FOR OFFICE USE ONLY
Application Approved:
License Number:
Issue Date:
Signature of Board Administrator
ID#:
Receipt #:

Rhode Island
Board of Licensure of Physician Assistants

Room 205
3 Capitol Hill
Providence, RI 02908-5097

Instructions and Application For

License As A

Physician Assistant

by

☐ **Examination** ☐ **Endorsement**

☐ **FCVS**

MILITARY STATUS ELIGIBILITY *(Documentation Required) see page 2 for instructions*

Please check ONE of the following criteria for expedited application:

- ☐ I am in active military duty or a reservist
- ☐ I am a military veteran with honorable discharge
- ☐ I am the spouse of someone in active military duty or the spouse of a reservist

Applicant - Print Name

LAST NAME	*FIRST NAME*	*MI*

☐ I am also applying for a RI Uniform Controlled Substances Registration (CSR) and I have attached the CSR application to this license application.

Phone: (401) 222-3855 **TTY/TDD: (800) 745-5555** **Fax: (401) 222-2158**

LICENSURE REQUIREMENTS

- ☐ Completed Application with Cover Page - Applications are valid for 1 year from the day they are received at RIDOH. If you are not licensed within the year you must submit a new application.
- ☐ Check or money order (preferred), made payable (in U.S. funds only) to the RI General Treasurer in the amount of **$110.00** and attached to the upper left-hand corner of the first (Top) page of the application. THIS APPLICATION FEE IS NONREFUNDABLE. Please be advised that this is an application fee and includes the first license **only** up until the next expiration date. All licenses expire June 30th of the odd numbered years.
- ☐ Official transcript from an accredited School of Physician Assistants submitted by the college/school/university, directly to the Board. Transcript must include date of completion, graduation date and degree **OR** Verified Credentials by the Federation of Credentials Verification Service (FCVS) through the Federation of State Medical Boards (FSMB). (**FCVS Telephone 1-888-275-3287 or website at http://www.fsmb.org/fcvs**
- ☐ Score/Certification sent directly from the National Commission on Certification of Physician Assistants (NCCPA) **OR** Verified Credentials by the Federation of Credentials Verification Service (FCVS) through the Federation of State Medical Boards (FSMB). (**FCVS Telephone 1-888-275-3287 or website at http://www.fsmb.org/fcvs**
- ☐ Submit a "self-query" of the **National Practitioner Data Bank (NPDB)**. The application is a Practitioner Request for Information Disclosure, which can be obtained by calling the NPDB, or downloading it from the NPDB web site. You must mail this completed form directly to NPDB. **When you receive a response, send the Department the ORIGINAL, UNOPENED** response. The Board must have this response in order to complete your application so you are encouraged to make this request as soon as possible. (**FCVS Telephone 1-888-767-6732 or website at http://www.npdb-hipdb.com**
- ☐ If you have ever been licensed in another state, license verification(s) must be sent directly from the state(s) in which you hold or have held a license. (Interstate Verification Form included in this application can be used for that purpose)
- ☐ If applying for expedited military status, please complete the Military Expedition Form at the end of this application packet.

Rhode Island Controlled Substance Registration (CSR)

- ☐ Completed Rhode Island Uniform Controlled Substances Act Registration Form (CSR) enclosed in this application to be used for that purpose.
- ☐ Check or money order (preferred), made payable (in U.S. funds only) to the RI General Treasurer in the amount of **$200.00**

In order to dispense, prescribe, store, or order controlled substances, **you must obtain a Rhode Island Controlled Substance Registration (CSR) and a Drug Enforcement Administration (DEA) Registration.** After you obtain your Rhode Island CSR you must apply for a federal DEA Number. That DEA number must be registered to a RI Business Address. An application for the federal DEA Number can be obtained by contacting DEA: DEA Phone Number (617) 557-2200. Web Site: http://www.deadiversion.usdoj.gov/drugreg/reg_apps/

Licensure Information

Please visit the RIDOH website at **http://www.health.ri.gov/licenses** to Verify your license, download Rules and Regualtions/Laws for your profession, download change of address forms, other licensing forms or obtain our contact information. HEALTH will not, for any reason, accelerate the processing of one applicant at the ex pense of others.

License Certificates

RIDOH will be providing wallet license cards ONLY on issuance of licenses. If you wish to receive a license certificate, suitable for framing, please check the box below and attach a separate check in the amount of $30.00 made payable to RI General Treasurer.

