



THE STATE

of

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

Alaska State Medical Board

State Office Building, 333 Willoughby Avenue, 9th Floor

PO Box 110806, Juneau, AK 99811-0806

Phone: (907) 465-2550 • Fax: (907) 465-2974

Email: medicalboard@alaska.gov

Website: ProfessionalLicense.Alaska.Gov/StateMedicalBoard

Addendum to Uniform Application for Physician State Licensure

This packet contains all the instructions and additional documents you will need, in addition to the uniform application, to apply for a permanent license, podiatric license, courtesy license, locum tenens permit, or resident permit 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 temporary permit is from twelve to fourteen weeks. Start the process far enough in advance to allow this process to occur. Applications are reviewed in order of receipt in our office. If there are items in the application about which the board requires additional information, or if there is any adverse or derogatory information that comes to light, the review process may take longer.
- Appropriate fees must accompany applications before initial screening can begin.
- An incomplete application or any unusual circumstances noted in the application may require additional processing time.
- While we understand your desire to conclude this process as quickly as possible, our licensing staff is responsible for reviewing many files and cannot complete the application process if required documents are missing. It is your responsibility to ensure 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.

IT IS ILLEGAL TO PRACTICE MEDICINE IN ALASKA WITHOUT A VALID LICENSE
— PLEASE PLAN AHEAD —

Threshold Qualifications for Licensure

Permanent Medical License

United States Graduates:

- Successful graduation from an AAMC- or AOA-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.
- NOT have a license to practice medicine in another state, territory, province, or international licensing jurisdiction suspended or revoked or otherwise disciplined.

Permanent Medical License

International Graduates:

- Successful graduation from a medical school listed in the *Medical Board of California's List of Approved Schools*.
- Successful completion of three (3) years of postgraduate training in accredited programs in recognized hospitals in the United States or Canada.
- Successful passage of appropriate examinations as defined by regulation.
- NOT have a license to practice medicine in another state, territory, or province suspended or revoked or otherwise disciplined.

Podiatric Medicine License:

- Successful graduation from a school of podiatry accredited by the Council of Podiatric Medical Education.
- Successful completion of post-graduate training in a program accredited by the Council of Podiatric Medical Education to include:
 - One year of internship training in podiatric medicine and;
 - One year of podiatric surgical training.
- Successful completion of the National Boards examination and the PMLexis examination.

Courtesy License:

- Successful graduation from an AAMC- or AOA-accredited medical school if U.S. or Canadian graduate; if any other international medical school graduate, successful graduation from a school listed in the World Health Organization directory of medical schools.
- Successful completion of post-graduate training in accredited programs in recognized hospitals in the United States or Canada.
- Active license in good standing (no disciplinary sanctions or restrictions) in state of residence; cannot be under investigation.
- Board certification in an American Board of Medical Specialties member board.

Locum Tenens Permit

United States Graduates:

- Successful graduation from an accredited medical school
- Successful completion of post-graduate training in an accredited program in a recognized hospital:
 - 1 Year – If graduated from medical school prior to 01/01/95
 - 2 Years – If graduated from medical school 01/01/95 or later
- Must be actively licensed in at least one other state
- NOT have a license to practice medicine in another state, province, or territory suspended or revoked

Locum Tenens Permit

International Graduates:

- Successful graduation from a medical school listed in the World Health Organization Directory
- Successful completion of three years of post-graduate training at an accredited program in a recognized hospital in the U.S. or Canada
- Must be actively licensed in at least one other state
- NOT have a license to practice medicine in another state, province, or territory suspended or revoked

Resident Permit:

- Acceptance by an eligible institution in Alaska for the purpose of residency or internship

HOW CAN YOU HELP?

1. First and foremost: apply far enough in advance to allow for application processing. ***Please DO NOT move to Alaska until you have a permit or license in hand.***
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 online resources to expedite the application process. (AMA Physician Profile, AOA Official Osteopathic Physician Profile, FCVS, VeriDoc)
5. Ensure the application is complete when you submit it; do not skip any sections or questions. Provide any necessary explanations with the application. Print legibly or type any "Yes" responses.
6. Provide complete explanations for any "Yes" responses; it saves time if we don't have to request the information.
7. Use the applicable checklist provided at the end of these instructions to ensure that you submit all materials.

General Information for Licensure

ADDRESS OF RECORD

The Uniform Application asks for your preferred board contact address. 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.

AMA OR AOA PROFILES

The Alaska State Medical Board requires all applicants to have a copy of their individual Physician Profile Report sent directly to the Board by the American Medical Association (AMA) or the American Osteopathic Association (AOA), even if you are not a member of these organizations.

