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

TENNESSEE BOARD OF MEDICAL EXAMINERS
COMMITTEE ON PHYSICIAN ASSISTANTS

(800) 778-4123, ext. 532-4384 or (615) 532-3202, ext. 532-4384

APPLICATION INSTRUCTIONS FOR LICENSURE AS AN ORTHOPEDIC PHYSICIAN ASSISTANT

Provided below is a checklist for your personal use and convenience containing all the things you must do to receive consideration for issuance of a Tennessee license to practice. **NOTE: All submissions must be executed and dated less than one (1) year before receipt or they will be rejected by the Committee.**

ALL APPLICATION FEES ARE NON-REFUNDABLE.

		Done
1.	Complete, have notarized, and mail the application pages 1 through 6.	
2.	Attach to the application a clear, recognizable, recently taken, signed and notarized passport photograph of yourself.	
3.	Complete and mail Attachment 1 to the institution at which you completed your orthopedic physician assistant program. Alternatively, if applying by exam/experience have supervising physician complete and have notarized Attachment 2.	
4.	If you are or have ever been licensed, certified, registered, or permitted by any state to practice as an orthopedic physician assistant or other health professional, you must complete and mail Attachment 3 to each and every state. Copies of Attachment 3 may be duplicated to accommodate each request.	
5.	If you are certified by the National Board for the Certification of Orthopedic Physician Assistants, you must complete and mail Attachment 4 to the Board for the Certification of Orthopedic Physician Assistants..	
6.	If you have a supervising physician, submit Attachment 5 along with your application. Attachment 5 must be signed by the supervising physician and must be submitted prior to beginning practice.	
7.	Submit a copy of your diploma from your orthopedic physician assistant program (if applicable)	
8.	Submit two (2) original letters of recommendation on letterhead from medical professionals who can attest to your character as an orthopedic physician assistant. These letters must identify the individuals as medical professionals and **must be originals** on signatory's letterhead.	
9.	Please complete the enclosed practitioner profile questionnaire and mail back with the application for licensure.	
10.	Attach to the application a check or money order in the amount of $335 made payable to the Committee on Physician Assistants. If requesting temporary certification or temporary authorization, attach to the application a check or money order in the amount of $385. All fees are non-refundable.	
11.	Effective June 1, 2006 applicants for initial licensure in Tennessee must obtain a criminal background check. For instructions to obtain a criminal background check, go to http://tn.gov/health/article/CBC-instructions.	
12.	The "Save Act" requires The Tennessee Department of Health (including all Boards, Commissions, and contractors), along with every local health department in the State, to verify that every adult applicant, for a professional license is either a U.S. citizen, a "qualified alien," or a nonimmigrant who meets the requirements set out in 8 U.S.C. 1621. Attachment 6 must be completed and submitted before this application can be processed.	

UNDERSTANDING THE APPLICATION PROCESS

1. **All application fees are non-refundable.**

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 Committee asks that you please give the Committee office every consideration in this matter.

4. If necessary documentation has not been received when your application has been received by the Committee office, an initial deficiency letter will be sent to you by certified mail. The supporting documentation requested in the letter must be received in the Board office sixty (60) days from the date of the initial deficiency letter. **(Files not completed within sixty (60) days will be closed.)**

5. Absent any complicating factors, the average application processing time is six (6) weeks. Once the application is completed, your file will be reviewed and an initial licensure determination made. You will be promptly 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. It is recommended that you do not make arrangements to accept employment in Tennessee until you are granted a license, temporary certificate, or temporary authorization by the Committee on Physician Assistants.

8. All practicing OPAs must have a written protocol outlining the range of services under which they practice in their respective medical communities.

Thank you for your cooperation. We will make every effort to work your application in a timely manner.

For Office Use Only

3629-001	$325
3629-006	$ 10
	$335
3629-001	$375
3629-006	$ 10
	$385

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

BOARD OF MEDICAL EXAMINERS
COMMITTEE ON PHYSICIAN ASSISTANTS
(800) 778-4123, ext. 532-4384 or (615) 532-3202, ext. 532-4384

APPLICATION FOR LICENSURE AS AN ORTHOPEDIC PHYSICIAN ASSISTANT

Choose the appropriate licensure category for which you are applying. Check the appropriate subcategory which applies to your application. See the Practice Act and the rules and regulations to determine the requirements for each category of practitioner and temporary certification.

