



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	<i>(Documentation Required) see page 2 for instructions</i>
Please check ONE of the following criteria for expedited application:	
<input type="checkbox"/> I am in active military duty or a reservist	
<input type="checkbox"/> I am a military veteran with honorable discharge	
<input type="checkbox"/> I am the spouse of someone in active military duty or the spouse of a reservist	

Applicant - Print Name

<i>LAST NAME</i>	<i>FIRST NAME</i>	<i>MI</i>

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.

Please visit the RIDOH website at <http://www.health.ri.gov/licenses> to Verify your license, download Rules and Regulations/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 expense 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 Division of Taxation to verify that no taxes are owed to the State.”

3. Gender

Please select from the dropdown.

4. Date of Birth

 / / 9

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

Country, if NOT U.S.

 -

Home Phone

State

Zip Code

 -

Postal Code, if NOT U.S.

 -

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

Country, if NOT U.S.

 -

Business Phone

State

Zip Code

 -

Postal Code, if NOT U.S.

 -

Extension

Business Fax

7. Preferred Mailing Address Please check <u>ONE</u>	<input type="checkbox"/> Please use my Home Address as my preferred mailing address <input type="checkbox"/> 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.	<table style="width:100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; height: 15px; width: 100%;"></td> </tr> <tr> <td style="font-size: 8px;">Type of School (University, College, Technical School, etc.)</td> </tr> <tr> <td style="border: 1px solid black; height: 15px; width: 100%;"></td> </tr> <tr> <td style="font-size: 8px;">Name of School</td> </tr> <tr> <td style="padding: 2px;">Date Graduated: <table style="display: inline-table; border-collapse: collapse;"><tr><td style="border: 1px solid black; width: 20px; height: 15px;"></td><td style="border: 1px solid black; width: 20px; height: 15px;"></td></tr><tr><td style="font-size: 8px; text-align: center;">Month</td><td style="font-size: 8px; text-align: center;">Year</td></tr></table> <table style="display: inline-table; border-collapse: collapse; margin-left: 20px;"><tr><td style="border: 1px solid black; width: 20px; height: 15px;"></td><td style="border: 1px solid black; width: 20px; height: 15px;"></td><td style="border: 1px solid black; width: 20px; height: 15px;"></td><td style="border: 1px solid black; width: 20px; height: 15px;"></td></tr><tr><td style="font-size: 8px; text-align: center;">Year</td><td style="font-size: 8px; text-align: center;">Year</td><td style="font-size: 8px; text-align: center;">Year</td><td style="font-size: 8px; text-align: center;">Year</td></tr></table></td> </tr> <tr> <td style="border: 1px solid black; height: 15px; width: 100%;"></td> </tr> <tr> <td style="font-size: 8px;">Degree Received (Bachelor of Arts, Master of Science, Diploma, etc.)</td> </tr> </table>		Type of School (University, College, Technical School, etc.)		Name of School	Date Graduated: <table style="display: inline-table; border-collapse: collapse;"><tr><td style="border: 1px solid black; width: 20px; height: 15px;"></td><td style="border: 1px solid black; width: 20px; height: 15px;"></td></tr><tr><td style="font-size: 8px; text-align: center;">Month</td><td style="font-size: 8px; text-align: center;">Year</td></tr></table> <table style="display: inline-table; border-collapse: collapse; margin-left: 20px;"><tr><td style="border: 1px solid black; width: 20px; height: 15px;"></td><td style="border: 1px solid black; width: 20px; height: 15px;"></td><td style="border: 1px solid black; width: 20px; height: 15px;"></td><td style="border: 1px solid black; width: 20px; height: 15px;"></td></tr><tr><td style="font-size: 8px; text-align: center;">Year</td><td style="font-size: 8px; text-align: center;">Year</td><td style="font-size: 8px; text-align: center;">Year</td><td style="font-size: 8px; text-align: center;">Year</td></tr></table>			Month	Year					Year	Year	Year	Year		Degree Received (Bachelor of Arts, Master of Science, Diploma, etc.)
Type of School (University, College, Technical School, etc.)																				
Name of School																				
Date Graduated: <table style="display: inline-table; border-collapse: collapse;"><tr><td style="border: 1px solid black; width: 20px; height: 15px;"></td><td style="border: 1px solid black; width: 20px; height: 15px;"></td></tr><tr><td style="font-size: 8px; text-align: center;">Month</td><td style="font-size: 8px; text-align: center;">Year</td></tr></table> <table style="display: inline-table; border-collapse: collapse; margin-left: 20px;"><tr><td style="border: 1px solid black; width: 20px; height: 15px;"></td><td style="border: 1px solid black; width: 20px; height: 15px;"></td><td style="border: 1px solid black; width: 20px; height: 15px;"></td><td style="border: 1px solid black; width: 20px; height: 15px;"></td></tr><tr><td style="font-size: 8px; text-align: center;">Year</td><td style="font-size: 8px; text-align: center;">Year</td><td style="font-size: 8px; text-align: center;">Year</td><td style="font-size: 8px; text-align: center;">Year</td></tr></table>			Month	Year					Year	Year	Year	Year								
Month	Year																			
Year	Year	Year	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? <input type="checkbox"/> Yes <input type="checkbox"/> 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.	<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%; vertical-align: top;"> State/Country: _____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive </td> <td style="width:50%; vertical-align: top;"> State/Country: _____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive </td> </tr> <tr> <td style="vertical-align: top;"> _____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive </td> <td style="vertical-align: top;"> _____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive </td> </tr> <tr> <td style="vertical-align: top;"> _____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive </td> <td style="vertical-align: top;"> _____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive </td> </tr> <tr> <td style="vertical-align: top;"> _____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive </td> <td style="vertical-align: top;"> _____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive </td> </tr> <tr> <td style="vertical-align: top;"> _____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive </td> <td style="vertical-align: top;"> _____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive </td> </tr> <tr> <td style="vertical-align: top;"> _____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive </td> <td style="vertical-align: top;"> _____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive </td> </tr> <tr> <td style="vertical-align: top;"> _____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive </td> <td style="vertical-align: top;"> _____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive </td> </tr> <tr> <td style="vertical-align: top;"> _____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive </td> <td style="vertical-align: top;"> _____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive </td> </tr> </table>	State/Country: _____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive	State/Country: _____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive
State/Country: _____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive	State/Country: _____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive																
_____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive																
_____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive																
_____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive																
_____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive																
_____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive																
_____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive																
_____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive																

