PAB Physician Assistant Board

APPLICATION FOR LICENSURE
PHYSICIAN ASSISTANT

Please **READ** all instructions and general information prior to completing this application. **ALL** questions on this application must be answered, and all supporting documents must be submitted with this application as per instructions. When space provided is insufficient, attach additional sheets of paper. Please type or print neatly, illegible applications will be returned. **Applications received without applicable fees will not be processed and returned to the sender as**

Select one option only:
Application processing and licensing fees ☐ ***$225.00 Application processing, licensing, & fingerprint cards fees*** ☐ ***$274.00***

PERSONAL INFORMATION

1. Name	Last	First	Middle	PAB Use Only
2. Other Names/Aliases (Including Birth Name)				
3. Gender		**4. SSN/ITIN**		
Male ☐ Female ☐				
5a. Address of Record/ Mailing Address Will be released by the Board to the public and posted on the PAB's website if a license is issued. This address will also be used for services of all official correspondence,	Number and Street (including apartment number, if applicable)			
	City	State	Zip Code	Country
5b. Confidential Address If you provided a PO Box in 5a, you must also provide a street address. This address will not be posted on the PAB's website.	Number and Street (including apartment number, if applicable)			
	City	State	Zip Code	Country
6. E-mail Address (For Office Use Only)		**7. Date of Birth (mm/dd/yyyy)**		
8. Telephone Numbers				
Home		Cell		

EDUCATION

9. Physician Assistant Program Attended

Name of PA Training Program	Graduation Date	Address	Telephone Number	School Code

MANDATORY DISCLOSURE OF SOCIAL SECURITY NUMBERS
Disclosure of your Social Security Number (SSN) or Individual Taxpayer Identification Number (ITIN) is mandatory. Sections 30 and 31 of the Business and Professions Code authorize collection of your SSN or ITIN will be used exclusively for tax enforcement purposes, for investigation of tax evasion and violations of cash-pay reporting laws as set forth in Section 329 of the Unemployment Insurance Code, for purposes of compliance with any judgement or order for family support in accordance with Section 17520 of the Family Code, measurement of employment outcomes of students who participate in career technical education programs offered by the California Community Colleges, or for verification of license or examination status by a licensing or examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your SSN or ITIN, your application for initial licensure will not be processed AND you may be reported to the Franchise Tax Board, which may assess a $100 penalty against you.

STATE TAX OBLIGATION NOTICE:
Effective July 1, 2012, the State Board of Equalization and the Franchise Tax Board may share taxpayer information with the Board. You are obligated to pay your state tax obligation and your license may be suspended or denied if the state tax obligation is not paid.

PA 1

MILITARY EXPERIENCE/LICENSE HISTORY

10. Are you serving in, or have you previously served in, the United States military? ☐ Yes ☐ No
If "Yes", please see application instructions for documentation required to expedite licensure.

11. Are you married to, or in a domestic partnership or other legal union, with an active duty Member of the Armed Forces of the United States who is assigned to a duty station in California under official active duty military orders and do you hold a current license in another state? ☐ Yes ☐ No
If "Yes", please see application instructions for documentation required to expedite licensure.

12. Have you ever applied for a California physician assistant license? ☐ Yes ☐ No

13. Are you, or have you ever been, licensed or otherwise registered in any manner in any state, country, or with any federal agency in any healthcare occupation? ☐ Yes ☐ No
All licenses must be listed regardless of status.

Type of License	State or Country	License Number	Date of Licensure From:	Date of Licensure To:	Current Status of License (active, inactive, suspended, revoked, probation, other, explain)

MALPRACTICE HISTORY

14. Has a claim or action ever been filed against you for the practice of medicine that resulted in a Malpractice settlement, in excess of $30,000 or resulted in any judgement or arbitration award of any amount? ☐ Yes ☐ No
If "Yes", please provide details (location, date, outcome) on a separate sheet of paper.

DISCIPLINARY HISTORY

QUESTIONS 15-19: If you answer "YES" to any of the questions in this section, please provide ALL official documentation regarding the matter, in addition to a written narrative description including locations, dates, and rulings. If applicable, an applicant should also provide official arrest/hearing/court documents and original letters of explanation from training program directors or other appropriate authorities.

15. Have you ever had a healthcare license or certificate, or narcotics (controlled substance) permit denied or disciplined by this State, any other state, agency of the federal government, or another country, or have you ever surrendered such a license, certificate or permit? ☐ Yes ☐ No

16. Have you ever had charges filed against a healthcare license that you currently hold or held in the past, including charges that are still pending or charges that were dropped? ☐ Yes ☐ No

2005 Evergreen Street, Suite 1100, Sacramento, CA 95815-3893 (916) 561-8780 FAX: (916) 263-2671 www.pac.ca.gov

Rev 01/2018

DISCIPLINARY HISTORY (continued)

State	Date	Charge	Disposition

17. Have you ever withdrawn from, been disciplined by, or been suspended, dismissed or expelled from a physician assistant training program or have you ever taken a leave of absence for academic or disciplinary reasons? ☐ Yes ☐ No

18. Have you ever been charged with, or been found to have committed unprofessional conduct, professional incompetence, gross negligence or repeated negligent acts or malpractice by any licensing board, other agency, or hospital or has any disciplinary action ever been filed or taken regarding any healthcare license which you now hold or have ever held, or is any such action pending? Include any disciplinary actions by the U.S. Military, U.S. Public Health Service or other U.S. governmental agency. ☐ Yes ☐ No

State	Date	Charge	Disposition

19. Have you ever been denied a license, permission to practice medicine or any other healthcare occupation, or denied permission to take an examination in any state, country, or U.S. federal Jurisdiction, or is any such action pending? ☐ Yes ☐ No

State	Date of Denial	Reason for Denial

PRACTICE IMPAIRMENT OR LIMITATIONS

QUESTIONS 20 – 22: If you answer "YES" to any of the questions in this section, please provide complete official medical, psychiatric and treatment records related to the specific medical or psychiatric issue, evidence of ongoing rehabilitation treatment, and a personal written statement identifying and describing the mental illness, disease, disorder, or other condition, Completion of an authorization and release of medical or psychiatric records form may be required by the Board to finalize the application process.