You must order the profiles directly from the organizations:

- AMA Profile (MDs only): commerce.ama-assn.org/amaprofiles
- AOA Profile (DOs only): doprofiles.org

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 must include passing 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 requires the USMLE examination series and has contracted with the Federation of State Medical Boards for administration of the examination. For more information, fsmb.org/licensure/usmle-step-3
For assistance, email usmle@fsmb.org or call (817) 868-4041

APPLICATION STATUS UPDATES

Licensing staff will send you a written status update upon the initial screening of the application, and periodically throughout the application process. It is your responsibility to provide your documents and to request or order documents from other agencies and organizations.

BOARD REVIEW OF APPLICATIONS

Only the board is authorized to grant licenses. Your application will be presented to the board for review and approval of your license at a regularly-scheduled board meeting. 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 on 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.

CONFIDENTIALITY

The contents of licensing files are generally considered public records. If you believe that the additional information you are attaching to explain a "yes" answer should be considered confidential, state that in the attachment. A request for confidentiality may or may not be granted.

CONTINUING MEDICAL EDUCATION REQUIREMENT

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

DEA CLEARANCE REPORT

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

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

DENIAL OF LICENSE

The denial of an application for licensure 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.

Unless you are using FCVS for credentials verification, you must request exam scores be sent to the board from the appropriate organization. There may be a fee involved. If using FCVS, this will be handled for you.

- USMLE / FLEX / SPEX – Request transcripts at <https://portal.fsmb.org/MyFsmb/>
For assistance, email usmle@fsmb.org or call (817) 868-4041 with your USMLE ID.
- NBME – Request your scores at: <https://apps.nbme.org/ciw2/prod/jsp/login.jsp>
For assistance, email scores@nbme.org or call (215) 590-9500
- NBOME/COMLEX-USA – Request a certified copy of your official transcript at: nbome.org/transcript-request.asp
For assistance, send a message to Client Services at nbome.org/contactform.asp or call (866) 479-6828.
- State Board Examination – Request the state board or jurisdiction to send your state exam information directly to the Alaska State Medical Board. A directory of state medical and osteopathic boards is available at fsmb.org/policy/contacts
- LMCC – Complete the Service Request form at: mcc.ca/forms/certified-transcript-examinations
For assistance, email service@mcc.ca or call (613) 521-6012
- ECFMG Certificate or Status Report – Request a Status Report at cvsonline2.ecfm.org
For assistance, email credentials@ecfm.org or call (215) 386-5900.

FAX DOCUMENTS

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

FEDERATION CREDENTIALS VERIFICATION SERVICE (FCVS)

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 FCVS in accordance with established policies and procedures set forth by the Board. FCVS staff uses primary sources to verify a physician's identity, education, training, and more, and creates a permanent profile of the verified credentials. The profile can be updated as needed throughout a physician's career and sent to boards and other entities without the need to verify each item again.

If you are using FCVS for credentials verification, do not provide a copy of your driver's license or passport, or a copy of any name change documents to the Board. Also, do not provide examination scores/transcripts, verification of medical education and official transcript, or verification of postgraduate training to the Board. FCVS will provide these verified credentials to the Board on your behalf.

To use FCVS, visit <https://portal.fsmb.org/MyFsmb/> and click on the FCVS graphic. Sign in and continue as directed. Complete an Initial Application if you are using FCVS for the first time. Complete a Subsequent Application if you need to update an existing FCVS profile. During the application process, designate your profile to be received by the Alaska State Medical Board. For assistance, contact FCVS through the messaging tool within FCVS, or call (888) 275-HG 1, 1 @ [~ ; FCVS ID number. Please do not contact the Alaska State Medical Board regarding your FCVS application.

FSMB BOARD ACTION DATABANK REPORT

The Alaska State Medical Board requires all applicants to have a copy of their individual Board Action Databank Report sent directly to the Board by the Federation of State Medical Boards Physician Data Center (FSMB PDC). The [^] [| cis æ d { asid } • ^ } c d c @ à [æ à à ØUT Ó , @ } ^ [~ • à { ã ^ [~ ! W ã [{ Q] | asid } È

FEES

For permanent licenses, 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.

Permanent Physician License:

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

Podiatric Medicine License:

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

Courtesy License:

Nonrefundable Application Fee	\$100
License Fee	\$100
Total Due	\$200

Locum Tenens Permit:

Nonrefundable Application Fee	\$100
Permit Fee	\$100
Total Due	\$200

Resident Permit:

Nonrefundable Permit Fee	\$50
Total Due	\$50

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), you will pay the entire license fee. Upon renewal, you will receive a renewal form that pro-rates the licensure fee for the coming licensure period. You 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, 2014, the expiration date will automatically be entered as December 31, 2016.

