

**Form A.
Physician Assistant
Application For
Licensure**

For office use only.
Fee Paid:

Maine Board of Licensure in Medicine
137 State House Station
Augusta, ME 04333-0137
Phone: 207-287-3601 Fax: 207-287-6590

APPLICATION DATE: _____

1. I have read the Board's rules and regulations. I hereby apply for licensure as a Physician Assistant within the state of Maine and submit the following information in support of my application. I am enclosing a non-refundable application fee of \$200.

NAME: _____
Last First Middle

Home Address: _____ Work Address: _____
[] Use this as my contact address Number and Street [] Use this as my contact address Number and Street

City State Zip/Postal Code City State Zip/Postal Code

Email address: _____

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

Date of Birth: ____/____/____ Place of Birth: _____
Mo. Day Yr City State Country

2. AFFIDAVIT OF APPLICANT

I, _____, being duly sworn, depose and say that I am the person described and identified in this application.

I have carefully read the questions in this application and have answered them completely, without reservations of any kind, and declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension or revocation of my license to practice medicine and surgery in the state of Maine, or other discipline as the Board may determine.

I hereby authorize all hospitals, medical institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present) and all governmental agencies and instrumentalities (local, state, federal, and foreign) to release to this licensing Board any information, files or records required by the Board for its evaluation of any professional and ethical qualifications for licensure in the state of Maine. I hereby release any and all entities from responsibility regarding the information they release to the Board of Licensure in Medicine.

I hereby authorize the Board of Licensure in Medicine to transmit any information contained in the application, or information that may otherwise become available to them, to any agency, organization, hospital, or individual, who, in the judgment of the Board, has a legitimate interest in such information.

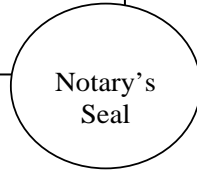
Signature of Applicant

Date

Signature of Notary

Notary Commission Expires:

Attach Current Passport-Type Photo Here
(Photo must be no larger than this square.)



1) APPLICANTS MUST SIGN THEIR FULL NAME IN THE PRESENCE OF A NOTARY PUBLIC.
2) NOTARY PUBLIC MUST COMPLETE THE AFFIDAVIT AND AFFIX NOTARIAL SEAL OVERLAPPING A PORTION OF THE PHOTOGRAPH BUT NOT COVERING ABOVE THE NECK.

3. Qualifying Training

School Attended: _____ Degree/Certificate*: _____
NAME

Mailing Address: _____
CITY, STATE, COUNTRY

* All documents must be notarized and attested as true copies of the original(s).

4. NCCPA Qualifying Exam

Certificate #*: _____

Location: _____ Date: _____

*If you are scheduled to sit for the examination, please provide proof of the date you will be taking the examination.

Have you ever taken the qualifying exam and failed? YES NO When? _____

5. References: Please furnish the names and addresses of two persons under whose supervision you have worked as a Physician Assistant during the most recent periods of employment. These references will be contacted for a professional assessment.

Name: _____ Title: _____

Address: _____

Name: _____ Title: _____

Address: _____

6. Personal Data: Circle each appropriate response. Every 'YES' response to questions 2-16 must be fully explained by a written statement on a separate 8.5" x 11" sheet of white paper. Each such explanation must be referenced by question number, and must be signed, dated, and enclosed with your application.

