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Division of Policy Development
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Scott Walker, Governor
Laura Gutiérrez, Secretary

RE-ENTRY TO PRACTICE COMMITTEE
MEDICAL EXAMINING BOARD
Room 121A, 1400 East Washington Avenue, Madison
Contact: Tom Ryan (608) 266-2112
June 20, 2018

The following agenda describes the issues that the Committee plans to consider at the meeting. At the time of the meeting, items may be removed from the agenda. Please consult the meeting minutes for a record of the actions of the Committee. ***A quorum of the Board may be present during any committee meetings.***

AGENDA

9:30 A.M.
(or immediately following the Medical Examining Board meeting)

OPEN SESSION – CALL TO ORDER – ROLL CALL

A. Adoption of Agenda (1)

B. Approval of Minutes of May 16, 2018 (2)

C. Administrative Updates
1. Department and Staff Updates

D. Re-Entry to Practice (3-38)
1. Other States Information – Renewal Questions
2. Topics for Next Meeting

E. Public Comments

ADJOURNMENT

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MEETINGS AND HEARINGS ARE OPEN TO THE PUBLIC, AND MAY BE CANCELLED WITHOUT NOTICE.

Times listed for meeting items are approximate and depend on the length of discussion and voting. All meetings are held at 1400 East Washington Avenue, Madison, Wisconsin, unless otherwise noted. In order to confirm a meeting or to request a complete copy of the council's agenda, please call the listed contact person. The council may consider materials or items filed after the transmission of this notice. Interpreters for the hearing impaired provided upon request by contacting the Affirmative Action Officer, 608-266-2112

MEDICAL EXAMINING BOARD
MEETING MINUTES
MAY 16, 2018

PRESENT: Mary Jo Capodice, D.O.; Rodney Erickson, M.D.; Lee Ann Lau, M.D.; David Roelke, M.D. *(via GoToMeeting)*

EXCUSED: David Bryce, M.D.

STAFF: Tom Ryan, Executive Director; Kate Stolarzyk, Bureau Assistant, and other Department staff

CALL TO ORDER

Lee Ann Lau, Chair, called the meeting to order at 11:25 a.m. A quorum of four (4) members was confirmed.

ADOPTION OF AGENDA

MOTION: David Roelke moved, seconded by Mary Jo Capodice, to adopt the agenda as published. Motion carried unanimously.

APPROVAL OF MINUTES OF APRIL 18, 2018

MOTION: Mary Jo Capodice moved, seconded by David Roelke, to approve the minutes of April 18, 2018 as published. Motion carried unanimously.

ADJOURNMENT

MOTION: David Roelke moved, seconded by Mary Jo Capodice, to adjourn the meeting. Motion carried unanimously.

The meeting adjourned at 12:53 p.m.

DRAFT

State of Wisconsin
Department of Safety & Professional Services

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request:	2) Date When Request Submitted:
Dale Kleven Administrative Rules Coordinator	6/8/18 Items will be considered late if submitted after 12:00 p.m. on the deadline date: ▪ 8 business days before the meeting

3) Name of Board, Committee, Council, Sections:

Reentry to Practice Committee of the Medical Examining Board

4) Meeting Date:	5) Attachments:	6) How should the item be titled on the agenda page?
6/20/18	☒ Yes ☐ No	Other States Information – Renewal Questions

7) Place Item in:	8) Is an appearance before the Board being scheduled?	9) Name of Case Advisor(s), if required:
☒ Open Session ☐ Closed Session ☐ Both	☐ Yes (Fill out Board Appearance Request) ☒ No	

10) Describe the issue and action that should be addressed:

11) Authorization

Dale Kleven — *June 8, 2018*

Signature of person making this request — Date

Supervisor (if required) — Date

Executive Director signature (indicates approval to add post agenda deadline item to agenda) — Date

Directions for including supporting documents:
1. This form should be attached to any documents submitted to the agenda.
2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director.
3. If necessary, Provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.

Revised 8/13

Illinois

LICENSE RENEWAL QUESTIONS: You must respond to ALL of the following questions in order to reinstate your license. Failure to answer ALL of these questions will result in the form(s) being returned to you for proper completion.

___Yes ___No Since July 31, 2014, have you had or do you now have any disease or condition that impairs or impaired your ability to perform the essential functions of your profession, including any disease of condition generally regarded as chronic by the medical community, i.e., (1) mental or emotional disease or condition; (2) alcohol or other substance abuse; (3) physical disease or condition? If yes, attach a detailed explanation including dates, names and addresses of treating physicians and/or counselors and nature of treatment.

___Yes ___No Since July 31, 2014, have you been denied a professional license or permit, or privilege of taking an examination, or had a professional license or permit disciplined in any way by any licensing authority in Illinois or elsewhere? If yes, attach a detailed explanation.

___Yes ___No Since July 31, 2014, have your clinical, hospital or practice privileges been restricted, suspended, or revoked, or have you submitted a resignation or not renewed clinical, hospital or practice privileges while under investigation (other than for non-completion of medical records)? If yes, attach a detailed explanation.

___Yes ___No Since July 31, 2014, has any action been taken on your Drug Enforcement Administration (DEA) Registration, including but not limited to surrender, revocation, or entry of memorandum of agreement? If yes, attach a detailed explanation.

___Yes ___No Have you been convicted of or are you currently charged with any criminal offense in any state or federal court (other than minor traffic violations) that you have not previously reported to this Department? If yes, attach a statement of each conviction including date and place of conviction, nature of the offense and, if applicable, the date of discharge from any penalty imposed.

Child Support Question: Response Required

___Yes ___No Are you more than 30 days delinquent in complying with a child support order? (Note: If you have no children or are not subject to a child support order, answer "No")

Iowa

QUESTIONS ASKED ON RENEWAL APPLICATIONS -- EVERY TWO YEARS (IOWA)

(Questions answered in the affirmative require detailed explanation and documentation.)

1. Have you been investigated or subject to an inquiry/review by any medical/osteopathic licensing agency, other than the Iowa Board of Medicine, including an investigation or review which resulted in no formal action since the date of your last renewal?
2. Have you been disciplined or sanctioned by another medical licensing authority, professional society, federal agency, including the U.S. Department of Health and Human Services, or health care facility since the date of your last renewal?
3. Aside from ordinary initial requirements of proctorship, have your clinical privileges or medical staff status at any hospital or health care entity, nursing facility, clinic, or other professional healthcare organization been limited, suspended, revoked, not renewed, voluntarily modified, relinquished, denied or subject to disciplinary or probationary conditions while under investigation, peer review or disciplinary action since the date of your last renewal?
4. Have you been charged with a felony or misdemeanor crime since the date of your last renewal?
5. Have you had a medical condition which in any way impaired or limited your ability to practice medicine with reasonable skill and safety since the date of your last renewal?
6. Have you been in violation of any child support order or written agreement to pay child support since the date of your last renewal?
7. Have you received a certificate of non-compliance from the College Student Aid Commission regarding non-payment of a student loan since the date of your last renewal?
8. Have you dispensed any drugs from your office other than samples since the date of your last renewal? In other words, do you give your patients any kind of medication that are not samples?

Maine

HAVE YOU EVER:
YES NO

☐ ☐ 1. Have you EVER had ANY licensing authority (INCLUDING MAINE) deny your application for any type of license, or take any disciplinary action against the license issued to you in that jurisdiction, including but not limited to warning, reprimand, fine, suspension, revocation, restrictions in permitted practice, probation with or without monitoring?

☐ ☐ 2. Have you EVER agreed with any licensing authority to voluntarily follow practice limitations, restrictions, guidelines, to make reports or to complete specific continuing education or course work?

☐ ☐ 3. Have you EVER been notified of the existence of allegations, investigations and/or complaints involving you, filed with or by ANY licensing authority (INCLUDING MAINE), which allegations, investigations and/or complaints remain open as of the date of this application?

SINCE YOUR LAST RENEWAL APPLICATION:
YES NO

☐ ☐ 4. Have you left a medical licensing jurisdiction (INCLUDING MAINE) while a complaint, investigation or allegation was pending?

5. Have you been denied registration, or had your ability to prescribe or dispense controlled substances modified, restricted, suspended, revoked, or voluntarily suspended by, or surrendered to

☐ ☐ a) U. S. Drug Enforcement Administration (DEA)?
☐ ☐ b) Any state/territory of U. S. INCLUDING MAINE?

☐ ☐ 6. Has there been a finding by any state or federal court or governmental agency that you violated any rule or law regulating the practice of health care?

☐ ☐ 7. Has there been a finding against you in any inquiry, investigation, or administrative or judicial proceeding by an employer, educational institution, professional organization, or licensing authority, or in connection with an employment disciplinary or termination procedure?

