**LOUISIANA STATE BOARD OF MEDICAL EXAMINERS**

Renewals: 504/568-6820 (Auto Attendant) + 1

Main Number: 504/568-6820

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# Allied Health other than CLAB

# Renewal Application Packet

(Rev. 3 31 2022)

### Visit the LSBME Website at

[www.lsbme.la.gov](http://www.lsbme.la.gov)

#### Louisiana State Board of Medical Examiners-New Orleans, Louisiana

Physical & Application Processing Address: LSBME, 630 Camp Street, New Orleans, LA 70130

Renewal Fees[[1]](#footnote-1)

*\*Foreign checks will NOT be accepted.*

|  |  |  |
| --- | --- | --- |
| **All disciplines below due on or before last day of licensee’s birth month.** | | |
| **Di**s**cipline** | **Scheduled Renewal Fee** | **After Due Date** |
| RESPIRATORY THERAPIST | $85.00 | $N/A |
| OCCUPATIONAL THERAPIST & ASSISTANTS | $100.00/$75.00 | $135.00/$110.00 |
| CLINICAL EXERCISE PHYSIOLOGIST | $100.00 | $125.00 |
| PERFUSIONIST | $150.00 | N/A |
| POLYSOMNOGRAPHY TECHNOLOGIST | $75.00 | N/A |
| POLYSOMNOGRAPHY TECHNICIAN | $50.00 | N/A |
| LICENSED ACUPUNCTURISTS | $100.00 | N/A |
| ACUPUNCTURE DETOXIFICATION SPECIALIST | $25.00 | N/A |
|  |  |  |
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| --- | --- | --- | --- |
| **The following dates and fees apply to Medical Psychologist, Midwives and Athletic Trainers:** | | | |
| **Discipline** | **Due Date** | **Scheduled Renewal Fee** | Late Renewal Fee ***(Penalty Fee + Renewal Fee)*** |
| MIDWIVES | March 31 | $200.00 | $250.00 |
| ATHLETIC TRAINERS | June 30 | $100.00 | N/A |
| MEDICAL PSYCHOLOGISTS | June 30 | $225.00 | N/A |
| MEDICAL PSYCHOLOGIST ADVANCED PRACTICE | June 30 | $100.00 | N/A |

#### LOUISIANA STATE BOARD OF MEDICAL EXAMINERS

LSBME, 630 Camp Street, New Orleans, LA 70130

(504) 568-6820 (Auto Attendant) + 1

#### ALLIED HEALTH RENEWAL APPLICATION

(Please allow 30 days for processing.)

**READ CAREFULLY AND TAKE NOTICE:** This application and any subsequently issued license, permit, certificate, or other authority to practice in the State of Louisiana are subject to all Louisiana laws and administrative rules governing the practice of medicine and allied health. A copy of the laws and rules can be found on the LSBME website. All applicants are hereby PLACED ON NOTICE that they are responsible for knowing the laws and rules and for complying with them. By submitting this application, you expressly acknowledge and agree that you are responsible for knowing and complying with the laws and administrative rules governing the practice of licensure for which you are applying.

**Complete this form *PRIOR* to printing. It contains form fields to make it user friendly.**

**Amount Due:**      *\*Foreign checks will NOT be accepted..*  **Due Date:**

|  |  |
| --- | --- |
| **Name and Mailing Address:** | **License #:**  **Credential Type:**  **Credential Status:** |

**INSTRUCTIONS:**

RENEWAL IS REQUIRED BY LAW ON OR BEFORE THE DUE DATE ABOVE.

FAILURE TO RENEW TIMELY MAY RESULT IN SUSPENSION FOR NON-RENEWAL. SEE SPECIAL INSTRUCTIONS FOR FORMS AND FEES.