DOCUMENTATION NEEDED FOR ENDORSEMENT APPLICANTS:

YOU 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 Conviction¹ (e.g. CA - Illegal Possession of a Controlled Substance):

Month		Year	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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? | <input type="checkbox"/> Yes <input type="checkbox"/> 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? | <input type="checkbox"/> Yes <input type="checkbox"/> 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? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. During any training, were you ever requested to leave or did you leave, temporarily or permanently, prior to completion of training? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Are there any charges or investigations pending, in any state, against you? | <input type="checkbox"/> Yes <input type="checkbox"/> 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? | <input type="checkbox"/> Yes <input type="checkbox"/> 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? | <input type="checkbox"/> Yes <input type="checkbox"/> 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? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Have you ever failed to pass an examination for licensure? | <input type="checkbox"/> Yes <input type="checkbox"/> 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)



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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Applicant has completed and passed the NCCPA Exam: <input type="checkbox"/> Yes <input type="checkbox"/> No	
License Status: <input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Lapsed	Original Date Issued:	Expiration Date:

Questions:

- Has this licensee ever been investigated by your Board? Yes No
- Has this licensee incurred any disciplinary proceedings in your state, or is any action pending? Yes No
- Has the applicant's license ever been denied, surrendered, reprimanded, suspended, revoked or placed on probation? Yes No
- 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.).

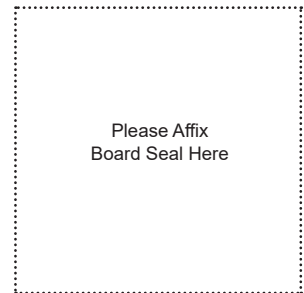
Certification:

Signature _____ Date _____

Type or Print Name _____

Title _____

Full Name of Licensing Board _____



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



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.