SINCE YOUR LAST RENEWAL APPLICATION:
YES NO

☐ ☐ 8. Have you received a sanction or entered into any settlement agreement or integrity agreement related to Medicare, TRICARE or any state Medicaid program?

9. The purpose of the following questions is to determine the current fitness of the applicant to practice medicine. The following inquiries concern medical, mental health, and substance misuse issues. This information is treated confidentially by the Board. The mere fact of treatment for medical, mental health or substance misuse is not, in itself, a basis on which an applicant is ordinarily denied licensure when he/she has demonstrated personal responsibility and maturity in dealing with these issues. The Board encourages applicants who may benefit from such treatment to seek it. The Board may deny a license to applicants whose ability to function in the practice of medicine or whose behavior, judgment, and understanding is impaired by substance misuse or a medical or mental health condition.

☐ ☐ a. Do you have a mental or physical condition that currently impairs your ability to safely and competently practice medicine?

☐ ☐ b. Have you been diagnosed with or treated for any medical or mental health disorder that impaired your behavior, judgment, understanding, or ability to function in school, work or other important life activities?

☐ ☐ c. Do you currently use any chemical substance(s), including alcohol, which in any way impairs or limits your ability to practice your profession with reasonable skill and safety?

☐ ☐ If any of your answers to questions 9(a-c) is "Yes," are the limitations or impairments caused by your medical, mental ☐ N/A health, or substance misuse condition reduced or improved because you receive ongoing professional treatment (with or without medication) or because you participate in a professional monitoring program? Current voluntary participation in the Medical Professionals Health Program or similar program will be kept confidential.

☐ ☐ d. Are you currently engaged in the illegal use of illicit drugs or prescription drugs that have not been prescribed to you pursuant to a legitimate physician-patient relationship? "Legitimate" means "Being in compliance with the law or in accordance with established and accepted standards."

☐ ☐ e. Have you used illegal drugs or prescription drugs that have not been prescribed to you pursuant to a legitimate physician-patient relationship?

☐ ☐ f. Have you obtained illegal drugs or prescription drugs that have not been prescribed to you pursuant to a legitimate physician-patient relationship?

☐ ☐ g. Have you furnished or provided illegal drugs to anyone other than medical marijuana per applicable state law?

☐ ☐ h. Have you furnished prescription drugs to or written a prescription for anyone without having a legitimate physician-patient relationship (This includes conduct for which you may NOT have been adjudicated in any civil, administrative or criminal proceeding)?

i. Have you been found in any civil, administrative or criminal proceeding to have:

☐ ☐ a. Possessed, used, prescribed for use, or distributed any drugs in any way other than for legitimate or therapeutic purposes?

☐ ☐ b. Diverted any drugs?

☐ ☐ c. Violated any drug law?

☐ ☐ d. Prescribed any controlled substances for yourself or family/household members?

☐ ☐ j. Have you raised the issue of consumption of drugs or alcohol or the issue of a medical, mental health or substance misuse disorder as a defense or in mitigation of, or as an explanation for your actions in the course of any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination action (educational, employer, government agency, professional organization, or licensing authority)?

☐ ☐ 10. Have you been charged, summonsed, indicted, arrested, or convicted of any criminal offense, including when those events have been deferred, set aside, dismissed, expunged or issued a stay of execution? Please include motor vehicle offenses such as Operating Under the Influence, but not minor traffic or parking violations.

☐ ☐ 11. Have you applied for hospital, HMO or other health care entity privileges which were denied?

SINCE YOUR LAST RENEWAL APPLICATION:
YES NO

☐ ☐ 12. Have you had your staff privileges or employment at any hospital, long term care facility, HMO, or other health care entity terminated, revoked, reduced, restricted in any way, suspended, made subject to probation, limited in any way, or withdrawn involuntarily?

☐ ☐ 13. Have you voluntarily surrendered privileges or resigned from staff membership during peer review or investigation or to avoid peer review or investigation?

☐ ☐ 14. Have you resigned from employment in lieu of termination or while under investigation?

☐ ☐ 15. Have you been terminated or suspended from any employment?

☐ ☐ 16. Have you been deselected from a managed care organization physician panel?

☐ ☐ 17. Have you been disciplined by a professional society or resigned while an accusation was pending?

☐ ☐ 18. Have you endangered the safety of others, breached fiduciary obligations, or violated workplace conduct rules?

☐ ☐ 19. Have you been named in any medical malpractice liability claim or lawsuit adjudicated by a court in favor of the other party, or settled by you or your insurance company/representatives with or without your express consent?

☐ ☐ 20. Do you have any open/pending malpractice claims?

☐ ☐ 21. Do you intend to practice medicine within the State of Maine without active medical staff privileges at a Maine hospital?

☐ ☐ 22. Do you plan to practice telemedicine in Maine? If so, please provide a short description of your plan to practice with Maine Patients, including your practice protocols, your physical practice location, your publicly available telemedicine website portal, and whether you will be combining in-person medical practice with telemedicine?

☐ ☐ 23. Has it been longer than 24 months since you last practiced clinical medicine?

Attestation questions Except for questions 1-4, please answer all questions by selecting Yes or No and provide an explanation when requested. Questions 1-4 do not have "No" as an option for confidentiality reasons. If you have a condition addressed by questions 1-4 and you are NOT participating in Health Professionals Services Program (HPSP) for monitoring of the condition, you must answer "Yes" to the applicable question(s). If you do not have this condition, OR if you are participating in HPSP for monitoring of this condition, do not answer the applicable question(s). For questions 1-2, the terms "impaired" and "limited" include but are not limited to impairments or limitations related to physical, psychological, or emotional disorders or conditions, or chemical dependency or chemical abuse. The purpose and intended use of this information is to enable the Board to determine whether you meet statutory and rule requirements for licensure. This information is classified as private while your application is pending and public after your license is granted. Exception: "Yes" answers are confidential during any investigation and private thereafter. This information will NOT be included in the profiling. If responses to questions change during the time your application is pending, you must make the board aware of the new information. If additional space is necessary please attach a separate sheet.

Yes 1. Is your cognitive, communicative, or physical capability to engage in the practice of medicine or surgery with reasonable skill and safety impaired or limited in any way? Please describe.

_____

_____

Yes No 1a. If yes, are the limitations or impairments reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? Please describe._____

_____

Yes No 1b. If yes, are the limitations or impairments reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? Please describe._____

_____

Yes 2. Does your use of alcohol or chemical substance(s), including prescription medications, in any way impair or limit your ability to practice medicine with reasonable skill and safety? Please describe.

_____

_____

Yes 3. Are you engaged in any illegal use of controlled substances including the use of illegal controlled substances (e.g. heroin, cocaine) or illegal use of legal controlled substances (i.e. not obtained pursuant to a valid prescription of a licensed health care provider)? Please describe.

_____

_____

Yes No 3a. If yes, have you taken any steps (i.e. treatment, psychotherapy, participation in a support group) to discontinue or reduce such use? Please describe.

_____

_____

Yes No 3b. If yes, are you not participating in a supervised rehabilitation program or professional assistance program which has as a component a monitoring regimen designed to assure that you are not currently engaging in the use of illegal controlled substances? Please describe._____

_____

Applicant Name_____ Last 4 digits of SSN _____ Date_____

Yes 4. Have you within the past five years been advised by your treating physician that you have a mental, physical, or emotional condition, which, if untreated, would be likely to impair your ability to practice medicine with reasonable skill and safety? I you answer this question "yes", please answer the following:

Yes No 4a. With regard to any condition referenced above, are you being treated so that such impairment is avoided?

Yes No 4b. With regard to any condition referenced above, are you in compliance with the recommended treatment?

Yes No 4c. With regard to any condition referenced above, has your treating physician advised you that you are able to practice medicine with reasonable skill and safety?

4d. Please explain_____

4e. Identify your treating physician_____

Yes No 5. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism, or other sexual behavior disorders? Please describe.

_____

_____

Yes No 6. Have you ever been the subject of an investigation by any Federal, State, or Local agency having jurisdiction over controlled substances? If so, give particulars.

_____

_____

Yes No 7. Have you ever been denied a license, or the privilege of taking an examination before any medical examining board, or has a conditioned license been issued to you by any state medical board or licensing authority? If so, give particulars.

_____

_____

Yes No 8. Has your license to practice medicine in any state or country been voluntarily or involuntarily (i.e. by medical Board Order or any other form of disciplinary action) revoked, suspended, restricted, or conditioned by a Medical Board or other licensing authority? If so, give particulars.

_____

_____

Yes No 9. Have you ever been notified of any investigation by any state medical board, medical society, or any hospital of any complaints against you relative to the practice of medicine, or have you been reprimanded or censure by any medical society or licensing board? If so, give particulars.