☐ I would like to receive a license certificate. I have enclosed a separate check in the amount of $30.00

NOTE: ALL physician assistant applicants must have a supervising physician who oversees the activities of, and accepts the responsibility for, the medical services rendered by the physician assistant.

State of Rhode Island
Board of Licensure of Physician Assistants
Application for License as a Physician Assistant

Refer to the Application Instructions when completing these forms. Type or block print only. Do not use felt-tip pens.

1. Name(s)

This is the name that will be printed on your License/Permit/Certificate and reported to those who inquire about your License/Permit/Certificate. Do not use nicknames, etc.

Title (i.e., Mr., Mrs., Ms., etc.)

First Name

Middle Name

Surname, (Last Name)

Suffix (i.e., Jr., Sr., II, III)

Maiden, if applicable

Name(s) under which originally licensed in another state, if different from above (First, Middle, Last).

2. Social Security Number

U.S. Social Security Number

"Pursuant to Title 5, Chapter 76, of the Rhode Island General Laws, as amended, I attest that I have filed all applicable tax returns and paid all taxes owed to the State of Rhode Island, and I understand that my Social Security Number (SSN) will be transmitted to the Divison of Taxation to verify that no taxes are owed to the State."

3. Gender

Please select from the dropdown.

4. Date of Birth

Month Day Year

5. Home Address

It is your responsibility to notify the board of all address changes.

1st Line Address (Apartment/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City State Zip Code

Country, If NOT U.S. Postal Code, If NOT U.S.

Home Phone Home Fax

Email Address (Format for email address is Username@domain e.g. applicant@isp.com)

6. Business Address (ONLY if it is RELATED to your license.)

It is your responsibility to notify the board of all address changes.

This address will appear on the Department of Health web site.

Name of Business/Work Location

1st Line Address (Department/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City State Zip Code

Country, If NOT U.S. Postal Code, If NOT U.S.

Business Phone Extension Business Fax

7. Preferred Mailing Address Please check <u>ONE</u>	☐ Please use my **Home Address** as my preferred mailing address ☐ Please use my **Business Address** as my preferred mailing address
8. Qualifying Education Please list the name and information about the school that you attended that qualifies you for this license.	Type of School (University, College, Technical School, etc.) Name of School Date Graduated: Month Year Degree Received (Bachelor of Arts, Master of Science, Diploma, etc.)
9. Other State License(s) Please answer the question and list state(s), if applicable	Have you ever held, or do you currently hold, a license in another state? ☐ Yes ☐ No If the answer to this question is ***"yes"***, enter all other state licenses in Question 10 (below):
10. Licensure List all states or countries in which you are now, or ever have been licensed to practice your profession.	State/Country: ☐ Active ☐ Inactive — State/Country: ☐ Active ☐ Inactive (9 rows each)

State/Country:			State/Country:		
	☐ Active	☐ Inactive		☐ Active	☐ Inactive
	☐ Active	☐ Inactive		☐ Active	☐ Inactive
	☐ Active	☐ Inactive		☐ Active	☐ Inactive
	☐ Active	☐ Inactive		☐ Active	☐ Inactive
	☐ Active	☐ Inactive		☐ Active	☐ Inactive
	☐ Active	☐ Inactive		☐ Active	☐ Inactive
	☐ Active	☐ Inactive		☐ Active	☐ Inactive
	☐ Active	☐ Inactive		☐ Active	☐ Inactive
	☐ Active	☐ Inactive		☐ Active	☐ Inactive

DOCUMENTATION NEEDED FOR ENDORSEMENT APPLICANTS:

<u>**YOU**</u> must send an "Interstate Verification Form" to each state in which you are, or ever have been, licensed (Make copies as needed) *(See page 7).*

11. Criminal Convictions

Respond to the question at the top of the section, then list any criminal conviction(s) in the space provided.

If necessary, you may continue on a separate 8½ x 11 sheet of paper.

Have you ever been convicted of a violation, plead Nolo Contendere, or entered a plea bargain to any federal, state or local statute, regulation, or ordinance or are any formal charges pending? ☐ Yes ☐ No

Abbreviation of State and Conviction[1] (e.g. CA - Illegal Possession of a Controlled Substance):

	Month	Year

12. Disciplinary Questions

Check either Yes or No for each question.

NOTE: If you answer "Yes" to any question, you are **required** to furnish complete details, including date, place, reason and disposition of the matter.