_____ Orthopedic Physician Assistant Licensure by Exam/Education (attach $335 payment)

_____ Apply with request for temporary certificate (attach $385 payment)

PERSONAL INFORMATION

PLEASE PRINT IN INK

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

Social Security Number: _____ Date of Birth: Mo. ____ Day ____ Yr._____

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

_____ Office Phone: (_____) _____

_____ Work Phone: (_____) _____-_____

Place of Birth: _____ Sex: (optional, for statistical purposes only)
Female _____
Male _____

U. S. Citizen: Yes_____ No_____

Email Address: _____

Do you wish to receive notification, including renewal notification, from the Department of Health via email? Y N

EDUCATIONAL AND EMPLOYMENT INFORMATION

Please provide the following information for all educational institutions you have attended beyond high school. Use the back of this page if you need additional space. (SEND **ATTACHMENT #1** TO THE EDUCATIONAL INSTITUTION WHERE YOU COMPLETED YOUR PROGRAM)

From: _____ To: _____ _____ _____
Mo/Yr Mo/Yr Educational Inst./Phys. Asst. Program Location

From: _____ To: _____ _____ _____
Mo/Yr Mo/Yr Educational Inst./Phys. Asst. Program Location

From: _____ To: _____ _____ _____
Mo/Yr Mo/Yr Educational Inst./Phys. Asst. Program Location

From: _____ To: _____ _____ _____
Mo/Yr Mo/Yr Educational Inst./Phys. Asst. Program Location

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**

From: _____ To: _____ _____ _____
Mo/Yr Mo/Yr City/State Position/Duties

From: _____ To: _____ _____ _____
Mo/Yr Mo/Yr City/State Position/Duties

From: _____ To: _____ _____ _____
Mo/Yr Mo/Yr City/State Position/Duties

From: _____ To: _____ _____ _____
Mo/Yr Mo/Yr City/State Position/Duties

From: _____ To: _____ _____ _____
Mo/Yr Mo/Yr City/State Position/Duties

From: _____ To: _____ _____ _____
Mo/Yr Mo/Yr City/State Position/Duties

From: _____ To: _____ _____ _____
Mo/Yr Mo/Yr City/State Position/Duties

LICENSURE INFORMATION

List below all states, countries, provinces in which you have ever been or currently are licensed, permitted, or certified as a Physician Assistant. Submit a copy of **Attachment 3** to all such states, countries, or provinces regarding such licensure, certification, or permit. Us the back of this page if you need additional space.

STATE	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS

List below **ALL** state, countries, or provinces in which you hold or have ever held a license as a health professional other than a Physician Assistant. Submit a copy of attachment #2 to all such state, country, or province regarding such licensure. Additional pages may be added if necessary.

STATE	PROFESSION	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS

		Yes	No
1.	Are you certified by the National Board for Certification of Orthopedic Pas (NBCOPA)? If so, complete **Attachment 3** and send it to the NBCOPA.	____	____
2.	Have you ever applied for a orthopedic physician assistant license in Tennessee?	____	____
3.	Have you ever received a temporary permit or license in Tennessee?	____	____

COMPETENCY INFORMATION

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

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

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

   a. The cognitive capacity to exercise reasoned professional judgments, to learn, and keep abreast of developments in your profession;

   b. The ability to communicate those judgments and information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and

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

2. **"Medical Condition"** includes physiological, mental or psychological conditions or disorders, such as, but not limited to; orthopedic, visual, speech and/or hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV, tuberculosis, drug addiction, and alcoholism.