_____

_____

Yes No 10. Have you ever been a defendant in any malpractice lawsuits, had any malpractice settlement, or have any pending? If so, give a detailed clinical explanation of each case on the Malpractice Liability Claims Information form as well as documentation of outcome (insurance papers or court documents).

Yes No 11. Have your hospital privileges been restricted or revoked? If so, give particulars.

_____

_____

Applicant Name_____ Last 4 digits of SSN _____ Date_____

Yes No 12. Have there ever been any criminal charges filed against you? This includes charges of disorderly conduct, assault or battery, or domestic abuse, whether the charges were misdemeanor, gross misdemeanor, or felony. This also includes any offenses which have been expunged or otherwise removed from your record by executive pardon. If so, submit a personal statement regarding the date of conduct, state and local jurisdiction in which the charges were filed, date of closure, what role you played, and the outcome.

Yes No 13. Have there ever been any charges or Driving While Intoxicated (DWI) or Driving Under the Influence (DUI) or other impaired driving offenses involving alcohol or other chemical filed against you? If so, submit a detailed personal statement regarding the date of conduct, state and local jurisdiction in which the charges were filed, explaining in detail the incident and consequences including whether a CD evaluation was done (if so, submit results), and description of current drinking habits.

Yes No 14. Have you ever voluntarily or involuntarily surrendered your DEA certificate or the right to prescribe controlled substances? If so, give particulars.

_____

_____

Applicant Name_____ Last 4 digits of SSN _____ Date_____

NCMB - Physician Renewal - Questions (Step 1 of 23)

Alice _testalice

Complaint includes, but is not limited to, any instance where any person or organization has raised a concern regarding you or your practice regardless of the outcome.

Investigation includes, but is not limited to, an inquiry into (in person or otherwise), examination or inspection of, or gathering of evidence or information regarding you or your practice regardless of the outcome. This also includes requests to meet with or appear before a professional licensing board or agency, formally or informally.

Registration includes, but is not limited to, a number, alphanumeric, or other unique identifier assigned to a health care provider allowing them to perform specific medical acts (such as the DEA registration number issued by the U.S. Drug Enforcement Administration allowing health care providers to issue prescriptions for controlled substances).

Inquiry includes, but is not limited to, a request for information related to a concern regarding you or your practice regardless of the outcome.

1) Since you last renewed, are you aware of any complaint or investigation or inquiry, regarding you that has been received or conducted by the following

- Professional licensing board or agency (NCMB actions do not need to be included.)
- Local, state, federal, or other governmental agency
- Private or governmental insurance company or payor
- Hospital or other healthcare organization
- Professional certifying board

○ Yes ○ No

If you answer "yes", then a description is required:

You have 900 characters remaining for your description.

2) Since you last renewed, have you:

- Withdrawn a license or registration application
- Been denied a license or registration
- Surrendered a license or registration
- Had a license or registration restricted or limited in any way
- Placed a license or registration on inactive status while under investigation or threat of investigation

○ Yes ○ No

If you answer "yes", then a description is required:

You have 900 characters remaining for your description.

3) Since you last renewed have you engaged in the excessive use of alcohol, controlled substances or prescription drugs, or the use of illegal drugs, or received any therapy or treatment for alcohol or drug use? (If you are an anonymous participant in the NC Physicians Health Program and are in compliance with your contract, you may answer "No" to this question).

○ Yes ○ No

If you answer "yes", then a description is required:

You have 900 characters remaining for your description.

4) **Important:** The Board recognizes that licensees encounter health conditions, including those involving mental health and substance use disorders, just as their patients and other health care providers do. The Board expects its licensees to address their health concerns and ensure patient safety. Options include seeking medical care, self-limiting the licensee's medical practice, and anonymously self-referring to the NC Physicians Health Program (www.ncphp.org), a physician advocacy organization dedicated to improving the health and wellness of medical professionals in a confidential manner.

The failure to adequately address a health condition, where the licensee is unable to practice medicine with reasonable skill and safety to patients, can result in the Board taking action against the license to practice medicine.

5) Since you last renewed have you had a professional liability insurance policy cancelled, denied, or not renewed?

○ Yes ○ No

If you answer "yes", then a description is required:

You have 900 characters remaining for your description.

6) Since you last renewed have you been separated or discharged other than honorably from U.S. military, Veteran's Administration, or public health service?

○ Yes ○ No

If you answer "yes", then a description is required:

You have 900 characters remaining for your description.

7) Since you last renewed are you aware of any reports made about you to the National Practitioner's Data Bank (NPDB)?

Please Note: If you answer "yes" because a report was made to NPDB as a result of a malpractice judgment, award, settlement or payment then you must also report that malpractice information when you get to Step 6.

○ Yes ○ No

If you answer "yes", then a description is required:

You have **900** characters remaining for your description.

8) Please see the public notice statement below and then check the box below to certify that you have read it.

☐ I have read and understand the public notice statement

9) In the past five (5) years, have you been investigated for employee misclassification as defined in the public notice statement below? If yes, please list the result of each occurrence.

○ Yes ○ No

If you answer "yes", then a description is required:

You have **900** characters remaining for your description.

Public Notice Statement

Required by N.C. Gen. Stat. § 143-764(a)(5), effective December 31,2017

Any worker who is defined as an employee by N.C. Gen. Stat. §§ 95-25.2(4)(NC Department Of Labor), 143-762(a)(3)(Employee Fair Classification Act), 96-1(b)(10)(Employment Security Act), 97-2(2)(Workers' Compensation Act), or 105-163.1(4)(Withholding; Estimated Income Tax for Individuals) shall be treated as an employee unless the individual is an independent contractor. Any employee who believes that the employee has been misclassified as an independent contractor by the employee's employer may report the suspected misclassification to the Employee Classification Section within the North Carolina Industrial Commission.

Employee Classification Section
North Carolina Industrial Commission
1233 Mail Service Center
Raleigh, NC 27699-1233
Telephone: (919) 807-2582
Fax: (919)715-0282
Email: emp.classification@ic.nc.gov

Employee misclassification is defined as avoiding tax liabilities and other obligations imposed by Chapter 95, 96, 97, 105, or 143 of the North Carolina General Statutes by misclassifying an employee as an independent contractor. *[N.C. Gen. Stat. § 143-762(5)]*

Wyoming

Wyoming Board of Medicine

Application to Renew License to Practice Medicine in Wyoming for the period July 1, 2018, through June 30, 2019

Note to Physician: Please carefully proofread your responses on this form before submitting it. You are responsible for all information on this form, including any errors or omissions.

CHECK ONE BOX:

☐ Renew my license (**Submit $275 fee**)
☐ Do not renew my license (State reason)
_____
☐ I hold an emeritus license*
☐ I hold an inactive license*

* Applicant **must** complete and return the applicable status affidavit available at **http://wyomedboard.wyo.gov** or by calling the Board at 307.778.7053

PLEASE PRINT:

Last Name: _____
First Name: _____
Middle Name/Initial: _____
License No.: _____

IMPORTANT: *Failure to (a) answer any question, (b) provide specific details regarding affirmative answers, or (c)* ***enclose the required $275 renewal fee****, will delay the processing of your application for renewal.*

Answer questions ONLY as they relate to the period since you last renewed, through present.

I. DISCIPLINARY, COMPETENCY AND HEALTH INFORMATION:	*Yes*	*No*
A. Since you last renewed your license, have you been convicted of, pled guilty or nolo contendere to, or had or have charges pending against you for any crime including felonies, misdemeanors, municipal ordinances, and/or Military Code of Justice violations (including, but not limited to, driving under the influence of any intoxicating substance, but not including non-moving traffic violations or moving violations which do not involve alcohol or substance impairment)?	☐	☐
If your answer to this question is "Yes," please provide a complete written explanation including, but not limited to: a. The name and location of the court where you were charged and the docket number of your case; b. The offense(s) to which you pled or of which you were found guilty; c. All terms of the sentence imposed, including fines, restitution, etc.; d. Whether you have completed the sentence; e. The date the sentence was imposed; and, f. If applicable, the name, address and telephone number of your probation officer. Attach to this renewal application form a copy of the sentencing order and any orders indicating that the sentence has been completed.		
	Yes	*No*
B. Since you last renewed your license, have you developed any medical condition which, in any way, impairs or limits, or might impair or limit, your ability to safely and skillfully practice medicine?	☐	☐
If your answer to this question is "Yes," please provide a complete written explanation for each such condition including, but not limited to: a. The diagnosis; b. The treatment plan and prognosis; c. The name, address and telephone number of your treating physician(s); d. The manner in which the condition impairs or may impair your ability to safely and competently practice medicine; e. Any restrictions or conditions imposed upon your practice by any licensing agency or health care facility due to such condition; and, f. How you are accommodating the condition in your practice. Attach to this renewal application form the most recent medical records and/or a written report from your treating physician(s) describing the diagnosis, the current treatment regime, a prognosis and any limitations arising from the condition.		

