

Dear Physician Assistant:

Enclosed are the application form and detailed instructions for renewing your Maine Physician Assistant license and your registration certificate. Please complete the application and registration and return them with the indicated fees and other forms as soon as possible. See page 2 for instructions. Any licensee who must be contacted about a missing or incomplete application will be subject to a \$100 late application processing fee. This fee will be applied to any licensee to whom a second notice must be sent. **I urge your immediate attention to the full completion and return of this application before the expiration date of your current license. The sooner we receive your complete application the sooner you will receive your renewed license.**

To maintain an Active status license you are required to report your continuing medical education (CME) activities as part of the application, and to meet certain CME requirements. A total of 100 hours of CME are required each 2 year cycle. Of those hours, 40 must be category I credits. Continuing medical education requirements are more fully explained in the enclosed instructions. A copy of the CME log submitted to the NCCPA or AAPA for recertification is acceptable in lieu of completing the attached report.

If you are a new licensee renewing for the first time, the year your license expires is determined by your year of birth. Licensees born in an odd year renew in odd years and licensees born in an even year renew in even years. If you have been licensed for less than 24 months, the CME credits you are required to submit are prorated accordingly. Please see the enclosed CME chart to determine the appropriate number of credits needed for renewal of your license.

The last page of the form contains a log for you to list each of your work sites. You may duplicate this page as necessary. Please provide full information for each work site. In addition, please submit a copy of the Plan of Supervision for each work site. Your application will not be complete without this information.

If you have any questions, please feel free to contact the Board office at (207) 287-3782.

Sincerely,

A handwritten signature in black ink, appearing to read "Gary R. Hatfield".

Gary R. Hatfield, M.D., Secretary
Maine Board of Licensure in Medicine

PHYSICIAN ASSISTANT RENEWAL APPLICATION INSTRUCTIONS

In order to successfully and timely renew your license, you must:

- Complete the renewal application, pages 5-8.
- Report CME credits earned.
- Renew your Primary Supervising Physician registration(s) and pay the \$50 fee for each.
- Terminate or have terminated registration of physicians no longer supervising you.
- Submit your updated Plan(s) Of Supervision.
- Pay the \$200.00 license renewal fee

In addition to your license, you must be registered with at least one Primary Supervising Physician in order to practice medicine, but you may have multiple Primary Supervising Physicians. Enclosed is a Form C to register the delegated relationship. Photocopy as necessary. The registration form (Form C) is also available on the Board's website at <http://www.docboard.org/me/licensure/paaprnformc.pdf>. The Board will issue you a Certificate of Registration under the scope of your supervising physician's practice, which will be in effect for two years as long as you retain your license and working relationship with your registered primary supervising physician(s). Since Physician Assistants are permitted registration with more than one Primary Supervising Physician at more than one work site, we must document all P.A./supervisor relationships. If you have more than one work location under the supervision of the same Primary Supervising Physician, these work locations are not considered multiple work sites and do not require separate registrations. If you terminate your working relationship with a Primary Supervising Physician you must notify the board in writing by letter or by submitting a form C. Accuracy in our records protects you and your supervising physician(s) in any case where professional liability, competency, or conduct may be an issue. Also, we request that you please list all Primary Supervising Physician arrangements on the enclosed form (page 8). Photocopy as necessary. Please do not include Secondary Supervising Physicians there.

The Board's Rules and Regulations require a written Plan Of Supervision for each work site, prepared by the Physician Assistant and the Primary Supervising Physician (see Rules, Chapter 2, §7). The Plan of Supervision must be updated as necessary and, at the very least, when you renew your license. A copy of the Plan of Supervision must be available for review at each work site. Signatures of Secondary Supervising Physicians accepting responsibility for the Physician Assistant must be included in this document. **A copy of the Plan of Supervision, for each work site, must be submitted with the renewal application.**

PRORATED CME CREDITS NEEDED FOR FIRST RENEWALS

If you are a new licensee, please use the chart below to determine the appropriate number of continuing Medical Education credits needed for renewal of your license.

Number of Months from Initial Licensure to Expiration	Total Hours Needed	Category I	Category II
4	20	8	12
5	25	10	15
6	30	12	18
7	35	14	21
8	40	16	24
9	45	18	27
10	50	20	30
11	50	20	30
12	50	20	30
13	55	22	33
14	60	24	36
15	65	26	39
16	70	28	42
17	75	30	45
18	80	32	48
19	85	34	51
20	90	36	54
21	95	38	57
22	100	40	60
23	100	40	60
24	100	40	60
25	105	42	63
26	110	44	66
27	115	46	69

You **must** maintain a file of your Continuing Medical Education activity, both current and historical. The board is not a repository for CME records. Please keep a copy of your CME log for your records.

