of your certification to this administrative office.**

DIRECTORY FOR BOARD APPROVED CERTIFYING AGENCIES

The following addresses and phone numbers may aid you in obtaining a verification letter

American Society for Clinical Pathology (ASCP)
333 West Monroe, Suite 1600
Chicago, IL 60603
Phone: 800-267-2727
Phone: (312) 541-4999
Fax: (312) 541-4498
website: www.ascp.org/bor

American Association for Clinical Chemistry (AACC)
American Board of Clinical Chemistry (ABCC)
1850 K Street, NW, Suite 625
Washington, DC 20006-2213
Phone: (202) 832-8287
Fax: (202) 835-4576
website: www.aacc.org

National Registry of Certified Microbiologists
c/o American Society for Microbiology
1752 N St, NW
Washington, DC 20036
Phone: (202) 942-9281
Website: www.asm.org/nrcm

Medical Technologists American (AMT)
10700 West Higgins Road, STE 150
Rosemont, IL 60018
Phone: (847) 823-5169
(800) 275-1268
Fax: (847) 823-0458
website: www.amt1.com

National Registry of Certified Chemists
927 S. Walter Reed Drive, Suite 11
Arlington, VA 22204-2311
Phone: (703) 979-9001
Fax: (703) 979-9809
Email: nrcc6@aol.com

National Credentialing Agency for Laboratory Personnel, Inc. (NCA)
P.O. Box 15945-289
Lenexa, KS 66285
Phone: (913) 895-4613
Fax: (913) 895-4652
website: www.nca-info.org

American Society for Histocompatibility & Immunogenetics (ASHI) & American Board of Histocompatibility (ABHI)
PO Box 19173
Lenexa KS 66285-9173
Phone: (913) 541-0009
Fax: (913) 599-5340
website: www.ashi-hla.org/abhi

American Board of Bioanalysis (ABB)
American Association of Bioanalysts (AAB)
906 Olive Street, Suite 1200
St. Louis, MO 63101-1434
Phone: (314) 241-1445
Fax: (314) 241-1449
website: www.abb.org

(AS OF October 23, 2009)
American Society for Clinical Pathology (ASCP)
BOC
333 West Monroe, Suite 1600
Chicago, IL 60603
Phone: 800-267-2727
Phone: (312) 541-4999
Fax: (312) 541-4498
website: www.ascp.org/boc

MEDICAL LABORATORY TECHNICIAN CHECKLIST (Rule 1200-6-1.22)

A check or money order in the amount of sixty ($60) dollars, payable to the State of Tennessee must accompany this form.

A medical laboratory technician shall meet one of the following requirements, in addition to possessing national certification by exam at the technician level:

___ Successful completion of a medical laboratory technician associate degree program.

___ An associate degree in a laboratory science and successful completion of an official military medical laboratory procedures course of at least fifty (50) weeks duration in residence and have held the military enlisted occupational specialty of Medical Laboratory Specialist (Medical Laboratory Technician). This information will be referenced on Form DD214, a copy of which must be included.

__ An associate degree in a laboratory science that meets specific science requirements (six (6) semester hours of chemistry and six (6) semester hours of biology) for entrance into a medical laboratory technician training program and three (3) years of full time clinical laboratory work experience.

MEDICAL LABORATORY TECHNICIAN APPLICATION SUMMARY

General Requirements

___ Completed application
___ Notarized application
___ Complete fees
___ Photograph (signed, on back passport-size)
___ Official transcript which indicates that a degree was conferred (sent directly from the University to this administration office) See Attachment 1
___ Graduation from a formal laboratory training program (NAACLS, CAHEA, CAAHEP) See Attachment 2
___ Proof of National Certification (sent directly from the agency or its designee) See Attachment 3
___ Declaration of Citizenship See Attachment 4
___ Completed Criminal Background Check-Initial Applicants Only, Effective June 1, 2006
___ Completed Practitioner Profile

CYTOTECHNOLOGIST CHECKLIST (Rule 1200-6-1-.24)

A check or money order in the amount sixty ($60) dollars payable to the State of Tennessee must accompany this form.

A cytotechnologist shall meet one of the following requirements:

___ Graduated from a school of cytotechnology accredited by the Committee on Accreditation of Allied Health Education Programs (CAAHEP), the Committee on Allied Health Education and Accreditation (CAHEA) or other accrediting agencies acceptable to the Board.

__ Be certified in cytotechnology by a certifying agency approved by the U.S. Department of Health and Human Services (HHS).

NOTE: You must have the certifying agency send proof of your certification directly to this office.

__ If awarded National Certification On or after August 1, 1988 applicant must also submit proof that the certification was awarded based upon the possession of a baccalaureate degree earned at a regionally accredited college/university.

__ If awarded prior to August 1, 1988, applicant need only submit proof that National Certification was awarded regardless of the prerequisites upon which it was based.