	Yes	No
C. Since you last renewed your license, have you been hospitalized for, missed work because of, or been significantly impaired by any mental or emotional condition?	☐	☐
If your answer to this question is "Yes," please provide a complete written explanation for each such condition including, but not limited to: a. The circumstances and the diagnosis; b. The treatment you are undergoing and the prognosis; c. The name, address and telephone number of your treating professional(s); d. The manner in which the condition impairs or may impair your ability to safely and competently practice medicine; e. Any restrictions or conditions imposed upon your practice by any licensing agency or health care facility due to such condition; and, f. How you are accommodating the condition in your practice. Attach to this renewal application form the most recent medical records and/or a written report from your treating professional(s) describing the diagnosis, the current treatment regime, a prognosis and any limitations arising from the condition.		
	Yes	**No**
D. Since you last renewed your license, have you been evaluated, diagnosed or treated for any substance abuse disorder including, but not limited to, alcohol, tranquilizers, sedatives, psychoactive medications, cocaine, marijuana, opiates, benzodiazepines or any other narcotic or potentially-addicting substance? NOTE: If you have a fully-executed contract in force with the Wyoming Professional Assistance Program ("WPAP"), you may answer "No" to this question.	☐	☐
If your answer to this question is "Yes," please provide a complete written explanation for each such substance including, but not limited to: a. The substance(s) in question; b. The treatment you are undergoing and the prognosis; c. The name, address and telephone number of your treating professional(s); d. Any restrictions or conditions imposed upon your practice by any licensing agency or health care facility due to such condition; and, e. How you are accommodating the condition in your practice. Attach to this renewal application form any agreement between you and any professional assistance program, Alcoholics Anonymous, or any other rehabilitation and/or monitoring group.		
	Yes	**No**
E. Since you last renewed your license, have you been reprimanded, demoted, disciplined, cautioned, placed on probation, been placed on or taken leave (except vacation leave), or been terminated by any employer, educational institution or training program for any reason?	☐	☐
If your answer to this question is "Yes," please provide a complete written explanation for each such action taken against you including, but not limited to: a. A detailed description of the circumstances and event(s) leading to the action(s); b. The effective date of the action(s); c. The name, address and telephone number of the persons and/or entities taking action(s); d. Any restrictions or conditions imposed upon your practice due to such action(s); e. The resolution and/or current status of such action(s); and, f. How you are accommodating the action(s) in your practice. Attach to this renewal application form all documents pertinent to the action(s).		
	Yes	**No**
F. Since you last renewed your license, have you been under investigation or had or have any adverse charges or complaints filed against you by: any education training program or facility; medical licensing board; local, state, federal or military professional or disciplinary body; any hospital privileging or credentialing body or grievance committee; or any other medical group, including medical societies and specialty boards?	☐	☐
If your answer to this question is "Yes," please provide a complete written explanation for each such action taken against you including, but not limited to:		

a. The charge(s) against you; b. A detailed description of the circumstances and event(s) leading to the action(s); c. The effective date of the action(s); d. The name, address and telephone number of the persons and/or entities taking action(s); e. Any restrictions or conditions imposed upon your practice due to such action(s); f. The resolution and/or current status of such action(s); and, g. How you are accommodating the action(s) in your practice. Attach to this renewal application form all documents pertinent to the action(s).		
	Yes	***No***
G. Since you last renewed your license, have you been denied licensure, privileges or membership by any licensing board, hospital medical facility, professional society, specialty board, or medical body?	☐	☐
If your answer to this question is "Yes," please provide a complete written explanation for each denial including, but not limited to: a. The basis for denial; b. A detailed description of the circumstances and event(s) leading to the denial(s); c. The name, address and telephone number of the entity making the denial(s); d. The date the denial was issued. Attach to this renewal application form all records of the application and denial process including, but not limited to, final orders and/or findings.		
	Yes	***No***
H. Since you last renewed your license, have you withdrawn an application for licensure or privileges in any jurisdiction?	☐	☐
If your answer to this question is "Yes," please provide a complete written explanation for each withdrawal including, but not limited to: a. The name, address and telephone number of the entity to which you had applied; b. The license, privileges or membership applied for; c. The date you withdrew the application; d. The reason for your withdrawal; and, e. Whether the withdrawal was permitted by the entity in lieu of a denial of your application. Attach to this renewal application form all records of the application process and your withdrawal including, but not limited to, final orders and/or findings.		
	Yes	***No***
I. Since you last renewed your license, have you entered into any agreements, consent decrees, stipulations, conditions or restrictions with any other licensing boards?	☐	☐
If your answer to this question is "Yes," please provide a written explanation for each situation including, but not limited to: a. A detailed description of the circumstances and event(s) leading to the agreement, consent decree, stipulation, condition or restriction; b. The name, address and telephone number of the licensing board with which you have the agreement, consent decree, etc. c. The effective date of the action(s); d. The resolution and/or current status of each agreement, consent decree, etc.; and, g. How you are accommodating the agreement, consent decree, etc. in your practice. Attach to this renewal application form all documents related to such actions including, but not limited to, the final agreement(s), consent decree(s), stipulation(s), condition(s), and restriction(s) and related orders and/or findings.		

[REMAINDER OF THIS PAGE INTENTIONALLY LEFT BLANK.]

II. LIABILITY INFORMATION:	Yes	No
A. Since you last renewed your license, have any professional liability claims been filed against you?	☐	☐
If your answer to this question is "Yes," please indicate how many claims have been filed and provide a complete written explanation for each claim including, but not limited to: a. The name and location of the court where the action was filed and the docket number of the case; b. The allegations of the claim against you; c. If applicable, the date and manner in which the claim was resolved; and, d. The amount, if any, paid to the claimant by you and/or your insurance carrier; Attach to this renewal application form all records of the application process and your withdrawal including, but not limited to, final orders and/or findings.		
	Yes	**No**
B. Since you last renewed your license, has any professional liability insurance carrier terminated your coverage?	☐	☐
If your answer to this question is "Yes," please provide a complete written explanation including, but not limited to: a. The name, address and telephone number of the company which terminated coverage; b. The basis for termination; and, c. The effective date of the termination. Attach to this renewal application form all records of the application process and your withdrawal including, but not limited to, final orders and/or findings.		

III. DEMOGRAPHIC INFORMATION:

A. ADDRESS

Office Address: (Published on Web Site)			
City:		State:	ZIP:
Office Phone:		Fax:	E-mail: (Not published)
All Board correspondence with you will be sent to this address:			
Mailing Address: (NOT published on Web Site)			
City:		State:	ZIP:

B. AREA OF PRACTICE

☐ Administration	☐ Clinic	☐ Consultant	☐ Direct Patient Care
☐ Government	☐ Hospitalist	☐ Locum Tenens	☐ Medical Teaching
☐ Military	☐ Permanent Part-Time Clinic	☐ Research	☐ Resident in Training
☐ Retired	☐ Tele-Medicine		

C. SPECIALTY

Specialty:	Sub-Specialty:	
Board Certified? ☐ Yes ☐ No	Board name:	Expires:
	Board name:	Expires:
	Board name:	Expires:

IV. CONTINUING MEDICAL EDUCATION:

Physicians renewing an active or emeritus license to practice medicine in Wyoming must verify satisfactory completion of at least 60 hours of qualified CME in the preceding three years. Please indicate below whether you have completed the required 60 hours of qualified CME since July 1, 2015, or, if you have not, indicate the reason you are not subject to the requirement, or request an extension of the deadline for completion of CME:

1. ☐ I verify that I have completed at least 60 hours of qualified CME since July 1, 2015

OR

2. ☐ I am exempt from the CME requirement because (check one):

☐ (a) As of July 1, 2018, I have held an initial Wyoming medical license for less than 3 years.

☐ (b) In the past 3 years I have been certified or recertified by an ABMS-member board.

☐ (c) I am currently, or in the last 3 years have been, enrolled in an ACGME- or RCPSC-approved residency program.

☐ (d) I hold an inactive license to practice in Wyoming, and am submitting herewith an affidavit to that effect. ***You must submit an affidavit to the Board office. The form is available on the Board's web page (http://wyomedboard.state.wy.us) or by calling the Board office (307-778-7053)***

☐ (e) Due to circumstances ***beyond my control*** (ex: temporary disability, mandatory military service or officially-declared disaster), I request an exemption from (check one) part ☐ all ☐ of the CME requirements for this year. The reason(s) for requesting this exemption is (Please be specific in stating reason(s) and whether you are requesting a partial or full exemption):

You will be notified in writing whether your request for exemption has been granted and, if so, whether it is for part or all of the CME requirement.

