DEPARTMENT OF HEALTH
COUNCIL ON PHYSICIAN ASSISTANTS

P.O. Box 6320
Tallahassee, Florida 32314-6320
(850) 245-4131

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or applicant has successfully completed a drug court program for that felony and provides proof that the plea has been withdrawn or the charges have been dismissed.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.

NOTE: This section **does not apply** to candidates or applicants for initial licensure or certification who were enrolled in an educational or training program on or before July 1, 2009, which was recognized by a board or, if there is no board, recognized by the department, and who applied for licensure after July 1, 2012.

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.

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.

17. PREVENTION MEDICAL ERRORS CONTINUING MEDICAL EDUCATION: Section 456.013(7), F.S., requires, as a condition of granting a license, each physician assistant to complete a 2-hour course on Prevention Medical Errors. Your license will not be issued unless you have completed this requirement. The course shall be a minimum of two (2) hours, approved for Category I or II AMA.

SUPPLEMENTAL DOCUMENTS: If any of the questions numbered 18-39 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 21-27: 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 and 29: 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 32-37: 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.

LETTERS OF RECOMMENDATION: Two letters of recommendation.

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 www.doh.state.fl.us/mqa/PhysAsst/frm.supervisiondata.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://www.doh.state.fl.us/mqa/PhysAsst/pa_home.html
(Applications and forms, renewal forms, CME requirements, 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://www.doh.state.fl.us/mqa/index.html

Supervision Data Form: www.doh.state.fl.us/mqa/PhysAsst/frm_supervisiondata.pdf

Web Board Address: www.doh.state.fl.us/mqa/medical/me_home.html

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

CME websites:

NET CE: www.netce.com/courselist.php

AKH: www.AKHealthcare.com

Florida Medical Association: www.fmaonline.org

American Medical Association: cme@ama-assn.org

The Total Fee (includes Application, Licensure, and Unlicensed Activity Fees) $305 Use a personal check or money order made payable to The Department of Health. Return all pages of the application. Application must be typed or legibly printed.	**DEPARTMENT OF HEALTH COUNCIL ON PHYSICIAN ASSISTANTS P.O. Box 6320 Tallahassee, Florida 32314-6320 (850) 245-4131** **APPLICATION FOR LICENSURE AS A PHYSICIAN ASSISTANT**	**For Deposit/Receipt Only CLIENT 1512**

1. FULL LICENSURE: ☐

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

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. E-mail Address:

PHYSICIAN ASSISTANT TRAINING PROGRAM:

10. Name and location of Program:

11. Dates of Attendance: **From:** **To:** **Graduation Date:**
(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 if needed.

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 ☐
CONTINUING MEDICAL EDUCATION	
17. I state that I have completed a minimum of two (2) hours of Prevention Medical Errors continuing medical education as defined by s.456.013(7), F.S. (See item #17 in instructions)	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.	
18. 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 ☐
19. Have you ever been notified to appear before any 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 ☐
20. Have you ever had a license to practice as a Physician Assistant or other health care practitioner revoked, suspended, or other disciplinary action taken in any state, territory or country?	YES ☐ NO ☐
21. 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 ☐
22. 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 #23.)	YES ☐ NO ☐
22a. If "yes" to 22, 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 ☐
22b. If "yes" to 22, 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 ☐
22c. If "yes" to 22, 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 ☐
22d. If "yes" to 22, 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 ☐
23. 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 ☐
23a. If "yes" to 23, 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 ☐
24. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? (If "No", do not answer 24a.)	YES ☐ NO ☐
24a. 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 ☐
25. 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 25a or 25b.)	YES ☐ NO ☐

Question	Answer
25a. Have you been in good standing with a state Medicaid program for the most recent five years?	YES ☐ NO ☐
25b. Did the termination occur at least 20 years before the date of this application?	YES ☐ NO ☐
26. 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 ☐
27. If "yes" to any of the questions 22-26 above, on or before July 1, 2009, were you enrolled in an educational or training program in the profession in which you are seeking licensure that was recognized by this profession's licensing board or the Department of Health? (If "yes", please provide official documentation verifying your enrollment status.)	YES ☐ NO ☐
28. Have any civil judgments ever been entered against you?	YES ☐ NO ☐
29. 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 ☐
30. Have you ever discontinued practice for any reason for a period of one month or longer?	YES ☐ NO ☐
31. Have you ever had employment terminated for cause?	YES ☐ NO ☐
32. 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 ☐
33. 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 ☐
34. 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 ☐
35. 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 ☐
36. 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 ☐
37. 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 ☐
38. Have you had any felony convictions? **Regardless of your answer you must complete the affidavit on page 9.**	YES ☐ NO ☐
39. Have you had any license revoked or denied? **Regardless of your answer you must complete the affidavit on page 9.**	YES ☐ NO ☐

AFFIDAVIT: (Applicable to questions 38 and 39 regardless of your answer.)

The foregoing instrument was sworn before me this ________ day of ___________________________, 20________,

by____, who is personally known to me or who has
(Name of Applicant)
produced_______________________ as identification and did take an oath.

Name of Notary:____ (typed, printed or stamped)

Signature of Notary:____

Date That Notary Commission Expires:

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, and Chapters 64B8-30, and 64B15-6, 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:	From: **Department of Health** **Council on Physician Assistants** **4052 Bald Cypress Way** **Bin #C03** **Tallahassee, Florida 32399-3253**
(Physician Assistant program address)	

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)

____
Name: (please print)

____
Title:

SEAL

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:	

Current status:	

SEAL

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)

Name: (please print)

Title:

SEAL

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

CME REQUIREMENTS FOR PA's

Initial licensure:
Two (2) credits in Prevention of Medical Errors

First renewal:
For the first renewal only, in addition to the CME below, include a one (1) hour course in category 1, AMA approved HIV/AIDS.

Every renewal thereafter:

If you ARE currently certified by NCCPA:
1. NCCPA certificate
2. Proof of completing a 2-hour course of category 1 or 2, Prevention of Medical Errors

If you ARE NOT currently certified by NCCPA:
1. Proof of completing no less than 100 hours of CME in accordance with Rule 64B8-30.005(2)(c), Florida Administrative Code plus
2. Proof of completing a 2-hour course of category 1 or 2, Prevention of Medical Errors

Prescribing Physician Assistants:
1. In addition to the above, proof of completing 10 hours of CME in the specialty area of your supervising physician(s). These 10 hours may be used to meet the general continuing education requirement.

In addition to the above, every third renewal must include:
Two (2) credits in Domestic Violence.

IMPORTANT: The CME courses you log for NCCPA will not satisfy the license renewal if completed outside of the license renewal biennium. CME courses must be completed between February 1 of the even year through January 31 of the next even year to be in compliance with the license renewal requirements.

Suggested CME web sites:
www.arcmesa.com www.findthatcme.com www.fmaonline.org cme@ama-assn.org

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.

☐ Two Letters of Recommendation.

☐ Explanation(s) and supporting documentation regarding affirmative response to questions 18-39.

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.