20. Have you ever been diagnosed or treated for a medically recognized mental illness, disease, or disorder that would currently interfere with your ability to practice medicine? ☐ Yes ☐ No

See application instructions for further details.

21. Do you have a current physical or mental impairment related to drugs or alcohol? ☐ Yes ☐ No

See application instructions for further details.

22. Have you been adjudicated by a court to be mentally incompetent or are you currently under a conservatorship? ☐ Yes ☐ No

If "Yes" , please submit copies of official court documents regarding the legal proceedings.

PA 3

CRIMINAL RECORD HISTORY

For each conviction disclosed, you must provide CERTIFIED copies of the arresting agency reports and court documents, including a plea form and court docket. You are required to submit a detailed written narrative (including locations, dates, and outcome) describing the incident that resulted in your conviction. All documents will need to be provided by the arresting agency and the court directly to the Board. For traffic violations that resulted in fines over $500, please submit a copy of your DMV record. If documents were purged by arresting agency and/or court, a letter of explanation from these agencies is required. YOU ARE REQUIRED TO INCLUDE ANY CONVICTION THAT HAS BEEN SET ASIDE AND DISMISSED OR EXPUNGED, OR WHERE A STAY OF EXECUTION HAS BEEN ISSUED.

23a. Have you ever been convicted of or plead nolo contendere to ANY criminal or civil offence in the United States, its territories, or a foreign country? This includes every citation or infraction (including traffic violations resulting in fines over $500), misdemeanor and/or felony. ☐ Yes ☐ No

Convictions that were adjudicated in the juvenile court or convictions under California Health and Safety Code sections 11357(b), (c), (d), and (e) or sections 11360(b) which are two years old or older should NOT be reported. Convictions that were later dismissed pursuant to sections 1203.4, 1203.4a, or 1203.41 of the California Penal Code or equivalent non-California law MUST be disclosed.

Proof of Dismissal: If you have obtained a dismissal (AKA expungement) of your conviction(s) pursuant to Penal Code sections 1203.4, 1203.4a, or 1203.41, please have the court provide the Board with a CERTIFIED copy of the order dismissing (AKA expunging) the conviction(s).

23b. Is any appeal related to the above pending? ☐ Yes ☐ No

23c. Have you had any conviction dismissed/expunged? ☐ Yes ☐ No

23d. Was a stay of execution of the court's judgment in your case issued? ☐ Yes ☐ No

Violation and Location	Date	Penalty or Disposition

24. Are you required to register as a sex offender in California or in another state, territory or under federal law? ☐ Yes ☐ No

PA 4

PHOTOGRAPH

INSTRUCTIONS

Photographs must be no more than 30 days old and of head and shoulders only.

Attach a 2" x 2" color passport photo in this space.

Scanned, altered, or self-printed photos are not acceptable.

NOTICE OF COLLECTION OF PERSONAL INFORMATION

All items in this application are mandatory; none are voluntary. ***Failure to provide any of the requested information will delay the processing of your application and may result in the application being rejected as incomplete.*** The information provided will be used to determine your qualifications for licensure per Section 3519 of the California Business and Professions Code and Title 16, California Code of Regulations sections 1399.506, which authorizes the collection of this information. The information on your application may be transferred to other medical licensing authorities, the Federation of State Medical Boards, other governmental or law enforcement agencies to perform their statutory or constitutional duties, or otherwise transferred or disclosed as provided in California Civil Code Section 1798.24. You have the right to review your application and your files except information that is exempt from disclosure as provided in California Public Records Act or as otherwise provided by California Information Practices Act. Certain information provided may be disclosed to a member of the public, upon request, under the California Public Records Act or pursuant to court order. The Executive Officer is responsible for maintaining the information in this form and may be contacted at 2005 Evergreen Street, Suite 1100, Sacramento, CA 95815-3893, telephone number (916) 561-8780 regarding questions about this notice or access to records.

CERTIFICATION

I hereby certify, under penalty of perjury under the laws of the State of California, that I have read the questions in the foregoing application and that all information, statements, attachments and representations provided by me in this application are true and correct. By submitting this application and signing below, I am granting permission to the Board or its assignees and agents to verify the information provided and to perform any investigation pertaining to the information I have provided as the Board deems necessary.

My signature on this application, or copy thereof, authorizes the National Practitioner Data Bank, the National Commission on Certification of Physician Assistants, and the Federal Drug Enforcement Agency to release any and all information required by the Physician Assistant Board of California.

NOTICE: FALSIFICATION OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT HERETO IS GROUNDS FOR DENYING OR REVOKING A LICENSE.

SIGNATURE OF APPLICANT: _____ **DATE:** _____

PRINT NAME: _____

2005 Evergreen Street, Suite 1100, Sacramento, CA 95815-3893 (916) 561-8780 FAX: (916) 263-2671 www.pac.ca.gov

Rev 01/2018