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 who is 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.

LICENSING PROCESS

Submit your complete application to the Board with fees and pertinent documents. Licensing staff will assemble the documents for your application file and advise you 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 7).

The complete application file is presented to the board at its next regularly-scheduled 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 ensure that you apply well in advance of your need for the permit or license. Board staff will not expedite one application before another.

NAME CHANGES

Unless you are using FCVS for credentials verification, 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. If you are using FCVS, the copies will be included in your profile.

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 with the board. Should an interview be required, you will be notified and an interview scheduled for the next board meeting. 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 refer to the Job Opportunities page of the Alaska State Medical Association website at: asmadocs.org/job-opportunities

PROCESSING TIME

In general, average processing time for a temporary permit is from twelve to fourteen 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
professionallicense.alaska.gov/

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

We recommend the use of VeriDoc to expedite processing of licensure verification from other states to the Alaska Board. VeriDoc eliminates the time delay often experienced when relying on post office mail. Visit www.veridoc.org for more information or to use this system.

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: professionallicense.alaska.gov/

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 in writing stating the reason for the withdrawal. Requests 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.

Uniform Application for Physician State Licensure

The UA was developed to simplify the licensure application process by eliminating redundancy. Once the core UA is completed, it can be sent when applying to another participating board without the need to reenter information. Updates can be made as needed.

As part of the online UA, you will be asked to complete a chronology of activities of all working and non-working time since medical school graduation and provide details of any malpractice liability claims. Having this information on hand before you begin will help you to complete the UA more efficiently.

To use the UA, visit www.fsmb.org/ua. Sign in and continue as directed.

Please note:

- The business address and home address must be two different addresses. You can select one of the addresses for both public contact and board mailings, if you like.
- Please ensure that your United States Social Security Number is listed correctly within the UA. It is required by state law, is considered CONFIDENTIAL information, and is not for public disclosure; it may be used to verify interstate licensure.
- Information on USMLE, FLEX, and SPEX exams and medical licenses issued in the U.S. and Canada will be pre-filled in your UA. All other examination information (NBME, NBOME, COMLEX, COMVEX, LMCC, state board exams, etc.) must be entered. If you are not using FCVS and need to request transcripts from an examination entity, see the information on page 4 for contact information.
- License information in the UA is reported to the FSMB by state boards. If you see incorrect information listed, email ua@fsmb.org with the correct information. It may take 1-2 business days for the updated information to show within your UA.
- For each malpractice case listed (all settlements, judgments, awards, and claims, even if no money was paid), provide an explanation in the specifics area and provide documentation. 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. Do not send all of the motions or filings for the case.
- We strongly recommend printing or saving a copy of your UA for your records when prompted.

In addition to completing the core UA:

- Complete the state addendum and other forms in this packet as instructed.
- Have each professional license you have ever held (including EMT, nursing, etc.) verified by the board that issued the license. Determine the fees and preferred verification method for each state medical board by using the resource at: fsmb.org/licensure/uniform-application
If the verifying board uses VeriDoc or another electronic method, use that instead of the form in this packet.
- Follow the appropriate checklist to ensure that you have sent all required materials to the Board.

For UA assistance, see the UA FAQ at: fsmb.org/licensure/uniform-application/faq

If your issue is not listed, contact UA customer service at (800) 793-7939 or ua@fsmb.org with a description of the problem. Please email a screenshot to ua@fsmb.org if you see an error.

Application for Licensure Checklist

Legend:

