



CHECK SHEET/GENERAL INFORMATION **To the Application for Physician Assistant Licensure**

We want to process your application as soon as possible. You can help! Please use the following information checklist to be sure that your application is complete and accurate before submitting it. All items listed that are applicable to you must be submitted in order for your qualifications for licensure to be assessed.

FORMS

- Form PA pages 1-4, *Application for Physician Assistant Licensure*
- Form PA page 5, *Certification of Completion of Physician Assistant Training Program* must be sent by you to your training program. The training program must complete the form and forward it *directly* to the PAC. Fax copies are **not** acceptable.
- Form PA 6 *Verification of Licensure* must be submitted by you to every state in which you are/have been licensed or otherwise registered to practice as a physician assistant or other health care provider. Please make additional copies of this form as needed. Each licensing agency must then forward the completed form, with their agency seal, directly to the Physician Assistant Committee (PAC). FAX copies are **not** acceptable.

PHOTOGRAPH

- One (1) recent 2" x 2" (approximate size) passport size photo of your head and shoulders only.

REQUEST FOR RELEASE OF PANCE SCORES FROM THE NCCPA

- Contact the National Commission on Certification of Physician Assistants, 12000 Findley Road, Suite 200, Duluth, GA 30097, www.nccpa.net, telephone: (678) 417-8100, to authorize release of your Physician Assistant National Certifying Examination (PANCE) scores. Your PANCE scores must be sent by the NCCPA directly to the PAC. FAX copies are **not** acceptable.

FINGERPRINT PROCEDURES

Before the PAC issues a license, clearances must be received from both the Department of Justice (DOJ) and Federal Bureau of Investigation (FBI) to verify that the applicant has no criminal history. Your physician assistant license will not be issued until the committee receives fingerprint clearance from both the Department of Justice and the Federal Bureau of Investigation.

Two methods are available to complete the fingerprint requirement:

1. Live Scan Process

For applicants residing in California you must use this process.

Live Scan Procedures:

1. Complete the PAC's "Request for Live Scan Services" form in triplicate.
2. Take the completed form (in triplicate) to a Live Scan location. Visit www.ag.ca.gov/fingerprints to locate a Live Scan location. Hours of operation and fees vary, so please contact the Live Scan site directly for information.
3. Pay the processing and rolling fees to the Live Scan site.
4. Submit the **second copy** of the form with your physician assistant license application. The PAC will be unable to process your application without the second copy of the "Request for Live Scan Services" form.

□ 2. Manual Fingerprint Card Process

If you reside outside of California or are unable to obtain Live Scan services in California, you must use the manual fingerprint card process. To submit manual fingerprint cards, obtain the 8" x 8" fingerprint cards (FD-258) from the PAC.

You may also request manual fingerprint cards online at the PAC website.

Instructions:

1. Complete all areas marked by a red "x" on both cards.
2. Take the completed cards to a local law enforcement office and have your fingerprints rolled.
3. Submit both fingerprint cards with your physician assistant license application. **DO NOT FOLD CARDS.** The PAC will be unable to process your application without two completed fingerprint cards. Please be sure to include the additional fee with your manual fingerprint cards.

FEES

Application (\$25) and License (\$200) Fees (licensing fee will be refunded if licensure not granted). If applicable, include the manual fingerprint cards. Make check or money order payable to the Physician Assistant Committee.

- With Live Scan fingerprinting = \$225 (\$25 application fee+ \$200 initial license fee)
- With Manual Fingerprint cards = \$274 (\$25 application fee+ \$200 initial license fee + \$49 manual fingerprint processing fee)

NOTARY

The completed application (pages 1-4) with photo attached, must be presented to a notary. You must affix your signature and date on the application in the presence of the notary, who must then affix a signature, date, and seal to officially notarize your application.

General Information

APPLICATION PROCESSING TIMES Your application is considered complete once all required forms, documentation, FBI and DOJ criminal record clearance, and appropriate fees have been received and approved. You will be notified of the status of your application, including any file deficiencies, generally within 30 days from the date your application is received. We recognize that some items may be in transit; however, in an effort to ensure that your application can be reviewed in a timely manner, **we ask for your patience in not calling for the status of your application until after this 30-day period.**

ADDRESS OF RECORD It is your responsibility to provide, in writing, notice of any address or name changes to the PAC. All correspondence will be sent to your address or record. **Once licensed, this is a public record and will be available on the PAC's website.**

CANCELED PHYSICIAN ASSISTANT LICENSE *Business and Professions Code Section 3526 states, "A person who fails to renew his or her license or approval within five years after its expiration may not renew it, and it may not be reissued, reinstated, or restored thereafter, but that person may apply for and obtain a new license or approval if he or she:*

(a) Has not committed any acts or crimes constituting grounds for denial of licensure under Division 1.5 (commencing with Section 475).