**Physician Assistant License
Renewal Application**
FEE: \$200.00

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

Fee: _____
Late: _____

Please remit fee with application by check/money order payable to "Maine Board of Licensure in Medicine".

Name: _____
Address: _____

Daytime Phone No: _____

Date of Birth: _____
License No: _____
Social Security No: _____

Email address: _____

PERSONAL DATA UPDATE:

- A. If the spelling of your name, social security number or date of birth, preprinted above, are not correct, please circle the error and legibly print the correct information.
- B. The Board requires BOTH your HOME mailing address and phone number and the address and phone number of your PRINCIPAL PLACE OF MEDICAL PRACTICE. **You may designate which of the two you wish to be used for mailings from the Board. Note however that the address you designate for that purpose will be the address circulated by the Board in listings and publications available to the general public, including the internet.**

I prefer Board contact me at Home, or at Business. (H/B) ____
Home mailing address:

If your home address is incorrect, please correct here:

Telephone: _____

Office mailing address:

If your office address is incorrect, please correct here:

Telephone: _____

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. I acknowledge my responsibility to notify the Maine Board of Licensure in Medicine of my subsequent change in my status from that reported here and, in particular, to notify the Board within 10 days of a change in my place of medical practice or residence.

P.A. Signature: _____

Date: _____

PROFESSIONAL HISTORY:

Check each appropriate response. Every 'YES' response must be fully explained by a written statement on a separate 8.5"x 11" sheet of white paper. Each explanation must be referenced by question number, and must be signed, dated, and enclosed with your application.

HAVE YOU EVER:

YES NO

- 1 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, or probation with or without monitoring?
- 2 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?
- 3 Left a medical licensing jurisdiction (INCLUDING MAINE) while a complaint or allegation was pending?
- 4 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 -
 - 4a) U. S. Drug Enforcement Administration (DEA)?
 - 4b) Any state/territory of U. S. INCLUDING MAINE?

SINCE YOUR LAST RENEWAL APPLICATION:

- 5 Have you received a sanction from Medicare or from any state Medicaid program?
- 6 Have you 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?
- 7 Have you been charged, summonsed, indicted, arrested, or convicted of any criminal offense (including motor vehicle offenses but not including minor traffic or parking violations)?
- 8 Have you applied for hospital, HMO or other health care entity privileges which were denied?
- 9 Have you had your hospital, HMO, or other health care entity privileges revoked, suspended, restricted, limited in any way, or withdrawn involuntarily?
- 10 Have you voluntarily surrendered privileges or resigned from staff membership during peer review or investigation or to avoid peer review or investigation?
- 11 Have you been deselected from a managed care organization physician assistant panel?
- 12 Have you been disciplined by a professional society or resigned while an accusation was pending?
- 13 Have you 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?
- 14 Do you have any open malpractice claims?
- 15 Do you practice medicine within the State of Maine without active medical staff privileges at a Maine hospital?

CONTINUING MEDICAL EDUCATION REPORT

[Refer to Chapter 2, §13 of the Rules of the Maine Board of Licensure in Medicine for specific definitions. See <ftp://ftp.maine.gov/pub/sos/cec/rcn/apa/02/373/373c002.doc>]

For reporting CME credits earned during the previous 24 months.

The Board will allow up to 6 months to secure Category I credits from NCCPA. You must request the extension in writing with your renewal application.

The Board will routinely and regularly audit CME credits claimed. Failure to provide proof of CME credits claimed upon request by the Board may be ground for discipline. **Therefore, it is vitally important that you retain documentation of all CME claimed.**

All CME taken outside the United States or Canada and all audited reports with discrepancies will be referred to the Board’s Licensure Committee for assessment.

CATEGORY I

Category I activities are those planned CME programs sponsored or co-sponsored by an organization or institution and that have been accredited by one or more of the following agencies: American Academy of Physician Assistants; the American Medical Association Council on Medical Education; the Accreditation Council for Continuing Medical Education, and/or the American Academy of Family Practice. At least forty (40) CME credits must be in Category 1.