MD = Medical Doctor
DO = Osteopathic Doctor

DPM = Doctor Podiatric Medicine
CSY = Courtesy License

LT = Locum Tenens
RES = Resident

Document:	Provided by:	Required for:					
		MD	DO	DPM	LT	CSY	RES
Uniform Application, including notarized Alaska addendum with recent passport-style photo	<input type="checkbox"/> You Provide	✓	✓	✓	✓	✓	✓
Authorization for Release of Records	<input type="checkbox"/> You Provide	✓	✓	✓	✓	✓	✓
Application and License Fees	<input type="checkbox"/> You Provide	✓	✓	✓	✓	✓	✓
Statement of Purpose	<input type="checkbox"/> You Provide				✓	✓	
Examination Scores	<input type="checkbox"/> Exam Agency or FCVS	✓	✓	✓			
Medical School Diploma, certified true copy	<input type="checkbox"/> You or FCVS Provide	✓	✓	✓	✓	✓	✓
Verification of Medical School Education	<input type="checkbox"/> Medical School or FCVS	✓	✓	✓	✓	✓	✓
ECFMG Certificate, if International Medical School Graduate	<input type="checkbox"/> ECFMG or FCVS Provide	✓	✓	✓	✓	✓	✓
Post-Graduate Training Certificates, certified true copies	<input type="checkbox"/> You or FCVS Provide	✓	✓	✓	✓	✓	
Post-Graduate Verifications of Training	<input type="checkbox"/> PG Programs or FCVS	✓	✓	✓			✓
Verification of Good Standing from Residency Training Program	<input type="checkbox"/> Program Provides						✓
Acceptance of Responsibility from Alaska Facility	<input type="checkbox"/> Facility Provides						✓
Specialty Board Certificate, Certified True Copy	<input type="checkbox"/> You Provide				✓	✓	
Verifications of Licensure in Other Jurisdictions	<input type="checkbox"/> Licensing Board or Veridoc	✓	✓	✓	✓	✓	✓
Hospital Privileges Verifications	<input type="checkbox"/> Hospitals Provide	✓	✓	✓			
DEA Clearance Report	<input type="checkbox"/> DEA Provides	✓	✓	✓			
FSMB Board Action Data Bank Report: <i>fsmb.org</i>	<input type="checkbox"/> FSMB Provides	✓	✓	✓	✓	✓	✓
AMA Profile: <i>ama-assn.org</i> AOA Profile: <i>osteopathic.org</i>	<input type="checkbox"/> AMA or AOA Provides	✓	✓				
NPDB Report	<input type="checkbox"/> Alaska Board will Obtain	✓	✓	✓	✓	✓	✓
Explanation and documentation of any "yes" responses in application	<input type="checkbox"/> You Provide	✓	✓	✓	✓	✓	✓



THE STATE
of **ALASKA**

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

MED

FOR DIVISION USE ONLY

Alaska State Medical Board

State Office Building, 333 Willoughby Avenue, 9th Floor
PO Box 110806, Juneau, AK 99811-0806
Phone: (907) 465-2550 • Fax: (907) 465-2974
Email: medicalboard@alaska.gov
Website: ProfessionalLicense.Alaska.Gov/StateMedicalBoard

Addendum to Uniform Application for Physician State Licensure

Applicant Name	
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Applying by	<input type="checkbox"/> Examination (NOT licensed in another state) <input type="checkbox"/> Credentials (Licensed in another state)
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<input type="checkbox"/> Permanent Medical License	<ul style="list-style-type: none"> · Nonrefundable Application Fee \$200 · License Fee \$300 · Total Due \$500
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<input type="checkbox"/> Permanent Osteopathic License	<ul style="list-style-type: none"> · Nonrefundable Application Fee \$200 · License Fee \$300 · Total Due \$500
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<input type="checkbox"/> Permanent Podiatric License	<ul style="list-style-type: none"> · Nonrefundable Application Fee \$200 · License Fee \$300 · Total Due \$500
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<input type="checkbox"/> Courtesy License	<ul style="list-style-type: none"> · Nonrefundable Application Fee \$100 · License Fee \$100 · Total Due \$200
--	--

<input type="checkbox"/> Locum Tenes Permit	<ul style="list-style-type: none"> · Nonrefundable Application Fee \$100 · License Fee \$100 · Total Due \$200
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<input type="checkbox"/> Resident Permit	<ul style="list-style-type: none"> · Nonrefundable Application Fee \$50 · License Fee \$0 · Total Due \$50
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Full Legal Name		Date of Birth	
Phone		Email	

• Duration at Address:

Duration at residence listed on your Uniform Application: Years _____ Months _____

• If, Previous Alaskan License or Permit:

Previous License or Permit Type: Permanent Courtesy Locum Tenens
 Podiatric Resident Temporary

Previous AK License or Permit Number: Date Issued: _____

• If, Member of the Armed Forces:

Branch: _____ Commission Date: _____

Discharge Date: _____ Discharge Type: _____

• If, International Graduate:

My school is listed on the 2006 Medical Board of California's list of approved schools.

I have attached a certified copy of my ECFMG certificate to this application.

— or —

My ECFMG certificate is included in my FCVS profile of primary-source verified credentials.

ECFMG Certificate Number: _____ Issue Date: _____

SELF-DESIGNATED SPECIALTY:

I do not have any specialty board certifications.

I have attached a certified copy of each specialty board certification(s) to this addendum. Details of my certification(s) are listed below and on an attached paper, if necessary.

Specialty / Subspecialty	Certification Date	Specialty Board	Recertification Date

Hospital Affiliations

Yes Have you ever held hospital privileges? If "Yes," list all hospitals where you currently hold or have ever held privileges or been credentialed within the past five years. Include residency privileges if appropriate.

