

QUALIFICATIONS APPLICATION

If you do not complete the application process you will be sent an email with a link to log back in to complete the documents. Be sure to look in your SPAM and JUNK folders. To apply for a Letter of Qualification for licensure through the Interstate Medical Licensure Compact please answer the questions below.

IS THIS A RE-APPLICATION(earned an LOQ in the past and now is reapplying)? YES NO

1. Which IMLC Member State do you want to serve as your State of Principal License (SPL)?
ALABAMA
2. Do you hold a full and unrestricted medical license to engage issued by a medical licensing board in the SPL (SPL Board) ALABAMA MEDICAL LICENSURE COMMISSION? Yes No

3. What is the license number issued to you by the SPL board? 38134

4. Which of the following apply to you(at least one must apply)?

- a. Your primary residence is in the SPL ALABAMA: Yes No

If yes, provide the following:

Residence Street address _____

Residence City State Zip _____
City St Zip

- b. At least 25% of your practice of medicine occurs in the SPL ALABAMA Yes No

If yes, describe your current practice Hospitalist

- c. Your employer is located in the SPL ALABAMA: Yes No

If Yes, Employer name Thomas Hospital

Employer street address 750 Morphy Ave

Employer City State Zip Fairhope AL 36532
City St Zip

- d. You have designated the SPL ALABAMA as your state of residence for U.S. federal income tax purposes: Yes No

If yes, give Tax ID # (SS#, EIN) _____ (must be most recent return)

5. Are you a graduate of a medical school accredited by the Liaison Committee on Medical Education or the Commission on Osteopathic College Accreditation, or a medical school listed in the International Medical Education Directory or its equivalent? Yes No

6. Have you passed each component of the United State Medical Licensing Examination (USMLE) or the Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA) within three (3) attempts, or any of their predecessor examinations accepted by your SPL medical board as an equivalent examination for licensure purposes(if in question contact your SPL)? Yes No

7. Have you successfully completed graduate medical education approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association? Yes No

8. Do you hold specialty certification or a time-unlimited specialty certificate recognized by the American Board of Medical Specialties (ABMS) or the American Osteopathic Association's Bureau of Osteopathic Specialists (AOABOS)? Yes No

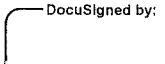
(Please note that answering any of the following questions with a "YES" will result in your application being denied per eligibility Rule 5.4. If eligibility is in question please contact the state board directly for information regarding application through the traditional method.)

9. Have you ever been convicted, received adjudication, community supervision, or deferred disposition for any offense by a court of appropriate jurisdiction? Yes No

10. Have you ever held a license authorizing the practice of medicine subjected to discipline by a licensing agency in any state, federal or foreign jurisdiction, excluding any action related to non-payment of fees related to a license? Yes No

11. Have you ever had a controlled substance license or permit suspended or revoked by a state or the United States Drug Enforcement Administration? Yes No

12. Are you under investigation by a licensing agency or law enforcement authority in any state, federal or foreign jurisdiction? Yes No

Physician's Signature: 

Type Name: Christopher Romano DeNapoles

Date: 6/24/2020 | 9:38 CDT

PHYSICIAN'S CORE DATA SHEET

(Must be the physician's accurate information to avoid delay or rejection)

Full Legal Name Christopher, Romano, DeNapoles
(Exactly as on DL or Passport) First Middle Last Suffix(Sr., Jr.)

Other names used(maiden, birth) _____
First Middle Last

Mailing address _____
Mailing address City State(XX) Zip

Office address 750 Morphy Ave, Fairhope, AL, 36532
Office address City State(XX) Zip

Date of Birth _____ Gender: Male Female
(mm/dd/yyyy)

Physician's office or practice telephone number of public record _____
(###-###-####)

Physician's cellular or alternative telephone number _____
(###-###-####)

Email address delegated by applicant to receive correspondence _____

Social Security Number: _____
(###-##-####)

Physician's National Provider Identifier Number _____

Medical Degree Received: M.D. D.O.

(Medical school must be accredited by the Liaison Committee on Medical Education or the Commission on Osteopathic College Accreditation, or be listed in the International Medical Education Directory or its equivalent.)

