

STATE OF UTAH
DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSING

APPLICATION FOR LICENSURE

PHYSICIAN ASSISTANT

APPLICATION INSTRUCTIONS AND INFORMATION

General Statement: The Utah Division of Occupational and Professional Licensing (DOPL) desires to provide courteous and timely service to all applicants for licensure. To facilitate the application process, **submit a complete application form including all applicable supporting documents and fees.** Failure to submit a complete application and supply all necessary information will delay processing and may result in denial of licensure. The fees are for processing your application and will not be refunded. **Please read all instructions carefully.**

Address of Record: The address you provide on this application will be your address of record. All correspondence from DOPL will be sent to that address. You are responsible to directly notify DOPL of any change to your address of record. Do not rely on a forwarding order.

Social Security Number: Your social security number is classified as a private record under the Utah Government Records Access and Management Act. It is used by DOPL as an individual identifier. It is also used for child support enforcement pursuant to Subsection 78-32-17(3) and is mandatory pursuant to Subsection 58-1-301(1), Utah Code Ann., which implements 42 U.S.C. 666(a)(13). If an SSN is not provided, the application is incomplete and may be denied.

SUPPORTING DOCUMENTS AND FEES:

In addition to submitting a completed application, complete the following:

1. Submit a “Certification of Completion of Physician Assistant Education” form (*attached to this application*) completed by an official representative of your accredited physician assistant program.
2. Using the “NCCPA Request and Authorization for Release of Information” form (attached to this application), submit a National Commission on Certification of Physician Assistant Certificate to document passing the NCCPA examination – unless you are applying for a temporary license.
3. Submit a completed take-home “Utah Physician Assistant Law and Rule Examination” (*pages 13, 14, and 15 of this application*).

4. If you are **currently** licensed as a physician assistant in another state, submit verification of licensure from that state. If you are licensed in more than one state, submit verification of licensure from at least two states in which you are **currently** licensed.

Request that the verifying state(s) complete the form(s) and mail them directly to DOPL or return them to you for submission with your application.

5. Submit a **\$180.00** non-refundable application-processing fee, made payable to “DOPL.”
6. If you are applying for a Utah controlled substance license, additionally submit the following:

- ❑ a completed take-home “Utah Controlled Substances Law and Rules Examination” (*pages 17 and 18 of this application*).
- ❑ an additional **\$90.00** non-refundable application-processing fee.

Note: The total fees for a physician assistant license and a Utah controlled substance license are \$270.00.

7. If you are applying for a temporary license, additionally submit the following:

- ❑ a “Physician Assistant Temporary License Request” form (*attached to this application*) – if you have met all requirements except passing the NCCPA Examination. (*See the “Additional Important Information” section below.*)
- ❑ an additional **\$50.00** non-refundable application-processing fee, made payable to “DOPL”

Note: The total fees for a physician assistant license and a temporary physician assistant license are \$230.00.

The total fees for a physician assistant license and a temporary physician assistant license and a Utah controlled substance license are \$320.00.

ADDITIONAL IMPORTANT INFORMATION:

1. **Law and Rules Examination:** Enclosed with this application is the take-home Utah Physician Assistant Law and Rules Examination. All applicants must complete the exam and submit it with your application for licensure. Do not submit it separately.

The following applicable laws and rules are available on the Internet at www.dopl.utah.gov:

- Division of Occupational & Professional Licensing Act
- General Rules of the Division of Occupational and Professional Licensing
- Utah Physician Assistant Practice Act
- Utah Physician Assistant Practice Act Rules
- Utah Controlled Substances Act
- Controlled Substance Act Rules of the Division of Occupational and Professional Licensing
- Health Care Providers Immunity from Liability Act

2. **Controlled Substances Law and Rules Examination:** Enclosed with this application is the take-home Utah Controlled Substances Law and Rules Examination. Return the completed examination with your application for licensure if you are applying for a controlled substance license in addition to your license. Do not submit it separately.

