Tennessee Department of Health
Division of Health Licensure and Regulation
Office of Health Related Boards

Reflexology Registry
665 Mainstream Drive, 2nd Floor
Nashville, TN 37243

(Toll Free In State) 1-800-778-4132
Local Nashville Area 615-741-3807
www.tn.gov/health

Application and Procedures for Registration

As a Reflexologist

LICENSURE APPLICATION INSTRUCTIONS AND CHECK SHEET

Provided below is a checklist for your personal use and convenience containing all the things you must do to receive consideration for registration as a reflexologist in Tennessee.

NOTE: All submissions must be executed and dated less than one (1) year before receipt or they will be rejected by the Registry.

ALL APPLICANTS MUST COMPLETE ITEMS 1-4	DONE
1. Complete pages 1 through 6 as directed, sign, date, have notarized and mail the application to the address at the top of the 1st page.	_____
2. Attach a 2X2 full face "passport-style" photograph recently taken to the application in the space provided.	_____
3. Submit with your application a check or money order in the amount of $110.00 made payable to the State of Tennessee.	_____
4. If the applicant has ever been licensed, certified or permitted to practice as a reflexology or any other health profession in any state or country, the applicant shall cause to be submitted the equivalent of a Tennessee Certificate of endorsement from such licensing agency. (Attachment 2).	_____
5. Complete the mandatory Criminal Background check, using **OCA #4082**. For instructions to obtain a criminal background check, click here.	_____
6. An applicant shall request documentation of completion of a two hundred (200) hour reflexology only course to be sent directly from the appropriate agency.	_____
7. An applicant shall submit proof that he/she has attained eighteen (18) years of age.	_____
8. An applicant shall provide two (2) original letters attesting to the applicant's character from health care professionals on the signature's letterhead and dated. The letter cannot be from the immediate family and/or relatives.	_____
9. All applicants **must** complete the Declaration of Citizenship attachment	_____

If an address change occurs <u>at any time, you must</u> notify the Registrar office, in writing, immediately.

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 Department of Health **Office of Health Related Boards** **Reflexology Registry** **665 Mainstream Drive, 2nd Floor** **Nashville, TN 37243**	**For Federal Express or Special Courier:** **Tennessee Department of Health** **Reflexology Registry** **665 Mainstream Drive, 2nd Floor** **Nashville, TN 37228**

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 Registrar office asks that you please give the Reflexology registry every consideration in this matter.

4. **We will discuss application status with the applicant or applicant's spouse only**. Please inform hospitals, employers, recruiters, referral companies or insurance companies that application status updates must be obtained from you.

5. If necessary documentation has not been received when your application has been received by the Registrar's 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 Registrar's office sixty (60) days from the date of the initial deficiency letter. Files not completed in a timely manner will be closed.

6. Absent any complicating factors, the average application processing time is **six to eight weeks**. Once the application is completed, your file will be promptly reviewed and an initial licensure determination made. You will be promptly notified by letter of the initial determination.

7. It is recommended that you **do not** make arrangements to accept employment as a reflexologist in Tennessee until you are granted a registration from the Registrar.

Thank you for your cooperation. We will make every effort to process your application in an expeditious efficient manner.

PLACE FULL FACE, PASSPORT SIZE PHOTOGRAPH HERE

For Office Use Only

Fee Codes		
4082	-001-	$100.00
4082	-006-	$ 10.00
TOTAL		$110.00

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
OFFICE OF HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE, 2nd FLOOR
NASHVILLE, TN 37243
REFLEXOLOGY
(615) 741-3807

Registration as a Reflexologist

APPLICANT: Read all instructions carefully and complete all portions applicable to you.
Please type or print in ink. If a question does not apply to you, place a **N/A** in the appropriate space.