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

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

5. **"Illegal use of controlled substances"** means the use of controlled substances obtained illegally (e.g., heroin, or cocaine) as well as the use of controlled substances 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 a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety?	___	___
a. If yes, are they reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program?	___	___
b. If you have any limitations or impairments caused by an existing medical condition, are they reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice?	___	___

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

COMPETENCY INFORMATION CONTINUED

QUESTIONS:		YES	NO
2.	Do you currently use chemical substances as defined on page 5?	____	____
	If yes, do they in any way impair or limit your ability to practice medicine with reasonable skill and safety?	____	____
	Please list: _____		
	_____		
3.	Are you currently engaged in the illegal use of controlled substances?	____	____
	If yes, are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you in order to assure that you are not engaged in the illegal use of controlled substances?	____	____
4.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, or voyeurism?	____	____
5.	If you have ever held or applied for a license or certificate to practice as an orthopedic physician in any state, country, or province, has or was it ever been denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	____	____
6.	If you have ever had staff privileges at any hospital or health care facility have they ever been revoked, suspended, curtailed, restricted, limited, otherwise disciplined, or voluntarily surrendered under threat of restriction or disciplinary action? *	____	____
7.	Have you ever been convicted of a felony or a misdemeanor other than a minor traffic violation?	____	____
8.	Have you ever been rejected or censured by a professional society?		
9.	In relation to the performance of your professional services in any profession:		
	a. Have you ever had a final judgment rendered <u>against</u> you; *	____	____
	b. Have you ever had settlement of any legal action rendered <u>against</u> you; or *	____	____
	c. Are there any legal actions pending <u>against</u> you or to which you are a party? *	____	____
10.	If you have ever held a license or certificate in any health care profession, has it ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action? *	____	____

APPLICANT: FILL OUT THE FOLLOWING AFFIDAVIT IN THE PRESENCE OF A NOTARY PUBLIC

AFFIDAVIT AND RELEASE

I, _____, PA, of _____
(*Applicant's Name)* *(City)* *(State)*
being duly sworn and identified as the person referred to in this application attests 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 Internet site and/or were provided to me by the Board office, and agree to abide by them in the practice of my profession 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 Committee, 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 my profession.

AUTHORIZE the Committee, 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 other qualifications.

RELEASE from liability the Committee, 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 other qualifications for licensure.

ACKNOWLEDGE that I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical, 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**

Sworn to before me this _____ day of _____, 20____

_____ Affix Seal Here
NOTARY PUBLIC

My Commission expires _____

ATTACHMENT 1

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

COMMITTEE ON PHYSICIAN ASSISTANTS
(800) 778-4123, ext. 532-4384 or (615) 532-3202, ext. 532-4384

EDUCATION VERIFICATION

APPLICANT: Supply the information requested in this box and then mail this entire form to the school at which you completed your physician assistant program. **NOTE:** Most schools require a fee, so you may want to contact the institution before mailing this form so that you can attach their fee..

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

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

_____

_____

_____

Student Identification Number: _____

Year of Graduation: _____

Degree Obtained: _____ Date Degree Conferred: _____

TO WHOM IT MAY CONCERN:

I am applying for a license to practice as a orthopedic physician assistant in the State of Tennessee. Please forward an original graduate transcript of courses, grades, and degree bearing the institution's official seal to:

Board of Medical Examiners
Committee on Physician Assistants
Nashville, TN 37243 (37228 for courier service only)

Thank you for your cooperation and prompt response.

_____ _____
Applicant's Signature Date

ATTACHMENT 2

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

COMMITTEE ON PHYSICIAN ASSISTANTS
(800) 778-4123, ext. 532-4384 or (615) 532-3202, ext. 532-4384
http://www.tennessee.gov/health

AFFIDAVIT OF EMPLOYMENT
ORTHOPEDIC PHYSICIAN ASSISTANT

I, _____ License Number _____, being
(Medical Doctor or Osteopathic Physician)

duly sworn hereby certify that _____
(Orthopedic Physician Assistant – type or print name)

was performing service as an orthopedic physician assistant in _____ on _____

These services were performed at _____
(Facility or Practice Setting)

_____
(City, State and Zip Code)

_____ _____
(Signature of Physician) (Date)

Sworn to 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

COMMITTEE ON PHYSICIAN ASSISTANTS
(800) 778-4123, ext. 532-4384 or (615) 532-3202, ext. 532-4384
http://www.tennessee.gov/health

CLEARANCE FROM OTHER STATE LICENSURE BOARDS

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 profession. (You may copy this form.) **NOTE:** Some states require a fee for providing clearance information. To expedite your application, you may wish to contact the applicable state(s).