(b) Takes and passes the examination, if any, which would be required of him or her if application for licensure was being made for the first time, or otherwise establishes to the satisfaction of the committee that, with due regard for the public interest, he or she is qualified to practice as a physician assistant.

(c) Pays all of the fees that would be required as if application for licensure was being made for the first time."

If your California physician assistant license has expired for more than five years and has been canceled you must submit a new application. Please contact the PAC for further information.

APPLICATION DENIAL If your application is denied by the PAC you will be notified in writing the reason(s) for denial and provided information about the appeal process.

ABANDONMENT OF LICENSURE APPLICATION Title 16, Division 13.8, Section 1399.512(d) states, "An applicant shall be deemed to have abandoned his or her licensure application if the application is not completed or if requested documents or information are not provided or if required fees are not paid, within one year from the date of filing or written request by the committee. An application submitted subsequent to an abandoned application shall be treated as a new application."

PRACTICING AS A PA You may **not** begin practicing as a PA in California until:

1. You have been granted a license by the PAC; and,
2. Have a supervising physician with whom you have established in writing:
 - Transport and back-up procedures for patients; and,
 - A Delegation of Services Agreement that includes guidelines for adequate supervision of the PA. A sample copy of this document is available on the PAC website: www.pac.ca.gov.

CONTINUING MEDICAL EDUCATION Licensees are required to complete continuing medical education as a condition of license renewal. The requirement may be met by completing 50 hours of medical education every two years or by obtaining certification by the National Commission on Certification of Physician Assistants.

PHYSICIAN ASSISTANT LAWS AND REGULATIONS It is the applicant's responsibility to know and to keep current on the laws and regulations pertaining to the practice as a physician assistant as they are subject to change. You may obtain a copy of the physician assistant laws and regulations at the PAC website: www.pac.ca.gov.

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. The information provided will be used to determine your qualifications for licensure per Section 3519 of the California Business and Professions Code, 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, or other governmental or law enforcement agencies. You have the right to review your application subject to the provisions of the Information Practices Act. The Executive Officer is the custodian of records.

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

10. Are you, or have you ever been, licensed or otherwise registered in any manner in any state or country in any healthcare occupation?
 (If YES, please complete Form PA6. See Instruction page.) Yes No
 If YES, list type of license, state, license number, issue date, expiration date and current status. (Use a separate sheet if necessary.)

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

11. Have you ever taken the Physician Assistant National Certifying Examination (PANCE) as administered by the National Commission on Certification of Physician Assistants (NCCPA) Yes No

12. Indicate the month and year of the PANCE examination:
 _____ Month _____ Year

QUESTIONS 13 - 18: For any affirmative response to the following questions, please provide ALL official documentation regarding the matter in addition to a written narrative description. If applicable, an applicant should also provide official hearing/court documents and original letters of explanation from training program directors or other appropriate authorities. APPLICANTS ARE ALSO REQUIRED TO REPORT ANY MATTER THAT IS PENDING OR IN WHICH CHARGES HAVE BEEN DROPPED OR EXPUNGED.

13. Have you ever had a healing arts license or certificate denied or disciplined by this state or any other state or have you ever surrendered such a license or certificate? Yes No
 (If YES, give details (locations, dates, rulings). Use a separate sheet if necessary.)

