ALABAMA BOARD OF MEDICAL EXAMINERS
ADMINISTRATIVE CODE

CHAPTER 540-X-3
CERTIFICATE OF QUALIFICATION

540-X-3-Appendix-C **Application For A Certificate Of Qualification Under The Retired Senior Volunteer Physician Program (RSVP).**

Under Alabama law, this document is a public record and will be provided upon request.
Required demographic information:

Name in full (First, Middle, Last, M.D./D.O.)

Alternate name(s) used

Address (Street, City, State, Zip)

Email address

Place of birth

Date of birth

Social Security Number (Pursuant to Ala. Code § 30-3-194, it is mandatory that we request and that you provide your social security number (SSN) on this application. The uses of your SSN are limited to the purpose of administering the state child support program and intra-agency for identification purposes. If your SSN is not provided, your application is not complete and no license will be issued)

Sex

Telephone (H or C)

Telephone (W)
Required background information:

If your answer is "yes," please provide a detailed explanation in the space provided.
Legal:

1. Have you ever been arrested for, cited for, charged with, or convicted of any crime, offense, or violation of any law, felony, or misdemeanor, including, but not limited to, offenses related to the practice of medicine or state or federal controlled substances laws, or driving under the influence (DUI)?

*This question excludes minor traffic violations such as speeding and parking tickets but includes felony and misdemeanor criminal matters that have been dismissed, expunged, sealed, subject to a diversion or deferred prosecution program, or otherwise set aside.

2. Have you ever been arrested for, cited for, charged with, or convicted of any sex offender laws or required to register as a sex offender for any reason?

3. Have you ever had a judgment rendered against you or action settled relating to an action for injury, damages, or wrongful death for breach of the standard of care in the performance of your professional service ("malpractice")?

4. To your knowledge, as of the date of this application, are you the subject of an investigation or proposed action by any law enforcement agency?
Administrative/Regulatory:

5. Have you ever had any Drug Enforcement Administration registration and/or state controlled substances registration denied, voluntarily surrendered while under investigation, or subject to any discipline, including, but not limited to revocation, suspension, probation, restriction, conditions, reprimand, or fine?

6. Have you ever been denied a license to practice medicine in any state or jurisdiction or has your application for a license to practice medicine been withdrawn under threat of denial?

7. Has your certificate of qualification or license to practice medicine in any state or jurisdiction ever been subject to any discipline, including but not limited to revocation, suspension, probation, restrictions, conditions, reprimand, or fine?

8. Have your staff privileges at any hospital or health care facility ever been revoked, suspended, curtailed, limited, or placed under conditions restricting your practice?

9. To your knowledge, as of the date of this application, are you the subject of an investigation or proposed action by any federal agency, any licensing board/agency, or any hospital or health care facility?

Fitness to Practice:

10. Are you currently suffering from any condition that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical, and professional manner?

11. Within the past five years, have you raised the issue of any physical or psychiatric health disorder as a defense, mitigation, or explanation for your actions during any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination by an educational institution; employer; government agency; professional organization; or licensing authority?

12. The Board recognizes that licensees encounter potentially impairing health conditions just as their patients and other health care providers do, including psychiatric or physical illnesses which may impact cognition, as well as substance use disorders. The Board expects its licensees to address their health concerns, both mental and physical, in a timely manner to ensure patient safety. Licensees should seek appropriate medical care and should limit their medical practice when appropriate and as needed. The Board encourages licensees to utilize the services of the Alabama Professionals Health Program, 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.

I have read and understand the statements above.

[Applicant Attestation]

Education/Training/Experience:

13. As of the date of this application, has it been more than two years since the last time you were actively engaged in clinical practice or direct patient care?

14. Has your medical education, training, or medical practice been interrupted or suspended, or have you ceased to engage in direct patient care, for a period longer than 60 days for any reason other than a vacation or for the birth or adoption of a child?

15. Have you ever been placed on academic or disciplinary probation by, or been required to remediate any portion of, a medical school or postgraduate program?

16. Were limitations or special requirements imposed on you because of questions of academic, clinical, or disciplinary problems, or any other reason during your medical education or postgraduate training, such as repeating a class or classes or taking time off from school to study for an examination?

17. Have you ever been disciplined for unprofessional conduct/ behavior reasons by a medical school or postgraduate program?

18. Pre-Medical education: List all schools attended, undergraduate and post-graduate work other than medical school, dates attended, and degree conferred.

