FLORIDA BOARD OF MEDICINE

COUNCIL ON PHYSICIAN ASSISTANTS

Apply for your license online at www.flboardofmedicine.gov

GENERAL INFORMATION

For a detailed list of licensure requirements, please visit www.flboardofmedicine.gov

Mailing Information:
Submit your application, fees, and any supplemental documentation you are sending with your application to the following address:

Department of Health
P.O. Box 6330
Tallahassee, Florida 32314-6330

Mail additional documentation, not included with your application, to the following

Address: Florida Board of Medicine
4052 Bald Cypress Way,
BIN #CO3 Tallahassee,
Florida 32399-3253

All documents must have your name as listed on your application to ensure materials reach your application in a timely manner.

Fees:
The application and initial license fee for any person who is issued a Physician Assistant license as provided in Sections 458.347 and 459.022, Florida Statutes, shall be $305. Submit a personal check, money order or cashiers check made payable to the Florida Department of Health in the amount of $305.

Application fee: $100.00 (non-refundable)
Initial license fee: $200.00
Unlicensed activity fee: $5
Military Veteran Fee Waiver: Application fee and initial fee waived if qualified.

Make one cashier's check or money order for the total amount payable to the Department of Health-Board of Medicine.

An applicant, who is denied licensure, or withdraws the application prior to licensure, is entitled to a refund of the initial licensure fee. A request to withdraw and receive a refund must be made in writing.

Please submit the following supporting documentation:

- ☐ Applicable fees
- ☐ Copy of your military discharge document (if applicable)
- ☐ Transcript(s)
- ☐ Course Description
- ☐ Statements for all yes answers and supporting documentation (if applicable)
- ☐ Diploma
- ☐ Name Change Document(s)

Please request the following be sent directly to the Florida Board of Medicine:

- ☐ Verification from Physician Assistants Program
- ☐ Verification of NCCPA Examination
- ☐ State License Verification

INSTRUCTIONS FOR COMPLETING THE APPLICATION FOR LICENSURE AS A PHYSICIAN ASSISTANT

The Department strongly suggests that you refrain from making a commitment or accepting a position in Florida until you are licensed.

Please take personal responsibility for preparing your application. Carefully read and follow all instructions. If you have questions, call for clarification.

IMPORTANT NOTICE:

Effective July 1, 2012, section 456.0635, Florida Statutes, provides that health care boards or the department **shall refuse** to issue a license, certificate or registration and **shall refuse** to admit a candidate for examination if the applicant:

1. Has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S., (relating to social and economic assistance), Chapter 817, F.S., (relating to fraudulent practices), Chapter 893, F.S., (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction unless the candidate or applicant has successfully completed a drug court program for that felony and provides proof that the plea has been withdrawn or the charges have been dismissed.

   Any such conviction or plea shall exclude the applicant or candidate from licensure, examination, certification, or registration, unless the sentence and any subsequent period of probation for such conviction or plea ended:

   - For the felonies of the first or second degree, more than 15 years from the date of the plea, sentence and completion of any subsequent probation;
   - For the felonies of the third degree, more than 10 years from the date of the plea, sentence and completion of any subsequent probation;
   - For the felonies of the third degree under section 893.13(6)(a), F.S., more than five years from the date of the plea, sentence and completion of any subsequent probation;

2. Has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss.
   801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues), unless the sentence and any subsequent period of probation for such conviction or pleas ended more than 15 years prior to the date of the application;

3. Has been terminated for cause from the Florida Medicaid program pursuant to section 409.913, F.S., unless the candidate or applicant has been in good standing with the Florida Medicaid program for the most recent five years;

4. Has been terminated for cause, pursuant to the appeals procedures established by the state or Federal Government, from any other state Medicaid program, unless the candidate or applicant has been in good standing with a state Medicaid program for the most recent five years and the termination occurred at least 20 years before the date of the application;

5. Is currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities.

THE FOLLOWING ITEMS MUST ACCOMPANY YOUR APPLICATION FOR LICENSURE AS A PHYSICIAN ASSISTANT:

1. APPLICATION / LICENSE FEE: No application will be processed without the application fee. APPLICATION FEE MUST ACCOMPANY THE APPLICATION AND IS NON-REFUNDABLE.