The following applicable laws and rules are available on the Internet at www.dopl.utah.gov:

- Division of Occupational & Professional Licensing Act
- General Rules of the Division of Occupational & Professional Licensing
- Utah Controlled Substances Licensing Act
- Utah Controlled Substances Licensing Act Rules

3. **Current Documents:** Applications, statutes, rules, and forms are occasionally changed. Go to www.dopl.utah.gov to ensure you have the most recent version of these documents.
4. **Controlled Substance License:** You must hold a Utah controlled substance license and a DEA registration to administer, possess, or prescribe a controlled substance in your practice in Utah. You must obtain your own controlled substance license and DEA registration. You may not use your supervising physicians' controlled substance licenses or DEA registrations.
5. **DEA Registration:** For DEA registration information, contact the Drug Enforcement Administration, Salt Lake District Office, 348 East South Temple, Salt Lake City, UT 84088. Telephone (801) 524-4389.

6. **Notification of Change Form:** Submission of a "Notification of Change" form to DOPL is required before any change in supervisor. DOPL maintains this supervisory information, and changes must be completed each time you change supervisors.
7. **Delegation of Services Agreement:** A "Delegation of Services Agreement" is to be maintained at each of your Utah practice sites and must be available to Division of Occupational and Professional Licensing upon request. Do not submit them with your application for licensure. The agreements contain written criteria jointly developed by you and your supervising physician and substitute supervising physicians that permit you, 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. A "Delegation of Services Agreement" form is included with this application for your convenience.
8. **Renewal Requirements / Continuing Education:** In order to renew your license you must complete at least 40 hours of Category 1 ACCME continuing education in each two-year license renewal cycle.
9. **Temporary License:** A temporary license will only be issued to an applicant who has never taken the NCCPA certification examination and who otherwise meets all licensure requirements.

A temporary license is valid from its date of issuance until the earlier of the following dates:

- 10 days after receiving the test results of the first scheduled NCCPA examination following issuance of the temporary license
- failure to take the first scheduled NCCPA examination following issuance of the temporary license

A physician assistant holding a temporary license may work:

- only under the direct supervision of an approved supervising or substitute supervising physician with the physician physically present on site and immediately available for consultation
- only with 100% review and countersigning of patient charts
- only in accordance with a Delegation of Services Agreement

10. **License Renewal:** All physician assistant licenses expire May 31 of each even-numbered year. If you possess a controlled substance license, it will expire at the same time as your physician assistant license and will also need to be renewed.

Unlike many other states, Utah's license renewal schedule **is not** based on the licensee's date of initial licensure. Under Utah's renewal system, all licenses in each profession expire as a group on the same day every two years. Therefore, the length of a licensee's

first renewal cycle depends on how far into the current renewal cycle initial licensure was obtained. Each renewal cycle thereafter is for a full two years.

Additionally, the fee paid with this application for licensure is an application-processing fee only. It does not include a renewal fee. Each licensee is responsible to renew licensure **PRIOR** to the expiration date shown on the current license. Approximately two months prior to the expiration date shown on the license, renewal information is disseminated to each licensee's last address of record, as provided to DOPL.

11. **Updating Address Information:** It is your responsibility to maintain a current address with DOPL. If your address is incorrect, you will not receive renewal notices or other correspondence. Address changes can be made online at www.dopl.utah.gov.
12. **Name Change:** If you have been licensed by DOPL under any other name, please submit documentation of your name change (*i.e. copy of a marriage license or divorce decree*).
13. **Ceremonial Certificate of Licensure:** After obtaining your license from DOPL, you can order a Ceremonial Certificate of Licensure, printed on parchment paper with original signatures and an embossed gold seal. Order forms can be obtained at www.dopl.utah.gov.
14. **Acceptable Forms of Payment:** Licensure fees can be paid by check or money order, made payable to "DOPL." Cash and debit/credit cards (*American Express, MasterCard, and Visa*) are also accepted in person at DOPL's main office – but not over the telephone.
15. **Mail Complete Application to:**

By U.S. Mail

Division of Occupational & Professional Licensing
P.O. Box 146741
Salt Lake City, Utah 84114-6741

By Delivery or Express Mail

Division of Occupational & Professional Licensing
160 East 300 South, 1st Floor Lobby
Salt Lake City, Utah 84111

16. **Telephone Numbers:** (801) 530-6628
(866) 275-3675 – Toll-free in Utah
17. **Fax Number:** (801) 530-6511

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APPLICATION FOR LICENSURE

GENERAL INFORMATION:

License(s) Applying For: PHYSICIAN ASSISTANT
 CONTROLLED SUBSTANCE
 PHYSICIAN ASSISTANT TEMPORARY

Last Name: _____ Maiden Name: _____

First Name: _____ Middle Name: _____

Gender: Male Female Date of Birth: ____/____/____

Social Security Number: ____ - ____ - ____

I certify under penalty of perjury that I am a United States citizen or a qualified alien who is lawfully able to work in the United States.