- YES NO 1. Do you now or have you ever held certification, registration or licensure as a Physician Assistant in any state(s)?
If yes, where? _____
- YES NO 2. Have you EVER had ANY licensing authority (including Maine) deny your application for any type of license, or take any disciplinary action against the license issued to you in that jurisdiction, including but not limited to warning, reprimand, fine, suspension, revocation, restrictions in permitted practice, probation with or without monitoring?
- YES NO 3. Have you EVER been notified of the existence of allegations involving you, filed with or by ANY licensing authority (including Maine), which allegations remain open as of the date of this application?
- YES NO 4. Have you EVER left a medical licensing jurisdiction (including Maine) while a complaint or allegation was pending?
- YES NO 5. Have you EVER been denied registration or had your ability to prescribe or dispense controlled substances modified, restricted (except by administrative rule or statute in a jurisdiction), suspended, revoked, or voluntarily suspended by
- YES NO a) U. S. Drug Enforcement Administration (DEA)?
- YES NO b) Any state/territory of the U. S., including Maine?
- YES NO 6. Have you EVER received a sanction from Medicare or from any state Medicaid program?
- YES NO 7. Have you EVER suffered from any physical, psychiatric, or addictive disorder that would impair or require limitations on your functioning as a physician assistant, or that resulted in the inability to practice medicine for more than 30 days?
- YES NO 8. Have you EVER been charged, summonsed, indicted, arrested, or convicted of any criminal offense (including motor vehicle offenses but not including minor traffic or parking violations)?
- YES NO 9. Have you EVER applied for hospital, HMO or other health care entity privileges, which were denied?
- YES NO 10. Have you EVER had your hospital, HMO, or other health care entity privileges revoked, suspended, restricted, limited in any way, or withdrawn involuntarily?
- YES NO 11. Have you EVER voluntarily surrendered privileges or resigned from staff membership during peer review or investigation or to avoid peer review or investigation?
- YES NO 12. Have you EVER been deselected from a managed care organization physician assistant panel?
- YES NO 13. Have you EVER been disciplined by a professional society or resigned while accusation was pending?
- YES NO 14. Have you EVER had a claim or suit alleging malpractice liability in which you are/were named as a defendant, including nuisance suits settled, adjudicated by a court in favor of the other party, or settled by your insurance company /representatives without your express consent?
- YES NO 15. Do you have any open malpractice claims?
- YES NO 16. Do you intend to practice medicine within the State of Maine without active medical staff privileges at a Maine hospital?

INSTRUCTIONS FOR PHYSICIAN ASSISTANT LICENSURE TWO-STEP PROCESS

- **Initial License:** Use Form A to apply and submit the \$200 application fee. The application fee is non-refundable. Note: the initial license is renewed biennially in odd or even years, depending on your year of birth. Your first license is typically not for a full renewal period of 2 years, but by rule it cannot be for a period of less than 3 months. So it is possible you would need to renew your license in as early as 4 months from issuance, depending on your date of birth.
- **Registration Form C:** Use Form C to apply to register with a Primary Supervising Physician (PSP) and submit it with the appropriate fee. Please see the additional instructions on the Form C. This form must be submitted and approved by the Board to allow active practice for the Physician Assistant. The Form C is online at <http://www.docboard.org/me/licensure/paaprnformc.pdf>

INFORMATION REQUIRED WITH INITIAL APPLICATION FOR LICENSURE (FORM A)

- Provide a copy of your diploma from the Physician Assistant program, notarized with a written statement as a “true copy of the original” by a Notary Public.
- Request that an original transcript of grades from the Physician Assistant program be sent directly to this Board.
- Request that a letter from the dean of the college or director of the Physician Assistant program confirming successful completion of the program, with the dates of attendance, be sent directly to this Board.
- Provide a copy of the NCCPA certificate, notarized with a written statement as a “true copy of the original” by a Notary Public. **If you have not yet taken the NCCPA certifying exam, submit proof that you are scheduled for the next available exam. Proof of scheduling should also be notarized with a written statement as a “true copy of the original” by a Notary Public. If you have not passed the exam you will be issued a temporary license. Please refer to paragraph 3 of the Physician Assistant Rules at <ftp://ftp.maine.gov/pub/sos/cec/rcn/apa/02/373/373c002.doc>**
- Request that your two professional references complete the enclosed Employment Verification Forms and send them directly to this Board. If the references listed on Form A are the same individuals who have employed you during the past five years (or if one was a preceptor, if you are applying as a new graduate from a PA program), those individuals may write a letter of confirmation of employment and give a professional assessment of your practice skills, ethics, and morals. Employment history for the past five years will be verified.
- Request that the enclosed Verification of License in another state or province be sent directly to this Board.
- Provide a Curriculum Vitae containing a complete employment history for the past five years, including complete mailing addresses. New graduates will list preceptor experience.