No

Hospital	Mailing Address	Date Privileged

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 verification 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:

MEDICAL SOCIETIES AND PROFESSIONAL ORGANIZATIONS:

- I do not belong to any medical societies or professional organizations.
- I belong to a medical society and/or professional organization, details listed below:

Name of Organization	Mailing Address	Membership Dates

DISCIPLINARY HISTORY AND PERSONAL HISTORY QUESTIONS

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

For each "Yes" response to any question, you must provide an explanation and documentation. Provide your explanation on a separate sheet of paper labeled with your name, and signed by you; include full details, dates, locations, type of action, organizations or parties involved, and specific circumstances. Documentation includes copies of court orders, charging documents, board or license actions, etc. When in doubt about your response, disclose and provide the required explanation and documents.

Applications submitted without the required attachments will be considered incomplete and will not be processed.

The contents of licensing files are generally considered public records. If you believe that the additional information you are attaching to explain a "yes" answer should be considered confidential, state that in the attachment. A request for confidentiality may or may not be granted.

For the purposes of this application, the word "discipline" is used. There are many forms of disciplinary actions that may be imposed by organizations, schools, programs, licensing authorities, and other agencies. Such disciplinary actions may include but not be limited to: Suspension, Surrender, Revocation, Probation, Academic Probation, Reprimand, Censure, Restricted License, Limited License, Conditioned License, or Letters of Counseling, Concern, Advice, Warning, Caution, Admonishment, Reprimand, etc. You must include non-reported disciplinary actions. Failure to disclose past history may be grounds for disciplinary sanctions.

WHEN IN DOUBT, DISCLOSE AND EXPLAIN

DISCIPLINARY HISTORY

- | | | |
|---|------------------------------|-----------------------------|
| <p>1. Have you ever been convicted of a crime (felony or misdemeanor) in any jurisdiction of the United States, including military, or any international jurisdiction?</p> | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Is any such action pending? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| <hr/> | | |
| <p>2. Have you ever been charged with a crime (felony or misdemeanor) in any jurisdiction of the United States, including military, or any international jurisdiction that did not result in acquittal or dismissal?</p> | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Is any such action pending? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| <hr/> | | |
| <p>3. Relating to the practice of medicine, has there ever been a finding of, or have you ever been found guilty of, professional misconduct, unprofessional conduct, incompetence, or negligence, by any jurisdiction of the United States, including military, or any international jurisdiction?</p> | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Is any such action pending? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| <hr/> | | |
| <p>4. Relating to the practice of medicine, have you ever had charges filed against you alleging professional misconduct, unprofessional conduct, incompetence, or negligence, in any jurisdiction of the United States, including military, or any international jurisdiction?</p> | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Is any such action pending? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| <hr/> | | |
| <p>5. Has any hospital or other health care facility disciplined, restricted, or terminated your professional training, employment, or privileges, or investigated a complaint or accusation regarding your practice (except for late medical records)?</p> | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Is any such action pending? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| <hr/> | | |
| <p>6. Have you ever voluntarily or involuntarily resigned or withdrawn from professional training, from employment, or your privileges from any hospital or other health care facility to avoid the imposition of disciplinary sanction, restriction or termination?</p> | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Is any such action pending? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| <hr/> | | |
| <p>7. Have you ever been disciplined by a medical school or post-graduate training program, including academic probation?</p> | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Is any such action pending? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| <hr/> | | |
| <p>8. Have you ever had a license to practice medicine disciplined by any authority including a state medical board or a military authority (except for late medical records)?</p> | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| <p><i>If you are unsure about your response to this question, please refer to the instructions and definitions for this section on page 2 of this addendum. When in doubt, disclose and explain.</i></p> | | |
| Is any such action pending? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
-

DISCIPLINARY HISTORY

(continued)

9. Have you ever been under investigation by any medical licensing jurisdiction or authority? <i>If you are unsure about your response to this question, please refer to the instructions and definitions for this section on page 2 of this addendum. When in doubt, disclose and explain.</i> Is any such action pending?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
10. Have you ever had a medical license application denied by any medical licensing jurisdiction or authority? Is any such action pending?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
11. Have you ever voluntarily or involuntarily withdrawn an application for a license to practice medicine in any United States jurisdiction or any international jurisdiction? Is any such action pending?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
12. Have you ever voluntarily or involuntarily surrendered or suspended your license to practice medicine in any United States jurisdiction or any international jurisdiction? Is any such action pending?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
13. Have you ever voluntarily or involuntarily agreed to any limitations, restrictions, or conditions to your license to practice medicine? Is any such action pending?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
14. 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? Is any such action pending?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Personal History

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

For each "Yes" response to any question, you must provide an explanation and documentation. Provide your explanation on a separate sheet of paper labeled with your name, and signed by you; include full details, dates, locations, type of action, organizations or parties involved, and specific circumstances. Documentation includes copies of court records, judgments, charging documents, etc. You must also have your treating physician submit a letter directly to the Board; the letter must include the following information:

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

Applications submitted without the required attachments will be considered incomplete and will not be processed.

