

<i>Official Use Only</i>
Number: _____
Date Approved/Denied: _____
Approved/Denied By: _____

Physician Assistant

APPLICANT INFORMATION

Full Legal Name: _____
First Middle Last

All Previous Legal Names: _____

Other DOPL Licenses Held: _____

SSN: _____ Date of Birth: _____ Gender: Male Female

Address: _____
Street Address (including Apt/Unit/Ste #) and/or PO Box

City State ZIP Code

Phone: _____ Email: _____

Please Select ONE:

- I am a United States citizen OR a non-citizen of the United States who is lawfully present.
- I am a foreign national not physically present in the United States.
- None of the above, please explain: _____

**Driver License
or State ID**

Card: _____
State of Issue License Number Expiration Date

NOTE: If you do not hold a US Driver License or a US State ID, you must present a legible copy of your current and valid government issued document(s) showing evidence of authorization to work in the United States.

AFFIDAVIT AND RELEASE

1. I certify that I am qualified in all respects for the license for which I am applying in this application.
2. I certify that to the best of my knowledge, the information contained in the application and all supporting document(s) are true and correct, discloses all material facts regarding the applicant, and that I will update or correct the application as necessary, prior to any action on my application.
3. I authorize all persons, organizations, governmental agencies, or any others not specifically listed, which are set forth directly or by reference in this application, to release to the Division of Occupational and Professional Licensing, State of Utah, any files, records, or information of any type reasonably required for the Division to properly evaluate my qualifications for licensure/certification/registration by the State of Utah.
4. I understand that it is the continuing responsibility of applicants and licensees to read, understand, and apply the requirements contained in all statutes and rules pertaining to the occupation or profession for which I am applying, and that failure to do so may result in civil, administrative, or criminal sanctions.
5. I certify that I do not currently pose a direct threat to myself, to my clients, or to the public health, safety or welfare because of any circumstance or condition.
6. I understand that I am responsible to update the Division of any changes relating to my license/certification/registration.

Signature of Applicant: _____ Date: _____

QUALIFYING QUESTIONNAIRE

Read thoroughly, and answer each question. Do not leave any question blank.

A "yes" answer does not necessarily mean you will not be granted a license; however, DOPL may request additional documentation if the information submitted is insufficient.

1. <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had a license, certificate, permit, or registration to practice a regulated profession denied, conditioned, curtailed, limited, restricted, suspended, revoked, reprimanded, or disciplined in any way?
2. <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever been permitted to resign or surrender your license, certificate, permit, or registration to practice in a regulated profession while under investigation or while action was pending against you by any professional licensing agency or criminal or administrative jurisdiction?
3. <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you currently under investigation or is any disciplinary action pending against you now by any <i>local, state or federal licensing, enforcement or regulatory agency</i> ?
4. <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever been declared by any court to be incompetent by reason of mental defect or disease and not restored?
5. <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had a documented case in which you were involved as the abuser in any incident of verbal, physical, mental, or sexual abuse?
6. <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you been terminated, suspended, reprimanded, sanctioned, or asked to leave voluntarily from a position because of drug or alcohol use or abuse within the past five (5) years?
7. <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you currently using or have you recently (<i>within 90 days</i>) used any drugs (<i>including recreational drugs</i>) without a valid prescription, the possession or distribution of which is unlawful under applicable state or federal laws?
8. <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever unlawfully used any drugs for which you have not successfully completed, or are not now participating in a supervised drug rehabilitation program, or for which you have not otherwise been successfully rehabilitated?
9. <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you currently have any criminal action pending?*
10. <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you pled guilty to, no contest to, entered into a plea in abeyance or been convicted of a misdemeanor in any jurisdiction within the past ten (10) years? *
11. <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever pled guilty to, no contest to, or been convicted of a felony in any jurisdiction?*
12. <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever been incarcerated for any reason in any correctional facility (<i>domestic or foreign</i>) in any jurisdiction or on probation/parole in any jurisdiction?*

***NOTE: Charges that were later dismissed and motor vehicle offenses such as driving while impaired or intoxicated must be disclosed; however, minor traffic offenses such as parking or speeding violations need not be listed.**

If you answered "Yes" to any of the above questions, enclose with this application complete information with respect to all circumstances and the final result, if such has been reached.