SPECIAL ANALYST-CYTOTECHNOLOGIST
APPLICATION SUMMARY

General Requirements

___ Completed application
___ Notarized application
___ Complete fees
___ Photograph (signed, on back, passport size)
___ Official transcript which indicates a degree was conferred (sent directly from the University to this administrative office) See Attachment 1 and NOTE above
___ Graduation from a formal laboratory training program (CAAHEP) See Attachment 2
___ Proof of National Certification (sent directly from the agency or its designee) See Attachment 3
___ Declaration of Citizenship See Attachment 4
___ Completed Criminal Background Check-Initial Applicants Only, Effective June 1, 2006
___ Completed Practitioner Profile

Application for Licensure

Tennessee State Laboratory Licensing Board

Return completed application form to:
Division of Health Related Boards/BHLR
Medical Laboratory Board
Metro Center Complex
665 Mainstream Drive, 2nd Floor
Nashville, TN 37243

For Office Use Only

05/001 $50 Application Fee
05/006 $10 Regulatory Fee
$60 Total Fee
Payable to: State of Tennessee

CATEGORY (Check One)

☐ Director _____ (Specify)
☐ Supervisor_____
☐ Medical Technologist
☐ Medical Lab Technician
☐ Special Analyst:
- ☐ Chemistry
- ☐ Hematology
- ☐ Immunogenetics
- ☐ Microbiology
- ☐ Histocompatibility/Immunogenetics
- ☐ Cytotechnology
- ☐ Toxicology
- ☐ Cytogenetics
- ☐ Flow Cytometry
- ☐ Andrology

☐ Other _____ (Specify)

PERSONAL INFORMATION

Last Name	**First**	**M.I.**	**Maiden**
Address		**Passport-size PHOTO Signed**	
City, State, Zip Code			
Zip Code			
(H) Phone		**(W) Phone**	
Citizenship* ☐**U.S.A.** ☐**Other** **Specify_____**		**Birthplace (city, state, foreign city)**	
***All applicants must complete and submit The Declaration of Citizenship: Attachment 4 pp 31-32**			
Social Security Number*		**Birthdate (mo/day/yr)**	
Sex (optional) ☐ **Male** ☐ **Female**		**Race:(optional)** ☐**White** ☐**Black** ☐**Other_____**	

Email Address_____
Do you wish to receive notification, including renewal notification, from the Deptartment of Health Via Email YES NO (you must circle either YES or NO)

Have you previously applied for a trainee permit? ☐ Yes ☐ No

Name Used:_____

Have you previously applied for licensure in the state of Tennessee from the Medical Laboratory Board?
☐Yes ☐ No
Name Used: _____ When Applied: _____

* You must put your social security number on this form for the application to be complete. State and federal law require social security numbers on this application. Tenn. Code Ann. § 36-5-1301 (a), as authorized by 42 U.S.C.§405(c)(2)(C)(i). The number will be used to verify your identity, to ask questions about your financial responsibility, and for any other purpose allowed by state or federal law. When you provide your social security number you are agreeing that the Department of Health may use your social security number in furtherance of federal and state law, for example, to collect delinquent fees.

EDUCATION INFORMATION

	Name and Address of School	Dates	Year of Degree	Type of Degree	Major
High School					
College					
Professional School					
Clinical Internship					

College Credits	Semester Hours	Quarter Hours	Laboratory Training (indicate length)
TOTAL CHEMISTRY			☐Clinical Chemistry_____
General Chemistry			☐Hematology_____
Organic Chemistry			☐Immunohematology _____
Biochemistry			☐Microbiology_____
TOTAL BIOLOGY			☐Mycology _____
Microbiology			☐Parasitology_____
General Biology			☐Serology_____
Physiology			☐Urinalysis_____
Comparative Anatomy			☐Body Fluids_____
Histology			☐Other_____
TOTAL MATH			

LICENSURE INFORMATION

Do you currently have a license from another state? ☐ Yes ☐ No
If yes, which state? ______________________

Do you currently have a National Certification? ☐ Yes ☐No **(If No, you must answer yes to the next question)**
If yes, which agency? ______________ License # ____________ Category ________________

Have you applied for National Certification? ☐ Yes ☐ No
If yes, which agency? ______________ When are you scheduled for the exam? _______________

EMPLOYMENT INFORMATION (LIST MOST RECENT FIRST)

Must be completed even if employment is unrelated to Medical Laboratory Practice

Name and Address of Employer	Job Title	Hours Per Week
	Dates of Employment From ______________to __________________	
Name of Supervisor and Title	List Depart.(s) of your employment	
Description of duties and responsibilities:		
Name and Address of Employer	Job Title	Hours Per Week
	Dates of Employment From ______________to __________________	
Name of Supervisor and Title	List Depart.(s) of your employment	
Description of duties and responsibilities:		
Name and Address of Employer	Job Title	Hours Per Week
	Dates of Employment From ______________to ___________	
Name of Supervisor and Title	List Depart.(s) of your employment	
Description of duties and responsibilities:		

COMPETENCY INFORMATION

PLEASE ANSWER THE FOLLOWING QUESTIONS. If any answers to the questions in this part are in the **affirmative, attach an explanation on a separate sheet**. **In support of your explanation, the final documents or orders from the issuing states, courts, and/or agencies must be submitted with this application.**

For the purposes of these questions, the following phrases or words have the following meanings:

1. **"Ability to practice in the medical laboratory field"** is to be construed to include all of the following:
   a. The cognitive capacity to make appropriate clinical decisions and exercise reasoned medical laboratory judgements and to learn and keep abreast of medical laboratory developments; and
   b. The ability to communicate those judgments and information to patients and other health care providers with or without the use of aids or devices, such as voice amplifiers; and
   c. The physical capability to perform medical laboratory tasks and procedures required of your profession, with or without the use of aids or devices, such as corrective lenses or hearing aids.
2. **"Medical Condition"** includes physiological, mental or psychological conditions or disorders, such as, but not limited to; orthopedic, visual, speech and/or hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning, HIV disease, tuberculosis, drug addiction and alcoholism.
3. **"Chemical substances"** is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.
4. **"Currently"** does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee, or within the past two (2) years.
5. **"Illegal use of controlled substances"** means the use of controlled substances obtained illegally (e.g. heroin, or cocaine) as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

QUESTIONS:

		YES	NO
1.	Do you currently have a medical condition which in any way impairs or limits your ability to practice in the medical laboratory field with reasonable skill and safety?	____	____
	a. If yes, are they reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program?	____	____
	b. If you have any limitations or impairments caused by an existing medical condition, are they reduced or ameliorated because of the practice, the setting or the manner in which you have chosen to practice?	____	____

(If you receive such ongoing treatment or participating in such a monitoring program, the Board will make an individual assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed or whether you are not eligible for licensure).