Signature of Applicant: _____ Date: ____/____/____

Have You Ever Held A Utah License Before? Yes No

If Yes, Name of Profession: _____ License Number: _____

MAILING ADDRESS:

Street: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Email: _____

DO NOT WRITE IN THIS SECTION - FOR DIVISION USE ONLY

License/Certificate Number: _____

Date License/Certificate Approved: ____/____/____

Approved By: _____

Date License/Certificate Denied: ____/____/____

Denied By: _____

Reason for Denial/Other Comments: _____

AFFIDAVIT FOR UTAH LAWS AND RULES

I understand that it is my responsibility to read and understand all statutes and rules pertaining to my practice as a physician assistant in the state of Utah and I agree to comply with such.

Signature of Applicant: _____ Date: ___/___/___

PHYSICIAN ASSISTANT SCHOOL *(Use additional sheets if necessary.)*

Name of School: _____ Dates Attended: _____ to _____

Location: _____

Degree Received: _____ Date of Graduation: ___/___/___

Name of School: _____ Dates Attended: _____ to _____

Location: _____

Degree Received: _____ Date of Graduation: ___/___/___

LICENSES

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

Issuing State: _____ Profession: _____

License Status: _____ License Number: _____ Effective Date: _____

Issuing State: _____ Profession: _____

License Status: _____ License Number: _____ Effective Date: _____

Issuing State: _____ Profession: _____

License Status: _____ License Number: _____ Effective Date: _____

PROFESSIONAL EXAMINATION REQUIREMENT

Answer “yes” or “no.”

_____ NCCPA, Date(s) Taken: ____/____/____

_____ Utah Physician Assistant Law and Rules Exam (*take-home, submit with application*)

_____ Utah Controlled Substances Law and Rule Exam (*take-home, submit with application*)

RECORD OF PROFESSIONAL EXPERIENCE

Account for all time periods since graduation from PA school. (*Use additional sheets if necessary.*)

Employer: _____

Address: _____

Dates of Employment: from ____/____ to ____/____ Telephone: _____

Contact Person: _____

Practice Type and Specialty: _____

Employer: _____

Address: _____

Dates of Employment: from ____/____ to ____/____ Telephone: _____

Contact Person: _____

Practice Type and Specialty: _____

Employer: _____

Address: _____

Dates of Employment: from ____/____ to ____/____ Telephone: _____

Contact Person: _____

Practice Type and Specialty: _____

IF PRACTICING AS A PHYSICIAN ASSISTANT IN UTAH

Complete the following for each of your practice sites. (*Use additional sheets if necessary.*)

Supervising Physician’s Name: _____

Supervising Physician’s Utah License Number: _____

Specialty: _____

Number of PAs supervised (*including the applicant*): _____ Number of FTE PAs: _____

Practice Site(s): _____

Type of Practice: _____

Percent of Direct Supervision: _____

Substitute Supervising Physician’s Name: _____

Specialty: _____

AFFIDAVIT:

I declare under penalty of perjury as follows:

I will be practicing as a physician assistant in Utah. I have completed a “Delegation of Services Agreement” with my supervising physician and have reviewed the agreement with each of my substitute supervising physicians.

A copy of the agreement is on file at each of my Utah practice sites and is available to DOPL upon request.

The agreement defines the working relationship and delegation of duties between me and my supervising physician and includes all of the following: the prescribing of controlled substances; the degree and means of supervision; the frequency and mechanism of chart review; procedures addressing situations outside my scope of practice; and procedures for providing backup for me in emergency situations. The written criteria were jointly developed by me and my supervising physician and by me and any substitute supervising physicians. The agreement permits me to work under the direction or review of my supervising physician(s) to assist in the management of illnesses and injuries common to the physician’s scope of practice.

Signature of Physician Assistant Applicant: _____ Date: ____/____/____

Signature of Supervising Physician: _____ Date: ____/____/____

IF NOT PRACTICING AS A PHYSICIAN ASSISTANT IN UTAH

I declare under penalty of perjury as follows:

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). I also agree to complete a “Delegation of Services Agreement” consistent with Utah law before I begin my practice in Utah. Said agreement(s) will be on file at my Utah practice site(s).

