Print Form

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TENNESSEE 37243
www.tn.gov/health

TENNESSEE BOARD OF MEDICAL EXAMINERS
(800) 778-4123, ext. 532-4384 or (615) 532-3202, ext. 532-4384

APPLICATION INSTRUCTIONS FOR LICENSURE AS A MEDICAL DOCTOR

Provided below is a checklist for your personal use and convenience containing all items that must be completed before your application for a Tennessee medical license will be considered.

ALL APPLICATION FEES ARE NON-REFUNDABLE

1. Complete and mail application pages 1 through 6. _____

2. Complete and mail attachment 1 to your medical school for transcript of courses, grades, and degree. If you are an international medical school graduate, please consult the Board's policy on international medical schools to determine whether you must also direct your medical school to provide this office with documentation proving that its standards meet or exceed the accreditation requirements of the LCME (Liaison Committee on Medical Education). Documentation must be submitted in English. _____

3. Complete and mail attachment 2 to each institution in the U.S. at which you received postgraduate medical training. **DO NOT HAVE THIS (VERIFICATION OF POSTGRADUATE MEDICAL TRAINING) FORM COMPLETED UNTIL THE APPROPRIATE NUMBER OF YEARS OF POSTGRADUATE EXPERIENCE HAVE BEEN TOTALLY COMPLETED (3 YEARS FOR INTERNATIONAL GRADUATES OR 1 YEAR FOR U.S. AND CANADIAN GRADUATES).** _____

4. Complete and mail attachment 3 to each state, country, or province in which you hold or have ever held a license to practice any medical profession. _____

5. Submit a clear and recognizable recently taken bust photograph of yourself that shows the full head, face forward from at least the shoulders up. _____

6. Submit proof of citizenship in the United States or Canada or evidence of being legally entitled to live or work in the United States. (Notarized copies of birth certificates, naturalization papers, H-1 visas, or current passports are acceptable.) License will not be issued to holders of J-1 Training Visa. _____

7. Submit two (2) original letters of recommendation dated within the preceding six months from licensed medical doctors on the signatory's letterhead attesting to your good moral character. The letters must contain original signatures. _____

8. You must have successfully completed a medical licensure examination or an approved combination of examinations. If you are submitting USMLE scores, **all three steps must be taken and passed within ten (10) years of the first successful step unless you qualify under an exception (please consult the Board's policy on** . An applicant who fails any step of the USMLE or FLEX more than three (3) times must show ABMS board certification and proof of meeting requirements for Maintenance of Certification to be considered for licensure. Please refer to attachment 4 for information in obtaining scores. _____

9. If you are an international medical school graduate, you must submit one of the following**:** _____

a. A notarized copy of your original permanent E.C.F.M.G. Certificate;
b. If you graduated from a Mexican Medical School, a letter from the E.C.F.M.G. stating that all certificate requirements have been met; or
c. If you cannot obtain an original certificate due to the phase out of the E.C.F.M.G., proof of successful completion of U.S.M.L.E. Steps 1 and 2 submitted directly from the testing agency to the Board Administrative Office.

10. Complete and submit along with your application the *Practitioner Profile Questionnaire* which is online at http://tn.gov/assets/entities/health/attachments/PH-3585.pdf. You are required by law update your profile within 30 days of any change as long as you have an active license. Failure to do so may subject you to disciplinary action. _____

11. **Attach to the application and submit a check or money order in U.S. funds in the amount of $410, payable to the Tennessee Board of Medical Examiners.** _____