Total Category I Credits Earned _____

CATEGORY II

Category II includes programs with non-accredited sponsorship, i.e., Medical Teaching, Papers, Books, Publications, and Exhibits. Also included are non-supervised individual CME activities and other meritorious learning experiences. Sixty (60) Category II credits are required unless more than 40 Category I credits are reported.

NOTE: Category I credits may be substituted for Category II credits.

Total Category II Credits Earned _____

Please note that 32MRSA, §3282-A,2,(A) states that ground for discipline includes the practice of fraud or deceit in obtaining a license.

AFFIDAVIT: I CERTIFY THAT THIS IS A TRUE AND CORRECT REPORT OF MY CME ACTIVITY.

Date: _____ Physician Assistant Signature: _____

List all Registered Primary Supervising Physicians here.

Physician Assistant Name:

License No:

<p>Full Name of Primary Supervising Physician: _____</p> <p>Practice Name (i.e., Dept. or Service, Clinic, Group, etc.): _____</p> <p>Facility/Institution Name (if applicable): _____</p> <p>Street Address: _____</p> <p>Town, State: _____ Zip: _____</p> <p>Business Phone: _____ Extension: _____</p>	<p>Practice specialty of Primary Supervising Physician</p> <p>_____</p> <p>Setting:</p> <p><input type="checkbox"/> Solo Private Practice</p> <p><input type="checkbox"/> Group Practice</p> <p><input type="checkbox"/> Organized Health Care Delivery System</p>
<p>Full Name of Primary Supervising Physician: _____</p> <p>Practice Name (i.e., Dept. or Service, Clinic, Group, etc.): _____</p> <p>Facility/Institution Name (if applicable): _____</p> <p>Street Address: _____</p> <p>Town, State: _____ Zip: _____</p> <p>Business Phone: _____ Extension: _____</p>	<p>Practice specialty of Primary Supervising Physician</p> <p>_____</p> <p>Setting:</p> <p><input type="checkbox"/> Solo Private Practice</p> <p><input type="checkbox"/> Group Practice</p> <p><input type="checkbox"/> Organized Health Care Delivery System</p>
<p>Full Name of Primary Supervising Physician: _____</p> <p>Practice Name (i.e., Dept. or Service, Clinic, Group, etc.): _____</p> <p>Facility/Institution Name (if applicable): _____</p> <p>Street Address: _____</p> <p>Town, State: _____ Zip: _____</p> <p>Business Phone: _____ Extension: _____</p>	<p>Practice specialty of Primary Supervising Physician</p> <p>_____</p> <p>Setting:</p> <p><input type="checkbox"/> Solo Private Practice</p> <p><input type="checkbox"/> Group Practice</p> <p><input type="checkbox"/> Organized Health Care Delivery System</p>
<p>Full Name of Primary Supervising Physician: _____</p> <p>Practice Name (i.e., Dept. or Service, Clinic, Group, etc.): _____</p> <p>Facility/Institution Name (if applicable): _____</p> <p>Street Address: _____</p> <p>Town, State: _____ Zip: _____</p> <p>Business Phone: _____ Extension: _____</p>	<p>Practice specialty of Primary Supervising Physician</p> <p>_____</p> <p>Setting:</p> <p><input type="checkbox"/> Solo Private Practice</p> <p><input type="checkbox"/> Group Practice</p> <p><input type="checkbox"/> Organized Health Care Delivery System</p>
<p>Full Name of Primary Supervising Physician: _____</p> <p>Practice Name (i.e., Dept. or Service, Clinic, Group, etc.): _____</p> <p>Facility/Institution Name (if applicable): _____</p> <p>Street Address: _____</p> <p>Town, State: _____ Zip: _____</p> <p>Business Phone: _____ Extension: _____</p>	<p>Practice specialty of Primary Supervising Physician</p> <p>_____</p> <p>Setting:</p> <p><input type="checkbox"/> Solo Private Practice</p> <p><input type="checkbox"/> Group Practice</p> <p><input type="checkbox"/> Organized Health Care Delivery System</p>

PHYSICIAN ASSISTANT

FORM C INSTRUCTIONS

RETURN TO: MAINE BOARD OF LICENSURE IN MEDICINE
137 STATE HOUSE STATION
AUGUSTA, ME 04333-0137
TEL: (207) 287-3601 FAX: (207) 287-6590

Please refer to Chapter 2 of the Board's Rules, which are available upon request by contacting the Board, or at http://www.docboard.org/me/me_home.htm

A Physician Assistant (PA) practicing under delegation must hold a valid license and a **Certificate of Registration, which documents the supervision relationship**, as described in Chapter 2, Section 2, B of the Board's Rules.