Signature of Applicant: _____ Date: ____/____/____

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UTAH PHYSICIAN ASSISTANT LAW AND RULES EXAMINATION

The reference listed after each question is provided to assist you in selecting your response. The examination is not intended to be difficult. The purpose of the exam is to bring to your attention specific practice issues you need to know in order to avoid violating Utah law and rule. If you are uncertain about any of the questions listed below, please refer to the reference listed in order to become familiar with your Utah physician assistant practice.

Answer “**true**” or “**false**” for each statement. Do not leave any statement blank. Return this completed examination with your application for licensure as a physician assistant.

1. _____ A physician can supervise only 2 full time equivalent (FTE) Physician Assistants.
[REF: Physician Assistant Practice Act Rules, R156-70a-501(4)]

2. _____ A physician assistant’s full time equivalent (FTE) is equal to 2080 hours of staff time for a one-year period.
[REF: Physician Assistant Practice Act Rules, R156-70a-102(1)]

3. _____ A supervising physician and his physician assistant have been working together for three months. The supervising physician must review and cosign sufficient numbers of patient charts and medical records to ensure that the patient’s health, safety, and welfare will not be adversely compromised.
[REF: Physician Assistant Practice Act Rules, R156-70a-501(3)]

4. _____ A physician assistant, while practicing, shall wear an identification badge indicating his/her license classification, and not represent his/herself as a physician to the patient.
[REF: Physician Assistant Practice Act, 58-70a-501(3 & 4)]

5. _____ In accordance with a Delegation of Services Agreement, in order for a physician assistant to prescribe or administer a controlled substance, a physician assistant must:
 - A. hold a Utah controlled Substance license and a DEA registration.
 - B. prescribe or administer the controlled substance within the prescriptive practice of the supervising physician and also within the delegated prescribing delineation.
 - C. have the supervising physician cosign any medical record of a prescription of a Schedule II or III controlled substance.
 - D. sign the prescription in ink and include his own DEA number on the prescription form.[REF: Physician Assistant Practice Act, 58-70a-501(2)]
[REF: Controlled Substance Act, 58-37-6(7) (d)]

(Continued on the next page.)

6. _____ Unlawful conduct includes engaging in practice as a physician assistant while not under the supervision of a supervising physician or substitute, supervising physician.
[REF: Utah Physician Assistant Practice Act, 58-70a-502]
7. _____ Unprofessional conduct includes failing to maintain a Delegation of Services Agreement that accurately reflects current practices at the practice site.
[REF: Utah Physician Assistant Practice Act, 58-70a-503(4)]
8. _____ Unprofessional conduct includes providing sample medications to a patient that does NOT have a legitimate medical need for it.
[REF: Utah Physician Assistant Practice Act, 58-70a-503]
9. _____ A physician assistant who violates the unlawful conduct provision may be found guilty of a third degree felony.
[REF: Utah Physician Assistant Practice Act, 58-70a-504]
10. _____ A physician assistant who violates the unprofessional conduct provision may be found guilty of a Class A misdemeanor.
[REF: Utah Physician Assistant Practice Act, 58-70a-504]
11. _____ A physician assistant may provide medical services under the following conditions:
 - A. if the services fall within the physician assistant's scope of skill and competence
 - B. if the services are provided in the Delegation of Services agreement with the supervising physician
 - C. if the supervising physician provides the same services[REF: Utah Physician Assistant Practice Act, 58-70a-501(1)]
12. _____ A physician assistant holding a temporary license may work only under the direct supervision of a supervising physician
[REF: Utah Physician Assistant Practice Act, 58-70a-306]
13. _____ A temporary license may be granted to a physician assistant who has met all of the licensing requirements except for passing the examination component.
[REF: Utah Physician Assistant Practice Act, 58-70a-306]
14. _____ A physician assistant may NOT independently bill a patient for services rendered.
[REF: Utah Physician Assistant Practice Act, 58-70a-501(4)]