The contents of licensing files are generally considered public records. If you believe that the additional information you are attaching to explain a "yes" answer should be considered confidential, state that in the attachment. A request for confidentiality may or may not be granted.

When in doubt about your response, disclose and provide the required explanation and documents.

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 or 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.

WHEN IN DOUBT, DISCLOSE AND EXPLAIN

15. 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?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
16. 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?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
17. Since completing your postgraduate training, have you ever been physically or mentally unable to practice medicine for a period of sixty (60) or longer?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
18. Are you currently the subject of any civil investigation or court process relating to your ability to practice in a safe and competent manner?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
19. 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)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
20. Are you currently engaged in the illegal use of any drug, whether by ingestion, injection, inhalation, or any other method?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
21. Have you used or are you currently using any chemical substance(s), legal or illegal, that in any way impaired or limited, or is currently impairing or limiting, your ability to practice medicine in a safe and competent manner?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
22. Have you ever been voluntarily or involuntarily committed or confined to any facility for mental health care?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
23. Have you ever been diagnosed with, treated for, or do you currently have:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Check each condition you have ever been diagnosed with, treated for, or currently have:		
<input type="checkbox"/> Bipolar Disorder	<input type="checkbox"/> Depressive Neurosis	<input type="checkbox"/> Kleptomania
<input type="checkbox"/> Hypomania	<input type="checkbox"/> Any Dissociative Disorder	<input type="checkbox"/> Pyromania
<input type="checkbox"/> Schizophrenia	<input type="checkbox"/> Any Psychotic Disorder	<input type="checkbox"/> Delirium
<input type="checkbox"/> Depression	<input type="checkbox"/> Any Organic Mental Disorder	<input type="checkbox"/> Paranoia
<input type="checkbox"/> Seasonal Affective	<input type="checkbox"/> Any condition requiring chronic medical or behavioral treatment	
Please describe: _____		
24. Have you ever taken, or are you currently taking, any controlled substance for any of these disorders?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
25. Have you ever been adjudicated, or declared incompetent, or been the subject of an incompetency proceeding?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
!	If you checked "Yes" to any of the above questions, you must attach a detailed explanation. You must also have your treating physician submit a letter directly to the Board regarding your ability to practice safely and competently. (See complete instructions on page 4 of this addendum.)	

Notarized Signature with Photograph

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

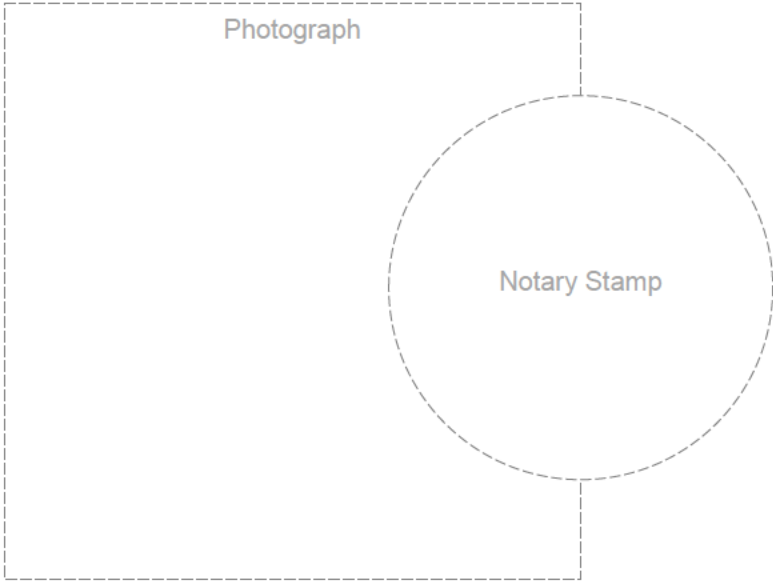
I understand that any falsification or misrepresentation of any item or response in this application, or any attachment hereto or falsification or misrepresentation of credentials to support this application, is sufficient grounds for denying, revoking, or otherwise disciplining a license or permit to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

I have read all of the instructions in the Uniform Application and in this addendum, including the instructions under Disciplinary History and Personal History.

