

**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, 2009, 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 has been:

- (a) Convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under chapter 409, chapter 817, chapter 893, 21 U.S.C. ss. 801-970, or 42 U.S.C. ss. 1395-1396, 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;
- (b) Terminated for cause from the Florida Medicaid program pursuant to s. 409.913, unless the applicant has been in good standing with the Florida Medicaid program for the most recent 5 years;
- (c) Terminated for cause, pursuant to the appeals procedures established by the state or Federal Government, from any other state Medicaid program or the federal Medicare program, unless the applicant has been in good standing with a state Medicaid program or the federal Medicare program for the most recent 5 years and the termination occurred at least 20 years prior to the date of the application.

As of July 1, 1997, the title "Physician Trained Assistant" cannot be used in Florida. The titles "Physician Assistant" or "Physician Assistant - Certified" may not be used until you are licensed in the State of Florida.

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.

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.

THE FOLLOWING SUPPORTING DOCUMENTS MUST BE SUBMITTED AND SHOULD ACCOMPANY THE APPLICATION:

IMPORTANT NOTICE: Illegible documents will be returned to the applicant unprocessed and will delay processing the application. It is acceptable, and preferred that large documents be reduced to 8 1/2" x 11".

2. NAME/CHANGES: (including marriage)

Proof of legal name change – If marriage or other legal proceeding has changed your name, a copy of your marriage certificate or a copy of the court order for each legal name change must be submitted. If the name change document is not in the English language, it must be accompanied by a copy of a translation prepared by a certified translator or faculty member of the Modern Language or Linguistics Department of a United States College or University. If change of name was made during naturalization, proof of name change must be submitted from the Department of Immigration and Naturalization. **IF A NAME OTHER THAN YOUR LEGAL NAME APPEARS ON ANY DOCUMENTATION SUBMITTED, YOU MUST PROVIDE A WRITTEN EXPLANATION.**

3. PHYSICIAN ASSISTANT DIPLOMA:

Submit a photocopy 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.

4. NCCPA:

Submit a photocopy of your certificate issued to you by the National Commission on Certification of Physician Assistants (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.

5. MILITARY:

For active military status, submit a photocopy of current military orders. For in-active military, submit a copy of your military discharge orders (DD214 indicating type of discharge) from all military service performed as a member of the Armed Forces of the United States or the Public Health Service. **IMPORTANT:** Please inform your application processor if you require a "military status" license or if you request a non-restricted license even though you are currently in the military. A military status license restricts you to practicing only in a military facility.

6. LETTERS OF RECOMMENDATION:

Two current, original, personalized and individualized letters of recommendation from physicians on their letterhead paper. Each letter must be addressed to the Council on Physician Assistants and must have been written no more than six (6) months prior to the filing of the application. Letters addressed only "TO WHOM IT MAY CONCERN" and/or containing a signature stamp will not be accepted. Identical letters that appear to have been composed by the same person, or from family members, will not be accepted. If you are a recent graduate, your recommendation letters must be from your preceptor physicians. If you were/are employed as a physician assistant, your recommendation letters must be from your last supervising physicians. If clinical rotations are completed in a state other than your program and your preceptor physician is submitting a recommendation letter, please have physician clarify his/her association with you. Letters should expound on your clinical skills and abilities. They can be mailed with the application or submitted under separate cover.

7. PHOTOGRAPH:

Submit a current 2"x 2" photograph of yourself (head and shoulders), on photo paper, taken within the last 60 days.

8. LICENSE VERIFICATIONS INCLUDING INACTIVE STATUS: (PA, LPN, RN, EMT, CNA, PARAMEDIC, RT, TT, PT, etc.)

Provide verification of licensure as a Physician Assistant **AND ALL other healthcare related licenses / certifications in any state**. Some agencies charge a fee for license verifications. 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. A copy of your license is not acceptable in lieu of a written verification of licensure from the State Licensing Agency. 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 "Licensure Verification Form" to all state Medical Boards where you have ever held a license/registration/certification as a health care provider. (Not limited to Physician Assistant licensure) provided with the application.

9. PREVENTION MEDICAL ERRORS CONTINUING MEDICAL EDUCATION:

Submit a copy of your Prevention Medical Errors certificate. 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.

10. MEDICAL AND NON-MEDICAL EMPLOYMENT HISTORY:

Question 20 part one must contain and account for **all non-medical employment, during the past 5 years**. Question 20 part two must contain **all medical employment only**. Omission of this information will cause a delay in the application process. Indicate N/A if applicable.

11. ACTIVITIES:

If you are asked to make a personal appearance before the Council, you are required to update your application by providing the Council with a written statement of your activities 30 days prior to the Council meeting to which your application is being considered. Also, you are required to update your activities prior to licensure.

12. SUPPLEMENTAL DOCUMENTS:

If any of the questions numbered 23 – 45 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 38-43:

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".

