TN Department of Health

Pain Management Clinic Employee Affidavit

Instructions: This form is provided for internal use by a pain management clinic. It may be used by a pain management clinic to ensure its compliance with regulations pertaining to certain employees of the clinic.

Pursuant to Tennessee Department of Health Rule 1200-34-01-.02(4), pain management clinics licensed in the State of Tennessee may be required to disclose certain information regarding employees, and others with whom they contract for services, who do not hold a DEA registration, but who have contact with patients or onsite patient information and/or have management responsibilities. In order to ensure compliance with this regulation, pain management clinics may require such employees to complete this form. Note: Affirmative answers to the questions may be considered in employment decisions and may be disclosed to the Tennessee Department of Health.

Please Print Legibly

Full Name: _____
Last First Middle Maiden

Address: _____

City: _____ State: _____ Zip: _____

Social Security Number: _____ Phone Number: (_____) _____

Have you ever been convicted of a felony? Yes ☐ No ■

If yes, please list for each conviction: the felony committed, the sentence imposed, whether the offense involved the sale, diversion, or dispensing of controlled substances under any state or federal law, any relevant dates. Note: "conviction" means any guilty verdict, any guilty plea, or any plea of Nolo Contendere ("No Contest") of a felony offense regardless of the penalty or sentence imposed. If necessary, use additional paper to answer completely and explain any circumstances.

_____

_____

_____

_____

Are you currently under indictment for any offense involving the sale, diversion or dispensing of controlled substances under any state or federal law? Yes ☐ No ☐

If yes, please list the offense, docket number, if known, and the court of jurisdiction.

_____

_____

_____

_____

Department of Health

Have you ever held a license in any jurisdiction under which you could prescribe, dispense, administer, supply, or sell a controlled substance which has been restricted, disciplined, or denied? Yes ☐ No ☐

If yes, please list the type of license, the state in which you possessed such license, and details of the restriction, discipline, or denial.

_____

_____

_____

_____

Please read and initial each statement below:

_____ I understand that any inaccurate or incomplete information may result in disciplinary action up to and including termination, if discovered after I begin employment.

_____ I understand that a comprehensive background check may be conducted. I hereby authorize a comprehensive background check. I further understand that this background check may be submitted to the Tennessee Department of Health in relation to the licensure of the pain management clinic, if required. A background check may include, but is not limited to, a review of criminal conviction records and driving records.

_____ I certify that, to the best of my knowledge, the information I have provided on this form, and any additional information I have provided in an attachment, is accurate and complete.

_____ _____

Signature Date

Subscribed and sworn to before me this _____ day of _____, 20_____.

_____

Notary Public

{SEAL}

_____

My Commission Expires

Please submit this Pain Management Clinic Employee Affidavit to: PainManagement.health@tn.gov