If you answered "Yes" to Questions 9,10,11 or 12 you must submit the following for **EACH** and **EVERY** incident:

- Personal account of the incident
- police report(s)
- court record(s)
- probation/parole officer report(s)

If you are unable to obtain any of the records required above, you must submit documentation on official letterhead from the police department and/or court indicating that the information is no longer available.

PROFESSIONAL LICENSES

List all other licenses, registrations or certification issued by any state which you now hold or have ever held in any profession. (Use additional sheets if necessary.)

Profession: _____ License Number: _____

Issuing State: _____ License Status: _____ Issue Date: _____

Profession: _____ License Number: _____

Issuing State: _____ License Status: _____ Issue Date: _____

MEDICAL QUALIFYING QUESTIONNAIRE

Read thoroughly, and answer each question. Do not leave any question blank.

A "yes" answer does not necessarily mean you will not be granted a license; however, DOPL may request additional documentation if the information submitted is insufficient.

1. Have your rights, privileges, and/or participation ever been denied, conditioned, curtailed, limited, restricted, suspended or revoked in any way by:

- Yes No a hospital or health care facility
 Yes No Medicaid, Medicare or any other state or federal health care payment reimbursement program
 Yes No the Federal Drug Enforcement Administration or any state drug enforcement agency
 Yes No malpractice insurance coverage
 Yes No other entity:

2. Have you ever been permitted to resign or surrender any rights, privileges and/or participation while under investigation or while action was pending against you from:

- Yes No a hospital or health care facility
 Yes No Medicaid, Medicare or any other state or federal health care payment reimbursement program
 Yes No the Federal Drug Enforcement Administration or any state drug enforcement agency
 Yes No malpractice insurance coverage
 Yes No other entity:

3. Is any action pending against you now by:

- Yes No a hospital or health care facility
 Yes No Medicaid, Medicare or any other state or federal health care payment reimbursement program
 Yes No the Federal Drug Enforcement Administration or any state drug enforcement agency
 Yes No malpractice insurance coverage
 Yes No other entity:

4. Yes No Have you been named as a defendant in a malpractice suit?

5. Yes No Have you ever had office monitoring, practice curtailments, individual surcharge assessments based upon specific claims history, or other limitation, restrictions or conditions imposed by any malpractice carrier?

If you answered "Yes" to question 4 you must submit a complete narrative of the circumstances and a National Practitioner Data Bank report outlining all professional liability claims made against your license and any settlements paid by or on your behalf. NPDB website: <http://www/npdb.hrsa.gov>.

If you answered "Yes" to any of the above questions, enclose with this application complete information with respect to all circumstances and the final result, if such has been reached.

UTAH CONTROLLED SUBSTANCE AFFIDAVIT (OPTIONAL)

If you are applying for a controlled substance license, you must read and sign the affidavit below.

1. I have reviewed and understand that I must abide by the additional laws and rules that govern the practice of my profession as it pertains to controlled substances.
2. I understand that I may need a written delegation of services agreement or a written consultation and referral plan for prescribing controlled substances as outlined in statute.
3. I understand that there may be additional continuing education requirements for those who hold a controlled substance license.
4. I understand it is required that I hold a valid Federal Drug Enforcement Administration (DEA) registration.

Signature of Applicant: _____ Date _____

Note: In addition to signing this affidavit, you must complete the items listed on the OPTIONAL CONTROLLED SUBSTANCE LICENSE checklist at the end of this application.

AFFIDAVIT OF PRACTICE

Complete only one section below:

Section 1: To be completed by applicants who will be practicing in Utah upon issuance of this license.

Complete the following for EACH of your practice sites. Use additional sheets if necessary.

Applicant's Name: _____

Name of Clinic: _____

Supervising Physician: _____ **License Number:** _____

Clinic Address: _____
Street/PO Box City State/Zip

Telephone Number: _____ **Email:** _____

Type of Practice: _____ **Specialty:** _____

Total Number of PAs supervised (including the applicant): _____ **Full-Time Equivalent:** _____

Percentage of Direct Supervision for this applicant: _____

We, the undersigned, declare under penalty of perjury we have completed a "Delegation of Services Agreement" that meets the requirements of R156-70a-501 and have reviewed the agreement with each substitute supervising physician. A copy of the agreement is on file at each of the PAs Utah practice sites and will be made available to DOPL upon request.