For Questions 26, 27 and 28:

Submit court certified 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 34 and 35: *

Submit a court certified 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".

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

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

Board Approved Prescriptive Courses:

**Nova Southeastern (800) 356-0026,
University of Florida (352) 265-7955,
Florida Academy of Physician Assistants (407) 774-7880,
Barry University (877) 267-2323
Medicaid: (850)414-2759 Medicare: (877)267-2323**

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

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| <p>The Total Fee (includes Application, Licensure, and Unlicensed Activity Fees) \$305</p> <p>Use a personal check or money order made payable to The Department of Health.</p> <p>Return all pages of the application.</p> <p>Application must be typed or legibly printed.</p> | <p>DEPARTMENT OF HEALTH COUNCIL ON PHYSICIAN ASSISTANTS P.O. Box 6320 Tallahassee, Florida 32314-6320 (850) 245-4131</p> <p>APPLICATION FOR LICENSURE AS A PHYSICIAN ASSISTANT</p> | <p>For Deposit/Receipt Only CLIENT 1512</p> |
| <p>Today's Date:</p> | | |
| <p>1. Application for: TEMPORARY LICENSURE: <input type="checkbox"/> (I am registered to take the 1st NCCPA exam after graduation) (check one) FULL LICENSURE: <input type="checkbox"/></p> | | |
| <p>2. Name:</p> <p>_____</p> <p>(First) (Middle) (Last)</p> | | |
| <p>3. Have you ever legally changed your name? (Including marriage), maiden, or other: YES <input type="checkbox"/> NO <input type="checkbox"/> If so, please provide legal documentation of each name change.</p> | | |
| <p>List maiden, marriage or other name(s)</p> | | |
| <p>4. Mailing address</p> <p>_____</p> <p>(No. & Street) (City) (State) (zip)</p> | | |
| <p>5. Permanent Address:</p> <p>_____</p> <p>(No. & Street) (City) (State) (zip)</p> | | |
| <p>6. Place of Birth: (City/State/ or Country)</p> | <p>7. Date of Birth: (Month, Day, Year) / /</p> | |
| <p>8. Home Telephone Number:</p> | <p>9. Work Telephone Number:</p> | |
| <p>OPTIONAL: E-mail Address</p> | | |
| <p>PHYSICIAN ASSISTANT TRAINING PROGRAM:</p> | | |
| <p>10. Name and location of Program:</p> | | |
| <p>11. Dates of Attendance: From: To: (month / day / year)</p> | | |

NON-MEDICAL EMPLOYMENT HISTORY:

20. Part One: In CHRONOLOGICAL order list all non-medical employment during the past 5 years 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. Write N/A if not applicable.

| Name and address of employment during the last 5 years (non-medical) | Dates of Employment (Month and Year) | Title of position held & reason for leaving |
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MEDICAL EMPLOYMENT HISTORY:

20. **Part Two:** In CHRONOLOGICAL order list all medical related employment. 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. Write N/A if not applicable.

| Name and address of facility and employer | Dates of employment (Month and Year) | Title of position held & reason for leaving |
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MILITARY HISTORY:

21. Have you ever been in the United States military? If yes, please provide below the branch of service, rank and all dates of service: (See item #5 in instructions)

YES NO

CONTINUING MEDICAL EDUCATION

22. 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 #9 in instructions)

YES NO

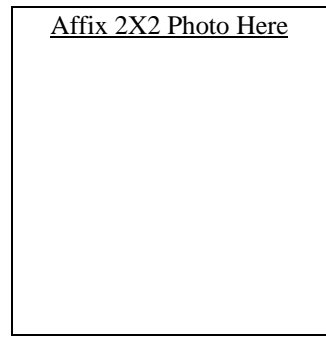
THE FOLLOWING QUESTIONS MUST BE ANSWERED YES OR NO. ALL AFFIRMATIVE ANSWERS MUST BE PERSONALLY EXPLAINED TO THE COUNCIL IN DETAIL ON AN ADDITIONAL SHEET. DOCUMENTATION SUBSTANTIATING THE EXPLANATION IS REQUIRED..