The application and initial license fee for any person who is issued a Physician Assistant license as provided in Sections 458.347 and 459.022, Florida Statutes, shall be $305. Submit a personal check, money order or cashiers check made payable to the Florida Department of Health in the amount of $305, (application fee $100, initial license fee $200, unlicensed activity fee $5).

Under the Federal Privacy Act, disclosure of Social Security numbers is voluntary unless specifically required by federal statute. In this instance, Social Security numbers are mandatory pursuant to Title 42 United States Code, Sections 653 and 654; and Sections 456.004, 409.2577 and 409.2598, Florida Statutes. Social Security numbers are used to allow efficient screening of applicants and licensees by Title IV-D child support agency to assure compliance with child support obligations. Social Security numbers must also be recorded on all professional and occupational license applications and will be used for licensee identification pursuant to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act), 104 Pub. L. 193, Section 317.

2. TEMPORARY LICENSURE: List date you will take the PANCE and contact the NCCPA and request direct verification of your examination registration be sent to this office.

3. PRESCRIBING AUTHORITY: If yes, submit a copy of your course transcripts and a copy of the course description from your physician assistant training program describing course content in pharmacotherapy. These documents must meet the evidence requirements for prescribing authority.

4. Name: List your name as it appears on your birth certificate and/or a legal name-change document. Nicknames or shortened versions are unacceptable. If you have a hyphenated last name, enter both names in the last name space. It will be recognized by the first letter of the first name; e.g., Diaz-Jones.

4a. List name(s). Name changes include marriage, naturalization, divorce, or by any other means. Provide a copy of the legal name-change document.

4b. List your aliases or any of your other names that may appear on supporting documentation.

5. Mailing address: List your current mailing address. We will mail correspondence to you at this address unless you notify the board in writing of an address change. NOTE: If your address changes prior to the issuance of the license, it is your responsibility to notify your reviewer of your address change in writing.

6. Physical location or address of employment: List your physical location or address of employment. This address will be available to the public on the MQA License Verification web site. Post Office Box is not acceptable.

7. Provide your place and date of birth.

8. Provide primary and alternate telephone numbers.

9. List your e-mail address. We will e-mail correspondence to you at this address instead of the mailing address when possible. If you do not want your e-mail address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

10. Physician Assistant Training Program: Provide name and location of the physician assistant training program graduated from. Submit a copy of your Physician Assistant diploma. Additionally, you are responsible for mailing to your Physician Assistant program the "Physician Assistant Program Verification Form" provided with the application.

11. Dates of attendance and graduation date of the Physician Assistant Training Program: Provide dates of attendance at the physician assistant training program and the graduation date. List the month, day and year.

12. National Commission Certifying Examination and/or Physician Assistant National Recertifying Examination administered by the National Commission of Physician Assistants: Provide date you passed, number of attempts and dates of attempts the PANCE and/or PANRE. Submit a photocopy of your certificate issued to you by the NCCPA. If you have had a previous certificate that lapsed, please indicate the certification number. Please indicate whether you were ever issued a certificate number other than your current NCCPA certificate number. Chapter 458.347(7)(a)2., and Section 459.022(7)(a)2., F.S. requires any person desiring to be licensed, as a physician assistant, must have "satisfactorily passed a proficiency examination by an acceptable score established by the NCCPA. If an applicant does not hold a current certification issued by the NCCPA and has not actively practiced as a physician assistant within the immediately preceding 4 years, the applicant must retake and successfully complete the entry-level examination of the NCCPA to be eligible for licensure." Additionally, you are responsible for mailing the "NCCPA Verification Form" to NCCPA provided with the application. For temporary licensure, contact NCCPA and request direct verification of your examination registration sent to this office.