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15. _____ Documentation of completed qualified continuing professional education may be provided by submitting to the Division copies of certificates from sponsoring agencies, transcripts of participation on applicable letterhead, or a copy of current national certification by NCCPA.
[REF: Utah Physician Assistant Practice Act Rules, R156-70a-304]
16. _____ As a condition for licensure renewal, each physician assistant must have completed 40 hours of continuing professional education during each two-year licensure cycle.
[REF: Utah Physician Assistant Practice Act Rules, R156-70a-304]
17. _____ The minimum length of time that records documenting completion of qualified continuing professional education must be kept after the two-year period to which the records pertain is 4 years.
[REF: Utah Physician Assistant Practice Act Rules, R156-70a-304]
18. _____ If an applicant DOES NOT take the next possible physician assistant examination, the temporary license expires on the date of the exam.
[REF: Utah Physician Assistant Practice Act, 58-70a-306]
19. _____ If an applicant does take the next succeeding physician assistant examination, the temporary license expires 10 days after the results are available.
[REF: Physician Assistant Practice Act, 58-70a-306]
20. _____ The supervising physician cannot be an employee of the physician assistant that s/he supervises.
[REF: Physician Assistant Practice Act, 58-70a-102(6)(c)]

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UTAH CONTROLLED SUBSTANCES LAW AND RULES EXAMINATION

The reference listed after each question is provided to assist you in selecting your response. The examination is not intended to be difficult. The purpose of the exam is to bring to your attention specific practice issues you need to know in order to avoid violating Utah law and rule. If you are uncertain about any of the questions listed below, please refer to the reference listed in order to become familiar with Utah's controlled substance prescribing practices.

Answer “**true**” or “**false**” for each statement. Do not leave any statement blank. Return this completed examination with your application for licensure.

1. _____ A prescription for a schedule II controlled substance may be filled in a quantity not to exceed a 30 day supply. [58-37-6(7)(f)(i)(B)]
2. _____ A prescription for a schedule III or IV controlled substance may be refilled 5 times within a six month period from the issue date of the prescription. [58-37-6(7)(f)(ii)]
3. _____ All prescription orders must be signed in ink or indelible pencil to prevent anyone from altering a legitimate prescription. [58-37-6(7)(d)]
4. _____ Licensed prescribing practitioners must make their controlled substance stock and records available to DOPL personnel for inspection during regular business hours. [R156-37-601]
5. _____ All records of purchasing, prescribing, and administering controlled substances must be maintained by the licensed prescribing practitioner for at least five years. [R156-37-602(3)]
6. _____ The name, address, and DEA registration number of the prescribing practitioner, and the name, address, and age of the patient are required to be included on the prescription for a controlled substance. [58-37-6(7)(d)]
7. _____ A controlled substance is taken according to the prescriber's instructions. A refill may be dispensed after 80% of the medication has been consumed. [R156-37-603(7)]
8. _____ After the discovery of any theft or loss of a controlled substance, the prescribing practitioner is required to file the appropriate forms with the DEA, report the incidence to the local police, and send copies of the filed DEA forms to DOPL. [R156-37-602(2)]

(Continued on the next page.)

9. _____ The maximum number of controlled substances that can be written on a single prescription form is one. [R156-37-603(3)]
10. _____ An emergency verbal prescription order for a schedule II controlled substance requires that the patient be under the continuing care of the prescribing practitioner for a chronic disease, the amount of drug prescribed is limited to what is needed to adequately treat the patient for no more than 72 hours, and a written prescription shall be delivered to the filling pharmacy within 7 working days of the verbal order. [R156-37-605]
11. _____ A prescribing practitioner in Utah may not dispense prescription medications to his/her patients except for manufacturers' samples. [58-37-2(1)(m) and 58-17b-102(28)]
12. _____ Issuing a prescription for a schedule II or III controlled substance for yourself is considered unprofessional conduct and may result in disciplinary action. [R156-37-502]
13. _____ A prescribing practitioner is using a schedule IV controlled substance in the treatment of weight reduction for obesity. The practitioner has completed a medical history of the patient, has performed a complete physical examination, has ruled out contra-indications, and has determined that the health benefits of treatment greatly out-weigh the risks. An informed consent signed by the patient is also required prior to initiating treatment. [R156-37-604(2)]

PHYSICIAN ASSISTANT QUALIFYING QUESTIONNAIRE

Answer “yes” or “no” for each question. Do not leave any question blank.