OR

3. ☐ I HAVE NOT COMPLETED at least 60 hours of qualified CME since July 1, 2015, and DO NOT QUALIFY FOR ANY EXEMPTIONS. I am requesting the Board to grant an extension of the deadline for up to one (1) year to complete the required CME credits. The good cause for granting me this extension is (Please be specific):

You will be notified in writing whether your request for an extension has been granted and, if so, the length of the extension (not to exceed one year).

By my signature I certify that all information provided in and on this renewal application and any materials submitted herewith is true and accurate. I understand that the omission or misrepresentation of any information on this renewal application or attached materials constitutes grounds for possible investigation of, disciplinary action affecting, and/or denial of renewal, of my license to practice medicine in Wyoming.

Signature	Printed/Typed Name	Date

RETURN *WITH RENEWAL FEE* TO:

Wyoming Board of Medicine
130 Hobbs Avenue, Suite A
Cheyenne, WY 82002

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Login

Ready to Register your license? Check **eligibility**, and then enter your license number and your Social Security Number below.

There are five simple steps to submit your online license renewal:

1. Please note that if you are not able to complete your online license renewal, your data will be automatically saved for you for 15 days. Upon your return to complete the renewal, you will be given the option to use your saved application or to begin again.
2. Enter your License Number and the last 4 digits of your Social Security Number (do not add spaces).
3. Review, confirm or update your information, and complete your registration.
4. Pay registration fees with MasterCard, Visa, Discover, American Express, or Electronic Check.
5. View and print receipt.

For information on registration fees click here

License Number (e.g. H1234, TM12345, AM12345, PH12345)

Last 4 digits of Social Security Number (numbers only - e.g. 1234)

Continue | Reset

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Confirm Login

Congratulations you are eligible to register your license online.

Name:
License Number:
License Type:
Registration Fee:
Degree:

If you are not please return to the Login Page using the "Return to Login" button below. If this problem persists please contact your licensing agency.

For information on registration fees click here.

Continue | Return to Login

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Practice Information

Please review the following information regarding your primary medical practice. Answer each question to the best of your knowledge, some answers may allow more than one response.

* = required information
** = optional information

1. Primary Type of Practice (select one): *

2. Primary Practice Setting (select one): *

Number in Group:

3. Do you conduct office-based anesthesia (OBA), excluding Level I, as either:

a. an operating surgeon performing a procedure for which anesthesia services are provided in an outpatient setting (including the use of analgesics and anxiolytics), or
b. a physician who provides anesthesia services to other physicians in an outpatient setting (including the use of analgesics and anxiolytics)?

(You are only required to register OBA locations in Texas)*

Note: Physicians who provide only Level I services are no longer required to register their OBA locations with TMB; however, they must meet all other requirements, including standards for qualified staff and equipment.

Click here for more details on office-based anesthesia and an explanation of the levels.

○ Yes
○ No

3. a) If you answered "Yes" to question 3, select the type of OBA provided at your primary practice address. "No" answers do not need to select a level.

Practice Hours

4. a) Total number of hours, on average, you practice each week (select one): *

Please Select

4. b) Of your total practice hours, how many per week are spent in your primary practice location (select one): *

Please Select

5. How many years have you actively practiced medicine in United States or Canada (including postgraduate training)? *

3

6. Of the above active practice years, how many were in the state of Texas? *

3

7. Physician-designated practice specialties: Your profile currently states your practice specialty as: *

8. Your profile currently states your secondary specialty as:

Secondary Practice Information

Please review the following information regarding your secondary medical practice. If applicable, answer each question to the best of your knowledge.

9. Secondary Practice Zip Code:

10. Secondary Practice Zip Code Ext.:

11. Secondary Practice County:

12. Secondary Practice Setting (select one):

13. Number in Group:

Continue

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Contact Information

P.O. Boxes are not allowed for practice addresses; this must be a physical address even if it is an international address.

Name:
License Number:
Degree:
Gender:
Original Date of Texas License:
Expiration Date of Physician's Permit:

Please select here if you are Not in Practice (NIP) ☐
If you are not in practice, do not furnish a primary practice address.

*MAILING ADDRESS - REQUIRED
All correspondence will be mailed to this address.

Please note that licensee mailing **addresses** are considered public information and may be provided as part of an open records request, a TMB data product available for purchase or the TMB online verification.

Mailing Address 1:*
Mailing Address 2:
Mailing City:*
Mailing State:*
Mailing Zip Code:*
Mailing Zip Code Ext:
Mailing Province/Country:*

*PRIMARY PRACTICE ADDRESS - REQUIRED
If you selected Not In Practice (NIP) above, do not furnish a primary practice address.

Primary Practice Address 1:*
Primary Practice Address 2:
Primary Practice City:*
Primary Practice State:*
Primary Practice Zip Code:*
Primary Practice Zip Code Ext:
Primary Practice County (Texas only):
Primary Practice Country/Province:*

Emergency Phone and Email Addresses - Please note the Texas Occupations Code, Section 156.006 requires that this information be provided if available.

Emergency Phone Number: (e.g., 5121234567)
Emergency Email Address: (e.g., john@doe.com)
Confirm Emergency Email Address: (e.g., john@doe.com)

If you do not wish to receive the TMB newsletter or other non-emergency communications (rule updates, press releases, etc.) from TMB by e-mail please uncheck here. Please note that the TMB newsletter is no longer available in paper copy and can only be provided electronically. ☑

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Office Based Anesthesia - Address Info

Please select a choice that best describes your situation.

Please select the option that best describes your practice of office based anesthesia (OBA):

- (●) I am a physician who performs procedures in an office based setting where anesthesia is provided by an anesthesiologist or certified registered nurse anesthetist (CRNA) who is a member of my practice. All equipment and additional personnel are provided by my office.
- ( ) I am a physician who performs procedures in an office based setting. My office provides the required equipment. The anesthesia provider and additional personnel is provided by an anesthesia service.
- ( ) I am a physician who performs procedures in an office based setting. The anesthesia provider, all equipment and additional personnel are provided by an anesthesia service.
- ( ) I am a physician who provides anesthesia to office based physicians. All equipment and additional personnel are provided by the anesthesia service I work for.
- ( ) I am a physician who provides anesthesia to office based physicians. All equipment and additional personnel are provided by the surgeon's office.
- ( ) I am a physician who provides anesthesia to office based physicians. All equipment is provided by the surgeon's office, any additional personnel is provided by the anesthesia service I work for.

Enter the address and OBA type for all other locations where OBA is practiced. You are allowed to list five (5) addresses (not including primary practice). * indicates required field.

Street Address 1*	Street Address 2	City*	ZIP*	ZIP extension	OBA Type*
					Select an OBA Type...

Add

Street Address 1	Street Address 2	City	Zip	Zip Extension	OBA Type	Edit	Delete

Continue

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EMS off-line Medical Director

An EMS Medical Director is defined in Board rule 197 as "A physician licensed by the board who is responsible for all aspects of the operation of an EMS system concerning provision of medical care. This physician may also be referred to as the off-line medical director."

* = required information

Please see Board rule 197, available on our website at: http://www.tmb.state.tx.us/page/board-rules for a complete listed of EMS off-line medical director requirements.

For information on the specific continuing education requirements for an EMS off-line medical director, please visit our website at: http://www.tmb.state.tx.us/page/renewal-physician-EMS

Are you an EMS off-line Medical Director as defined above? *

(●) Yes ( ) No

If yes, please select the EMS Provider(s) below:

EMS Provider County	EMS Provider	Start Date (MM/DD/YYYY)	End Date (MM/DD/YYYY)
	Select EMS Provider		

Add

EMS Providers

EMS Provider Name	EMS License Number	EMS Provider Status	Start Date (MM/DD/YYYY)	End Date (MM/DD/YYYY)	Update	Delete
					Edit	Delete

Continue

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Pain Management Clinics

The Texas Occupation Code, section 168.001, defines a "pain management clinic" as a publicly or privately owned facility for which a majority of patients are issued on a monthly basis a prescription for opioids, benzodiazepines, barbiturates, or carisoprodol, but not including suboxone.

Effective September 1, 2010, a pain management clinic may not operate in Texas without obtaining a certificate from the Texas Medical Board (TMB), unless an exception as defined in the Texas Occupation Code, section 168.002, is met.

Please note that a "yes" response to either of the questions below does not constitute the registration of pain management clinic ownership with the Texas Medical Board.