Signature of Applicant: _____ Date _____

Signature of Supervisor: _____ Date: _____

Section 2: To be completed by applicants who will not immediately begin practice in Utah.

I declare under penalty of perjury that I will not be practicing as a Physician Assistant in Utah at this time. If, at any future time, I choose to practice in Utah, I agree to complete and submit to DOPL a "Notification of Change" form. I understand that I must receive approval from DOPL before I begin practice with the proposed supervisor(s).

Signature of Applicant: _____ Date _____

TEMPORARY LICENSE (OPTIONAL)

Temporary licensure is an optional license available for applicants who have not previously passed the PANCE only. Please see the checklist at the end of this application for additional instructions.

Applicant's Name: _____

Name of Clinic: _____

Supervising Physician: _____ **License Number:** _____

Clinic Address: _____
Street/PO Box City State/Zip

Telephone Number: _____ **Email:** _____

To be completed by the applicant:

I hereby certify that I will not practice until I have been granted a temporary license, and will cease practice upon the expiration of the license. Once the temporary license has been issued, I will only practice under the direct supervision of my supervising physician or substitute supervising physician as outlined in UCA 58-70a-306 (2)(c)

Signature of Applicant: _____ **Date** _____

To be completed by the supervising physician:

I certify that I am licensed in good standing and will provide direct supervision to the above named applicant as outlined in UCA 58-70a-306 (2)(c). I understand that I am responsible for their activities and services performed, and that once issued their temporary license to practice is valid for only 120 days. I understand that the applicant cannot work without a valid temporary license, either before it is issued or after it expires.

Signature of Supervisor: _____ Date: _____

Certification of Completion of Physician Assistant Education

This form may be used in lieu of transcripts to document completion of an approved PA program. It must be completed by an official representative of the school and bear the schools official seal. Additionally it must be sent directly from the school to DOPL or sealed in an envelope bearing the school's stamp/seal on the envelope flap and submitted with your application. If the form is presented to DOPL unsealed, it will be rejected.

APPLICANT INFORMATION

To be completed by the applicant.

Full Legal Name: _____
First Middle Last

Mailing Address: _____
Street/PO Box City State/Zip

EDUCATION

To be completed by the Accredited Physician Assistant Program Official Representative

Name of Institution: _____

Institution Address: _____
Street/PO Box City State/Zip

Telephone Number _____ **Email:** _____

Accrediting Body: _____ **Accreditation Date:** _____

I attest that the above named applicant attended this physician assistant program from:

Start Date: _____ End Date: _____
MM/DD/YYYY MM/DD/YYYY

and graduated on: _____
MM/DD/YYYY

Signature of Official Program Representative: _____

Printed Name: _____ **Title:** _____

Signed and the school seal affixed this _____ day of _____, 20_____.

{School Seal}

PHYSICIAN ASSISTANT DELEGATION OF SERVICES AGREEMENT

A Delegation of Services Agreement must be maintained at each practice site. It does not need to be submitted with your application. It consists of written criteria jointly developed by all parties involved that permits a physician assistant, working under the direction or review of the supervising physicians, to assist in the management of illnesses and injuries common to the physician's scope of practice.

Full Legal Name: _____
First Middle Last

Address: _____
Street Address (including Apt/Unit/Ste #) and/or PO Box

City State ZIP Code

Phone: _____ **Email:** _____

SUPERVISOR INFORMATION

Name of Establishment: _____ **License Number:** _____

Supervisor: _____ **License Number:** _____

Substitute Supervisor: _____ **License Number:** _____

Establishment Address: _____
Street/PO Box City State/Zip

Telephone Number _____ **Email:** _____

DEGREE AND MEANS OF SUPERVISION

The supervising professional shall provide supervision to the physician assistant to adequately serve the health care needs of the practice population and ensure that the patient's health, safety, and welfare will not be adversely compromised. A physician assistant holding a temporary license may work only under 100% direct supervision.