- A. **Initial Registration:** Before beginning employment, each PA who is newly licensed or who has inactive status must be registered with a Primary Supervising Physician by filing a Form C registration with the Maine Board of Licensure in Medicine.
- B. **Primary Supervising Physician Change:** Each PA has **14 days** in which to notify the Board upon changing Primary Supervising Physicians or adding a Primary Supervising Physician. Effective January 1, 1998, a **\$100 late registration fee** will be assessed if the Form C registration is not filed within 14 days of beginning employment. Both the Physician Assistant and Primary Supervising Physician must sign the form. The PA is responsible to notify the Board when the supervising relationship ends.
- C. **Secondary Supervision:** In the temporary absence of the Primary Supervising Physician, the responsibility of the supervising of the named PA must be transferred to another licensed physician. The secondary supervisor must designate in writing in the written Plan of Supervision his/her willingness to accept the responsibility and liability for the performance of the named PA.
- D. **Termination:** You may use this form to notify the Board when the Primary Supervising Physician relationship has terminated. Please use a separate page if more space is needed. State the date of and reason for the termination and return the Board-issued Certificate Of Registration after it has been signed by the Primary Supervising Physician.

FORM C: REGISTRATION OF PHYSICIAN ASSISTANT SUPERVISORY RELATIONSHIP

To ensure that the physician you plan to work with has been approved by the Board to serve as a Primary Supervising Physician, call the Board at 287-3782 prior to the start date of your working relationship.

PLEASE PRINT OR TYPE ALL INFORMATION CLEARLY

Physician Assistant _____
Maine License No.

Primary Supervising Physician _____
Maine M.D. License No.

Primary Supervising Physician Email Address

Name/Address of Practice Setting:

Tel: _____

Please check the appropriate box: Fee

- | | | |
|--------------------------|--|------|
| <input type="checkbox"/> | First time registration with a New Primary Supervising Physician (PSP)
(The first time registration is valid only upon approval by the Board). | \$50 |
| <input type="checkbox"/> | Change of Primary Supervising Physician relationship*.
(Registering a new PSP and terminating a relationship with a former PSP.
Please refer to page 9, paragraph D, Termination.) | \$50 |
| <input type="checkbox"/> | Renewal of Primary Supervising Physician relationship. File with license renewal. | \$50 |
| <input type="checkbox"/> | Renewal of multiple Primary Supervising Physician relationships.
(Fee is per registration - not to exceed \$250 per registration period.) | \$50 |
| <input type="checkbox"/> | Renewal of Primary Supervising Physician relationship within 1 year of initial
registration of relationship. File with license renewal. | \$25 |

*Termination of a Primary Supervising Physician relationship: fill out the fields below.

Name of Former Primary Supervising Physician: _____

Effective Relationship End Date: _____

Reason for termination: _____

FORM C
ATTESTATIONS

PHYSICIAN ASSISTANT

I have read, fully understand, and accept the responsibilities and liability of a Physician Assistant as described in 32 M.R.S.A. § 3270-A and § 3270-B and in the current Chapter 2 of the Rules of the Board of Licensure in Medicine. I affirm that a written Plan of Supervision addressing the technical requirements of supervision as set forth in Chapter 2, Section 6 of the Rules has been prepared and is available for inspection at the above named practice setting. I agree to notify the Board of Licensure in Medicine in writing no later than 14 days after the effective date of any change to or addition of a Primary Supervising Physician.

I hereby certify that to the best of my knowledge and belief the statements made in this application are true and correct.

Signature, Physician Assistant

Date

Name Printed

PRIMARY SUPERVISING PHYSICIAN

I have read, fully understand, and accept the responsibilities and liability for the supervision of a Physician Assistant as described in 32 M.R.S.A. § 3270-A and § 3270-B and in the current Chapter 2 of the Rules of the Board of Licensure in Medicine. I affirm that a written Plan of Supervision addressing the technical requirements of supervision as set forth in Chapter 2, Section 5 of the Rules has been prepared and is available for inspection at the above named practice setting.

I hereby certify that to the best of my knowledge and belief the statements made in this application are true and correct.

Signature, Primary Supervising Physician

Date