1. _____ Have you ever applied for or received a license, certificate, permit, or registration to practice in a regulated profession under any name other than the name listed on this application?
2. _____ Have you ever been denied the right to sit for a licensure examination?
3. _____ 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?
4. _____ 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 health care profession licensing agency, hospital or other health care facility, or criminal or administrative jurisdiction?
5. _____ Are you currently under investigation or is any disciplinary action pending against you now by any licensing agency or governmental agency?
6. _____ Have you ever had hospital or other health care facility privileges denied, conditioned, curtailed, limited, restricted, suspended, or revoked in any way?
7. _____ Have you ever been permitted to resign or surrender hospital or other health care facility privileges, while under investigation or while action was pending against you by any licensing agency, hospital or other health care facility, or criminal or administrative jurisdiction?
8. _____ Is any action related to your conduct or patient care pending against you now at any hospital or health care facility?
9. _____ Have you ever had rights to participate in Medicaid, Medicare, or any other state or federal health care payment reimbursement program denied, conditioned, curtailed, limited, restricted, suspended, or revoked in any way?
10. _____ Is any action pending against you now by Medicaid, Medicare, or any other state or federal health care payment reimbursement program?
11. _____ Have you ever been permitted to resign from Medicaid, Medicare, or any other state or federal health care payment reimbursement program while under investigation or while action was pending against you by any licensing agency, hospital, or other health care facility, or criminal or administrative jurisdiction?

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12. _____ Have you ever had a federal or state registration to sell, possess, prescribe, dispense, or administer controlled substances denied, conditioned, curtailed, limited, restricted, suspended or revoked in any way by either the federal Drug Enforcement Administration or any state drug enforcement agency?
13. _____ Have you ever been permitted to surrender your registration to sell, possess, prescribe, dispense, or administer controlled substances while under investigation or while action was pending against you by any health care profession licensing agency, hospital or other health care facility, or criminal or administrative jurisdiction?
14. _____ Is any action pending against you now by either the Federal Drug Enforcement Administration or any state drug enforcement agency?
15. _____ Have you been named as a defendant in a malpractice suit?
16. _____ Have you ever had office monitoring, practice curtailments, individual surcharge assessments based upon specific claims history, or other limitations, restrictions, or conditions imposed by any malpractice carrier?
17. _____ Have you ever had any malpractice insurance coverage denied, conditioned, curtailed, limited, suspended, or revoked in any way?
18. _____ If you are licensed in the occupation/profession for which you are applying, would you pose a direct threat to yourself, to your patients or clients, or to the public health, safety, or welfare because of any circumstance or condition?
19. _____ Have you ever been declared by any court of competent jurisdiction incompetent by reason of mental defect or disease and not restored?
20. _____ Have you been terminated from a position because of drug use or abuse within the past five (5) years?
21. _____ Are you currently using or have you recently (*within 90 days*) used any drugs (*including recreational drugs*) without a valid prescription, the possession or distribution of which is unlawful under the Utah Controlled Substances Act or other applicable state or federal law?
22. _____ 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?
23. _____ Have you ever used any drugs without a valid prescription, the possession or distribution of which is unlawful under the Utah Controlled Substances Act or other applicable state or federal law, 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?

(Continued on the next page.)

24. _____ Do you currently have any criminal action pending?
25. _____ 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? Motor vehicle offenses such as driving while impaired or intoxicated must be disclosed but minor traffic offenses such as parking or speeding violations need not be listed.
26. _____ Have you ever pled guilty to, no contest to, or been convicted of a felony in any jurisdiction?
27. _____ Have you, in the past ten (10) years, been allowed to plea guilty or no contest to any criminal charge that was later dismissed (*i.e. plea in abeyance or deferred sentence*)?
28. _____ Have you ever been incarcerated for any reason in any federal, state or county correctional facility or in any correctional facility in any other jurisdiction or on probation/parole in any jurisdiction?



If you answered "yes" to question 15 above, you must submit a National Practitioner Database document outlining all professional liability claims made against your license and any settlements paid by or on your behalf.

Additionally, if you answered "yes" to questions 23, 24, 25, 26, 27, or 28 above, you must submit a complete narrative of the circumstances that occurred for EACH and EVERY conviction, plea in abeyance, and/or deferred sentence. You must also attach copies of all applicable police report(s), court record(s), and 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.

If you have formally expunged a criminal record as evidenced by a court order signed by a judge, you do not need to disclose that criminal history. Expungement orders must be sent to the Bureau of Criminal Identification and the FBI to enable the expungement to be completed and the criminal history eliminated from the records.



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.

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.

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AFFIDAVIT and RELEASE AUTHORIZATION

I am the applicant described and identified in this application for licensure, certification, or registration in the State of Utah.

I am qualified in all respects for the license, certificate, or registration for which I am applying in this application.