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

Applicant's Signature	
Date	
Printed Name	

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

<p>Attach a recent photo that is no larger than 3" x 3".</p> <p>The notary seal must overlie a portion of the photograph.</p>	<p>Photograph</p>  <p>Notary Stamp</p>
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THE STATE
of

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

Alaska State Medical Board

State Office Building, 333 Willoughby Avenue, 9th Floor

PO Box 110806, Juneau, AK 99811-0806

Phone: (907) 465-2550 • Fax: (907) 465-2974

Email: medicalboard@alaska.gov

Website: ProfessionalLicense.Alaska.Gov/StateMedicalBoard

Authorization for Release of Records

To Whom It May Concern:

I, _____
First Name Middle Name Last Name

residing at _____
Address City State ZIP Code

authorize the Alaska Division of Corporations, Business, and Professional Licensing and its investigators to examine my medical and dental records, employment and education records including all training which pertains to my medical practice, and any records pertaining to litigation, judgments, suits, and/or settlements, and any law enforcement records pertaining to me and discuss them with persons having possession of them. I also expressly permit and authorize the release of any and all such records pertaining to me to the Alaska Division of Corporations, Business, and Professional Licensing and its investigators. This release also applies to all records that pertain to credentialing records at facilities at which I have applied for or held privileges to practice medicine.

I authorize the Division to discuss my records with persons or organizations that are considered appropriate by the Division in connection with an official investigation, and to provide copies of my records to those persons or organizations deemed appropriate by the Division.

This release also applies to any documents or records which contain information pertaining to psychiatric, psychological, drug, or alcohol evaluation, counseling, diagnosis or treatment received by me and which were prepared or made in conjunction with, or under the authority or guidance of any local, state, or federal law which relates to psychiatric, drug or alcohol evaluation, diagnosis or treatment, including all information previously identified, collected, or stored under the authority of any state or federal law, including 42 CFR Part 2.

I request that upon presentation of this release, or a Certified True Copy thereof, that you provide copies of those records to the Division and/or its investigators, and/or representatives of the Office of the Attorney General of the State of Alaska.

This authorization expires one (1) year from the date of my signature below.

Signature: _____ Date: _____

Home Telephone: _____ Work Telephone: _____



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Verification of Licensure

→ **Applicant:** Complete this top part and then forward a copy to all states, territories or other countries' licensing jurisdictions where you have ever been licensed. Make copies as needed.

Full Legal Name		Birth Date	
Medical or Osteopathic School Attended		Year Graduated	
Applicant's Signature		Date of Signature	

→ **Licensing Agency:** Complete this bottom part for the physician identified above and return the form directly to the Alaska State Medical Board.

State Board or Licensing Jurisdiction		License Number	
Initial License Date		Expiration Date	
Basis of Licensure (FLEX, USMLE, etc.)		Current License Status	

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

Board Seal	Signed by: _____	Date: _____
	Printed Name: _____	Title: _____



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Website: ProfessionalLicense.Alaska.Gov/StateMedicalBoard

Verification of Hospital Privileges

→ **Applicant:** Complete this top part and then forward a copy to each hospital where you have held privileges in the immediate past five years. Include privileges held during residency.

Full Legal Name		Birth Date	
Applicant's Signature		Date of Signature	

→ **Hospital:** Complete this bottom part for the physician identified above and return the form directly to the Alaska State Medical Board.

Hospital Name		Dates of Hospital Privileges	
Mailing Address			

— THE FOLLOWING PART TO BE COMPLETED BY HOSPITAL STAFF ONLY —

1.	Has your hospital ever taken any disciplinary action against this physician?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2.	Have there ever been limitations or restrictions on this physician's privileges?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3.	Are any disciplinary actions pending against this physician?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
4.	Is there any derogatory information on file regarding this physician?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
5.	Is there any reason you would not readmit this physician to your medical staff?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

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

Board Seal	Original Signature:	
	Printed Name:	Title:
	Date:	Phone:



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Verification of Medical or Osteopathic Education

→ **Applicant:** Complete this top part and then send it to the medical school which awarded your diploma.

Full Legal Name		Birth Date	
Applicant's Signature		Date of Signature	

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

Exact Date on Diploma	
Medical School Name	
Medical School Address	

THE FOLLOWING PART TO BE COMPLETED BY MEDICAL STAFF ONLY

During this physician's medical school education, was he/she ever investigated by the school or disciplined by the school for any reason? Disciplinary actions include but are not limited to being placed on probation, issued a letter of reprimand, censured, suspended, restricted, or otherwise disciplined.

Yes

No

! If you answered "Yes" to this question, please attach a detailed explanation and reason for the action, signed and dated by the person whose signature appears below.