13. LICENSE VERIFICATIONS INCLUDING INACTIVE STATUS: (PA, LPN, RN, EMT, CNA, PARAMEDIC, RT, TT, PT, etc.) List state licensure information as a Physician Assistant AND ALL other healthcare related licenses / certifications in any state. If you are, or have been, licensed in the United States, contact each state and have them forward licensure/registration/certification, (including temporary licenses/permits) verification directly to the Florida Council on Physician Assistants. If no license/registration/certification was required during your employment, please request that the state board provide such statement directly to this office. You may want to request state licensure verifications as soon as possible; some states can take up to 6 weeks to complete and mail verifications. Additionally, you are responsible for mailing the attached "Licensure Verification Form" to all state boards where you have ever held a license/registration/certification as a health care provider.

14. UNDERGRADUATE, GRADUATE AND PROFESSIONAL EDUCATION – List all schools, colleges and universities attended in chronological order. If applicable, list the date of graduation.

15. EMPLOYMENT HISTORY:
Account for all employment since graduation from an approved physician assistant educational program until present. Give full name and address of the facility, dates of employment (month and year), positions / titles held, and reason for leaving. Failure to provide all required information will delay processing the application.

16. UNITED STATES MILITARY AND/OR PUBLIC HEALTH: Provide a copy of your discharge documents indicating type of discharge.

SUPPLEMENTAL DOCUMENTS: If any of the questions numbered **17-36** on the application are answered **"YES"**, you must submit a detailed statement, composed by you, explaining the circumstances. Should any of the questions in the "YES/NO" portion of the application fail to provide sufficient space for the requested information, use an additional page and number the additional information with the corresponding number in the application.

For Questions 20-24: Submit copies of charges/arrest report(s), indictments(s) and judgment(s) and satisfaction of judgment(s) Submit copies of any litigation or any other proceedings in any court of law or equity, any criminal court, any arbitration Board or before any governmental Board or Agency, to which you have been a party, either as a plaintiff, defendant, co-defendant, or otherwise. Also see "Supplemental Documents".
For Questions 28: Submit a copy of the complaint, amended complaint(s), and judgment. If litigation is pending, the attorney representing the case must submit a letter addressed to the Council on Physician Assistants explaining the current litigation status. Submit a statement, composed by you, stating how many cases you have been named in and the details of your involvement. Also see "Supplemental Documents".

For Questions 31-36: Reports from all treating physicians/hospitals/institutions/agencies, including admission and discharge summary, regarding any and all treatment on conduct assessment(s); mental or physical conditions. Reports must include all DSM III R/DSM IV, Axis I and II diagnoses and codes and Axis III condition and prescribed medications. Applicants, who have any history of those listed above, may be required to undergo a current conduct assessment through Florida's Professionals Resource Network, Inc. Also see "Supplemental Documents".

Section 456.013(3)(c), Florida Statutes, permits the Council to require your personal appearance.

Upon employment you must notify the Board of Medicine within 30 days of beginning such employment and after any subsequent changes in the supervising physician(s) including address changes. A Physician Assistant Supervision Data Form must be used for this purpose and will be supplied to you upon licensure. This form can also be printed from the DOH web site at http://flboardofmedicine.gov/forms/frm_supervision-data.pdf
Any change to your application, including address changes, must be submitted to the Board within 30 days of the occurrence.

Keep a copy of these frequently used phone numbers and web sites

Physician Assistant Website: http://flboardofmedicine.gov/renewals/physician-assistants/
(Applications and forms, renewal forms, address changes, laws & rules)

MQA Services (Look-up License, request an application, request license certification for another state medical Board, current list of supervising physicians) http://flboardofmedicine.gov/resources/

Supervision Data Form http://flboardofmedicine.gov/forms/frm_supervision-data.pdf

Web Board Address: http://flboardofmedicine.gov

American Medical Association: (312) 464-5000

American Academy of Physician Assistants: (703) 836-2272

Florida Academy of Physician Assistants: (407) 774-7880

American Osteopathic Association: (800) 621-1773

NCCPA: (770) 734-4500

Electronic Fingerprinting

Take this form with you to the Livescan service provider. Please check the service provider's requirements to see if you need to bring any additional items.