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

The Committee on Physician Assistants of Tennessee requests that I submit evidence of the current status of that license in your state. You are hereby authorized to release any information in your files, favorable or otherwise, directly to:

Committee on Physician Assistants
665 Mainstream Drive
Nashville, TN 37243

Date: _____

_____
Applicant's Signature

_____
Applicant's typed or printed name

ADMINISTRATIVE OFFICE OF STATE LICENSURE BOARD, PLEASE COMPLETE:

Name In Full As It Appears On License:

License Number _____ Profession _____ Date Issued _____

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

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

_____ _____ _____
Authorized Signature Title Date

ATTACHMENT 4

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

COMMITTEE ON PHYSICIAN ASSISTANTS
(800) 778-4123, ext. 532-4384 or (615) 532-3202, ext. 532-4384
http://www.tennessee.gov/health

NBCOPA VERIFICATION

Only if or when you are credentialed with the NBCOPA, please complete this form and mail it to the address below:

NATIONAL BOARD FOR THE CERTIFICATION OF
ORTHOPEDIC PHYSICIAN ASSISTANTS
c/o ASOPA Headquarters Specialty Society Services AAOS
6300 North River Road, Suite 727
Rosemont, IL 60018-4226

To Be Completed By Applicant (Please Print In Ink)

Dear NBCOPA Official:

I am applying for a license to practice as an Orthopedic Physician Assistant in the State of Tennessee. The State Board of Medical Examiners' Committee on Physician Assistants requires that a credential letter by **forwarded directly to their** office by the NBCOPA.

Applicants Name: _____
(First) (Middle) (Last)

Social Security Number: _____ Credential #_____

Name applicant tested by if different from above:

_____
(First) (MI) (Last)

Date Certified _____ Basis of Examination _____

_____
(NBCOPA Official's Signature)

PLEASE MAIL CREDENTIAL VERIFICATION DIRECTLY TO:

Committee on Physician Assistants
665 Mainstream Drive
Nashville, Tennessee 37243

ATTACHMENT 5 **Applicant's Name** _____

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

COMMITTEE ON PHYSICIAN ASSISTANTS
(800) 778-4123, ext. 532-4384 or (615) 532-3202, ext. 532-4384

SUPERVISING PHYSICIANS

This section must be completed by the supervising physician(s).
(This page may be duplicated if necessary)

List all practice settings:

1) Setting:

_____
Supervising Physician Signature

_____
Printed Name

_____
Address

_____
Tennessee Medical License Number

2) Setting:

_____
Supervising Physician Signature

_____
Printed Name

_____
Address

_____
Tennessee Medical License Number

3) Setting:

_____
Supervising Physician Signature

_____
Printed Name

_____
Address

_____
Tennessee Medical License Number

4) Setting:

_____
Supervising Physician Signature

_____
Printed Name

_____
Address

_____
Tennessee Medical License Number

ATTACHMENT 6

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

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

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

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

Please Print Legibly

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

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

7. If you checked "No" in question 4 please indicate from the list below which category applies to you: (circle one)

   a) Permanent Residents

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

Applicants claiming **qualified alien status** (question 7 above), please submit two of the following forms of "documentation of identity and immigration status" as determined by U.S. Homeland Security to be acceptable for verification through the SAVE program. Common types of documents used to verify immigration status are listed below. (Note: If you can provide only one document, your status will be verified through the U.S. Department of Homeland Security's SAVE program):

I-327 (Reentry Permit)

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

I-571 (Refugee Travel Document)

I-766 (Employment Authorization Card)

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

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

I-94 (Arrival/Departure record)

Unexpired foreign passport

WT/WB Admission Stamp in unexpired foreign passport

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

DS2019 (Certificate of Eligibility for Exchange Visitor (J-1) Status)

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

Signed this _____ day of _____, 20__.

_____
Signature

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

_____ AFFIX SEAL HERE
NOTARY PUBLIC

My Commission Expires:_____

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