12. Pursuant to T.C.A. § 63-6-221, physicians who perform Level II office based surgery must so report at the time of initial application, reinstatement, or renewal of a medical license. Level II office based surgery means "level II surgery, as defined by the board of medical examiners in its rules and regulations, that is performed outside of a hospital, an ambulatory surgical treatment center, or other medical facility licensed by the Department of Health." The Board of Medical Examiners' rules regarding office based surgery, including definitions of Level II and Level III surgery, can be found at: http://www.state.tn.us/sos/rules/0880/0880-02.20150426.pdf. Please review these rules carefully if you perform level II procedures in your office. Under T.C.A. § 63-6-221, you are further required to report certain "unanticipated events" to the board of medical examiners within mandated time frames of the occurrence. To review T.C.A. § 63-6-221 please go to http://state.tn.us/sos/acts/105/pub/pc0927.pdf. It is imperative that you review this new law and adhere to it strictly. _____

13. A criminal background check is required. For instructions to obtain a criminal background check, go to http://tn.gov/health/article/CBC-instructions _____

14. All applicants must complete, sign and have notarized the Declaration of Citizenship form and submit the documents required by the Declaration of Citizenship form. The Declaration is available online at http://tn.gov/assets/entities/health/attachments/PH-4183.pdf. _____

UNDERSTANDING THE APPLICATION PROCESS

1. **All application fees are non-refundable. Accordingly, please familiarize yourself with the laws, rules and requirements for licensure prior to submitting your application.**

2. All documents and fees required to be submitted by you or which must be requested from the appropriate institutions in this application process must be mailed directly to:

   Tennessee Board of Medical Examiners
   665 Mainstream Drive
   Nashville, TN 37243 (37228 for courier service only)

3. **Allow fourteen (14) working days** for information mailed to our office to be received and placed in your file. Federal Express or special courier services will not appreciably reduce the processing time. Additionally, if Federal Express or special courier services are used, you will be responsible for charges incurred. The Board's Administrative Office asks that you please give the Board office every consideration in this matter.

4. If necessary documentation has not been received when your application has been received by the Board office, an initial deficiency letter will be sent to you. The supporting documentation requested in the letter must be received in the Board office ninety (90) days from the date of the initial deficiency letter. **(Files not completed within ninety (90) days may be closed.)**

5. Absent any complicating factors, the average application processing time is eight (8) weeks. Once the application is completed, your file will be reviewed and an initial licensure determination made. You will be notified by letter of the initial determination.

6. If an address change occurs at any time during the application process, you must notify the Board office, in writing, immediately.

7. You have the option to receive all correspondence from the Department of Health electronically. Should you "opt in," you will no longer receive physical mail from this office. Opting in does not discharge your obligation to provide the Department with a current physical address and email address. You are required by statute and rule to notify the Department of an address change within thirty (30) days of any such change.

8. It is strongly recommended that you do not make arrangements to accept employment as a physician in Tennessee until you are granted a license number by the Board of Medical Examiners.

9. All documents which are provided to this office in conjunction with your request for a medical license becomes part of the public record and must be released pursuant to a public records request.

Thank you for your cooperation. We will make every effort to process your application in an efficient manner.

FOR OFFICIAL USE ONLY

1606-001 $400.00
1606-006 $ 10.00

ATTACH A CURRENT FULL-FACE PHOTOGRAPH

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243

BOARD OF MEDICAL EXAMINERS
(800) 778-4123, ext. 532-4384 or Local (615) 532-3202, ext. 532-4384
www.tennessee.gov

APPLICATION FOR LICENSURE AS A MEDICAL DOCTOR

READ INSTRUCTIONS PRIOR TO COMPLETING APPLICATION. APPLICANTS MUST COMPLY WITH ALL INSTRUCTIONS. FILL IN ALL BLANKS; IF NOT APPLICABLE, STATE N/A

Attach to this application a check or money order in the amount of $410, payable in U.S. funds to the Tennessee Board of Medical Examiners.