- Background screening results are obtained from the Florida Department of Law Enforcement and the Federal Bureau of Investigation by submitting to a fingerprint scan using the Livescan method;
- You can find a Livescan service provider at: http://www.floridahealth.gov/licensing-and-regulation/background-screening/index.html.
- Failure to submit background screening will delay your application;
- Applicants may use any Livescan service provider approved by the Florida Department of Law Enforcement to submit their background screening to the department;
- If you do not provide the correct Originating Agency Identification (ORI) number to the Livescan service provider the Board office will not receive your background screening results;
- The ORI number for the **Board of Medicine is EDOH2014Z**.
- You must provide accurate demographic information to the Livescan service provider at the time your fingerprints are taken, including your Social Security number (SSN);
- Typically background screening results submitted through a Livescan service provider are received by the Board within 24-72 hours of being processed.
- If you obtain your Livescan from a service provider who does not capture your photo you may be required to be reprinted by another agency in the future.

Name: _____ Social Security Number: _____

Aliases: _____ Date of Birth: _____
(MM/DD/YYYY)

Citizenship: _____ Place of Birth: _____

Race: _____ Sex: _____

White/Latino(a); **B**-Black; **A**-Asian; **NA**-Native American; **U**-Unknown) (**M**=Male; **F**=Female)

Weight: _____ Height: _____

Eye Color:_____ Hair Color: _____

Address:_____Apt. Number: _____

City:_____State:_____Zip Code: _____

Transaction Control Number (TCN#):_____
(This will be provided to you by the Livescan service provider.)

Keep this form for your records.

FLORIDA DEPARTMENT OF LAW ENFORCEMENT

NOTICE FOR APPLICANTS SUBMITTING FINGERPRINTS WHERE CRIMINAL RECORD RESULTS WILL BECOME PART OF THE CARE PROVIDER BACKGROUND SCREENING CLEARINGHOUSE

NOTICE OF:

- **SHARING OF CRIMINAL HISTORY RECORD INFORMATION WITH SPECIFIED AGENCIES,**
- **RETENTION OF FINGERPRINTS,**
- **PRIVACY POLICY, AND**
- **RIGHT TO CHALLENGE AN INCORRECT CRIMINAL HISTORY RECORD**

This notice is to inform you that when you submit a set of fingerprints to the Florida Department of Law Enforcement (FDLE) for the purpose of conducting a search for any Florida and national criminal history records that may pertain to you, the results of that search will be returned to the Care Provider Background Screening Clearinghouse. By submitting fingerprints, you are authorizing the dissemination of any state national criminal history record that may pertain to you to the Specified Agency or Agencies from which you are seeking approval to be employed, licensed, work under contract, or to serve as a volunteer, pursuant to the National Child Protection Act of 1993, as amended, and Section 943.0542, Florida Statutes. "Specified agency" means the Department of Health, the Department of Children and Family Services, the Division of Vocational Rehabilitation within the Department of Education, the Agency for Health Care Administration, the Department of Elder Affairs, the Department of Juvenile Justice, and the Agency for Persons with Disabilities when these agencies are conducting state and national criminal history background screening on persons who provide care for children or persons who are elderly or disabled. The fingerprints submitted will be retained by FDLE and the Clearinghouse will be notified if FDLE receives Florida arrest information on you.

Your Social Security Number (SSN) is needed to keep records accurate because other people may have the same name and birth date. Disclosure of your SSN is imperative for the performance of the Clearinghouse agencies' duties in distinguishing your identity from that of other persons whose identification information may be the same as or similar to yours.