State	Date	Charge	Disposition

14.	Have you ever withdrawn from, or been suspended, dismissed or expelled from a physician assistant training program or have you ever taken a leave of absence from such a program? If YES, please attach a written explanation. <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>																
15.	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 healing arts license which you now hold or have ever held, or is any such actions pending? Include any disciplinary actions by the U.S. Military, U.S. Public Health Service or other U.S. governmental agency. If YES, give details below <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>																
	<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:15%;">State</th> <th style="width:15%;">Date</th> <th style="width:20%;">Charge</th> <th style="width:50%;">Disposition</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>	State	Date	Charge	Disposition													
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16.	Have you ever been denied a license, permission to practice medicine or any other healing art, or denied permission to take an examination in any state, country, or U.S. federal jurisdiction, or is any such action pending? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, give details below.	<input type="checkbox"/>																
	<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:10%;">State</th> <th style="width:25%;">Date of Denial</th> <th style="width:65%;">Reason for denial</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </tbody> </table>	State	Date of Denial	Reason for denial														
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17.	Have you ever voluntarily surrendered a license to practice in the healing arts in this or any other state, or voluntarily surrendered your narcotic (controlled substance) permit (state or federal) to any licensing board or any other agency, or is any such action pending? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>																
18.	Do you have any condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety, including but not limited to, any of the following? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please check the appropriate box(es) below: <input type="checkbox"/> A condition which required admission to an inpatient psychiatric facility. <input type="checkbox"/> Alcohol or chemical substance dependency or addiction <input type="checkbox"/> Emotional, mental or behavioral disorder. <input type="checkbox"/> Other, explain: _____ For any of the boxes checked above, please submit complete <u>official</u> inpatient and outpatient treatment records, evidence of ongoing rehabilitation treatment, and a personal written explanation.	<input type="checkbox"/>																
19.	For any affirmative response to the following questions, please provide CERTIFIED arrest (including police reports) and CERTIFIED hearing/court documents in addition to a detailed written narrative description of the incident that led to the conviction. All documents will need to be provided directly by the issuing agency to the Committee. 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.																	
19a.	Have you ever been convicted of or pled nolo contendere to any violation (including misdemeanor or felony) of any local, state, or federal law of any state, territory, country, or U.S. federal jurisdiction? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>																
19b.	Is any appeal related to the above pending? <input type="checkbox"/> Yes <input type="checkbox"/> No																	
19c.	Have you had any conviction expunged? <input type="checkbox"/> Yes <input type="checkbox"/> No																	
19d.	Have you had any conviction dismissed? <input type="checkbox"/> Yes <input type="checkbox"/> No																	
19e.	Was a stay of execution issued? <input type="checkbox"/> Yes <input type="checkbox"/> No																	
	If YES, give details below.																	
	<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:35%;">Violation and Location</th> <th style="width:15%;">Date</th> <th style="width:50%;">Penalty or disposition</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </tbody> </table>	Violation and Location	Date	Penalty or disposition														
Violation and Location	Date	Penalty or disposition																
		PA3																

TOP OF PHOTO

INSTRUCTIONS: Photographs, must be of head and shoulders only.

Attach a 2@ x 2" (approximate size) photograph in this space.

Scanned, altered, or Polaroid photos are not acceptable.

BOTTOM OF PHOTO

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. The information provided will be used to determine your qualifications for licensure per Section 3519 of the California Business and Professions Code, 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, or other governmental or law enforcement agencies. You have the right to review your application subject to the provisions of the Information Practices Act. The Executive Officer is the custodian of records.

The applicant, _____, _____, being first duly sworn upon his/her
(Please print full name) (date of birth)

oath deposes and says: that I am the person herein named subscribing to this application: that I have read the complete application and know the full content thereof, and declares that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; that I am the lawful holder of the Physician Assistant Licenses as prescribed by this application, that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, were procured without fraud or misrepresentation or any mistake of which the applicant is aware and that I am the lawful holder thereof. Further, I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past, present, and future), business and professional associates (past, present, and future), and all government agencies (local, state, federal or foreign) to release to the Physician Assistant Committee or its successors any information, files or records, including medical records, educational records, and records of psychiatric treatment and treatment for drug and/or alcohol abuse or dependency, requested by the Committee in connection with this application; or any further or future investigation by the Committee necessary to determine my medical competence, professional conduct or physical or mental ability to safely engage in the practice of medicine. I further authorize the Physician Assistant Committee or list successors to release to the organizations, individuals or groups listed above any information which is material to this application or any subsequent licensure.

I UNDERSTAND THAT FALSIFICATION OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHEMENT HERETO IS A SUFFICIENT BASIS FOR DENYING OR REVOKING A LICENSE.

PLEASE INITIAL BOX

SIGNATURE OF APPLICANT:

(PLEASE SIGN FULL NAME)

State of _____ County of _____

Subscribed and sworn to (or affirmed) before me on

this _____ day of _____, 20____, by: (applicant's name to be printed here) _____

proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

NOTARY SEAL

SIGNATURE OF NOTARY PUBLIC



VERIFICATION OF LICENSURE – PHYSICIAN ASSISTANT OR OTHER HEALTH CARE PROFESSIONAL

Instructions to the Applicant: Please complete Part I below and forward a copy of this form to all states, territories, licensing or registration jurisdictions where you have ever been licensed or registered, including any other health care professions. Copy this form as needed. Please type or print legibly.

PART I

Full Name (Last, First, Middle)	Other names used	Date of Birth (MM/DD/YY)	
Mailing Address	City	State	Zip Code
Signature of Applicant		Date of Signature	

I hereby authorize your agency to release information concerning my licensure/registration/certification status. Please return this completed form to the PAC at the address listed above. All questions must be answered.