PERSONAL INFORMATION

Name as it will appear on license: _____
(First) *(Middle)* *(Last)*

Have you been known by any other name? Y N If yes, list names: _____

_____

Date of Birth: Mo. _____ Day _____ Yr. _____ Place of Birth _____
(City) *(State or Country)*

Social Security Number: _____ - _____ - _____ Are you a U.S. Citizen? Y◯N◯ Gender: M◯F◯

Are you entitled to Live and Work in U.S.? Y◯N◯ Race: _____

Are you a member of the U.S. armed forces who has, within the preceding 180 days, retired from the armed forces, received any discharge other than a dishonorable discharge from the armed forces, or been released from active duty to a reserve component of the armed forces? Y◯ N◯ (If yes, please provide proof of status.)

Are you the spouse of a member of the armed forces who has been transferred by the military to Tennessee or who has, within the preceding 180 days, retired from the armed forces, received a discharge other than a dishonorable discharge from the armed forces or been released from active duty to a reserve component? Y◯ N◯ (If yes, please provide proof of same.)

Present Mailing Address: _____ Home Phone: (_____) _____ - _____

_____

_____ Work Phone: (_____) _____ - _____

Email address: _____

Do you wish to receive notification, including renewal notification, from the Department of Health via email? Y◯N◯
Please note, by opting in, all correspondence from the Department of Health will be delivered to the email address on file for you. You will no longer receive physical mail from our office.

Type of intended primary specialty practice in Tennessee _____

EDUCATIONAL AND EXAMINATION INFORMATION

PRE-MEDICAL EDUCATION

From: _____ To: _____ _____ _____
MM/YY *MM/YY* *Educational Institution* *Location*

From: _____ To: _____ _____ _____
MM/YY *MM/YY* *Educational Institution* *Location*

From: _____ To: _____ _____ _____
MM/YY *MM/YY* *Educational Institution* *Location*

MEDICAL EDUCATION

I have spent _____ years in the study of medicine in the medical educational institutions below:

From: _____ To: _____ _____ _____
MM/YY *MM/YY* *Educational Institution* *Location*

From: _____ To: _____ _____ _____
MM/YY *MM/YY* *Educational Institution* *Location*

POSTGRADUATE TRAINING

I have spent _____ years in medical training in the medical educational institutions below:

From: _____ To: _____ _____ _____
MM/YY *MM/YY* *Educational Institution* *Location*

From: _____ To: _____ _____ _____
MM/YY *MM/YY* *Educational Institution* *Location*

From: _____ To: _____ _____ _____
MM/YY *MM/YY* *Educational Institution* *Location*

I have taken the following medical licensure examinations: (Check all applicable)

1.____ National Boards (NBME) Certificate Number
2.____ FLEX examination administered by the State of _____on _____.
(Date(s))
3.____ Licensure by the Medical Council of Canada (LMCC)
4.____ USMLE
5.____ State Board administered by _____ prior to 1972.
(State)

Are you ABMS Board certified? Y◯N◯

If yes, identify board of specialty/subspecialty: _____

I intend to perform Level II Office Based Surgery which is integral to a planned treatment regimen and <u>not</u> performed on an urgent or emergent basis. Y◯N◯

If you intend to perform Level III Office Based Surgery, you must apply for and obtain a permit prior to engaging in such practice. You may access the application by visiting: https://tn.gov/assets/entities/health/attachments/PH-3963.pdf

PRACTICE AND LICENSURE INFORMATION

	YES	NO
Are you or have you ever been licensed to practice medicine in another state?	___	___
Are you or have you ever been licensed in any other profession in Tennessee or another state?	___	___

List below all states, countries or provinces in which you have ever been or currently are licensed, permitted or certified. Submit a copy of **Attachment 1** to all such states, countries, or provinces regarding such licensure, certification or permit. Use the back of this page if you need additional space.

STATE	PROFESSION	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS

Do you have a DEA Registration? Y ◯ N ◯

If yes, please provide: _____

_____

Intended practice location in Tennessee:

Name: _____

Address: _____

_____

Please complete your entire employment history starting with the most current position first. Use the back of this page if you need additional space.

