THE STATE
of
ALASKA
Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing

Alaska State Medical Board
PO Box 110806, Juneau, AK 99811
Phone: (907) 465-2550
Email: *MedicalBoard@Alaska.Gov*
Website: *ProfessionalLicense.Alaska.Gov/StateMedicalBoard*

Requirements for Extension of Locum Tenens Permit

Alaska Statute 08.64.275 (e) provides that the permit holder may request a one-time extension of the locum tenens permit of 60 days. There are several qualifications that must be met before a permit can be extended.

The following must be submitted to the board before the expiration of the initial 90-day permit:

1. REQUEST FOR EXTENSION OF LOCUM TENENS PERMIT
A completed Request for Extension of Locum Tenens Permit form (#08-4923, pages 1-2).

2. FEES
Fees made payable to "State of Alaska."

Extension of Locum Tenens Permit Fee:	$150.00
Permanent License Application Fee:*	$400.00

***Note:** this $400 fee is for the nonrefundable application fee and temporary permit fee. The remaining $350 permanent license fee must be paid before the permanent license is issued.

3. APPLICATION FOR PERMANENT LICENSURE
A completed application for permanent licensure (#08-4105, pages 1-10).

4. AUTHORIZATION FOR RELEASE OF RECORDS
A completed Authorization for Release of Records form (#08-4923a).

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MED

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Request for Extension of Locum Tenens

State law provides for the initial issuance of a locum tenens permit with one extension of 60 days.

Extensions must be specifically requested in advance and must be processed prior to the expiration of the original permit. Check the appropriate use of the locum tenens permit, complete the applicable portions of this form and submit it at least two weeks prior to the expiration of the original permit along with the other documents necessary for an extension of the permit. (See Requirements for Extension of Locum Tenens Permit.)

YOU MUST INCLUDE THE EXTENSION FEE OF $150 WITH THIS REQUEST. You must also submit the permanent license application along with those required minimum fees of $750. Type or print legibly. Faxed documents are not accepted.

PART I Payment of Fees

Required Fees:	☐ Extension Fee	**$150.00**

PART II Personal Information

Full Legal Name:			
Provide all other names used (maiden, nicknames, aliases). If any documentation will be received in a prior name, you must provide a certified true copy of the documentation showing proof of legal name change(s). ☐ Not Applicable ☐ Other Names Used: _____			
Residence Address:	Street / City / State / Zip		
Practice Address:	Street / City / State / Zip		
Which address do you want to use for your mailing address and for the public record?		☐ Residence Address ☐ Practice Address	
Contact Phone:		**Date of Birth:**	
Place of Birth:		**Gender:**	
EMAIL AGREEMENT: By choosing to receive correspondence on any matter affecting my license or other business with the Alaska Division of Corporations, Business and Professional Licensing, I agree to maintain an accurate email address through the MY LICENSE web page. I understand that failure to check my email account or to keep the email address in good standing may result in an inability to receive crucial information, potentially resulting in my inability to obtain or maintain licensure.			
Email Address:		**Select One:**	☐ Send my Correspondence Electronically ☐ Send my Correspondence by Mail
Note: If both boxes are selected above, you will receive correspondence electronically.			
SOCIAL SECURITY NUMBER: AS 08.01.060 requires you to provide your United States Social Security Number. It is considered confidential information and will not be publicly disclosed; it may be used to verify inter-state licensure.			

PART III Statement of Purpose

☐ **1.** Locum Tenens physician substituting for absent Alaska physician.	
Name of Alaska Physician:	
☐ **2.** Locum Tenens physician temporarily employed for evaluation purposes for permanent employment.	
Name of Alaska Physician Employer:	
☐ **3.** Temporarily employed by hospital or community mental health center while facility is recruiting for permanent physician.	
Name of Hospital or Community Mental Health Center:	
Name of Administrator or Director of Facility:	
☐ **4.** Request for Exception to 60-day Extension. *Extension of locum tenens permit necessary to provide essential medical services for the protection of public health and safety.*	

If you check #4 above, attach a separate sheet of paper, and provide details for the board to support this request. Your explanation should include the location where you will be providing medical services, the patient population you are serving, the type of practice you are conducting, and why this practice is essential and necessary for the public health and safety. This information will be reviewed by the board and a decision made following that review.

Locum Tenens Physician Signature:		**Date Signed:**	

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Authorization for Release of Records

I hereby authorize the Alaska Division of Corporations, Business, and Professional Licensing and its investigators to examine my employment and education records including all training which pertains to my medical practice, and any records pertaining to litigation, judgments, suits, and/or settlements, and any law enforcement records pertaining to me and discuss them with persons having possession of them. I also expressly permit and authorize the release of any and all such records pertaining to me to the Alaska Division of Corporations, Business, and Professional Licensing and its investigators. This release also applies to all records that pertain to credentialing records at facilities at which I have applied for or held privileges to practice medicine.

I authorize the division to discuss these records with persons or organizations that are considered appropriate by the division in connection with an official investigation, and to provide copies of these records to those persons or organizations deemed appropriate by the division.

I request that upon presentation of this release, or a Certified True Copy thereof, that you provide copies of those records to the division and/or its investigators, and/or representatives of the Office of the Attorney General of the State of Alaska.

This authorization expires one (1) year from the date of my signature below.

Name:	First Middle Last		
Full Address:	P.O. Box or Street City State Zip		
Phone:		**Date of Birth:**	
Email:			
Signature:		**Date Signed:**	

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Credit Card Payment Form

All major credit cards are accepted. For security purposes, do not email credit card information. Include this credit card payment form with your application.

Name of Applicant or Licensee:			
Profession Type *(e.g., Acupuncture)*:		**License Number *(if applicable)*:**	
I wish to make payment by credit card for the following *(check all that apply):*			**AMOUNT**
☐ **Application Fee:**			
☐ **License or Renewal Fee:**			
☐ **Other *(fine, exam, etc.)*:**			
1.			
2.			
		TOTAL:	0

Name *(as shown on credit card)*:			
Mailing Address:			
Phone Number:		**Email *(Optional)*:**	
Signature of Credit Card Holder:	X		

CREDIT CARD INFO: Your payment cannot be processed unless all fields are completed.

1. Credit Card Number:		**All 3 fields MUST be completed.**
2. Expiration Date:		**This section will be destroyed after the payment is processed.**
3. Security Code:		