COMPETENCY INFORMATION CONTINUED

QUESTIONS:	YES	NO
2. Do you currently use chemical substances (see definition)?	_____	_____
a. If yes, do they in any way impair or limit your ability to practice in the medical laboratory field in regard to skill or safety?	_____	_____
3. Are you currently engaged in the illegal use of controlled substances?	_____	_____
a. If yes, are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you in order to assure that you are not engaged in the illegal use of controlled substances?	_____	_____
4. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?	_____	_____
5. If you have ever applied for a license or certificate to practice in the medical laboratory field in any state, country or providence was or has it ever been denied, reprimanded, suspended, restricted, revoked, or otherwise disciplined, curtailed or voluntarily surrendered under threat of investigation or disciplinary action?	_____	_____
6. Have you ever applied for and been denied a state or federal controlled substance certificate?	_____	_____
a. If you have possessed such a certificate has it ever been revoked, suspended, restricted or otherwise disciplined or voluntarily surrendered under threat of investigation or disciplinary action?	_____	_____
7. Have you ever been convicted of a felony or a misdemeanor other than a minor traffic offense?	_____	_____
8. In relation to the performance of your professional services in any profession:		
a. Have you ever had a final judgment rendered against you; or	_____	_____
b. Have you ever had a settlement of any legal action rendered against you; or	_____	_____
c. Are there any legal actions pending against you or to which you are a party?	_____	_____
9. If you have ever held a license or certificate in any health care profession, has it ever been reprimanded, suspended, restricted, revoked, or otherwise disciplined, curtailed or voluntarily surrendered under threat of investigation or disciplinary act?	_____	_____
10. Have you ever been dropped, suspended, expelled or disciplined by any school, college or training program for any reason?	_____	_____

APPLICANT: COMPLETE THE FOLLOWING AFFIDAVIT IN THE PRESENCE OF A NOTARY PUBLIC

AFFIDAVIT OF APPLICANT
APPLICANT'S CONSENT AND RELEASE

In applying for licensure in the State of Tennessee, I HEREBY:

SIGNIFY MY WILLINGNESS to appear to answer such questions as the Board may find necessary and which may include a full Board interview:

AUTHORIZE THE BOARD, its staff and representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others and other qualifications;

CONSENT TO THE RELEASE of such information;

RELEASE FROM LIABILITY the Board, its staff and representatives for their acts performed and statements made in good faith and without malice in connection with evaluating my application, credentials and qualifications.

RELEASE FROM LIABILITY all organizations which provide information in good faith and without malice concerning my professional competence, ethics, character and other qualifications for licensure.

ACKNOWLEDGE THAT I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical and other qualifications and for resolving any doubt about such qualifications.

THIS CERTIFIES THAT THE INFORMATION SUBMITTED IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

_____ _____
SIGNATURE DATE

In the state of _____ and county of _____, being duly sworn and identified as the person referred to in this application, he/she attests to the truth of each statement made in said application. He/she further swears that he/she has read and understands that law and the rules and regulations which were enclosed in the application packet and agrees to abide by them while in practice in the State of Tennessee and acknowledged said instrument by him/her executed, to be his/her free act and deed.

NOTARY SEAL

Sworn to before me, this _____day of _____, 20_____.

_____My commission expires_____.
NOTARY PUBLIC

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
DIVISION OF HEALTH RELATED BOARDS
METRO CENTER COMPLEX
665 MAINSTREAM DRIVE, 2ND FLOOR
NASHVILLE, TENNESSEE 37243

TENNESSEE MEDICAL LABORATORY BOARD
CLEARANCE FROM OTHER STATE LICENSURE BOARDS

APPLICANT: *Please provide the information requested in the top box and then mail one (1) form to the licensure board in EACH state where you hold OR HAVE EVER HELD a license to practice any profession. (Copies of this form may be used.)* ***NOTE:*** *Some states require a fee for providing clearance information. To expedite your application, you may wish to contact the applicable state(s).*

_____ was granted a license to practice _____ with license
(Name of Applicant) *(Profession)*
Number _____ on _____ in the State of _____. The Medical
(Date)
Laboratory Board of Tennessee requests that I submit evidence of the current status of that license in your state. You are hereby authorized to release any information in your files, favorable or otherwise, directly to:

State of Tennessee
Medical Laboratory Board
Metro Center Complex
665 Mainstream Drive, 2nd Floor
Nashville, TN 37243

Date: _____ _____
Applicant's Signature

_____
Applicant's typed or printed name

ADMINISTRATIVE OFFICE OF STATE LICENSURE BOARD, PLEASE COMPLETE:

Name In Full As It Appears On License: _____

License Number _____ Profession _____ Date Issued _____

Basis of issuance: ____ Endorsement/Reciprocity with _____
(Check One) (State)

____ Written Examination _____
(Name of Exam)

The license is currently active and registered? _____ _____
yes no

Is there any derogatory information on file? _____ _____ If yes, an explanation must be attached.
yes no

_____ _____ _____
Authorized Signature Title Date

ATTACHMENT 1

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
DIVISION OF HEALTH RELATED BOARDS
METRO CENTER COMPLEX
665 MAINSTREAM DRIVE, 2ND FLOOR
NASHVILLE, TENNESSEE 37243

MEDICAL LABORATORY
1-800-778-4123 EXT. 5325128 OR (615) 532-5128

APPLICANT: Complete this attachment: MAIL THIS FORM TO YOUR COLLEGE(S).