GENERAL INFORMATION

- A. Fees are non-refundable. Include a \$200 fee with Form A for licensure and a \$50 fee with Form C for registration.
- B. The licensure process will take approximately two weeks after all information is received.
- C. Please read the enclosed Chapter 2 Rules. You will be governed by these Rules. The Rules are also online at <ftp://ftp.maine.gov/pub/sos/cec/rcn/apa/02/373/373c002.doc>
 - 1. Note there is no formulary. **You may not prescribe Schedule II drugs without written approval from the Medical Board.**
 - 2. You are required to have a Plan Of Supervision available at your work site, upon request.
 - 3. Note that secondary supervising physicians need not be reported to this Board, but they must be listed in your Plan Of Supervision and must accept, in writing, delegation of supervision.
- D. Please be aware that there are two sets of Rules under which you may practice. They are the revised P.A. Rules for Allopathic Medicine and the revised P.A. Rules for Osteopathic Medicine. These Rules have some differences regarding practice ownership. You will be governed by the set of Rules passed by the Board with which you are registered, based on whether your primary supervising physician (PSP) is a M.D. or a D.O.
- E. **Disclosure Statement:** The following statement is made pursuant to the Privacy Act of 1974, Section 7(b). Disclosure of your social security number is mandatory. Solicitation of your social security number is solely for tax administration purposes pursuant to 36 M.R.S.A. §175 as authorized by the Tax Reform Act of 1976 [42 U.S.C. §405(c) (2) (C) (I)]. Your social security number will be disclosed to the State Tax Assessor or an authorized agent for use in determining filing obligations and tax liability pursuant to Title 36 of the Maine Revised Statutes. No further use will be made of your social security number and it shall be treated as confidential tax information pursuant to 36 M.R.S.A. §191.

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Employment Verification Form

APPLICANT: Please list your name below and forward this form to your previous employers. Duplicate this form as necessary.

Applicant's Name

Name of Institution/Practice

To Whom it May Concern:

The individual listed above has made application to be licensed as a Physician Assistant with the Board of Licensure in Medicine. We would appreciate your completing the form below, including your evaluation of the applicant's competence, ethics, and moral character. Please return this form directly to the Board at the address above.

1. In what capacity was the Physician Assistant affiliated with your institution?

2. Dates of Affiliation:
From: _____ To: _____

3. Please assess the professional ability and performance of this applicant.

Date: _____

Signature: _____

Print Name: _____

Title: _____

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3. Please assess the professional ability and performance of this applicant.

Date: _____

Signature: _____

Print Name: _____

Title: _____

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VERIFICATION OF LICENSE - STATE/PROVINCE OF: _____

APPLICANT: Complete the top section of this form and mail it to the Board of each state in which you hold or have held a license.
Please duplicate this form as necessary.

I am applying for medical licensure in the State of Maine as a Physician Assistant. The Maine Board of Licensure in medicine requires that your Board complete this form in order that I may be considered for licensure.

This is my authorization to release any information in your files, favorable or otherwise, to the Maine Board of Licensure in Medicine.

Print or type full name: _____ Signature: _____

Address License number Date Issued

City State Zip

THE SECTION BELOW IS TO BE COMPLETED BY AN OFFICIAL OF THE BOARD

RETURN TO:

137 State House Station
Augusta, ME 04333-0137

This is to certify that the records of the Board of Medical Examiners in the State/Province of

_____ indicate that _____ was issued a license,
number _____, dated _____, which will expire on _____, to practice medicine
on the basis of: _____.

Is the licensure current and in good standing? Yes No

Has the holder of this license ever been summoned to appear before your Board? Yes No

Has the holder of this license ever been placed on probation? Yes No

Has the holder of this license ever been suspended or revoked? Yes No

Derogatory information: _____

Date: _____

Signed: _____

SEAL

Title: _____