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



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Verification of DEA Registration Status

Complete this top part and then mail it to the Drug Enforcement Administration (DEA) at:

→ **Applicant:**

Drug Enforcement Administration
Attn: Diversion Unit
300 5th Avenue, Suite 1300
Seattle, WA 98104

Full Legal Name			
Other Names Used			
Birth Date		DEA Registration Number	
Mailing Address			
Address of DEA Registration			
Applicant's Signature		Date of Signature	

→ **DEA Use Only:**

Please search your records and advise if there is any derogatory information on file against this physician. Please return this form directly to the Alaska State Medical Board at the letterhead address.

Has this applicant ever surrendered (for cause) or had a federal controlled substance registration revoked, suspended, restricted or denied?

Yes

No

Is any such investigation pending?

Yes

No

DEA Comments:



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Verification of Post-Graduate Training

→ **Applicant:** Complete this top part and then send it to the post-graduate training program(s) you attended.

Full Legal Name		Birth Date	
Medical or Osteopathic School Name		Year Graduated	
School Address		IMG or ECFMG (if applicable)	
Name and Location of Post-Graduate Program			
Applicant's Signature		Date of Signature	

→ **Post-Graduate Staff:** Please complete this bottom part for the student identified above and return the form directly to the Alaska State Medical Board.

Verification for Post-Graduate Year Number	Year 1 <input type="checkbox"/>	Year 2 <input type="checkbox"/>	Year 3 <input type="checkbox"/>	Year 4 <input type="checkbox"/>	Year 5 <input type="checkbox"/>	Year 6 <input type="checkbox"/>
Dates of Training						

- At the time this individual completed training in your program, was the program accredited through:

<input type="checkbox"/> Accreditation Council for Graduate Medical Education	<input type="checkbox"/> American Osteopathic Association
<input type="checkbox"/> Royal College of Physicians and Surgeons of Canada	<input type="checkbox"/> None of these
- 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?

Yes <input type="checkbox"/>	No <input type="checkbox"/>
------------------------------	-----------------------------
- Is there anything in this physician's postgraduate training records that would indicate he/she would be unable to practice medicine competently and safely?

Yes <input type="checkbox"/>	No <input type="checkbox"/>
------------------------------	-----------------------------

Please provide a detailed explanation for any "Yes" answers.

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



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Authorization to Discuss Application and Share Information

Medical Board staff is authorized to communicate only with the applicant. If the applicant is using a credentialing agency, or is accepting assistance from a staffing or employment agency, then Board staff must have a signed release from the applicant to discuss the application and share information.

If you wish to authorize such communication, please complete this form and file with your application.

Name of Applicant			
Profession	<input type="checkbox"/> Physician	<input type="checkbox"/> Physician Assistant	<input type="checkbox"/> MICP
Applicant's Email		Phone	
Authorized Agency		Phone	
Authorized Agent		Email	

I hereby authorize staff of the Alaska State Medical Board to share and exchange information relating to my licensing application with the above-named authorized agent and agency.

This release applies to status updates and documents and information required to complete my application for licensure in the State of Alaska.

Applicant's Signature:

Date:

Information for credentialing, staffing or employment agencies:

- *Licensing staff will respond to one inquiry from agencies each week. Staff will respond as quickly as possible, though it may not be possible to respond the same day as the inquiry is received. More than one inquiry per week will not be accepted.*
- *Applicants are sent a written status letter and may contact staff to query application status at any time.*
- *The Board will not accept applications that list an agency address as the practice address, and will likewise not accept the telephone numbers or email addresses for such agencies as the applicant's own. The Board may only accept those addresses, phone numbers, and email addresses if the applicant is actually practicing in that office. Alaska law requires the applicant to provide their information, not the agency information.*



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State of Alaska
Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing
550 West 7th Avenue, Suite 1500, Anchorage, AK 99501
Phone: (907) 269-8160

CREDIT CARD PAYMENT

For security purposes please **do not email** credit card information. Fax or mail this credit card payment form to the Division. Completion of this form is not proof of payment until the Division processes the information. If any information on this form is illegible, the form will be rejected.

Name of Applicant or Licensee: _____

Type of License: _____ License Number (if applicable): _____

I wish to make payment by credit card for the following (check all that apply):	Amount
<input type="checkbox"/> Application Fee: _____	_____
<input type="checkbox"/> License or Renewal Fee: _____	_____
<input type="checkbox"/> Other (name change, wall certificate, fine, duplicate license, exam, etc.):	
1. _____	_____
2. _____	_____
Total:	_____

Name (as shown on credit card): _____

Mailing Address: _____

Phone: _____ Email (optional): _____

Credit Card Type: VISA — or — Mastercard

→ **Signature of Credit Card Holder:** _____

.....

VISA or Mastercard Number: _____ **Expiration Date:** _____

This section below the dotted line will be destroyed upon processing of the payment.