Full Name: _____
(Last) (First) (Middle/Maiden)

Address: _____ Social Security Number : ____-____-____
_____
_____
_____

Student Identification Number: _____

Year of Graduation: _____

Degree Obtained: _____

TO WHOM IT MAY CONCERN:

I am applying for a license to practice as a Medical Laboratory Professional in the State of Tennessee.

Please forward an original transcript bearing the institution's official seal to:

State of Tennessee
Medical Laboratory Board
Metro Center Complex
665 Mainstream Drive, 2nd Floor
Nashville, TN 37243

_____ _____
Applicant's Signature Date

ATTACHMENT 2

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
DIVISION OF HEALTH RELATED BOARDS
METRO CENTER COMPLEX
665 MAINSTREAM DRIVE, 2ND FLOOR
NASHVILLE, TENNESSEE 37243

MEDICAL LABORATORY BOARD
1-800-778-4123 EXT. 5325128 OR (615) 532-5128

APPLICANT: Complete this attachment: MAIL THIS FORM TO YOUR LABORATORY TRAINING PROGRAM DIRECTOR.

FULL NAME: _____
(Last) (First) (Middle) (Maiden)

ADDRESS: _____

_____

_____

_____

_____

Social Security Number: _____-_____-_____

Student Identification Number: _____

Degree Obtained: _____

Date of Graduation: _____

To Whom It May Concern:

Name of Program Director: _____
Official Name and Address _____
Of Training Institution: _____
_____
_____

Phone number: (_____) _____

Was this program accredited at the time this student was in training? YES NO
Name of accrediting agency. _____

_____ _____
Signature of Program Director Date

ATTACHMENT 3

NATIONAL CERTIFICATION VERFICATION

Complete this attachment by type or printing legibly in ink.
MAIL THIS FORM TO THE AGENCY

Certifying Agency Name: _____
And Address: _____
_____
_____
_____

I am authorizing **the certifying agency** listed above to release my examination scores, pass or fail, and certification number to the Tennessee Medical Laboratory Board. Please **forward this information directly to office at the address below.**

Applicant's Name _____
(Last) (First) (M.I.) (Maiden)

Social Security No.: _____-_____-_____ Date Exam Taken: _____
Certification Category: _____ Certification Number: _____

Please mail certification verification directly to:

State of Tennessee
Department of Health
Tennessee Medical Laboratory Board
Metro Center Complex
665 Mainstream Drive, 2nd Floor
Nashville, TN 37243
1-800-778-4123 Ext. 5325128 or (615) 532-5128

Declaration of Citizenship

The following two (2) pages labeled Attachment 4

Is a mandatory form for Initial and Reinstated Licenses (this includes any status change requiring one to complete a new application)

It is very important this form be signed in the presence of a Notary Public and that a photocopy of one of the documents (given as examples for citizenship or immigration status) IS included in your application submission.

PLEASE READ CAREFULLY, ANSWER EACH QUESTION AND PROVIDE REQUESTED DOCUMENTS. HANDLING THIS FORM INCORRECTLY MAY RESULT IN AN ADDITIONAL DELAY IN THE ISSUANCE OF YOUR LICENSE.

ATTACHMENT 4

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
METRO CENTER COMPLEX
665 MAINSTREAM DRIVE, 2ND FLOOR
NASHVILLE, TN 37243

DECLARATION OF CITIZENSHIP
MUST ACCOMPANY ALL APPLICATIONS FOR INITIAL LICENSURE OR REINSTATEMENT OF LICENSURE

The "SAVE Act" requires Tennessee Department of Health (including all Boards, Commissions, and contractors), along with every local health department in the State, to verify that *every adult* applicant for a professional license is either a U.S. citizen, a "qualified alien," or a nonimmigrant who meets the requirements set out at 8 U.S.C. 1621.

I am a(n) _____ _____.
Healthcare Profession (Please Print) License number if applicable

Please Print Legibly

1. **Name_____**
   Last First Middle Maiden
2. **Mailing Address:_____**
3. **Phone Number: Home: (____)____-_____ Office: (___)____-_____ Fax: (___)____-_____**
4. **I am a United States Citizen _____YES _____NO**
5. **I am a foreign national not physically present in the United States _____YES _____NO. If you answered yes, to this question, please sign this form in the presence of a notary and return it with your application. No further documentation is required.**
6. **Applicants Claiming United States Citizenship MUST provide one of the following:**

   a) Tennessee Driver's License, or photo ID issued by Department of Safety.
   b) A valid driver license or ID issued by another state, provided its issuance requirements meet Department of Safety criteria.
   c) An official birth certificate issued by a U.S. state, territory, or other jurisdiction. Puerto Rican birth certificates issued before July 1, 2010 do not count.
   d) A federally issued birth certificate.
   e) A valid, unexpired U.S. passport.
   f) A report of birth abroad of a U.S. citizen.
   g) A certificate of citizenship.
   h) A certificate of naturalization.
   i) A U.S. citizen ID card.
   j) Any successor document to #'s a-i above.
   k) SSN that the entity or local health department may verify with the Social Security Administration in accordance with federal law.