To the best of my knowledge, the information contained in the application and its supporting document(s) is free of fraud, misrepresentation, or omission of material fact.

To the best of my knowledge, the information contained in the application and its supporting document(s) is truthful, correct, and complete; and discloses all material facts regarding the applicant and associated individuals necessary to properly evaluate the applicant's qualifications for licensure.

I will ensure that any information subsequently submitted to the Division of Occupational and Professional Licensing in conjunction with this application or its supporting documents meet the same standard as set forth above.

I understand that it is unlawful and punishable as a class A misdemeanor to apply for or obtain a license or to otherwise deal with the Division of Occupational and Professional Licensing or a licensing board through the use of fraud, forgery, or intentional deception, misrepresentation, misstatement, or omission.

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

I authorize all persons, institutions, organizations, schools, governmental agencies, employers, references, or any others not specifically included in the preceding characterization, 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 of Occupational and Professional Licensing to properly evaluate my qualifications for licensure/certification/registration by the State of Utah.

Signature of Applicant: _____

Signature Date: ____/____/____

Printed Name of Applicant: _____

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Utah Division of Occupational and Professional Licensing
160 East 300 South, P.O. Box 146741
Salt Lake City, Utah 84114-6741

CERTIFICATION OF COMPLETION OF PHYSICIAN ASSISTANT EDUCATION

TO BE COMPLETED BY THE APPLICANT:

Request that the official representative of your accredited physician assistant program complete this form and return it to you for submission with your application.

Applicant Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Social Security Number: _____ Date of Graduation: ____/____/____

**TO BE COMPLETED BY THE ACCREDITED PHYSICIAN ASSISTANT PROGRAM
OFFICIAL REPRESENTATIVE:**

Name of Institution: _____

Location of Institution: _____

Telephone of Institution: _____

Date of Accreditation: ____/____/____

Accredited By: _____

I attest that the above named applicant attended this physician assistant program from
____/____/____ to ____/____/____ and graduated on ____/____/____.

Signature of Official Program Representative: _____

Title: _____

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

(School Seal)

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Utah Division of Occupational and Professional Licensing
160 East 300 South, P.O. Box 146741
Salt Lake City, Utah 84114-6741
FAX: (801) 530-6511

REQUEST FOR VERIFICATION OF LICENSE

(Use this form to verify licensure from another state, if applicable.)

TO BE COMPLETED BY THE APPLICANT:

Complete the first section of the form and submit it to a state in which you are **currently** licensed as a physician assistant. Request that the verifying state complete the form and mail it directly to DOPL or return it to you for submission with your application.

Applicant Name: _____

Street Address: _____

City: _____

State: _____ Zip: _____

I am requesting licensure in the state of Utah as a _____

I am/have been licensed in your state under the name _____

My social security number is _____

My date of birth is ____/____/____

My license number in your state is/was _____

I have enclosed the necessary license verification fee in the amount of \$ _____

Signature of Applicant: _____

TO BE COMPLETED BY THE VERIFYING AGENCY:

Please furnish the information requested, sign and verify the document, and mail it directly to DOPL, or place the completed form in a sealed envelope and provide it to the applicant in person or by mail. The applicant will include the sealed verification of licensure with his/her Utah application. Thank you.

(Continued on the next page.)

Name of Verifying State: _____

Name of Licensee (*as it appears in verifying state's records*): _____

Classification of License Issued: _____

License Number: _____ Current Status: _____

Original Date of Licensure: ___/___/___ Expiration Date: ___/___/___

Continuously Licensed:

Yes No, please explain: _____

Licensed By:

Exam, Type: _____ Date: ___/___/___

Endorsement: from what state? _____

Examination Scores: _____

Education Required for Licensure: _____

Disciplinary Action or Pending Disciplinary Action:

No Yes, please provide certified copies of all Petitions, Orders, etc.

Signature: _____

Title: _____

Agency: _____

Date: ___/___/___

(SEAL)

Utah Division of Occupational and Professional Licensing
160 East 300 South, P.O. Box 146741
Salt Lake City, Utah 84114-6741

PHYSICIAN ASSISTANT TEMPORARY LICENSE REQUEST

TO BE COMPLETED BY THE APPLICANT:

Name: _____

Address: _____

Telephone: _____ Date Taking Certifying Exam: ___/___/_____

Supervising Physician: _____

Address: _____

Telephone: _____ Date Employment to Begin: ___/___/_____

Clinic Location: _____

Address: _____

Telephone: _____

I hereby certify that I will not practice until I have been granted a temporary license. Once the temporary license has been issued, I will only practice under the direct supervision of my supervising physician or substitute supervising physician.