FOLLOWING TO BE COMPLETED BY STATE BOARD OR OTHER LICENSING JURISDICTION ONLY

Instructions to the licensing agency: Please complete Part II below for the applicant identified above and return this document directly to the Physician Assistant Committee.

PART II

License Type	State	License Number
Issue Date	Expiration Date	

1. Have any complaints been filed against the license? YES NO Unable to answer
2. Is there any pending investigation regarding the license? YES NO Unable to answer
3. Has any disciplinary activity been taken regarding this license? YES NO Unable to answer

If YES to any of the above, please provide any information and documentation which may be released; including charges and final disposition.

Official
Seal

Verified by _____
 SIGNATURE

Print Name _____

Title _____

Date _____

Telephone Number _____

REQUEST FOR LIVE SCAN SERVICE
Applicant Submission

ORI: A0433 Type of Application: License
Code assigned by DOJ

Job Title or Type of License, Certification or Permit: Physician Assistant

Agency Address Set Contributing Agency:
Physician Assistant Committee 06339
Agency authorized to receive criminal history information Mail Code (five digit code assigned by DOJ)

2005 Evergreen Street, Ste. 1100 Licensing Staff
O. Box Contact Name (Mandatory for all school submissions)

Sacramento CA 95815 (916) 561-8781
City State Zip Code Contact Telephone No.

Name of Applicant: _____
(please print) Last First MI

Alias: _____ Driver's License No. _____
Last First

Date of Birth: _____ Sex: Male Female Misc. No. **BIL-** N/A
Agency Billing Number (if applicable)

Height: _____ Weight: _____ Misc. No: _____

Eye Color: _____ Hair Color: _____ Home Address: _____
Street or P.O. Box

Place of Birth: _____
City, State and Zip Code

SOC: _____

Your Number: _____ Level of Service DOJ FBI
OCA No. (Agency Identifying No.)

If resubmission, list Original ATI No. _____

Employer: (Additional response for agencies specified by statute)
This section is not applicable

Employer Name _____

Street No. _____ Street or P.O. Box _____ Mail Code (five digit code assigned by DOJ) _____
()

City _____ State _____ Zip Code _____ Agency Telephone No. (optional) _____

Live Scan Transaction Completed By: _____ Date: _____
Name of Operator

Transmitting Agency _____ ATI No. _____ Amount Collected/Billed _____

REQUEST FOR LIVE SCAN SERVICE
Applicant Submission

ORI: <u>A0433</u> <small>Code assigned by DOJ</small>	Type of Application: <u>License</u>
Job Title or Type of License, Certification or Permit: <u>Physician Assistant</u>	

Agency Address Set Contributing Agency: <u>Physician Assistant Committee</u>		<u>06339</u> <small>Mail Code (five digit code assigned by DOJ)</small>
Agency authorized to receive criminal history information <u>2005 Evergreen Street, Ste 1100</u>		<u>Licensing Staff</u> <small>Contact Name (Mandatory for all school submissions)</small>
<u>Sacramento</u> <u>CA</u> <small>City State</small>	<u>95815</u> <small>Zip Code</small>	<u>(916) 561-8781</u> <small>Contact Telephone No.</small>

Name of Applicant: _____ <small>(please print) Last First MI</small>		
Alias: _____ <small>Last First</small>	Driver's License No. _____	
Date of Birth: _____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Misc. No. BIL- <u>N/A</u> <small>Agency Billing Number (if applicable)</small>	
Height: _____ Weight: _____	Misc. No: _____	
Eye Color: _____ Hair Color: _____	Home Address: _____ <small>Street or P.O. Box</small>	
Place of Birth: _____	_____ <small>City, State and Zip Code</small>	
SOC: _____		

Your Number: _____ <small>OCA No. (Agency Identifying No.)</small>	Level of Service <input checked="" type="checkbox"/> DOJ <input checked="" type="checkbox"/> FBI
If resubmission, list Original ATI No. _____	

Employer: (Additional response for agencies specified by statute) This section is not applicable		
Employer Name _____		
Street No. _____	Street or P.O. Box _____	Mail Code (five digit code assigned by DOJ) _____
City _____	State _____	Zip Code _____
() _____ <small>Agency Telephone No. (optional)</small>		

Live Scan Transaction Completed By: _____ <small>Name of Operator</small>	Date: _____	
Transmitting Agency _____	ATI No. _____	Amount Collected/Billed _____