7. **If you checked "NO" in question 4, please indicate from the list below which category applies to you: (Circle one)**

   a) Permanent Residents

b) A nonimmigrant applicant for a professional or commercial license whose visa for entry into the United States is related to such employment, or a nonimmigrant under the Immigration and Nationality Act (8 U.S.C. 1101 *et seq.*).
c) Asylees who meet the qualifications set out in 8 U.S.C. 1158
d) Refugees who meet the qualifications set out in 8 U.S.C. 1157
e) Persons who have been "paroled into the United States," under 8 U.S.C. 1182(d)(5) or whose deportation has been withheld under 8 U.S.C. 1253.
f) Cuban or Haitian entrants as defined by section 501(e) of the Refugee Education Assistance Act of 1980
g) Persons granted conditional entry into the U.S. under 8 U.S.C. 1153(a)(7) before April 1, 1980, because of persecution or fear of persecution on account of race, religion, or political opinion or because of being uprooted by catastrophic national calamity.
h) An alien who has been "battered" or subjected to "extreme cruelty" by a parent or spouse as defined by 8 U.S.C. 1641(c), and also meets the qualifications set out 8 U.S.C. 1641(c)(1)(B). Under the circumstances set out in 8 U.S.C. 1641(c)(2) and (3), victims' children, or the parents of children who are victims, may also apply for benefits as qualified aliens.

Applicants claiming **qualified alien status**, please submit one or more of the following forms of "documentation of identity and immigration status" as determined by U.S. Homeland Security to be acceptable for verification through the SAVE program. Common types of documents used to verify immigration status:

I-327 (Reentry Permit)

I-551 (Permanent Resident Card or "Green Card")

I-571 (Refugee Travel Document)

I-766 (Employment Authorization Card)

Machine Readable Immigrant Visa (with Temporary I-551 language)

Temporary I-551 stamp (on passport or I-94)

I-94 (Arrival/Departure record)

Unexpired foreign passport

WT/WB Admission Stamp in unexpired foreign passport

I-20 (Certificate of Eligibility for Nonimmigrant F(1) student status– "student

I affirm under the penalty of perjury that the above is true and correct.

Signed this _____ day of _____, 20__.

_____
Signature

Sworn to before me this _____day of _____, 20__.

_____ AFFIX SEAL HERE
NOTARY PUBLIC

My Commission Expires:_____

If an applicant is discovered to be an unqualified alien, or otherwise ineligible for benefits under the Act, all recurring benefits provided to that applicant must be immediately terminated. Anyone who purposefully makes a false, fictitious, or fraudulent claim of U.S. citizenship or qualified alien status will be liable under the Tennessee Medicaid False Claims Act, or Tennessee's False Claims Act. Any person who conspires to defraud the state or any local health department by securing a false claim allowed or paid to another person in violation of the Act may be liable under Tennessee's False Claims Act. Upon discovery of an applicant's false, fictitious, or fraudulent claim of U.S. citizenship, state governmental entities and local health departments must also file a criminal complaint with the United States Attorney.

MANDATORY PRACTITIONER'S PROFILE

The following pages 35-45 is the Mandatory Practitioner's Profile and is to be completed by designated, licensed health care professionals. Medical Laboratory Personnel are included in those required to complete this form. Please read the instructions carefully. Space is limited. Please condense your answers. If a question does not apply to you or your practice, please mark NA and proceed to the next question. Please be sure to complete the heading on EACH page, sign and date. Incomplete forms may delay your license.

TENNESSEE DEPARTMENT OF HEALTH

MANDATORY PRACTITIONER PROFILE QUESTIONNAIRE FOR LICENSED HEALTH CARE PROVIDERS

The Health Care Consumer Right-to-Know Act of 1998, T.C.A. §§ 63-51-101, et seq., requires designated licensed health professionals to furnish certain information to the Tennessee Department of Health, and is requested in this questionnaire. From the information submitted, the Department compiles practitioner profiles which the law requires to be made available to the public via the World Wide Web and our toll-free telephone line. Each practitioner who has submitted information must update that information in writing by notifying the Department of Health, within 30 days after the occurrence of an event or an attainment of a status that is required to be reported by the law. A copy of your initial or updated profile will be furnished to you for your review prior to publication. That opportunity will allow you to make corrections, additions and helpful explanatory comments. Failure to comply with the requirement to submit and update profiling information may result in a delay or denial of your licensure application and/or may result in disciplinary action against your license. The professions required to submit a profile questionnaire are:

Advanced Practice Nurses
Alcohol and Drug Counselors
Audiologists
Chiropractic Physicians
Clinical Pastoral Therapists
Dentists
Dietitian/Nutritionists
Dispensing Opticians
Electrologists
Licensed Registered Respiratory Therapists
Licensed Certified Respiratory Therapists
Licensed Laboratory Personnel
Marital & Family Therapists
Massage Therapists
Medical Doctors
Nursing Home Administrators
Occupational Therapists
Optometrists
Orthopedic Physician Assistants
Osteopathic Physicians
Pharmacists
Physician Assistants
Physical Therapists
Podiatrists
Professional Counselors
Psychologists
Respiratory Care Assistants
Social Workers
Speech Language Pathologists
Veterinarians

A blank copy of the profile questionnaire may be obtained from the following web site address: http://health.state.tn.us/Downloads/g6019027.pdf.