* = required information

Do you currently own or operate a pain management clinic in the state of Texas?* ○ Yes ○ No

Do you intend to own or operate a pain management clinic in the state of Texas in the future?* ○ Yes ○ No

Click here for more information on registration requirements for pain management clinics (including inspection information and locations that are exempt from registration).

Click here for more information on the continuing education requirements for pain management clinic personnel.

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ABMS/BOS Specialty Board Certification

Please review the American Board of Medical Specialties/Board of Osteopathic Specialties information listed below. You are allowed to list three (3) specialty certifications issued by a board that is a member of the American Board of Medical Specialties or the Bureau of Osteopathic Specialists. The information provided will be reported in your online profile.

List specialty certifications issued by a board that is a member of the American Board of Medical Specialties or the Bureau of Osteopathic Specialists:

Specialty Board Name	Certification Year YYYY
Select Board Certification	

Add

Continue

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Professional History

* = required information

1. Have you met current CME requirements of 1 hour Ethics, 11 hours Other Formal and 12 hours Informal for each year you are registering? If you are a newly licensed physician, you do not have to comply with CME requirements the first time you register and may answer "yes" to the CME question. See detailed information on requirements and exemptions *

○ Yes ◉ No

2. Since your last registration or submission of your license application, not including investigations and disciplinary actions by TMB, are there pending investigations, pending disciplinary matters, or final disciplinary actions against you by any licensing agency or health-care entity?: *

○ Yes ◉ No

If you check "Yes," please use the text box below to provide the details of the issue as well as the current status.

3. Since your last registration or submission of your license application, have you been arrested, fined, charged with or convicted of a crime, indicted, imprisoned, placed on probation, or received deferred adjudication? (Unless the offense involved alcohol or drugs, you may exclude: 1) traffic tickets; and, 2) violations with fines of $250 or less.) *

○ Yes ◉ No

If you check "Yes," please use the text box below to provide the details of the issue as well as the current status.

4. Since your last registration or submission of your license application, do you have any condition or behavior, including, but not limited to, any physical, mental or emotional condition, which has impaired, which could impair, or which is impairing or limiting, your ability to practice as a physician in a competent manner?: *

○ Yes ◉ No

If you check "Yes," please use the text box below to provide the details of the issue as well as the current status.

5. Since your last registration or submission of your license application, has your DEA registration been revoked or restricted?: *

○ Yes ◉ No

If you check "Yes," please use the text box below to provide the details of the issue as well as the current status.

6. Since your last registration or submission of your license application, have you been convicted of, or received deferred adjudication for, a felony, a Class A or Class B misdemeanor for a violation relating to: *

a. Medicare, Medicaid or insurance fraud: *

○ Yes ◉ No

b. the Texas Controlled Substances Act or intoxication or alcoholic beverage offenses: *

◉ Yes ○ No

c. Sexual or Assaultive offenses: *

○ Yes ◉ No

d. Tax Fraud or Evasion: *

○ Yes ◉ No

(required - Tex. Occ. Code, Sec. 156.001(e))

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Health Care Liability Lawsuits & Settlements - Report Summary

Please be aware that in order to add or edit lawsuit or settlement information, you must complete the entire form. If you do not have all the required information at this time (ex. cause number), please download the hardcopy Health Care Liability Claims Report form available at **http://www.tmb.state.tx.us/page/resources-special-topics** to submit your information to the TMB. If you do not have your complete information at this time, please click the **Continue** button below to proceed with your registration.

Lawsuits

Please review the Lawsuit Reports information listed below.

Please click the Add button to add a lawsuit report.

Add

Settlements

Settlement is defined in 22 TEX. ADMIN. CODE, Section 176(1)(c), and includes payment on a health care liability claim on which a lawsuit has not been filed, as well as any dismissal, settlement, or judgment in a lawsuit that is based on a health care liability claim.

Please review the Settlement Reports information listed below.

Please click the Add button to add a Settlement/Dismissal report.

Add

Continue

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Health Care Liability - Add Lawsuit

Texas Medical Board
P.O. Box 2018, MC-263
Austin, Texas 78768-2018
HEALTH CARE LIABILITY REPORT

PART I. COMPLETE FOR ANY COMPLAINT FILED IN A LAWSUIT. If this complaint has not already been reported to the TMB, by either you or your insurance company, send a copy of the Complaint and Expert Report to the Texas Medical Board (the "Board") at the address above. If an Expert Report is not filed with the Court at the time the lawsuit is filed, the Expert Report shall be filed with the Board within 30 days after it is received.

Please be aware that in order to add or edit lawsuit information, you must complete the entire form. If you do not have all the required information at this time (ex. cause number), please download the hardcopy Health Care Liability Claims Report form available at **http://www.tmb.state.tx.us/page/resources-special-topics** to submit your information to the TMB. If you do not have your complete information at this time, please click the "Cancel" button below to proceed with your registration.

Please select your primary insurer from the list below. If you are unable to locate your primary insurer on the list, please select "OTHER".

Primary Insurer: Select Insurance Company

Plaintiff's Name:

Injured party first name:

Injured party last name:

Policy Number:

Date claim reported to insurer/self-insured licensee (mm/dd/yyyy):

Cause Number:

(Cause numbers must be between 5 and 20 characters; no spaces or commas allowed and may contain numbers, letters and the special character "-". Cause numbers containing all zeros are not valid and will not be accepted.)

Please select the court in which you filed your complaint. If you are unable to locate the court on the list, please select "ALL OTHERS".

Court: Select Court

County of Suit: Select County

Initial reserve amount after investigation (no commas - e.g. $1200):

(If a reserve is not determined within 30 days, report this data to the Board within 30 days after determination.)

Add Cancel

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Health Care Liability - Add Settlement

Texas Medical Board
P.O. Box 2018, MC-263
Austin, Texas 78768-2018
HEALTH CARE LIABILITY REPORT

PART II. COMPLETE UPON SETTLEMENT OF THE CLAIM. If this disposition has not already been reported to the TMB, by either you or your insurance company, send a copy of any Court Order or Settlement Agreement to the Board at the address above. "Settlement" is defined in 22 TEX, ADMIN, CODE, Section 176(1)(c), and includes payment on a health care liability claim on which a lawsuit has not been filed as well as any dismissal, settlement, or judgment in a lawsuit that is based on a health care liability claim.

Please be aware that in order to add or edit settlement information, you must complete the entire form. If you do not have all the required information at this time (ex. cause number), please download the hardcopy Health Care Liability Claims Report form available at **http://www.tmb.state.tx.us/page/resources-special-topics** to submit your information to the TMB. If you do not have your complete information at this time, please click the "Cancel" button below to proceed with your registration.

Plaintiff's Name:

Injured party first name:

Injured party last name:

Cause Number:

(Cause numbers must be between 5 and 20 characters; no spaces or commas allowed and may contain numbers, letters and the special character "-". Cause numbers containing all zeros are not valid and will not be accepted.)

Please select the court from the list below. If you are unable to locate the court on the list, please select "ALL OTHERS".

Court: Select Court

County of Suit: Select County

Date of Settlement(mm/dd/yyyy):

Type of Settlement: Select Settlement Type...

If Other (Please specify):

Amount of indemnity agreed upon or ordered on behalf of this defendant (no commas - e.g. $1200.00):

NOTE: If percentage of fault was not determined by the court or insurer in the case of multiple defendants, the insurer may report the total amount paid for the claim followed by a slash and the number of insured defendants (Example: $100000/3)

Appeal?
- Yes
- No
- Not known

If yes, which Party? Select a party...

Add Cancel

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Medical Schools Attended

Please review the following information regarding your medical schools attended. Changes can be made to those entries that are already present, and you are allowed up to four (4) medical schools attended. The following information will be reported in your profile.

Physicians who attended international medical schools: Fifth Pathway is a process by which a student who, after the completion of all the didactic work at a medical school located outside the US or Canada and satisfactory completion of one academic year of supervised clinical training in a US medical school Fifth Pathway program, is considered to have a degree equivalent to doctor of medicine or doctor of osteopathy.

** = optional information

Fifth Pathway Information: **

Completion Date (MM/YYYY)

Name of each medical school attended: **

Country: Select Country | Medical School: Select School | Graduation Date (MM/YYYY)

Add

Medical School Name	Graduation Date	Delete
		Delete

Continue

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Graduate Medical Education

Please review the following information regarding your graduate medical education. Changes can be made to those entries that are already present, and you will be allowed up to seven (7) graduate medical schools attended. The following information will be reported in your profile.