1.	During any Professional/Medical Education, were you ever dismissed, suspended, restricted, put on probation, or otherwise acted against or did you take a leave of absence for medical reasons?	☐ Yes ☐ No
2.	During any Professional/Medical Education, were you ever requested to leave or did you leave, temporarily or permanently, prior to completion of training?	☐ Yes ☐ No
3.	During any training, were you ever dismissed, suspended, restricted, put on probation, or otherwise acted against or did you take a leave of absence for medical reasons?	☐ Yes ☐ No
4.	During any training, were you ever requested to leave or did you leave, temporarily or permanently, prior to completion of training?	☐ Yes ☐ No
5.	Are there any charges or investigations pending, in any state, against you?	☐ Yes ☐ No
6.	Have your staff privileges at any hospital, nursing home, or other health care facility or health care provider or HMO ever been reduced, revoked, or suspended or have you voluntarily surrendered your clinical privileges from any such unit or facility while under investigation in any state?	☐ Yes ☐ No
7.	Have you ever had any disciplinary action(s) taken, or is any pending, against your License to practice medicine, DEA Permit, State Controlled Substances Registration, Medicare Privileges, Medicaid Privileges, or are any complaints pending in any state?	☐ Yes ☐ No
8.	Have you ever had a membership in a professional society revoked, suspended, or limited in any manner or have you voluntarily withdrawn while under investigation?	☐ Yes ☐ No
9.	Have you ever failed to pass an examination for licensure?	☐ Yes ☐ No

Note: If you answer "Yes" to any question, you are **required** to furnish complete details, including date, place, reason and disposition of the matter. You may use the space below or, if needed, on a separate sheet of paper.

13. Affidavit of Applicant

Complete this section and sign.

Make sure that you have completed all components accurately and completely.

I, being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents.

I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and 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 shall constitute cause for denial, suspension or revocation of my license to practice as a Physician Assistant in the State of Rhode Island.

I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Board of Licensure of Physician Assistants of any change in the answers to these questions after this application and this affidavit is signed.

Signature of Applicant

Date of Signature (MM/DD/YY)

Substitute forms are not acceptable, copy this form as needed.

Rhode Island Board of Licensure of Physician Assistants
Room 205, 3 Capitol Hill
Providence, RI 02908-5097
(401) 222-3855

INTERSTATE VERIFICATION FORM - OTHER STATE LICENSE(S)

I am applying for a license to practice as a Physician Assistant in the State of Rhode Island. The Rhode Island Board of Licensure of Physician Assistants requires that the following form be completed by the jurisdiction(s) in which I hold or have held a license. This constitutes authority for you to release all information in your files, favorable or otherwise, directly to the Rhode Island Board of Licensure of Physician Assistants at the above address.

Print/Type Full Name

Signature _____ Date _____

Previous Names Used

Social Security Number Date of Birth

License Number _____ Date Issued _____

THIS SECTION TO BE COMPLETED BY THE PHYSICIAN ASSISTANT BOARD

Physician Assistant Program Completed:	**Location:**	**Graduation Date:**

Licensed by Examination? ☐ Yes ☐ No	**Applicant has completed and passed the NCCPA Exam:** ☐ Yes ☐ No

License Status: ☐ Active ☐ Inactive ☐ Lapsed	**Original Date Issued:**	**Expiration Date:**

Questions:

1. Has this licensee ever been investigated by your Board? ☐ Yes ☐ No
2. Has this licensee incurred any disciplinary proceedings in your state, or is any action pending? ☐ Yes ☐ No
3. Has the applicant's license ever been denied, surrendered, reprimanded, suspended, revoked or placed on probation? ☐ Yes ☐ No
4. Do you know of any information that may discredit this person? ☐ Yes ☐ No

If you answer "Yes" to questions 1-4, please provide a written explanation below, and attach a copy of all supporting documentation (e.g., Board order, complaint, etc.).

_____

_____

_____

Certification:

Signature _____ Date _____

Type or Print Name

Title

Full Name of Licensing Board

Please Affix
Board Seal Here

Please return directly to the Board at the above address. Thank you for your prompt cooperation.