Licensing and employing agencies are allowed to release a copy of the state and national criminal record information to a person who requests a copy of his or her own record if the identification of the record was based on submission of the person's fingerprints. Therefore, if you wish to review your record, you may request that the agency that is screening the record provide you with a copy. After you have reviewed the criminal history record, if you believe it is incomplete or inaccurate, you may conduct a personal review as provided in s. 943.056, F.S., and Rule 11C-8.001, F.A.C. If national information is believed to be in error, the FBI should be contacted at 304-625-2000. You can receive any national criminal history record that may pertain to you directly from the FBI, pursuant to 28 CFR Sections 16.30-16.34. You have the right to obtain a prompt determination as to the validity of your challenge before a final decision is made about your status as an employee, volunteer, contractor, or subcontractor.

Until the criminal history background check is completed, you may be denied unsupervised access to children, the elderly, or persons with disabilities.

The FBI's Privacy Statement follows on a separate page and contains additional information.

US Department of Justice, Federal Bureau of Investigation, Criminal Justice Information Services Division

Privacy Statement

Authority: The FBI's acquisition, preservation and exchange of information requested by this form is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include numerous Federal statutes, hundreds of State statutes pursuant to Pub.L.92-544, Presidential executive orders, regulations and/or orders of the Attorney General of the United States, or other authorized authorities. Examples include, but are not limited to: 5 U.S.C. 9101; Pub.L.94-29; Pub.L.101-604; and Executive Orders 10450 and 12968. Providing the requested information is voluntary; however, failure to furnish the information may affect timely completion of approval of your application.

Social Security Account Number (SSAN): Your SSAN is needed to keep records accurate because other people may have the same name and birth date. Pursuant to the Federal Privacy Act of 1974 (5 USC 552a), the requesting agency is responsible for informing you whether disclosure is mandatory or voluntary, by what statutory or other authority your SSAN is solicited, and what uses will be made of it. Executive Order 9397 also asks Federal Agencies to use this number to help identify individuals in agency records.

Principal Purpose: Certain determinations, such as employment, security, licensing and adoption, may be predicated on fingerprint based checks. Your fingerprints and other information contained on (and along with) this form may be submitted to the requesting agency, the agency conducting the application investigation, and/or FBI for the purpose of comparing the submitted information to available records in order to identify other information that may be pertinent to the application. During the processing of this application, and for as long hereafter as may be relevant to the activity for which this application is being submitted, the FBI (may disclose any potentially pertinent information to the requesting agency and/or to the agency conducting the investigation. The FBI may also retain the submitted information in the FBI's permanent collection of fingerprints and related information, where it will be subject to comparisons against other submissions received by the FBI. Depending on the nature of your application, the requesting agency and/or the agency conducting the application investigation may also retain the fingerprints and other submitted information for other authorized purposes of such agency(ies).

Routine Uses: The fingerprints and information reported on this form may be disclosed pursuant to your consent, and may also be disclosed by the FBI without your consent as permitted by the Federal Privacy Act of 1974 (5 USC 552a(b)) and all applicable routine uses as many be published at any time in the Federal Register, including the routine uses for the FBI Fingerprint Identification Records System (Justice, FBI-009) and the FBI's Blanket Routine Uses (Justice/FBI-BRU). Routine uses include, but are not limited to, disclosures to: appropriate governmental authorities responsible for civil or criminal law enforcement counterintelligence, national security or public safety matters to which the information may be relevant; to State and local governmental agencies and nongovernmental entities for application processing as authorized by Federal and State legislation, executive order, or regulation, including employment, security, licensing, and adoption checks; and as otherwise authorized by law, treaty, executive order, regulation, or other lawful authority. If other agencies are involved in processing the application, they may have additional routine uses.

Additional Information: The requesting agency and/or the agency conducting the application investigation will provide you additional information pertinent to the specific circumstances of this application, which may include identification of other authorities, purposes, uses, and consequences of not providing requested information. In addition, any such agency in the Federal Executive Branch has also published notice.

PHYSICIAN ASSISTANT
APPLICATION FOR LICENSURE
Apply for your license online at www.flboardofmedicine.gov

For Deposit/Receipt Only
CLIENT 1512

Application must be typed or legibly printed.