** = optional information

Describe all graduate medical education in the United States or Canada: **

Program Name | City/State | Type

Specialty | Begin Date (MM/YYYY) | End Date * (MM/YYYY)

*If you are currently in a program, enter your projected end date

Add

Program Name	City/State	Type	Speciality	Begin Date (mm/yyyy)	End Date (mm/yyyy)	Edit	Delete
						Edit	Delete

Continue

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Texas Hospital Privileges

Please review the following information regarding your Texas hospital privileges. Changes can be made to those entries that are already present, and you will be allowed to enter up to nine (9) hospitals or hospital names. The following information will be reported in your profile. If you see no hospital privileges currently displayed, and you enter none in this process, your profile will report "None" under the Texas Hospital Privileges section.

List Texas hospitals where you have privileges:

Hospital Name: City:

Add

Hospital Name	City	Edit	Delete
		Edit	Delete

Continue

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Patient Services Info

Please review the following information regarding your primary practice. The following information will be reported in your profile.

* = required information ** = optional information

List all language translating services, including services for persons with hearing impairment, that are available at your primary practice location (If you leave this field blank, your profile will report "None" in the Language Translating Services section). **

Do you participate in the Medicaid program? *

○ Yes ◉ No

Is your patient service area accessible to persons with disabilities, as defined by federal law(Americans with Disabilities Act***)? *

◉ Yes ○ No

*** Title III of the Americans with Disabilities Act, Public Accommodations and Services Operated by Private Entities, 42 USC Sec. 12183, sets out the requirements to be met in a professional office of a health care provider. Discrimination against persons with disabilities with respect to the full and equal enjoyment of goods, services, facilities, privileges, advantages, or accommodations is prohibited.

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Additional Information

AWARDS AND HONORS

The following information will be reported in your profile.

You may submit descriptions of up to five Awards, Honors, Publications, and Academic Appointments.

Awards, Honors, Publications, and Academic Appointments:

ADDITIONAL INFORMATION

Please verify your previously reported race and origin. Modify as necessary.

Select your race from the list provided: *

Are you of Hispanic Origin? *

○ Yes ◉ No

If you would like to include your race and origin in your Physician Profile, please check here: ☑

You have previously reported your place of birth as:
TEXAS

If you would like to include your place of birth in your Physician Profile, please check here: ☑

Please verify your county of high school graduation (Texas high school graduates only). Modify if needed.

Do you provide utilization review services for a group health plan provided by an insurance company? (This does not include utilization review provided in relation to workers compensation claims.)

○ Yes ◉ No

Continue

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Physician Profile

If you believe any of this information is in error, please send a letter to the TMB.

Your physician profile will report the description of final resolution taken by TMB on medical malpractice claims or complaints required to be opened by the TMB under Tex. Occ. Code Ann. §164.201 (Vernon 2000) as follows:

None

Your physician profile will report any filings, actions or restrictions taken against you, including formal complaints, petitions and/or responses related to licensure contested matters at the State Office of Administrative Hearings, and a description of any formal complaint file at the State Office of Administrative Hearings.

No formal complaints or disciplinary action.

STATUS INFORMATION

Registration Status:

Disciplinary Status:

Licensure Status:

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Review

After you have reviewed the registration information submitted, please select the pay option at the bottom of the page to continue. If you need to correct or add any information, please use the links on the left of the screen to navigate thru the registration steps.

For information on registration fees click here

Contact Information:

Name:	
License Number:	
License Type:	
Registration Fee:	
Degree:	
Mailing Address 1:	
Mailing Address 2:	
Mailing City:*	
Mailing State:*	
Mailing Zip Code:*	
Mailing Zip Code Ext:	
Mailing Province/Country:*	
Not In Practice checked:	

Primary Practice Address 1:*	
Primary Practice Address 2:	
Primary Practice City:*	
Primary Practice State:*	
Primary Practice Zip Code:*	
Primary Practice Zip Code Ext:	
Primary Practice County (Texas only):	
Primary Practice Country/Province:*	

Emergency Phone Number: (e.g., 5121234567)	
Emergency Email Address: (e.g., john@doe.com)	
Confirm Emergency Email Address: (e.g., john@doe.com)	
Receive non-emergency communications	

Practice Information:

Primary type of practice:	
Primary practice setting:	
Number in group:	
Office based anesthesia:	
Type of OBA:	
Practice hours:	
Primary practice hours:	
Years of practice in US:	
Years of practice in Texas:	
Primary Speciality	
Secondary Speciality	
Secondary Practice Zip Code:	
Secondary Practice Zip Code Ext.:	
Secondary Practice County:	
Secondary Practice Setting:	
Number in secondary group	

Office Based Anesthesia:

OBA Description:	

Secondary OBA practices:

Address 1	Address 2	City	Zip	Zip Ext.	Type

Emergency Medical Service director:

EMS Provider Name	EMS License Number	EMS Provider Status	Start Date (MM/DD/YYYY)	End Date (MM/DD/YYYY)

Pain Management Clinics:

Do you currently own or operate a pain management clinic in the state of Texas?* ◉ Yes ○ No

Do you intend to own or operate a pain management clinic in the state of Texas in the future?* ◉ Yes ○ No

Specialty Board:

Issuing Board	Effective Date

Professional History:
Since your last registration or submission of your license application:

Have you met current CME requirements of 1 hour Ethics, 11 hours Other Formal and 12 hours Informal for each year you are registering?	
Any pending investigations, pending disciplinary matters, or final disciplinary actions against you by any licensing agency or health-care entity?	
Have you been arrested, fined, charged with or convicted of a crime, indicted, imprisoned, placed on probation, or received deferred adjudication? (Unless the offense involved alcohol or drugs, you may exclude: 1) traffic tickets; and, 2) violations with fines of $250 or less.)	
Any condition or behavior, including, but not limited to, any physical, mental or emotional condition, which has impaired, which could impair, or which is impairing or limiting, your ability to practice as a physician in a competent manner?	
Has your DEA or DPS registration been revoked or restricted?	

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Physician Profile

Please note that the following information is required to be part of the online physician profile and available to the public per Board rule 173.1. Failure to respond completely and truthfully may result in disciplinary action.

Disciplinary Action by Other States

Description of Disciplinary Action by Other States Previously Reported (You cannot change the information in this area. This is for viewing only):

Describe any disciplinary action taken against you by a medical or osteopathic board of another state. Description should include the name of the state board and the action taken. If no action by another state is listed, you are certifying that you have none and your profile will report "none". A total of 1000 characters will be allowed.

Description of Disciplinary Action(s) by Other States (You may enter information in this area. The information you enter will be added to the information previously reported):

Criminal Charges and Convictions

Description of Criminal Charges and Convictions Previously Reported (You cannot change the information in this area. This is for viewing only):

List all charges and convictions of any offense constituting a felony, Class A or B misdemeanor, or Class C misdemeanor involving moral turpitude. This list must include those offenses to which you have pled no contest or nolo contendre, accepted deferred adjudication or pretrial diversion, or in which sufficient facts of guilt were found and the matter was continued by a court of competent jurisdiction. You are not required to report charges that are pending, or that have been dismissed without first being placed on deferred adjudication or pretrial diversion. If you have been convicted, but are appealing, you do have to report this information.

You must describe any such charges and convictions in the space below. Description should include the type of charge or offense, the type of action (No Contest, Deferred Adjudication, Pre-Trial Diversion or Conviction), date of conviction or other action, city/state and court name. If no charges or convictions are listed, you are certifying that you have none that meet the stated criteria and your profile will report "none". A total of 1000 characters will be allowed.