DATES	LOCATION	POSITION AND DUTIES
From: _____ To: _____ (MM/YY) (MM/YY)	_____ (City) (State)	_____
From: _____ To: _____ (MM/YY) (MM/YY)	_____ (City) (State)	_____
From: _____ To: _____ (MM/YY) (MM/YY)	_____ (City) (State)	_____
From: _____ To: _____ (MM/YY) (MM/YY)	_____ (City) (State)	_____

COMPETENCY INFORMATION

PLEASE ANSWER THE FOLLOWING QUESTIONS. If you answer "yes" to any of the questions in this part, you must supplement your affirmative response with a thorough explanation on a separate page. **IN SUPPORT OF YOUR EXPLANATION, THE FINAL DOCUMENTS OR ORDERS FROM THE ISSUING STATES, COURTS, AND/OR AGENCIES MUST BE SUBMITTED ALONG WITH THIS APPLICATION. Additional information may be requested and/or required before a licensure decision may be made.**

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

1. "**Ability to practice your profession**" is to be construed to include all of the following:

   a. The cognitive capacity to make appropriate clinical diagnoses, exercise reasoned medical judgments, to learn, and keep abreast of medical developments;

   b. 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

   c. The physical capability to perform professional tasks and procedures required of your profession, with or without the use of aids or devices, such as corrective lenses or hearing aids.

2. "**Medical Condition**" includes physiological, mental or psychological conditions including, but not limited to: orthopedic, visual, speech and/or hearing impairments, emotional or mental illness, specific learning disabilities, drug addiction, and alcoholism.

3. "**Minor Traffic Offense**" generally means moving and non-moving violations punishable by fines only and does not include offenses such as driving under the influence or while intoxicated or reckless driving.

4. "**Chemical substances**" is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

5. "**Currently**" does not mean on the day of or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee or within the past two (2) years.

6. "**Illegal use of illicit or controlled substances**" means the use of substances obtained illegally (e.g., heroin or cocaine) as well as the use of controlled substances that are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

QUESTIONS:	**YES**	**NO**
1. Do you currently have any physical or psychological limitations or impairments caused by an existing medical condition which are reduced or ameliorated by ongoing treatment or monitoring, or the field of practice, the setting or the manner in which you have chosen to practice?	____	____
2. Do you currently use any chemical substances which in any way impair or limit your ability to practice medicine with reasonable skill and safety?	____	____

If so, please list: _____

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

COMPETENCY INFORMATION
CONTINUED

QUESTIONS: Please respond to ALL questions. If you answer "YES" to any question, please attach a written explanation.			**YES**	**NO**
3.	At any time within the past two years, have you engaged in the illegal use of illicit or controlled substances?			
4.	Are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you to assure that you do not consume alcohol and/or do not engage in the illegal use of illicit or controlled substances?			
5.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or other diagnosis of a predatory nature?			
6.	Have you ever held or applied for a license or certificate to practice medicine in any state, country, or province, that has been or was ever denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?			
7.	Have you ever had staff privileges at any hospital or health care facility that were ever revoked, suspended, curtailed, restricted, limited, otherwise disciplined, or voluntarily surrendered under threat of restriction or disciplinary action?			
8.	Have you ever applied for or held a state or federal controlled substance certificate that was ever denied, revoked, suspended, restricted, voluntarily surrendered or otherwise disciplined or surrendered under threat of restriction or disciplinary action?			
9.	Have you ever been convicted (including a nolo contendere plea or guilty plea) of a felony or misdemeanor (other than a minor traffic offense) whether or not sentence was imposed or suspended?			
10.	Have you ever been rejected or censured by a medical society?			
11.	In relation to the performance of your professional services in any profession:			
	a.	Have you ever had a final judgment rendered against you;		
	b.	Have you ever entered into any settlement of any legal action; or		
	c.	Are there any legal actions pending against you or to which you are a party?		
12.	Have you ever held a license or certificate in any health care profession that has ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?			
13.	My name has been placed on the registry of persons who have abused, neglected or misappropriated the property of vulnerable individuals (Tennessee abuse registry or an abuse registry in another state).			