ALL APPLICATION FEES ARE NON-REFUNDABLE

ATTACH A CHECK OR MONEY ORDER HERE IN THE AMOUNT OF $110.00 FOR REFLEXOLOGIST. PLEASE MAKE CHECK PAYABLE TO: STATE OF TENNESSEE

Applying for licensure by: **(check only one)** _____ Education _____ Reciprocity

PERSONAL INFORMATION

Name: _____
Last First Middle Maiden

Social Security Number: _____-_____-_____ Date of Birth: _____

You must put your social security number on this form for the application to be complete. State and federal law require social security numbers on this application. Tenn. Code Ann. §.36-5-1301 (a), as authorized by 42 U.S.C. §405 (c) (2) (C) (i). The number will be used to verify your identity, to ask questions about your financial responsibility, and for any other purpose by state or federal law. When you provide your social security number on this application and sign the form, you are agreeing that the Department of Health may use your social security number in furtherance of federal and state law, for example, to collect delinquent fees.

U.S. Citizen: ☐ YES ☐ NO *All applicants **must** complete the Declaration of Citizenship attachment.*

Do you wish to receive notification, including renewal notification, from the Department of Health via email?
☐ YES ☐ NO Email Address:_____

County (TN Applicants Only): _____

Mailing Address:_____ Home Phone: (_____) _____

_____ Work Phone: (_____) _____

_____ Sex: (optional - for statistical purposes only)
☐ Male
☐ Female

Place of Birth: _____

EDUCATIONAL AND EMPLOYMENT INFORMATION

Please provide the following information for all educational institutions you have attended beyond junior high or middle school. Use the back of this page if you need additional space.

High School
From: _____ To: _____ _____ _____
Mo/Yr Mo/Yr Educational Institution Location

College/University
From: _____ To: _____ _____ _____
Mo/Yr Mo/Yr Educational Institution Location

Trade School or Reflexology Training
From: _____ To: _____ _____ _____
Mo/Yr Mo/Yr Educational Institution 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	POSITION AND DUTIES
From: _____ To: _____ Mo/Yr Mo/Yr	_____ (City) (State)	_____ _____
From: _____ To: _____ Mo/Yr Mo/Yr	_____ (City) (State)	_____ _____
From: _____ To: _____ Mo/Yr Mo/Yr	_____ (City) (State)	_____ _____
From: _____ To: _____ Mo/Yr Mo/Yr	_____ (City) (State)	_____ _____
From: _____ To: _____ Mo/Yr Mo/Yr	_____ (City) (State)	_____ _____
From: _____ To: _____ Mo/Yr Mo/Yr	_____ (City) (State)	_____ _____

LICENSURE AND CERTIFICATION INFORMATION

List below all states, countries or provinces in which you have ever been or currently are licensed permitted, certified, or registered as a Reflexologist. Submit a copy of **Attachment 2** to all such states, countries, or provinces regarding such licensure, certification, permit, or registration. Use the back of this page if you need additional space.

STATE	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS

List below all states countries or provinces in which you hold or have ever held a license, certification, permit, or registration as a health professional other than a Reflexologist. Submit a copy of **Attachment 2** to all such states, countries or provinces regarding such licensure, certification, permit, or registration. Use the back of this page if you need additional space.

STATE	PROFESSION	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS

List below any memberships you have in any Reflexology related organization or association and the length of time you have been a member.

ORGANIZATION/ASSOCIATION	LOCATION	DATE OF MEMBERSHIP

	Yes	No
1. Are you certified by the ARCB (American Reflexology Certification Board) or IIR (International Institute of Reflexology)? If you are applying by national certification, complete **Attachment 3** Or **Attachment 4** and send it to the appropriate certifying body.	☐	☐
2. Are you certified by any nationally or internationally recognized Reflexology organization other than the ARCB or IIR?	☐	☐
3. Have you ever previously applied for registration as a Reflexologist 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"** is to be construed to include all of the following:

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

   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 disease, 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 which 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 medication) 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 Board 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?	____	____
If yes, do they in any way impair or limit your ability to practice your profession with reasonable skill and safety?	____	____
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?	____	____
10. If you have ever held or applied for a license or certificate to practice reflexology in any state, country or province, has it been or was it ever denied, reprimanded, suspended, restricted, revoked, or otherwise disciplined, curtailed or voluntarily surrendered under threat of investigation or disciplinary action?	____	____
10. If you have ever had staff privileges at any hospital or health care facility have they ever been revoked, suspended, curtailed, restricted, limited or otherwise disciplined or voluntarily surrendered under threat or 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; or	____	____
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, or 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, _____, of _____,
(Applicant's Name *(City)* *(State)*
being duly sworn and identified as the person referred to in this application and signed photos, 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 which were enclosed in the application packet 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 Registrar may find necessary which may include an interview.

RELEASE to the Registrar, 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 Registrar, 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 any other qualifications;

RELEASE from liability the Registrar, 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 and other qualifications and for resolving any doubts about such qualifications.

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 _____, _____.

_____
NOTARY PUBLIC

Affix Seal Here

My Commission expires _____

ATTACHMENT #1

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
OFFICE OF HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE, 2ND FLOOR
NASHVILLE, TN 37243
www.tn.gov/health

REFLEXOLOGY REGISTRY
(615) 741-3807 or (800) 778-4123

EDUCATION VERIFICATION

APPLICANT: Supply the information requested in the box below, and then mail this entire form to the educational institution(s) where you completed your two hundred (200) hour reflexology only course.

NOTE: Most educational institution(s) require a fee, so you may want to contact the institution(s) before mailing this form. If you attended more than one educational institution, please send copies of this form to each one you intend to rely upon in obtaining licensure.

TO WHOM IT MAY CONCERN:

I am applying for a license or limited permit to practice as a Reflexologist in the State of Tennessee. The Reflexology Registrar requires verification of educational attainment. Please forward an original transcript showing degree awarded and bearing the institution's official seal to the Registry's address below.

Applicant's Full Name: _____
(Last) (First) (Middle/Maiden)

Applicant's Address: _____

_____

Applicant's Social Security Number: _____ – _____ – _____

Applicant's Student Identified Number: _____

Date of Graduation: _____

Degree Conferred: _____ Date Degree Conferred: _____

Please forward an original graduate transcript bearing the institution's official seal to:

Tennessee Reflexology Registry
665 Mainstream Drive, 2nd Floor
Nashville, TN 37243

Thank you for your cooperation and prompt response.

_____
Applicant's Signature Date

ATTACHMENT #2

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
TENNESSEE REFLEXOLOGY REGISTRY
665 MAINSTREAM DRIVE, 2nd FLOOR
NASHVILLE, TN 37243
Local: (615) 741-3807 or Toll Free: (800) 778-4123 Ext. 7413807
www.tn.gov/health

VERIFICATION FROM OTHER STATE LICENSURE BOARDS

APPLICANT: Please provide the information requested in the top box and then mail one form to the certification board for ***each*** state where you ***hold or have ever held*** a certificate/license/permit to practice ***any*** profession. (Copies of this form can be used.)
NOTE: Some states require a fee for providing clearance information. To expedite your application, please contact the applicable state(s) to inquire about required fees.

To Be Completed By Applicant (Please Type or Print In Ink)

I, the undersigned applicant, was granted a **(circle one)** license/certificate/permit to practice _____
(Profession)
with **(check one)** ☐ License ☐ Certificate ☐ Permit

Number _____ on _____ , in the State of _____.
(Date)

The Tennessee Reflexology Registrar requests that I submit evidence of the current status of that license/certificate/permit in your state. You are hereby authorized to release any information in your files, favorable or otherwise, directly to the Tennessee Reflexology Registrar.

Applicant's printed name: _____

Applicant's signature: _____ Date: _____

To Be Completed By Administrative Office of State Licensure Board

Name In Full As It Appears On License/Certificate or Permit:

_____
(First) (M.I.) (Last)

License/Certificate/Permit Number: _____ Profession: _____

State: _____ Date Issued: _____ Date of Expiration: _____

Basis of issuance: **(check one)**

☐ Endorsement/Reciprocity with _____
(State)

☐ Written Examination _____ ☐ Other _____
(Name of Exam)

Is the license/certificate/permit currently active and registered? ☐ YES ☐ NO

Is there any derogatory information on file? ☐ YES ☐ NO

If yes, please attach supporting documentation.