Description of Criminal Charge(s) and/or Convictions as Described Above (You may enter information in this area. The information you enter will be added to the information previously reported):

Medical Malpractice Jury Awards

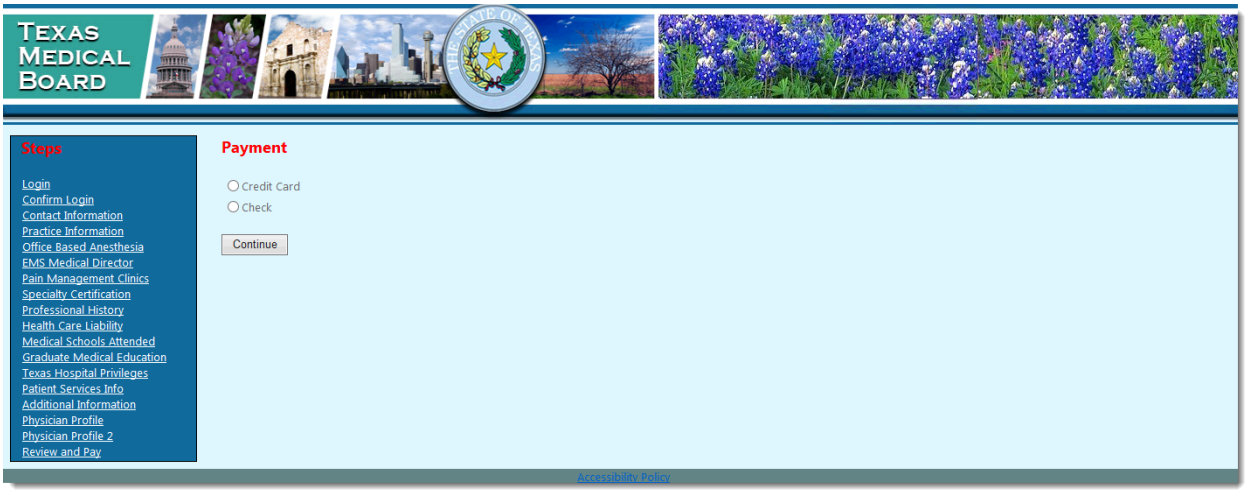
Description of Medical Malpractice Claims Previously Reported (You cannot change the information in this area. This is for viewing only):

You may enter information in this area. The information you enter will be added to the information previously reported. Describe any medical malpractice claims against you, for which all of the following apply:

1. for which you were found liable,
2. a jury awarded monetary damages to the claimant, and
3. the award has been determined to be final and not subject to further appeal.

You do not have to include a description of any offers by you to settle the claim. If no claims are listed, you are certifying that you have none that meet the stated criteria and your profile will report "none".

Continue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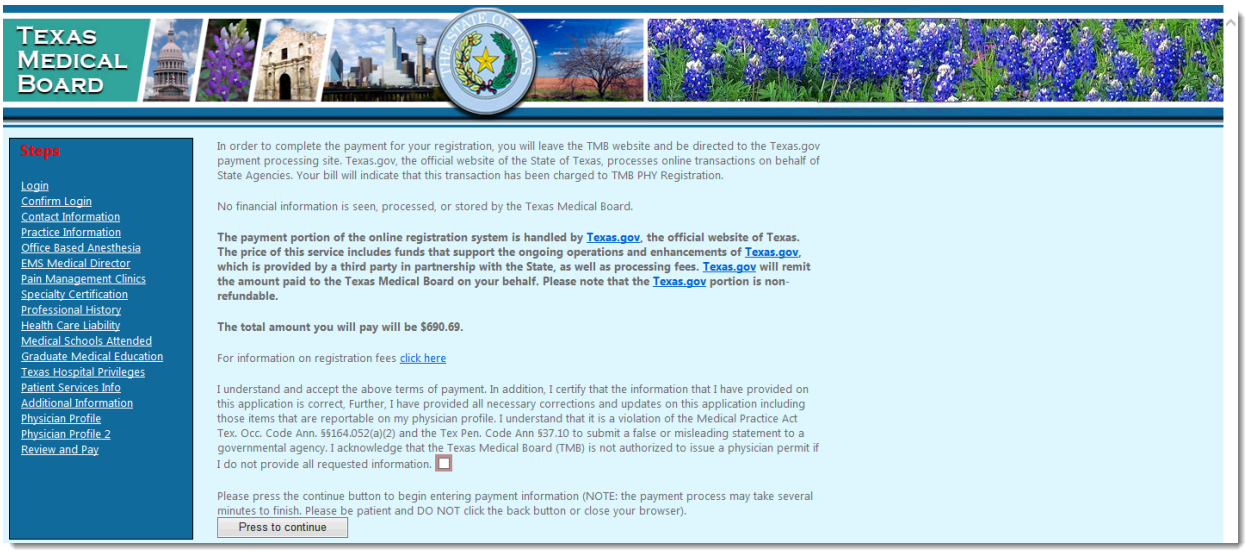
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In order to complete the payment for your registration, you will leave the TMB website and be directed to the Texas.gov payment processing site. Texas.gov, the official website of the State of Texas, processes online transactions on behalf of State Agencies. Your bill will indicate that this transaction has been charged to TMB PHY Registration.
No financial information is seen, processed, or stored by the Texas Medical Board.
The payment portion of the online registration system is handled by Texas.gov, the official website of Texas. The price of this service includes funds that support the ongoing operations and enhancements of Texas.gov, which is provided by a third party in partnership with the State, as well as processing fees. Texas.gov will remit the amount paid to the Texas Medical Board on your behalf. Please note that the Texas.gov portion is non-refundable.
The total amount you will pay will be $690.69.
For information on registration fees click here
I understand and accept the above terms of payment. In addition, I certify that the information that I have provided on this application is correct, Further, I have provided all necessary corrections and updates on this application including those items that are reportable on my physician profile. I understand that it is a violation of the Medical Practice Act Tex. Occ. Code Ann. §§164.052(a)(2) and the Tex Pen. Code Ann §37.10 to submit a false or misleading statement to a governmental agency. I acknowledge that the Texas Medical Board (TMB) is not authorized to issue a physician permit if I do not provide all requested information.
Please press the continue button to begin entering payment information (NOTE: the payment process may take several minutes to finish. Please be patient and DO NOT click the back button or close your browser).
Press to continue

NIC the people behind eGovernment

Contact

1 Payment Type | 2 Customer Info | 3 Payment Info | 4 Submit Payment

Transaction Detail

When you complete this transaction, Texas.gov will remit the following amounts to the agency on your behalf.

SKU	Description	Unit Price	Quantity	Amount
4416	PHY RENEWAL	$467.45	1	$467.45
4442	PHYSICIAN RENEWAL OBA	$210.00	1	$210.00
5515	PHY PMP FEE	$13.24	1	$13.24
Total				$690.69

Payment

Payment Type ✓

Credit Card

Customer Information

Complete all required fields [*]

Transaction Summary

PHY RENEWAL	$467.45
PHYSICIAN RENEWAL OBA	$210.00
PHY PMP FEE	$13.24
Texas.gov Administration Fee	$0.00
Texas.gov Price	**$690.69**

Texas.gov Price **$690.69**

Need Help?

Please complete the Customer Information Section

NIC the people behind eGovernment

Contact

Payment Info

Complete all required fields [*]

Credit Card Number *

Credit Card Type

Expiration Month *

Select a Month

Expiration Year *

Select a Year

Security Code *

Name on Credit Card *

Next

Cancel

Transaction Summary

PHY RENEWAL	$467.45
PHYSICIAN RENEWAL OBA	$210.00
PHY PMP FEE	$13.24
Texas.gov Administration Fee	$0.00
Texas.gov Price	**$690.69**

Need Help?

You have selected to pay by credit card. Complete Customer Billing Information and enter Credit Card Information.

NIC the people behind eGovernment

Contact

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Transaction Detail

When you complete this transaction, Texas.gov will remit the following amounts to the agency on your behalf.

SKU	Description	Unit Price	Quantity	Amount
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Total				$690.69

Payment

Transaction Summary

PHY RENEWAL	$467.45
PHYSICIAN RENEWAL OBA	$210.00
PHY PMP FEE	$13.24
Texas.gov Administration Fee	$0.00
Texas.gov Price	**$690.69**

Need Help?

Review payment information. You may edit Billing and Payment Method here if needed. When complete, select Make Payment. You will receive a printable receipt at the end of your successful payment transaction.

Payment

Payment Type ✓

Credit Card

Customer Information ✓

Edit

Address **Phone**

Payment Info ✓

Edit

Credit Card **Name on Credit Card**

Verification

VHNYD

Enter the characters from the above image:

Transaction Summary

PHY RENEWAL	$467.45
PHYSICIAN RENEWAL OBA	$210.00
PHY PMP FEE	$13.24
Texas.gov Administration Fee	$0.00
Texas.gov Price	**$690.69**

Need Help?

Review payment information. You may edit Billing and Payment Method here if needed. When complete, select Make Payment. You will receive a printable receipt at the end of your successful payment transaction.

Cancel

Submit Payment

If there are problems with how this message is displayed, click here to view it in a web browser.

From: noreply@TMB.state.tx.us
To:
Cc:
Subject: Texas Medical Board Payment Receipt

Payment Receipt Confirmation

Your payment was successfully processed. You may print this receipt page for your records by selecting Print.

Transaction Summary

Description		Amount
		$690.69
Texas.gov Administration Fee		$0.00
TMB Phy Registration	Texas.gov Price	$690.69

Customer Information		Payment Information	
Customer Name		Payment Type	
Local Reference ID		Credit Card Type	
Receipt Date		Credit Card Number	
Receipt Time		Order ID	
		Billing Name	

Billing Information			
Billing Address		Phone Number	
Billing City, State		Fax Number	
ZIP/Postal Code		This receipt has been emailed to the address below.	
Country		Email Address	