AFFIDAVIT AND RELEASE

I, _____, M.D., of _____
(*Applicant's Name)* *(City)* *(State)*
being duly sworn and identified as the person referred to in this application attest to the truth of each statement made in said application. I further swear that I have read and understand the law and the Rules and Regulations regarding the practice of my profession, which are posted on the Board's website at http://share.tn.gov/sos/rules/0880/0880-02.20150426.pdf, and agree to abide by them in the practice of medicine in the State of Tennessee.

I HEREBY:

SIGNIFY my willingness to appear to answer such questions as the Board may find necessary, which may include a full Board interview.

RELEASE to the Board, its staff, and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice medicine.

AUTHORIZE the Board, its staff, and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others, and/or other qualifications.

RELEASE from liability the Board, its staff, and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character, and/or other qualifications for licensure.

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

AUTHORIZE release, use and disclosure of otherwise HIPAA-protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

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

_____ _____
SIGNATURE **DATE**

ATTACHMENT 1

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TENNESSEE 37243

TENNESSEE BOARD OF MEDICAL EXAMINERS
(800) 778-4123, ext. 532-4384 or (615) 532-3202, ext. 532-4384

APPLICANT: Supply the information requested in the box below then mail this entire form to your medical school.

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

Address: _____ Social Security Number: ___ - ___ - ___
_____
_____
_____

Student Identification Number: _____

Year of Graduation: _____

Degree Obtained: _____

TO WHOM IT MAY CONCERN:

I am applying for a license to practice medicine in the State of Tennessee.

Please forward an original graduate transcript of courses, grades, and degree bearing the institution's official seal to:

State of Tennessee
Board of Medical Examiners
665 Mainstream Drive
Nashville, TN 37243 (37228 for courier service only)

Thank you for your cooperation and prompt response.

_____ _____

Applicant's Signature Date

ATTACHMENT 2

TENNESSEE BOARD OF MEDICAL EXAMINERS
(800) 778-4123, ext. 532-4384 or (615) 532-3202, ext. 532-4384

VERIFICATION OF POSTGRADUATE MEDICAL TRAINING

APPLICANT: Provide the information requested in the top box and then mail this form to each institution in which you received any postgraduate medical training. If additional forms are required, copy this one.

Institution Administration: I am applying for a Tennessee medical license and hereby authorize you to release any and all information in your files concerning my medical training. I was in training at your institution as follows:

Applicant's name: _____
(Last) (First) (Middle/Maiden)

Name of Institution: _____ **Program Title:** _____

_____ _____
Applicant's Signature **Dates**

THIS PORTION IS TO BE COMPLETED BY THE TRAINING PROGRAM'S ADMINISTRATIVE OFFICE

Please complete (including questions) and return to:

State of Tennessee
Board of Medical Examiners
665 Mainstream Drive
Nashville, TN 37243

	CIRCLE ONE	
Is your training program currently ACGME approved?	Yes	No
Was the above program LCME/ACGME approved at the time the applicant completed training?	Yes	No
Were there any adverse charges or actions taken during the residency? If yes, please attach supporting information and/or documentation.	Yes	No
Would you recommend the applicant for licensure?	Yes	No
Did the applicant successfully complete the program?	Yes	No

The applicant attended the program from _____ (Mo/Yr) to _____ (Mo/Yr). I certify that the information on this form is true and correct.

_____ _____
Program Director's/Dean's Signature Date

Subscribed and sworn before me this the ____ day of _____, _____.