RHODE ISLAND UNIFORM CONTROLLED SUBSTANCES ACT REGISTRATION (CSR)

☐ NEW APPLICATION
☐ CHANGE OF OWNERSHIP
☐ CHANGE OF LOCATION

**** FOR OFFICE USE ONLY ****
RECEIPT #
ID#
ISSUE DATE
LICENSE #

1) PLEASE TYPE OR PRINT IN UPPERCASE
2) DO NOT SEND CASH - MAIL CHECK OR MONEY ORDER, PAYABLE TO: **RI GENERAL TREASURER**
3) PRACTITIONER FEE - $200.00 - FACILITY FEE - $100.00
4) RETURN ENTIRE APPLICATION TO:

RI BOARD OF PHARMACY
ROOM 103
3 CAPITOL HILL
PROVIDENCE, RI 02908-5097

REGISTRANT NAME AND BUSINESS LOCATION ONLY:

FULL NAME

BUSINESS ADDRESS

TELEPHONE NUMBER

CURRENT STATE LICENSE OR CERTIFICATION NUMBER

E-MAIL ADDRESS - **(THIS WILL BE USED FOR REGISTRATION TO THE RHODE ISLAND PRESCRIPTION MONITORING PROGRAM)**

Complete the following information to apply for a registration to prescribe, dispense, store or ship controlled substances in or into the State of Rhode Island. A CSR is not required if there will be no controlled substances prescriptions prescribed, dispensed, stored or shipped in or into this state. The CSR is renewed at the same time as the professional or facility license is renewed. NOTE: Please read important information on the next page.

REGISTRATION CLASSIFICATION:
BUSINESS ACTIVITY (CHECK ONE ONLY):

A. ☐ COMMUNITY PHARMACY B. ☐ PRACTITIONER C. ☐ MANUFACTURER/DISTRIBUTOR D. ☐ RESEARCHER
E. ☐ MEDICAL INSTITUTION/CLINICF. ☐ TEACHING INSTITUTION G. ☐ NTP PROGRAM H. ☐ ANALYTICAL LAB

DRUG SCHEDULE - Check all that apply (Non-practitioners only)

1. ☐ SCHEDULE I *Attach Protocol* 2. ☐ SCHEDULE II 3. ☐ SCHEDULE III 4. ☐ SCHEDULE IV 5. ☐ SCHEDULE V

DRUG ENFORCEMENT ADMINISTRATION (DEA) REGISTRATION

Provide DEA number if one has been issued, or check "pending" if an application is being made for the DEA Registration. **A copy of the DEA Registration must be provided to the BOARD within 60 days of its issuance by the DEA.**

DEA NUMBER

☐ **PENDING**

ALL APPLICANTS MUST ANSWER THE FOLLOWING:

A. Has the applicant been convicted of, or entered a plea of nolo contendere to a violation of any state or federal law relating to manufacturing, distributing, possessing, prescribing, administering or dispensing of drugs presently defined as controlled substances under Chapter 21-28, General Laws of Rhode Island? ☐ Yes ☐ No

B. Has the registration application or registration of the applicant, corporation, firm, partner, or officer of the applicant been surrendered, revoked, suspended or denied under any law of the United States or of any state relating to drugs presently defined as controlled substances under Chapter 21-28 of the General Laws of Rhode Island, or is such action pending? ☐ Yes ☐ No

IF "A" OR "B" IS ANSWERED IN THE AFFIRMATIVE, ATTACH LETTER SETTING FORTH CIRCUMSTANCES

DATE **SIGNATURE OR APPLICANT OR AUTHORIZED INDIVIDUAL** **OFFICIAL TITLE**

PLEASE KEEP FOR YOUR RECORDS:

IMPORTANT INFORMATION

Licensed drug facilities and licensed practitioners with prescriptive privileges cannot dispense, possess, store or ship controlled substances in or into the State of Rhode Island without a valid drug facility or professional license, Rhode Island Controlled Substances Registration (CSR), and a federal Drug Enforcement Administration (DEA) Registration. Practitioners may only dispense, possess, and store controlled substances within their particular "scope of practice". "Controlled Substances", for purposes of this application, means a prescription drug in Schedules II through V, pursuant to the Rhode Island Uniform Controlled Substances Act, and 21 CFR 1300 of the Federal Code of Regulations. Schedule I drugs are used by researchers, and require the submission of a protocol.

Without a Rhode Island CSR and federal DEA Registration, licensed drug facilities and practitioners with prescriptive privileges may dispense or possess non=controlled prescription medications under its facility or professional license. A CSR will not be granted to an applicant whose BOARD licensure application is "pending" in this state.