INSTRUCTIONS

QUESTIONNAIRE DEADLINE The provider must complete and submit the questionnaire before a license will be granted. Providers who have completed a similar questionnaire for another state's licensing board are, nevertheless, required to complete and submit this form. Changes to the questionnaire must be submitted within 30 days of the change.

COMPLETING THE QUESTIONNAIRE Complete the questionnaire by typing the information or by printing neatly in block letters in ball point pen. If a question does not apply to you, indicate so by checking the "Does not apply" box. **Illegible questionnaires will be returned.** If you need further instruction, contact your profession's licensing board by calling (615) 532-3202 or by calling toll free at (800) 778-4123.

SUBMITTING THE QUESTIONNAIRE Mail the completed profile questionnaire to:

Tennessee Board of *(board for your profession)*
Healthcare Provider Information
Metro Center Complex
665 Mainstream Drive, 2nd Floor
Nashville, TN 37243

- **Do not return pages 1 through 4 with the questionnaire to the department.**
- **Keep a copy of the questionnaire for your records.**

The following numbered parts correspond to the matching number on the questionnaire form.

I. PRACTITIONER DATA

Complete Part I, noting the following:

- License number: Fill in your Tennessee license number and indicate your profession in the space provided. **If you have not been issued a license number, please leave this blank.**
- Social security number: **Your social security number will not be published or in any way given out to the public. It is required for in-house tracking purposes only.**
- Primary Practice Address: Complete the practice address (if applicable). If your practice address is also your home address, you should know the Department is prohibited from placing your home address on the Internet without your request to do so. There is a box to check in Part I to request this. Retirees: Write in "N/A" for practice address. If you do not have a practice address at the time of completing this questionnaire, you must report your practice address within 30 days of obtaining a practice address.
- Supervising Physician: Physician assistants and advanced practice nurses must list all supervising physicians. In addition, advanced practice nurses must also complete the Notice and Formulary if you are prescribing. The Notice and Formulary is available online at http://health.state.tn.us/boards/Nursing/applications.htm.

II. GRADUATE/POSTGRADUATE MEDICAL/PROFESSIONAL EDUCATION AND TRAINING

List chronologically medical/health professional related graduate/postgraduate education and training completed. Exclude any program or courses taken to satisfy continuing education requirements for licensure renewal. Provide information about health related degrees you have received including your licensure degree.

III. SPECIALTY BOARD CERTIFICATIONS

Provide information on any certification, specialty or subspecialty from any specialty board recognized by the American Medical Association, American Osteopathic Medical Association, American Podiatry Association, American Chiropractic Association, American Dental Association or any other specialty certifying body as determined by your Tennessee licensing board.

IV. FACULTY APPOINTMENTS

Answer ALL yes/no questions with a "yes" or "no" response. A brief statement in the space provided should follow a "yes" answer. If the space is insufficient for your response, attach an additional page, being sure to number the response to match the appropriate question.

V. STAFF PRIVILEGES

A. List all hospitals at which you hold staff privileges. The definition for "hospital" can be found at T.C.A. § 68-11-201.

VI. MANAGED CARE AND TENNCARE PLANS

A. In the spaces provided, answer information about the Managed Care plans in which you participate and accept as a provider, if any. If the space is insufficient for your response, attach an additional page, being sure to number the response to match the appropriate question.

B. In the spaces provided, answer information about the TennCare plans in which you participate and accept as a provider, if any. If the space is insufficient for your response, attach an additional page, being sure to number the response to match the appropriate question.

VII. FINAL DISCIPLINARY ACTION

These questions refer to final disciplinary or adverse actions taken within the previous **ten (10) years**, whether in this state or any other jurisdiction. The term **final** means the matter was fully adjudicated at a hearing and the appeal's period expired, or that the applicable board issued an agreed order or consent decree.

In the "Description of Violation" spaces, indicate the nature of the conduct in question such as malpractice, unethical conduct, drug-related, sex related, impairment, fraud, etc.

In the "Description of Action" spaces, indicate the type of disciplinary action imposed against your professional license such as censure, reprimand, probation, etc.

The term **disciplinary action** includes, but is not limited to:

- Probation
- Limitation/Restriction
- Suspension
- Revocation
- Voluntary relinquishment in lieu of disciplinary action
- Any other adverse action taken against a license or privilege by a medical/health related institution
- Compulsory surrender of license or privilege
- Civil or other monetary fine or penalty
- Resignation from or non-renewal of medical staff membership at a hospital in lieu of, or in settlement of, a pending disciplinary case related to competence or character
- Restriction of privileges in lieu of, or in settlement of, a pending disciplinary case related to competence or character

If you answer "yes" to any of the questions regarding Final Disciplinary Actions and/or Criminal Offenses and if the action is under appeal, you must attach a copy of the notice of appeal. Note: You must submit a copy of the final written order of disposition immediately after the appeal is disposed of by the adjudicating authority. Please read questions B and C in Part VII in their entirety before answering those questions.

VIII. CRIMINAL OFFENSES

This part requires you to report any state or federal felony criminal offense convictions. It also requires the reporting of misdemeanor offenses, regardless of classification, in which any element of the offense involves sex; alcohol or drugs; physical injury or threat of injury to any person; abuse or neglect of any minor, spouse or the elderly; fraud or theft in Tennessee or another jurisdiction; or unlicensed practice within the most recent ten (10) years. If you answer "yes" to this question and the offense is under appeal, you must submit a copy of the notice of appeal of that criminal offense. Immediately upon disposition of the appeal, you must submit a copy of the final written order of disposition. If any misdemeanor conviction reported is expunged, a copy of the order of expungement signed by the judge must be submitted to the Department before the conviction will be removed from any profile.