Signature of Applicant: _____

Date of Signature: ___/___/_____

TO BE COMPLETED BY SUPERVISING PHYSICIAN:

Name: _____

Address: _____

Telephone: _____ Utah License Number: _____

Signature of Supervisor: _____ Date of Signature: ___/___/_____

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PHYSICIAN ASSISTANT DELEGATION OF SERVICES AGREEMENT

A Delegation of Services Agreement is to be maintained at each practice site and is to be available to DOPL upon request. It consists of written criteria jointly developed by a physician assistant's supervising physician and any substitute supervising physicians and the physician assistant 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.

The following information must be legible. *(Use additional sheets if necessary.)*

DO NOT SUBMIT YOUR DELEGATION OF SERVICES AGREEMENTS TO DOPL WITH YOUR APPLICATION FOR LICENSURE. KEEP THIS ON SITE AT YOUR FACILITY.

Physician Assistant Name: _____

Utah License Number: _____

Supervising Physician Name: _____

Utah License Number: _____

Substitute Supervising Physician(s):

Name: _____ Utah License Number: _____

Name: _____ Utah License Number: _____

Name: _____ Utah License Number: _____

PRACTICE SITE(S):

1. Name of Facility: _____

Address: _____

City: _____ State: _____ Zip: _____

2. Name of Facility: _____

Address: _____

City: _____ State: _____ Zip: _____

DEGREE AND MEANS OF SUPERVISION:

The supervising Physician 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 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: _____

List the method of supervision when the supervising physician is on vacation: _____

FREQUENCY AND MECHANISM OF CHART REVIEW:

List the method for chart review and co-signatures of the supervising practitioner for supervision. Include the process for chart review and co-signatures required:

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 practitioner and also within the delegated prescribing stated in the delegation of services agreement; and the supervising practitioner co-signs any medical chart record of a prescription of a Schedule 2 or Schedule 3 controlled substance made by the physician assistant.

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.

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

SCOPE OF PRACTICE:

Please define procedures addressing situations outside the physician assistant’s scope of practice.

EMERGENCY SITUATIONS:

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

ADDITIONAL CONSIDERATIONS RELATING TO THE PRACTICE:

List any additional items, procedures, and expectations pertinent to the physician assistant at your site: _____

Signature of Physician Assistant: _____

Signature Date: ____/____/____

Signature of Supervising Physician: _____

Signature Date: ____/____/____

Signature of Substitute Supervising Physician: _____

Signature Date: ____/____/____

NOTE: It is “unprofessional conduct” under the Physician Assistant Practice Act to fail to maintain at the practice site(s) a “Delegation of Services Agreement” that accurately reflects current practices; or to fail to make the “Delegation of Services Agreement” available to DOPL for review upon request.

Mail completed form directly to:
NCCPA
12000 Findley Road, Suite 200
Duluth GA 30097

NCCPA Request and Authorization for Release of Information

Please type or print. Duplicate as needed.

Section 1: Identification

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Daytime Telephone: (____) _____ - _____ Social Security Number: _____ - _____ - _____

Section 2: Exam Information

Indicate for which exam and examination period you're requesting information. (Only one request per form.)

- PANCE (Physician Assistant National Certifying Exam)
- PANRE (Physician Assistant National Recertifying Exam)
- Pathway II
- Surgery Exam

Year: _____ Spring Fall

Section 3: Information Request

Indicate the nature of this request and the person or agency to whom it should be sent.

- Eligibility letter, verifying that you are eligible for and registered to take the above exam
- Pending letter, verifying that you have taken the above exam and are waiting scores
- Exam results

(Complete only if different from above.)

Name: _____

Agency: _____

Address: _____

City: _____ State: _____ Zip: _____

Want us to send the information via fax? If so, please provide the fax number here: (____) _____ - _____

Section 4: Signature and Authorization

Each state licensing authority sets its own rules and regulations. NCCPA strives to stay up-to-date on individual state regulations. We will send the required information, which may consist of current scores and/or score history, to the agency listed above in accordance with the information on state requirement on file with NCCPA.

I acknowledge that I read and understand the above statement and authorize NCCPA to release all information required by the agency listed above.

(signature)

(date)