1. FULL LICENSURE: ☐ MILITARY VETERANS FEE WAIVER ☐

2. TEMPORARY LICENSURE: ☐ List date you will take the PANCE_____

If you were honorably discharged from the U.S. armed services within 60 months of your application you will qualify for a waiver of the application fee and the initial licensure fee. In order to qualify, please check the box above indicating that you are seeking a waiver and submit **a DD-214 or NGB-22 form as proof of honorable discharge.**

3. DO YOU WANT PRESCRIBING AUTHORITY: YES ☐ NO ☐

If yes, submit copy of course transcript, course description describing from your physician assistant training program describing course content in pharmacotherapy. These documents must meet the evidence requirements for prescribing authority.

4. Name: _____
(First) (Middle) (Last)

4a. Have you ever legally changed your name? (Including marriage), maiden, or other: ☐YES ☐NO
If so, please provide legal documentation of each name change.

4b. List any other names by which you have been known _____

5. Mailing address _____
(No. & Street) (City) (State) (zip)

6. Physical location or address of employment – This address will be available to the public on the MQA License Verification website. Post Office Box is not acceptable.

_____
(No. & Street) (City) (State) (zip)

7. Place of Birth: (City/State/ or Country) _____ Date of Birth: _____
(Month, Day, Year)

8. Primary Telephone Number: _____ Alternate Telephone Number: _____

9. **Email Address:**_____

Under Florida law, email addresses are public records. If you do not want your e-mail address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

PHYSICIAN ASSISTANT TRAINING PROGRAM:

10. **Name and location of Program**:_____

11. Dates of Attendance: From: _____ To: _____ Graduation Date: _____
(Month / Day / Year) (Month / Day / Year)

NATIONAL COMMISSION CERTIFICATION

12. Date you passed the Physician Assistant National Certifying Examination (PANCE) and/or Physician Assistant National Recertifying Examination (PANRE) administered by the National Commission on Certification of Physician Assistants (NCCPA)?	PANCE _____ Number of Attempts_____ Dates of Attempts_____ PANRE _____ Number of Attempts_____ Dates of Attempts_____

STATE LICENSE INFORMATION
Not Limited to Physician Assistant Licensure

13. Do you hold or have you ever held a license to practice medicine as a physician assistant or any other profession in the United States or territory? YES☐ NO☐

If yes list below (attach additional sheets if necessary).

State:	Type of License:	License Number:	Original Issue Date:

EDUCATION
Not limited to Physician Assistant Educational Program

14. List all undergraduate, graduate and professional education in chronological order. Submit on a separate sheet

School/College/University Name and Address	Major and Degree	From: mm/yy	To: mm/yy	Graduation Date

EMPLOYMENT HISTORY:

15. In CHRONOLOGICAL order list all employment since graduation from an approved physician assistant educational program until present. Give full name and address of the facility, dates of employment (month and year), positions / titles held, and reason for leaving. Failure to provide all required information will delay processing the application. Add additional sheets if necessary.

Name and Address of Employment	Dates of Employment (Month and Year)	Title of position held & reason for leaving

MILITARY HISTORY:

16. Have you ever been in the United States Military and/or Public Health Service? Provide a copy of your discharge documents indicating type of discharge. ☐YES ☐NO

THE FOLLOWING QUESTIONS MUST BE ANSWERED YES OR NO. ALL AFFIRMATIVE ANSWERS MUST BE PERSONALLY EXPLAINED TO THE COUNCIL IN DETAIL ON AN ADDITIONAL SHEET. DOCUMENTATION SUBSTANTIATING THE EXPLANATION IS REQUIRED.