**ADDRESSES: Must provide at least 1 physical address. Check to specify one Public and one Mailing address.**

|  |  |
| --- | --- |
| **\*Public Address:** Address that is posted on the LSBME Website. **\*Mailing Address:** Mailings from the LSBME will go to this address. | |
| **BUSINESS ADDRESS** **Public Address** **Mailing Address** | **PHONE:**        **FAX:**        **E-MAIL:** |
| **HOME ADDRESS Public Address Mailing Address** | **PHONE:**        **FAX:**        **E-MAIL:** |
| **OTHER ADDRESS Public Address Mailing Address**  (i.e., P.O. Boxes, Alt. Business Address, etc**)** | **PHONE:**        **FAX:**        **E-MAIL:** |

|  |
| --- |
| **ANSWER THE FOLLOWING:** |
| US Citizen:  Yes  No Visa Naturalization Certificate #       Date       (YOU **MUST** INCLUDE A CURRENT COPY OF YOUR PAPERWORK) |

My Signature certifies my understanding that I am required to obtain CEU’s annually as a prerequisite to the continued renewal of my license to practice

* Clinical Exercise Physiologist / Respiratory Therapists / Polysomnograpy-**10** (every year)
* Occupational Therapists / Assistants- **12** (every year)
* Midwives-**30** (every 2 years)
* Athletic Trainers- **12** (every year)
* Medical Psychologist - **35** (MP-20 & PSY-15) **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- |
| IF PHYSICIAN’S ASSISTANT, OCCUPATIONAL THERAPY ASSISTANT, MIDWIFE APPRENTICE, ACUPUNCTURIST ASSISTANT, OR PRIVATE RADIOLOGICAL TECHNOLOGIST, HAVE YOUR SUPERVISING PHYSICIAN, OCCUPATIONAL THERAPIST, MIDWIFE, POLYSOMNOGRAPHY TRAINEE OR ACUPUNCTURIST COMPLETE THE FOLLOWING:    DATE       LICENSE NO.       SUPERVISOR’S SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**By submitting this application, I expressly acknowledge that I understand and agree I am responsible for knowing and complying with the laws and administrative rules governing the practice of licensure for which I am applying. A copy of which are available for my review on the LSBME website.** [**CLICK HERE TO READ THE RULES BY SELECTING YOUR LICENSE CATEGORY**](https://www.lsbme.la.gov/licensure/rules)**.**

**\*\*This page is for Medical Psychologists Only\*\***

**Controlled Dangerous Substance - Continuing Medical Education**

As per legislation passed in 2017, all practitioners with a Controlled Dangerous Substance (CDS) license in Louisiana are now required to complete at least **3** hours of Board approved continuing medical education (CME) that includes **ALL 4** of the below topics. This course is a once in a lifetime requirement under current law.  This 3 hour requirement will be considered a part of, and not in addition to, the prescriber’s annual CME requirement.

By checking the boxes below I certify that I have completed at least 3 hours of ***Board Approved*** CME covering the topics below. **The course(s) MUST be on the approved course list or it will not be accepted**. To see the list of approved courses go to [www.lsbme.la.gov](http://www.lsbme.la.gov). Click on *Orientations & Education,* then click on \***NEW** [Board Approved CME Courses for CDS Requirements](http://www.lsbme.la.gov/content/board-approved-cme-courses-cds-requirements).

**Best Practices**

**Chronic Pain**

**Diversion**

**Addiction Tx**

\*You must attach copies of your certificates of completion to this renewal.

If you have already submitted your certificate(s) of completion and they were approved, check the box below:

**Certificate(s) of completion previously submitted & approved**

**\*Exemption Requests\***

An authorized prescriber renewing his/her license for the first time may be excused from the CME requirement upon submission of a certification attesting that he/she has not prescribed, administered or dispensed any CDS in Louisiana during the entire year covered by the prescriber’s expiring license. The Board will verify the certification through the Louisiana Prescription Monitoring Program. An exempted licensee, who subsequently prescribes, administers or dispenses a CDS shall satisfy the CME requirement as a condition to license renewal for the year immediately following that in which the CDS was prescribed, administered or dispensed.