List the process by which this supervision will be accomplished, including how supervision will be accomplished when the supervising physician is on vacation:

List the method of immediate consultation whenever the physician assistant is not under the direct supervision of the supervising physician:

List the process and degree of onsite supervision:

FREQUENCY AND MECHANISM OF CHART REVIEW

List the method for chart review and co-signatures of the supervising professional. Include the process for chart review and co-signatures required by the professional practice act:

PRESCRIBING OF CONTROLLED SUBSTANCES

A physician assistant may prescribe or administer an appropriate controlled substance if the physician assistant holds a current Utah controlled substance license covering the appropriate schedules of controlled substances and a current DEA registration covering the appropriate schedules of controlled substances; the prescription or administration of the controlled substance is within the prescriptive practice of the supervising professional and also within the delegated prescribing stated in the delegation of services agreement.

In order to prescribe controlled substances, the physician assistant must have obtained his or her own controlled substance license and DEA registration. The physician assistant may not use his or her supervising physician's controlled substance licenses or DEA registrations. A supervising physician cosigns any medical chart record of a prescription of a Schedule 2 or Schedule 3 controlled substance made by the physician assistant.

Please define the process for the physician assistant prescribing controlled substances and expectations.

SCOPE OF PRACTICE

Please define procedures addressing how situations outside the physician assistant's scope of practice will be handled.

EMERGENCY SITUATIONS

List procedures for providing backup support for the physician assistant in emergency situations:

ADDITIONAL CONSIDERATIONS

List any additional items, procedures, and expectations pertinent to the physician assistant's practice at the charity site:

Signature of Physician Assistant: _____ Date: _____

Signature of Supervisor: _____ Date: _____

Signature of Substitute Supervisor: _____ Date: _____

NOTE: A copy of this "Delegation of Services Agreement" is required to be available at the practice site(s). The agreement needs to accurately reflect current practices.

APPLICATION CHECKLIST AND INSTRUCTIONS

This checklist is for your convenience, you do not need to include it with your application.

NOTE: Incomplete applications will be denied.

Your application is classified as a public record and may be available for inspection by the public, except with regard to the release of information which is sub-classified as controlled, private, or protected under the Government Records Access and Management Act or restricted by other law.

ALL APPLICANTS

The following items are required to complete your application:

- \$180.00 non-refundable application processing fee, made payable to "DOPL".
- Supporting documentation for any "yes" answers provided on either of the qualifying questionnaires. See pages 2 and 3 of the application for more information.
- Documentation of meeting the education requirements. Submit one of the following:
 - Official transcripts documenting a degree from a physician assistant school accredited by the Accreditation Review Commission of Education for the Physician Assistant (ARC-PA). **NOTE:** Transcripts are considered "official" when they are sent directly from the school to DOPL or sealed in an envelope bearing the school's stamp/seal on the envelope flap.
 - OR**
 - Certification of Completion of Physician Assistant Education form (page 5 of this application).
- Request official documentation from NCCPA of a passing score on the PANCE or PANRE be sent directly to DOPL. Please contact NCCPA via their website, www.nccpa.net.

OPTIONAL CONTROLLED SUBSTANCE LICENSE

If your practice in the state of Utah will include administering, possession or prescribing of controlled substances, you must apply for a Utah Controlled Substance License by submitting the following:

- \$100.00 non-refundable application processing fee, made payable to "DOPL".
 - Complete the "Utah Controlled Substance Law and Rule Affidavit" found on page 3 of this application.
- *NOTE:** In addition to the Utah Controlled Substance License, you must hold a valid Federal Drug Enforcement Administration (DEA) registration.

OPTIONAL TEMPORARY LICENSURE

If you meet all the requirements for licensure but have not yet passed the PANCE, you *may* apply for temporary licensure. In addition to the items required for all applicants, you must submit the following:

- \$50.00 non-refundable Temporary Physician Assistant application fee.
- Completed "Temporary License" section of this application (see page 4).

Submit the above items with your completed application to:

In person or via express delivery:

Division of Occupational and Professional Licensing
Heber M Wells Building, 1st Floor Lobby
160 E 300 S
Salt Lake City, UT 84111

US Postal Service:

Division of Occupational and Professional Licensing
PO BOX 146741
Salt Lake City, UT 84114-6741