17. Have you ever been denied a license as a Physician Assistant or health care practitioner by any state board or other governmental agency of any state or country? ☐YES ☐NO

18. Have you ever been notified to appear before <u>any</u> licensing agency for a hearing or complaint of any nature, including, but not limited to, a charge of violation of the medical practice act, unprofessional or unethical conduct? ☐ YES ☐ NO

19. Have you ever had a license to practice as a Physician Assistant or other license to practice any regulated profession revoked, suspended, or otherwise acted against including denial of license? ☐ YES ☐ NO

20. Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to a crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, even if the court withheld adjudication so that you would not have a record of conviction. Driving under the influence or driving while impaired is not a minor traffic offense for purposes of this question. ☐ YES ☐ NO

21. I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the "Privacy Statement" document from the Federal Bureau of Investigation. ☐ YES ☐ NO

22. Have you had any felony convictions? ☐ YES ☐ NO

23. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction?
(**If you responded "no", skip to #24**.) ☐ YES ☐ NO

a. If "yes" to 23, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence and completion of any subsequent probation? ☐ YES ☐ NO

b. If "yes" to 23, for the felonies of the third degree, has it been more than 10 years from the date of the plea, sentence and completion of any subsequent probation? (This question does not apply to felonies of the third degree under Section 893.13(6)(a), Florida Statutes) ☐ YES ☐ NO

c. If "yes" to 23, for the felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years from the date of the plea, sentence and completion of any subsequent probation? ☐ YES ☐ NO

d. If "yes" to 23, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or charges dismissed? (**If "yes", please provide supporting documentation**) ☐ YES ☐ NO

24. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)? ☐ YES ☐ NO

a. If "yes" to 24, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended? ☐ YES ☐ NO

25. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? (**If "No", do not answer 25a**) ☐ YES ☐ NO

a. If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years? ☐ YES ☐ NO

26. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? (**If "No", do not answer 26a or 26b**.) ☐ YES ☐ NO

a. Have you been in good standing with a state Medicaid program for the most recent five years? ☐ YES ☐ NO

b. Did the termination occur at least 20 years before the date of this application? ☐ YES ☐ NO

27. Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities? ☐ YES ☐ NO

28. Have you ever been named in a lawsuit for malpractice or has any settlement or claim been paid on your behalf in relation to a claim of malpractice? ☐ YES ☐ NO

29. Have you ever discontinued practice for any reason for a period of one month or longer? ☐ YES ☐ NO

30. Have you ever had employment terminated for cause? ☐ YES ☐ NO

31. In the last five years, have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past five years? ☐ YES ☐ NO

32. In the last five years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment? ☐ YES ☐ NO

33. During the last five years, have you been treated for or had a recurrence of a diagnosed mental disorder that has impaired your ability to practice medicine within the past five years? ☐ YES ☐ NO

34. In the last five years, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice medicine? ☐ YES ☐ NO

35. In the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder or, if you were previously in such a program, did you suffer a relapse within the last five years? ☐ YES ☐ NO

36. During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol/drug) disorder that has impaired your ability to practice medicine within the last five years? ☐ YES ☐ NO

Statement of Applicant:

I state that these statements are true and correct. I recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to Sections 456.067, 775.083, and 775.084 F.S. I state that I have read Chapters 456, 458 and 459, and Sections 766.301- 316, Florida Statutes, Rule Chapters 64B8 and 64B15, Florida Administrative Code.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Florida Board of Medicine information which is material to my application for licensure.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind. I state 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 constitutes cause for denial, suspension, or revocation of my license to practice medicine in the State of Florida. If there are any changes to my status or any change that would affect any of my answers to this application I must notify the board within 30 days.

I understand that my records are protected under federal and state regulations governing Confidentiality of Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my records are protected under federal and state regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42CFR Part 2 and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it.

Signature of Applicant: Date:

We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43 FR38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

Male ☐ Female ☐

Black ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Asian ☐ Other ☐

CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE*

Florida Department of Health
Board of Medicine
Physician Assistant License Application

Name: _____
Last **First** **Middle**

Social Security Number: _____

This page is exempt from public records disclosure. The Department of Health is required and authorized to collect Social Security Numbers relating to applications for professional licensure pursuant to Title 42 USCA § 666 (a)(13). For all professions regulated under chapter 456, Florida Statutes, the collection of social security numbers is required by Section 456.013(1)(a), Florida Statutes.