A Rhode Island Controlled Substances Registration must be obtained prior to applying for the DEA Registration. Federal regulations require that applicants comply with individual state requirements prior to issuance of a DEA Registration. Once the CSR is issued, applicants must apply to the US Drug Enforcement Administration for a federal registration using that agency's DEA Form 224 (New application for Retail Pharmacy, Hospital/Clinic, Practitioner, Teaching Institution, or Mid-Level Practitioner). Applicants may apply online for the DEA Registration at the following web site:

www.deadiversion.usdoj.gov/drugreg/reg_apps/index.html

or by contacting the Drug Enforcement Administration at the following location:

Registration Unit
US Drug Enforcement Administration
JFK Federal Building
15 New Sudbury Street
Boston, MA 02203-0131
1-888-272-5174

Call the Drug Enforcement Administration to check on the status of a pending DEA Registration. ***A copy of the DEA Registration must be provided to the BOARD within 60 days of its issuance by the DEA.***

PLEASE NOTE: Prescriptions in Schedules III, IV, and V cannot be written for more than one hundred (100) dosage units. A "dosage unit" is defined as a single capsule, tablet or suppository, or not more than one (1) teaspoon or an oral liquid. Prescriptions in Schedule II may be written for up to a 30-day supply, with a maximum of two hundred fifty (250) dosage units, as determined by the prescriber's directions for us of the medication.

The Rhode Island Uniform Controlled Substances Act can be accessed at the following website:

http://www.rilin.state.ri.us/Statutes/Title21/21-28/index.htm

---

*** Rhode Island Prescription Monitoring Program - (RIPMP) ***

The RIPMP is a database that allows you to view patient's prescription history prior to your writing a prescription for them.

Once your RI Controlled Substances Registration is issued we will email a user id and temporary password to the email address that you provided on the CSR form. RI Law requires that all prescribers of controlled substances be registered with the RIPMP. It is important to make sure your email address is current with the Department.

It is the Department's expectation that you utilize this valuable tool that not only protects you as a prescriber but more importantly protects your patients.

Please visit our website for more information about the program and expectations.

http://www.health.ri.gov/programs/prescriptionmonitoring/

Rhode Island Department of Health
Military Expedition Form

Please attach this form to the *front* of your completed application and mail to the address shown on the application cover.

Pursuant to Rhode Island General Laws § 5-88-1 et seq., upon application, this state may recognize occupational licenses, certificates or permits obtained from other states for military members and their spouses who relocate to this state pursuant to military orders. The Rhode Island Department of Health (RIDOH) will expedite your or your spouse's health professional license application provided the following conditions are met.

I. PROFESSION/LICENSE TYPE

Please indicate the profession and/or license type you are applying for so that your application can be routed to the correct office:

Profession/License Type: _____

II. MILITARY STATUS

Please check ONE of the following criteria for expedition:

- ☐ I am in active military duty or a reservist.
- ☐ I am the spouse of someone in active military duty or the spouse of a reservist.
- ☐ I am a military veteran with honorable discharge. *You do not need to complete the rest of this application – please skip to the signature line.*

III. PROOF OF MILITARY STATUS

- ☐ Please attach a copy of proof of your military status such as one of the following: Leave Earning Statement (LES), Letter from Command, or Copy of Orders

IV. MILITARY CHANGE OF STATION ORDER

- ☐ Permanent Change of Station Order

V. PROOF OF GOOD STANDING

- ☐ Proof of good standing from the board in the other state in which the person has a license.

VI. Criminal Background Check (a "BCI") *(unless required in the initial license application)*

- ☐ BCI completed from the RI Attorney General's Office.

VII. ATTESTATIONS:

Check all that apply:

- ☐ No board in any other state has revoked the license for which I am applying as a result of negligence or intentional misconduct.
- ☐ I have never surrendered an occupational license, certificate, or permit because of negligence or intentional misconduct.
- ☐ I do not have a complaint, allegation, or investigation currently pending before a board in another state which relates to unprofessional conduct or an alleged crime.

I attest that the above responses and information are true and accurate to the best of my knowledge and that none of the information set forth above is false, erroneous, or defective in any important, as set forth in R.I. Gen. Laws § 11-18-1. I understand that this application is being made to the Rhode Island Department of Health, which shall rely upon my attestation and the information provided in this document.

Signature of Applicant Date

On a case-by-case basis RIDOH may grant a temporary license should the military member or spouse need additional time to complete education, training, and/or experience for the licensure in Rhode Island. RIDOH will contact the applicant directly should that be needed.