23. 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

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| 24. Have you ever been notified to appear before <u>any</u> licensing agency for a hearing or complaint of <u>any</u> nature, including, but not limited to, a charge of violation of the medical practice act, unprofessional or unethical conduct? | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 25. 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 <u>any</u> state, territory or country? | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 26. Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to a crime in <u>any</u> 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 <input type="checkbox"/> NO <input type="checkbox"/> |
| 27. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, Chapter 817, or Chapter 893, Florida Statutes; or 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396? (If no, do not answer 28.) | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 28. Has it been more than 15 years prior to the date of this application since the sentence and completion of any subsequent period of probation for each such conviction? | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 29. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? (If no, do not answer 30.) | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 30. 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 <input type="checkbox"/> NO <input type="checkbox"/> |
| 31. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state or federal government, from any other state Medicaid program or the federal Medicare program? (If no, do not answer 32 and 33) | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 32. Have you been in good standing with a state Medicaid program or the federal Medicare program for the most recent five years? | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 33. Did the termination occur at least 20 years prior to the date of this application? | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 34. Have any civil judgments ever been entered against you?. | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 35. 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 <input type="checkbox"/> NO <input type="checkbox"/> |
| 36. Have you ever discontinued practice for any reason for a period of one month or longer? | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 37. Have you ever had employment terminated for cause? | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 38. 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 <input type="checkbox"/> NO <input type="checkbox"/> |
| 39. 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 <input type="checkbox"/> NO <input type="checkbox"/> |
| 40. 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 <input type="checkbox"/> NO <input type="checkbox"/> |
| 41. 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 <input type="checkbox"/> NO <input type="checkbox"/> |
| 42. 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 <input type="checkbox"/> NO <input type="checkbox"/> |
| 43. 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 <input type="checkbox"/> NO <input type="checkbox"/> |
| 44. Have you had any felony convictions? | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 45. Have you had any license revoked or denied? | YES <input type="checkbox"/> NO <input type="checkbox"/> |

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| 46. Are you a United States citizen? If no please list your alien number. | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| AFFIDAVIT: (Applicable to questions 44 and 45 only) | |
| The foregoing instrument was sworn before me this _____ day of _____, 200_____, | |
| 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: _____ | |
| 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 <input type="checkbox"/> Female <input type="checkbox"/> Black <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Other <input type="checkbox"/> | |
| Color of Eyes: _____ | Color of Hair: _____ |
| Weight: _____ | Height: _____ |
| OTHER MEANS OF IDENTIFICATION (if any) | |
| <u>Statement of Applicant:</u> | |
| 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 declare 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 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 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, and cannot be disclosed without my written consent unless otherwise provided in the regulations. | |
| Signature of Applicant: _____ | Date: _____ |



PHYSICIAN ASSISTANT PROGRAM VERIFICATION FORM

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

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| Name: | <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border-bottom: 1px solid black; width: 33%;"></td> <td style="border-bottom: 1px solid black; width: 33%;"></td> <td style="border-bottom: 1px solid black; width: 33%;"></td> </tr> <tr> <td style="font-size: small;">First</td> <td style="font-size: small;">Middle</td> <td style="font-size: small;">Last</td> </tr> </table> | | | | First | Middle | Last |
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|------|-----------|
| DOB: | / / |
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|-------------|----------------------------|--------------------|-----------|
| 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 |
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*** Completed by the applicant – Please print**

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|---------|--|-------|--------|------|
| * Name: | <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; border-bottom: 1px solid black;">First</td> <td style="width: 33%; border-bottom: 1px solid black;">Middle</td> <td style="width: 33%; border-bottom: 1px solid black;">Last</td> </tr> </table> | First | Middle | Last |
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| * Date of Birth: | <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; border-bottom: 1px solid black;">/</td> <td style="width: 33%; border-bottom: 1px solid black;">/</td> <td style="width: 33%; border-bottom: 1px solid black;"></td> </tr> </table> | / | / | |
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Completed by NCCPA

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| NCCPA Certificate #: | | Previous NCCPA Certificate # if applicable | |
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|---------------------------------------|--|--|--|
| Number of times NCCPA exam was taken: | | Number of times NCCPA exam was failed: | |
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| Dates of exams: | |
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| Original issue date: | |
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| Expiration date: | |
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| 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**

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| Name: | <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border-bottom: 1px solid black; width: 33%;"></td> <td style="border-bottom: 1px solid black; width: 33%;"></td> <td style="border-bottom: 1px solid black; width: 33%;"></td> </tr> <tr> <td style="text-align: center; font-size: small;">First</td> <td style="text-align: center; font-size: small;">Middle</td> <td style="text-align: center; font-size: small;">Last</td> </tr> </table> | | | | First | Middle | Last |
| | | | | | | | |
| First | Middle | Last | | | | | |
| *DOB: | / / | | | | | | |

Completed by Medical Board

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|-------------|--|--------------|--|
| Profession: | | License #: | |
| Issue date: | | Expiry date: | |

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| Was a temporary certificate issued prior to full licensure? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;">License #</td> <td style="width: 33%;">Issue date:</td> <td style="width: 33%;">Expiry date:</td> </tr> </table> | License # | Issue date: | Expiry date: |
| License # | Issue date: | Expiry date: | |

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| Has any disciplinary action ever been taken against this license? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 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) 412-1268



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
- 2x2 head & shoulders photo of you on photocopy paper taken within 60 days prior to filing the application
- Legal name change document, i.e. marriage certificate, divorce decree, naturalization, etc. if applicable
- Military honorable 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 from MD's or DO's
- Prevention Medical Errors CME Certificate
- Malpractice, Mental Condition, Misdemeanor or Felony;

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.