PHYSICIAN ASSISTANT PROGRAM VERIFICATION FORM

To: (Physician Assistant program address)	From: **Department of Health** **Council on Physician Assistants** **4052 Bald Cypress Way** **Bin #C03** **Tallahassee, Florida 32399-3253**

The individual listed below has applied to the Florida Department of Health, Council on Physician Assistants for licensure as a physician assistant. A diploma from your school was submitted as proof of having completed educational prerequisites for licensure in Florida. Please authenticate by signature and seal that the following is true and correct to your records.

Name:	_____ First Middle Last

DOB:	/ /

Profession:	**Physician Assistant**	Degree issue date:	/ /

Comments (if any):_____

_____

_____

_____

_____
Verified by: (signature)

SEAL

_____
Name: (please print)

_____
Title:

NCCPA VERIFICATION FORM

National Commission on Certification of Physician Assistants **12000 Findley Road, Suite 100** **John Creek, GA 30097 (678) 417-8100**	**From: Department of Health** **Council on Physician Assistants** **4052 Bald Cypress Way, Bin #C03** **Tallahassee, Florida 32399-3253**

*** Completed by the applicant – Please print**

* Name:	First Middle Last

* Date of Birth:	/ /

Completed by NCCPA

NCCPA Certificate #:		Previous NCCPA Certificate # if applicable	

Number of times NCCPA exam was taken:		Number of times NCCPA exam was failed:	

Dates of exams:	

Original issue date:	

Expiration date:	

SEAL

Current status:	

Comments if any

Signature and title:

LICENSE VERIFICATION FORM

(Mail to each state where you were/are licensed except Florida)

To:	**FROM:** **Department of Health** **Council on Physician Assistants** **4052 Bald Cypress Way** **BIN #C03** **Tallahassee, Florida 32399-3253**

The physician assistant listed below has submitted an application for licensure in Florida. He/she states that he/she was licensed/registered in your state as a healthcare practitioner. Please complete and return this form as soon as possible. Thank you for your cooperation.

***Completed by applicant – Please Print**

Name:	_____ First Middle Last
*DOB:	/ /

Completed by Medical Board

Profession:		License #:	
Issue date:		Expiry date	

Was a temporary certificate issued prior to full licensure? YES☐ NO☐
License # Issue date: Expiry date:

Has any disciplinary action ever been taken against this license? YES☐ NO☐
If yes, please explain.

_____
Verified by: (signature)

SEAL

_____
Name: (please print)

_____
Title:

Change of Address for Current Physician Assistant Licensees

License Number	PA	
Name (as printed on license)		
NEW mailing address:		
City/State/Zip:		
Country (other than US)		
NEW practice location:		
City/State/Zip:		
Country (other than US)		
Telephone:	Home:	Work:
E-mail Address:		
Signature:		Date:

NOTE: Only practice locations are published on the Internet. Any change to your licensure information must be up-dated within 30 days of the occurrence.

Telephone: (850) 245-4131
Fax: (850) 412-1285

Checklist of Supporting Documents for the Initial Application

☐ Personal check or money order, in the amount of $305, made payable to The Department of Health, must accompany the application

☐ All pages of the application with all information required

☐ Legal name change document, i.e. marriage certificate, divorce decree, naturalization, etc. if applicable

☐ Military discharge certificate (DD214) if applicable

☐ Physician Assistant program diploma

☐ Physician Assistant Program Verification Form (provided with the application)

☐ NCCPA certificate

☐ NCCPA Verification Form (provided with the application)

☐ License Verification Form (provided with the application) if applicable.

☐ Explanation(s) and supporting documentation regarding affirmative response to questions 17-36.

Please review the application instruction pages regarding each item in the checklist and how to submit them.

To expedite processing, submit all available supporting documents with your application. Remaining supporting documents may be sent under separate cover to the physical address. Supporting documents received in the Board office prior to receiving the application will be held until the application is received.