



REQUEST FOR AUTHORIZATION TO PRACTICE WITHOUT A CALIFORNIA LICENSE AT A REGISTERED FREE HEALTH CARE EVENT

In accordance with California Business and Professions Code Section 901 any physician assistant licensed and in good standing in another state, district, or territory in the United States may request authorization from the Physician Assistant Board (board) to participate in a free health care event offered by a local government entity or a sponsoring entity, registered with the board pursuant to Section 901, for a period not to exceed ten (10) days.

PART 1 - APPLICATION INSTRUCTIONS

An application must be complete and must be accompanied by all of the following:

- A processing fee of \$25.00, made payable to the Physician Assistant Board.
- A copy of each valid, current active license authorizing the applicant to engage in the practice as a physician assistant issued by any state, district, or territory of the United States.
- A copy of a valid photo identification of the applicant issued by one of the jurisdictions in which the applicant holds a license to practice.
- A full set of fingerprints or Live Scan inquiry and the associated fee. This will be used to establish your identity and to conduct a criminal history record check. The applicant shall pay any costs for furnishing the fingerprints and conducting the criminal history record check. However, this requirement shall apply only to the first application for authorization that you submit.
- Educational records to prove you graduated from a physician assistant training program that is approved by the board.
- Verification of PANCE scores.
- A completed Delegation of Services agreement signed and dated by the applicant and each supervising physician.

The board will not grant authorization until this form has been completed in its entirety, all required enclosures have been received by the board, and any additional information requested by the board has been provided by the applicant and reviewed by the board, and a determination made to grant authorization.

The board shall process this request and notify the sponsoring entity listed in this form whether the request is approved or denied within 20 calendar days of receipt. If the board requires additional or clarifying information, the board will contact you directly, but **written approval or denial of requests will be provided directly to the sponsoring entity or local government entity.** It is the applicant's responsibility to maintain contact with the sponsoring entity or the local government entity.

- Have not been the subject of any adverse judgment resulting from the practice for which the applicant is licensed that the board determines constitutes evidence of a pattern of negligence or incompetence.

No If no, you are not eligible to participate as an out-of-state practitioner in the sponsored event.

Yes If yes, list every license, certificate, and registration authorizing you to engage in the practice as a physician assistant in the following table. If there are not enough boxes to include all the relevant information please attach an addendum to this form. Please also attach a copy of each of your current licenses, certificates, and registrations.

State/ Jurisdiction	Issuing Agency/Authority	License Number	Expiration Date

2. Have you ever had a license to practice as a physician assistant revoked or suspended?

___ Yes ___ No

3. Have you ever been subject to any disciplinary action or proceeding by a licensing body?

___ Yes ___ No

4. Have you ever committed any act or been convicted of a crime constituting grounds for denial or licensure?

___ Yes ___ No

5. If you answered "Yes" to any of questions 2-4, please explain (*attach additional page(s) if necessary*): _____

PART 4 – SPONSORED EVENT

1. Name of and address of local government entity, non-profit, or community-based organization hosting the free healthcare event (the “sponsoring entity”): _____

2. Name of event: _____

3. Date(s) & location(s) of the event: _____

4. Date(s) & location(s) applicant will be performing healthcare services (if different): _____

5. Please specify the healthcare services you intend to provide: _____

6. Name and phone number of contact person with sponsoring entity or local government entity: _____

PART 5 – ACKNOWLEDGMENT/CERTIFICATION

I, the undersigned, declare under penalty of perjury under the laws of the State of California and acknowledge that:

- I have not committed any act or been convicted of a crime constituting grounds for denial of licensure by the board.
- I am in good standing with the licensing authority or authorities of all jurisdictions in which I hold licensure to practice as a physician assistant.
- I am responsible for knowing and will comply with all applicable practice requirements required of licensed physician assistants and all laws and regulations of the board.
- In accordance with Business and Professions Code Section 901(i), I will only practice within the scope of practice for California-licensed physician assistants.
- I will provide the services authorized by this request and Business and Professions Code Section 901 to uninsured and underinsured persons only and shall receive no compensation for such services.
- I will provide the services authorized by this request and Business and Professions Code Section 901 only in association with the sponsoring entity or

local government entity listed herein and only on the dates and at the locations listed herein for a period not to exceed 10 calendar days.

- I must post the notice required by California Code of Regulations Section 1399.622(e).
- Practice of a regulated profession in California without proper licensure and/or authorization may subject me to potential criminal penalties.
- The board may notify the licensing authority of my home jurisdiction and/or other appropriate law enforcement authorities of any potential grounds for discipline associated with my participation in the sponsored event.
- All information provided by me in this application is true and complete to the best of my knowledge. By submitting this application and signing below, I am granting permission to the board to verify the information provided and to perform any investigation pertaining to the information I have provided as the board deems necessary.

Signature

Date

Name Printed