IX. LIABILITY CLAIMS

This section requires you to indicate all medical malpractice court judgments, arbitration awards, or settlements in which a payment was awarded to a complaining party beginning with judgments or settlements entered or executed after May 19, 1998. That means if the act or event leading to the claim occurred in, for instance, 1995, but was finally adjudicated against you after May 19, 1998, you must indicate that claim in the space provided. JUDGMENTS OR SETTLEMENTS BELOW THE FOLLOWING AMOUNTS ARE NOT REQUIRED TO BE SUBMITTED.

A) For Medical Doctors and Osteopathic Physicians, judgments or settlements below $75,000 are not required to be submitted.
B) For Chiropractors, judgments or settlements below $50,000 are not required to be submitted.
C) For Dentists, judgments or settlements below $25,000 are not required to be submitted.
D) For all other professions, judgments or settlements below $10,000 are not required to be submitted.

Pending malpractice claims are not required to be reported unless/until final adjudication against you.

X. OPTIONAL INFORMATION

This section is voluntary. You may list, briefly describe, and submit any information/documentation regarding your professional practice in the spaces provided. Attach an additional sheet labeled with the question number if additional space is required.

Practitioner's Name _____ **License #** _____

Profession _____

TENNESSEE BOARD OF MEDICAL LABORATORIES
HEALTHCARE PROVIDER INFORMATION
TENNESSEE DEPARTMENT OF HEALTH
OFFICE OF HEALTH RELATED BOARDS
METRO CENTER COMPLEX
665 MAINSTREAM DRIVE, 2ND FLOOR
NASHVILLE, TENNESSEE 37243

I. PRACTITIONER DATA

A. PROFESSION: _____ LICENSE NUMBER: _____

B. SOCIAL SECURITY NUMBER: _____ **(This will not be published)**.

C. NAME (INCLUDE MAIDEN AND ON 2ND/3RD LINES ANY ALIASES, IF APPLICABLE):

CURRENT NAME:

_____
(LAST) (FIRST) (MIDDLE AND MAIDEN NAME) (IF APPLICABLE)

FORMER NAME(S):

_____
(LAST) (FIRST) (MIDDLE)

_____
(LAST) (FIRST) (MIDDLE)

D. PRIMARY PRACTICE ADDRESS (attach additional sheets if necessary):

☐ Check here if your primary practice address is your home address and you want it to be published as part of the profile and on the web

_____
(PRACTICE NAME)

_____
(STREET NUMBER AND NAME)

_____
(CITY) (STATE) (ZIP CODE)

E. E-MAIL ADDRESS: _____ ☐
Your e-mail address will be published unless you elect not to by checking here.

F. WEB PAGE ADDRESS: _____ ☐
Your web page address will be published unless you elect not to by checking here.

G. PRACTICE TELEPHONE: (_____) _____ ☐
Your telephone number will be published unless you elect not to by checking here.

H. LANGUAGES, OTHER THAN ENGLISH: Indicate languages other than English or translation services that may be available at your primary practice location.

1. _____ 2. _____

I. SUPERVISING PHYSICIAN: If you are required by law to be supervised by a physician (physician assistant or advanced practice nurse) indicate the name(s) and address(es) of each supervising physician. If you need more space, attach additional sheets:

1. _____
2. _____

Practitioner's Name _____ **License #** _____

Profession _____

II. GRADUATE/ POSTGRADUATE MEDICAL EDUCATION AND TRAINING

A. What school(s)/educational programs have you attended? And, what type(s) of degree(s) do you hold? Do not include coursework taken to meet the continuing education requirement for licensure renewal. (Authority: T.C.A. §63-51-105(a)(6) and (7))

PROGRAM/INSTITUTION	CITY/STATE/COUNTRY	DATE OF GRADUATION MM/DD/YYYY	TYPE OF DEGREE
1.			
2.			
3.			

B. List in chronological order from date of graduation to the present, all completed medical/professional graduate and/or post-graduate training (internship, residency, fellowship or other program). Do not include coursework taken to meet continuing education requirements for licensure renewal. (Authority: T.C.A. § 63-51-105(a)(6))

PROGRAM AND SPECIALTY AREA (INTERNSHIP, RESIDENCY, FELLOWSHIP, ETC.)	LOCATION OF TRAINING (CITY,STATE,COUNTRY)	FROM MM/DD/YYYY	TO MM/DD/YYYY
1.			
2.			

III. SPECIALTY BOARD CERTIFICATIONS:

Do you hold a certification, specialty or subspecialty from any specialty board recognized by the board regulating the profession for which you are licensed? (see instructions) YES ❑ NO ❑

(Authority: T.C.A. § 63-51-105(a)(8)) If "Yes", complete section below

CERTIFYING BODY/BOARD INSTITUTION	CERTIFICATION/SPECIALTY/SUBSPECIALTY
1.	
2.	
3.	
4.	
5.	

Practitioner's Name _____ **License #** _____

Profession _____

IV. FACULTY APPOINTMENTS

A. Have you had the responsibility for graduate medical education within the last ten (10) years? (Authority: T.C.A. § 63-51-105(a)(10)) YES ❑ NO ❑

B. Do you currently hold a faculty appointment at a medical/health related institution of higher learning? (Authority: T.C.A. § 63-51-105(a)(10)) YES ❑ NO ❑

If "YES", list the title of the appointment, name(s) and city/state of institution(s). (Attach additional sheets, clearly labeled with this question number, if necessary.)