19. Medical School: List all medical schools attended, dates, and complete addresses of institutions. Do not list post-graduate medical education training.

20. Post-Graduate medical education training: List all post-graduate medical education training since graduation from medical school, dates, and complete addresses of institutions. Do not list practice experience.

Certification:

1. I hereby certify that I am now or was licensed to practice medicine in the states of [list states], that my license to practice medicine in each of the states indicated is now or was on the date of expiration unrestricted and in good standing and that there are no currently pending disciplinary actions or investigations concerning my license in any of the states listed

above. I further certify that my license to practice medicine in the states listed above has never been revoked, suspended, placed on probation, or otherwise subject to disciplinary action and that I have not had my hospital medical staff privileges revoked, suspended, curtailed, limited, or surrendered while under investigation.

2. I certify that I am fully retired from the active practice of medicine; however, I wish to volunteer my services as a physician in a free medical clinic located in [city], Alabama, and it is my expectation that I will provide not less than 100 hours of voluntary services for the calendar year [year].

3. I understand and acknowledge that issuance of a certificate of qualification and license to practice medicine under the Retired Senior Volunteer Physician Program requires that I comply with the continuing medical education requirement for physicians as specified in Chapter 14 of the rules of the Alabama Board of Medical Examiners.

Release:

I, [name prints here], certify that all of the information supplied in the submitted application is true and correct to the best of my knowledge, that the photograph submitted is a true likeness of myself and was taken within sixty days prior to the date of this application. I acknowledge that any false or untrue statement or representation made in this application may result in the denial of this application or revocation of my license to practice medicine and criminal prosecution to the fullest extent of the law.

I further consent to and authorize the release of this application and any information submitted with it or information collected by the Alabama Board of Medical Examiners in connection with this application, including derogatory information, to any person or organization having a legitimate need for the information, and I release the Alabama Board of Medical Examiners from all liability for the release of this information. I further consent to and authorize the release of information, including derogatory information, which may be in the possession of other individuals or organizations to the Alabama Board of Medical Examiners, and I release this individual or organization from any liability for the release of information.

I understand and agree that by typing my name, I am providing an electronic signature that has the same legal effect as a written signature pursuant to Ala. Code §§ 8-1A-2 and 8-1A-7. I attest that the foregoing information has been provided by me and is true and correct to the best of my knowledge, information and belief.

Applicant’s typed name

Print or upload signed affidavit and release, attach color picture if not uploaded, and return original to the Alabama Board of Medical Examiners.

(Letterhead)

CERTIFICATION OF FREE CLINIC

DATE:_____

TO: State Board of Medical Examiners

This is to certify that _____, M.D./D.O. has agreed to perform no fewer than 100 hours of voluntary professional services annually at _____(Clinic Name), located at _____, Alabama, which is an established free medical clinic operating under the provisions of Ala. Code §6-5-660 and provides outpatient medical care to patients unable to pay for it.

I understand and agree that by typing my name, I am providing an electronic signature that has the same legal effect as a written signature pursuant to Ala. Code §§ 8-1A-2 and 8-1A-7. I attest that the foregoing information has been provided by me and is true and correct to the best of my knowledge, information and belief.

Clinic or Facility Administrator

Address

Telephone

Facsimile

Email

Author: Board of Medical Examiners
Statutory Authority: Code of Ala. 1975, §§34-24-70, 34-24-73, 34-24-75.
History: Repealed: Filed December 17, 1997; effective January 21, 1998. New Appendix: Filed January 21, 2005; effective February 25, 2005. **Amended:** Filed February 17, 2012; effective March 23, 2012. **Amended:** Filed July 22, 2013; effective August 26, 2013.

Amended: Filed March 20, 2014; effective April 24, 2014. **Amended:** Filed October 20, 2016; effective December 4, 2014. **Repealed and New Rule:** Filed February 27, 2018; effective April 14, 2018. **Amended:** Filed November 1, 2018; effective December 16, 2018. **Amended:** Published February 28, 2020; effective April 13, 2020. **Repealed and New Rule:** Published December 30, 2022; effective February 13, 2023. **Repealed and New Rule:** Published March 31, 2025; effective May 15, 2025.

Ed. Note: Appendix C was renamed Appendix B, and Appendix E was renamed Appendix C per certification filed February 27, 2018; effective April 14, 2018.