Medical School Trinity School of Medicine

Date of Degree Issued 04/30/2013 Name of School (no abbreviations or acronyms)
(mm/dd/yyyy)

Physicians must have successfully completed graduate medical education approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association. (NOTE: One-year transitional residencies do not meet this requirement)

Residency Program Stamford Hospital/Columbia University Completion Date 06/30/2017
Full Program Name (no abbreviations or acronyms) (mm/dd/yyyy)

What is the specialty of the program Family Medicine

Qualifying Licensing exam taken: USMLE COMLEX Other _____
Must specify by name

Number of attempts taken to pass the USMLE:

Step 1: _____ Step 2 CS: _____ Step 2 CK: _____ Step 3: _____

Number of attempts taken to pass the COMLEX:

Step 1: _____ Step 2 PE: _____ Step 2 CE: _____ Step 3: _____

Number of attempts taken to pass other licensing exam:

Step 1: _____ Step 2: _____ Step 3: _____

Specialty Board Certification must be by an ABMS or AOABOS board.

Specialty Board Certification: American Board of Family Medicine
Full Specialty Board Name (i.e. American Board of Pediatrics)(no abbreviations or acronyms)

Expiration of Specialty Board Certification:

Lifetime:

Time limited: Expiration date of time limited _____
(mm/dd/yyyy)

Physicians must possess a full and unrestricted medical license issued by an IMLC Member Board.

License # 38134 Date of Original Licensure 04/04/2019 (not renewal)
(mm/dd/yyyy)

Expiration Date 12/31/2020 Status of License: Current: Not Current:
(mm/dd/yyyy)

Thank you for applying through the Interstate Medical Licensure Compact.

*The state will contact you to give instructions on obtaining your fingerprints for a criminal background check. **YOU HAVE 60 DAYS TO COMPLY WITH REQUESTS FROM THE STATE** to avoid automatic withdraw. Background checks may take some time, so please be patient. If you have any concerns contact your SPL. SPL contact numbers can be found at www.IMLCC.org. You will receive an email regarding the status of your qualification. Be sure to check your spam folder and set your email to accept messages from the @docuSign.net and @docuSign.com domains.*

FOR USE OF STATE OF PRINCIPAL LICENSE

I have conducted the verification process of this physician's application.

State Authorized Signature _____

DocuSigned by:

Warning: The signature tab will default to your Board's name. Please change it to your name in Adopt and Sign.

Type Name Tiffany E Seamon

Title Director of Credentialing

Letter of Qualification

IS THIS A RE-APPLICATION? YES NO

Date 07/24/2020
mm/dd/yyyy

Name: Christopher Romano DeNapoles

Address: _____

CityStZip _____

Dear Dr. DeNapoles:

RE: Your application for IMLC Letter of Qualification

The Alabama Board of Medical Examiners ("Board"), on behalf of the State of Principal Licensure ("SPL") you selected, has received and reviewed your application for a Letter of Qualification ("LOQ") for licensure through the Interstate Medical Licensure Compact ("IMLC").

Based upon the information you submitted with your application, data in the Board's files regarding your licensure by the Board, verifications of your credentials, and the results of the check of national databases, the Board has determined that you are ELIGIBLE to be licensed through the IMLC. Therefore, this notice will serve as your LOQ for licensure in IMLC Member States through the IMLC, and will remain in effect for 365 days from date of issuance, set out above.

An email has been sent to you with instructions regarding how to select the IMLC Member State(s) where you wish to be licensed. After you make your selection(s) and make payment for each license, your information will be forwarded to the selected board(s) ("Member Boards") for issuance of a medical license in by each.

All medical licenses issued by Member Boards through the IMLC are full and unrestricted licenses. You will be responsible for complying with all laws and regulations pertaining to holding each license and the practice of medicine in those jurisdictions including, but not limited to, each Member Board's continuing medical education requirements. It is also your obligation to keep your SPL, the Member Boards which have licensed you, and the IMLC Commission informed of any changes in your contact information or qualifications and eligibility for licensure through the IMLC.

Authorized Signature from SPL _____
DocuSigned by:
Type Name Tiffany B. Seamon
Title of Authorized SPL Director of Credentialing
DATE 7/24/2020 | 3:14 CDT