	TITLE	INSTITUTION	CITY/STATE
1.			
2.			
3.			

V. STAFF PRIVILEGES

A. Do you currently hold staff privileges at a hospital? (Authority: T.C.A. §63-51-105(a)(9)) YES ❑ NO ❑

If "YES", list each hospital at which you currently have staff privileges: (Attach additional sheets, clearly labeled with this question number, if necessary)

NAME OF HOSPITAL	CITY/STATE
1.	
2.	
3.	
4.	
5.	

VI. MANAGED CARE PLANS

A. Do you participate in any managed care plans? (Authority: T.C.A. §63-51-105(a)(15)) YES ❑ NO ❑

If "YES", list each: (Attach additional sheets, clearly labeled with this question number, if necessary)

NAME OF MANAGED CARE PLAN
1.
2.
3.
4.
5.

Practitioner's Name _____ **License #** _____

Profession _____

B. Do you currently participate in and accept any TennCare plan(s) as a provider? YES ❑ NO ❑

If "YES", list each plan in which you currently participate or accept as a provider: (Authority: T.C.A. § 63-51-105(a)(16))

NAME OF TENNCARE PLAN
1.
2.
3.
4.
5.

VII. FINAL DISCIPLINARY ACTION (See Instructions):

A. Within the previous ten (10) years, have you ever had any final disciplinary action taken against you by the agency regulating your license, in this state or any other jurisdiction? (Authority: T.C.A. § 63-51-105(a)(8)) YES ❑ NO ❑

If "YES", list name(s) and address(es) of agency(s) and a brief description of the final disciplinary action(s) and stated reason(s) for taking the action. (Attach additional sheets, clearly labeled with this question number, if necessary.)

	AGENCY NAME/ADDRESS	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION
1.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❑ NO ❑

2.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❑ NO ❑

Practitioner's Name _____ **License #** _____

Profession _____

B. Within the previous ten (10) years, have you ever had your hospital privileges revoked or involuntarily restricted or reasons related to competence or character by the hospital's governing body? (Authority: T.C.A. § 63-51-105(a)(4)) YES ❑ NO ❑

If "YES", list name(s) and address(es) medical institution(s) and a brief description of the final disciplinary action(s) and stated reason(s) for the action. (Attach additional sheets, clearly labeled with this question number, if necessary)

	HOSPITAL NAME/ADDRESS	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION
1.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❑ NO ❑

2.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❑ NO ❑

C. Within the previous ten (10) years, have you ever been asked to or allowed to resign from or had any medical staff privileges restricted or not renewed by <u>any</u> hospital in lieu of or in settlement of a pending disciplinary action related to competence or character? (Authority: T.C.A.: § 63-51-105(a)(4))

YES ❑ NO ❑

If "YES", list name(s) and address(es) of the hospital(s) and a brief description of the final disciplinary action(s) and stated reason(s) for the action. (Attach additional sheets, clearly labeled with this question number, if necessary)

	HOSPITAL NAME/ADDRESS	DATE	DESCRIPTION OF ACTION
1.			

If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❑ NO ❑

2.			

If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❑ NO ❑

Practitioner's Name _____ **License #** _____

Profession _____

VIII. CRIMINAL OFFENSES (See Instructions)

Have you within the most recent ten (10) years, been found guilty, regardless of whether adjudication of guilt was withheld, or pled guilty or nolo contendere to a criminal misdemeanor or felony in any jurisdiction? (Authority: T.C.A. § 63-51-105(a)(1)) YES ❑ NO ❑

If "YES" briefly describe the offense(s):

	DESCRIPTION OF OFFENSE(S)	DATE	JURISDICTION
1.			

If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❑ NO ❑

2.			

If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❑ NO ❑

3.			

If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❑ NO ❑

IX. LIABILITY CLAIMS

Have you had a medical malpractice court judgment, arbitration award, or settlement against you since May 19, 1998? (Authority: T.C.A. § 63-51-105(a)(5)) YES ❑ NO ❑

If "YES", indicate a brief description of the nature(s) of the claim, the date(s) of the claim report(s), and the amount of the judgment(s), award or settlement(s):

	ENTRY DATE OF DISPOSITION ORDER OR SETTLEMENT	AMOUNT
1.		
2.		
3.		
4.		

Practitioner's Name _____ **License #** _____

Profession _____

X. OPTIONAL INFORMATION:

A. PUBLICATIONS: List any publications you have authored in peer-reviewed medical literature: (optional) (Authority: T.C.A. § 63-51-105(a)(11))

	TITLE	PUBLICATION	DATE
1.			
2.			
3.			
4.			

B. PROFESSIONAL OR COMMUNITY SERVICE ACTIVITIES AWARDS: List any information regarding professional or community service associates, activities and awards: (optional) (Authority: T.C.A. § 63-51-105(a)(12))

	COMMUNITY SERVICE/AWARD/HONOR	ORGANIZATION
1.		
2.		
3.		
4.		

I affirm these statements are true and correct and recognize that providing false information may result in disciplinary action against my license pursuant to T.C.A. §§ 63-51-113 and/or 63-51-118.

_____ Date:_____

(Signature of Provider)

REMINDER: Each practitioner who has submitted information must update that information in writing by notifying the Department of Health, Healthcare Provider Information Unit, within 30 days after the occurrence of an event or an attainment of a status that