_____
Notary Public (Affix Seal Here)

My Commission Expires:

ATTACHMENT 3

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 Mainstream Drive
NASHVILLE, TENNESSEE 37243

TENNESSEE BOARD OF MEDICAL EXAMINERS
(800) 778-4123, ext. 532-4384 or (615) 532-3202, ext. 532-4384

VERIFICATION OF OTHER STATE LICENSE(S)

APPLICANT: Please provide the information requested in the top box and then mail one form to the licensure board in EACH state where you hold OR HAVE EVER HELD a license to practice any medical profession. (You may copy this form.) **NOTE:** Some states require a fee to process verification of licensure information.

_____ was granted a license to practice _____
(Name of Applicant) *(Profession)*
with license number _____ on _____ in the State of _____.
(Date)

The Tennessee Board of Medical Examiners requests that I submit evidence of the current status of my license in your state. You are hereby authorized to release any information in your files, favorable or otherwise, directly to:

State of Tennessee
Board of Medical Examiners
665 Mainstream Drive
Nashville, TN 37243

Date: _____ _____
Applicant's Signature

_____
Applicant's typed or printed name

THIS PORTION IS TO BE COMPLETED BY THE ADMINISTRATIVE OFFICE OF THE STATE MEDICAL BOARD

Name in Full As it Appears on License: _____

License Number _____ Profession _____ Date Issued _____

Basis of issuance: _____ Endorsement/Reciprocity with _____
(Check One) (State)
_____ Written Examination _____
(Name of Exam)

The License is currently active and registered? Yes ____ No ____
Is there any derogatory information on file? Yes ____ No ____ If yes, an explanation must be attached.

_____ _____ _____
Authorized Signature Title Date

ATTACHMENT 4

Tennessee Requires Medical Examination Scores be Sent Directly to the Tennessee Board of Medical Examiners

In order to have medical examination scores reported to the Tennessee Board please read the following:

For FLEX, SPEX and USMLE scores, contact the Federation of State Medical Boards to obtain a score reporting form at:

Federation of State Medical Boards of the U.S., Inc.
Federation Place
Suite 300
400 Fuller Wiser Road
Euless, TX 76039-3855
(800) 876-5396

or download the form from the website at:

http://www.fsmb.org

For NBME Parts I, II, and III or any **COMBINATION** of NBME Parts, the request form is now available on the NBME web site at:

http://www.nbme.org/programs/nbmecert.asp

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

For NBME Parts I, II, and III administered by ECFMG or for information concerning FMGEMS contact:

Educational Commission for Foreign Medical Graduates
3624 Market Street
Philadelphia, PA 19104
Phone (215) 386-5900

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 Mainstream Drive
NASHVILLE, TENNESSEE 37243

TENNESSEE BOARD OF MEDICAL EXAMINERS
(800) 778-4123, ext. 532-4384 or (615) 532-3202, ext. 532-4384

APPLICANT: USE THIS FORM ONLY IF YOU HAVE TAKEN A STATE EXAM PRIOR TO DECEMBER 1972. IF YOU HAVE, COMPLETE THE INFORMATION IN THE BOX AND THEN SEND IT TO THE STATE BOARD FOR WHICH YOU TOOK THE EXAMINATION:

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

Social Security Number: _____ - _____ - _____ State License Number: _____

CERTIFICATE OF SECRETARY OF STATE BOARD ISSUING ORIGINAL LICENSE

I, _____, Secretary of the _____
(State)
Board of Medical Examiners, certify that _____ of
(Applicant's Name)
_____ was granted License/Certificate number _____
(City & State)
to practice Medicine in this State on the ____ day of _____, _____. I further certify that the aforesaid in the written examination before this Board, which was administered on _____,
(Date)
obtained a general average of _____ percent and the following percentages on each subject:

Subject	Percent	Subject	Percent
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	

Acting on behalf of the _____ Board of Medical Examiners, I hereby
(State)
certify that the Applicant successfully completed the state licensure examination.

Seal of the Board _____ Date: _____
Board Secretary's Signature

Please return to: **State of Tennessee**
Board of Medical Examiners
665 Mainstream Drive
Nashville, TN 37243