**Apply for an exemption –** Go to [www.lsbme.la.gov](http://www.lsbme.la.gov), click on *Orientations & Education,* then click on \***NEW** [Board Approved CME Courses for CDS Requirements](http://www.lsbme.la.gov/content/board-approved-cme-courses-cds-requirements) to download the exemption form (at the bottom of the page). You must attach the exemption request to this renewal.

If you have already submitted your exemption request and it was approved, check the below box:

**Exemption Request previously submitted & approved**

Name (Printed or typed):  SS#:

**Louisiana State Board of Medical Examiners**

LSBME, 630 Camp Street, New Orleans, LA 70130

Telephone: (504) 568-6820

Oath or Affirmation: **RENEWAL - ALLIED HEALTH PERSONNEL**

Answer the following questions (Yes answers must be explained in an affidavit - AFFIDAVIT MUST BE TYPED & NOTARIZED!)

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | Yes | No |
| 1 | **SINCE YOUR LAST RENEWAL -** Have you had any physical injury or disease or mental illness or impairment, which could reasonably be expected to affect your ability to practice medicine or other health profession? ***You may answer no to this question if you are currently in the Physicians' Health Foundation of Louisiana and in good standing.*** |  |  |
| 2 | **SINCE YOUR LAST RENEWAL -** Have you been referred to or obtained treatment for a substance abuse disorder including alcohol abuse?  ***You may answer no to this question if you are currently in the Physicians' Health Foundation of Louisiana and in good standing.*** |  |  |
| 3 | **SINCE YOUR LAST RENEWAL -** Have you been cited, arrested, charged with, convicted of or pled guilty or nolo contendere to a violation of any municipal, state or federal statute **including any that have been expunged or judicially removed for any reason** with the exception of misdemeanor traffic offenses or traffic ordinance violations that do NOT involve the use of drugs or alcohol? |  |  |
| 4 | **SINCE YOUR LAST RENEWAL -** Has your application for any professional license, certificate, or registration been denied by any state licensing board or federal authority? |  |  |
| 5 | **SINCE YOUR LAST RENEWAL -** Has your professional license, certificate, or registration been the subject of investigation or revoked, suspended, probated, restricted, reprimanded, limited, or subjected to any other disciplinary action by any state licensing board or federal authority? |  |  |
| 6 | **SINCE YOUR LAST RENEWAL -** Have you voluntarily surrendered any professional license, or agree with any licensing authority not to seek re-licensure in order to avoid disciplinary action, investigation or inquiry? |  |  |
| 7 | **SINCE YOUR LAST RENEWAL -** Was your application for staff or clinical privileges at any hospital, clinic, or other health care institution denied? |  |  |
| 8 | **SINCE YOUR LAST RENEWAL -** Were you the subject of an inquiry or investigation by any hospital, clinic, or other health care institutions |  |  |
| 9 | **SINCE YOUR LAST RENEWAL -** Did you surrender or fail to renew staff or clinical privileges at any hospital, clinic, or other health care entity in lieu of investigation, while under investigation or while you were the subject of disciplinary proceedings? |  |  |
| 10 | **SINCE YOUR LAST RENEWAL -** Has your membership in a professional society been revoked, suspended, or disciplined or have you resigned membership while under investigation |  |  |
| 11 | **SINCE YOUR LAST RENEWAL -** Were any malpractice claims settled by you or on your behalf? |  |  |
| 12 | **SINCE YOUR LAST RENEWAL -** Has any court determined you are currently in violation of a court’s judgment or order for the support of dependent children? |  |  |

I hereby certify that to the best of my knowledge, all statements I have made in this application for renewal are true and correct.

Signed (no stamps) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Fees are not prorated (i.e. License received mid year fee payable in full, next annual renewal payable in full) [↑](#footnote-ref-1)