_____ _____ _____
Authorized Signature Title Date

State Board: Please return this form to: **Reflexology Registry**
665 Mainstream Drive, 2nd Floor
Nashville, Tennessee 37243

ATTACHMENT #3

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
TENNESSEE REFLEXOLOGY REGISTRY
665 MAINSTREAM DRIVE, 2nd FLOOR
NASHVILLE, TN 37243
Local: (615) 741-3807or Toll Free: (800) 778-4123 Ext. 7413807
www.tn.gov/health

NATIONAL CERTIFICATION VERIFICATION

Fee: $5.00 per report. Please enclose a certified check or money order made payable to the appropriate agent. Do not send cash.

SEND TO: **American Reflexology Certification Board**
P.O. Box 740879
Arvada, CO 80006-0879

To Be Completed By Applicant (Please Type or Print In Ink)

I, the undersigned applicant, was granted certification _____ with the American Reflexology Certification Board on _____/_____/_____.

The Tennessee Reflexology Registrar requests that I submit evidence of the current status of that certification.

You are hereby authorized to release any information in your files, favorable or otherwise, directly to the Tennessee Reflexology Registrar.

_____
Applicant's Signature

Date: _____

_____
Applicant's typed or printed name

To Be Completed By Certification Board

Name In Full As It Appears On Certificate:

_____
(First) (M.I.) (Last)

Certificate Number: _____ Profession: _____

Date Issued: _____

Basis of issuance: **(check one)**

☐ Endorsement/Reciprocity with _____
(State)

☐ Written Examination _____ ☐Other _____
(Name of Exam)

The Certification License is currently active and registered? ☐ YES ☐ NO

Is there any derogatory information on file? *If yes, please attach supporting documentation.* ☐ YES ☐ NO

_____ _____ _____
Authorized Signature Title Date

Certification Board: Please return this form to: **Reflexology Registry**
665 Mainstream Drive, 2nd Floor
Nashville, Tennessee 37243

ATTACHMENT #4

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
TENNESSEE REFLEXOLOGY REGISTRY
665 MAINSTREAM DRIVE, 2nd FLOOR
NASHVILLE, TN 37243
Local: (615) 741-3807 or Toll Free: (800) 778-4123 Ext. 7413807
www.tn.gov/health

NATIONAL CERTIFICATION VERIFICATION

Fee: $5.00 per report. Please enclose a certified check or money order made payable to the appropriate agent. Do not send cash.

SEND TO: **International Institute of Reflexology**
PO Box 12642
St. Petersburg FL 33733-2642

To Be Completed By Applicant (Please Type or Print In Ink)

I, the undersigned applicant, was granted certification _____ with the American Reflexology Certification Board on _____/_____/_____.

The Tennessee Reflexology Registrar requests that I submit evidence of the current status of that certification.

You are hereby authorized to release any information in your files, favorable or otherwise, directly to the Tennessee Reflexology Registrar.

_____
Applicant's Signature

Date: _____

_____
Applicant's typed or printed name

To Be Completed By Certification Board

Name In Full As It Appears On Certificate:

_____
(First) (M.I.) (Last)

Certificate Number: _____ Profession: _____

Date Issued: _____

Basis of issuance: **(check one)**

☐ Written Examination _____ ☐ Other _____
(Name of Exam)

The Certification License is currently active and registered? ☐ YES ☐ NO

Is there any derogatory information on file? *If yes, please attach supporting documentation.* ☐ YES ☐ NO

_____ _____ _____
Authorized Signature Title Date

Certification Board: Please return this form to: **Reflexology Registry**
665 Mainstream Drive, 2nd Floor
Nashville, Tennessee 37243

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.