



State of Utah

DIVISION OF OCCUPATIONAL & PROFESSIONAL LICENSING

160 East 300 South, P.O. Box 146741
Salt Lake City, Utah 84114-6741
Telephone (801) 530-6628
www.dopl.utah.gov

- PHYSICIAN ASSISTANT *(\$180.00 Non Refundable Application Fee)*
- CONTROLLED SUBSTANCE *(\$100.00 Non Refundable Application Fee)*
- PHYSICIAN ASSISTANT TEMPORARY *(\$50.00 Non Refundable Application Fee)*

(Note: Microsoft Word users can fill in the blanks, print the form and save it for their records)

Please list your <u>full legal name</u> as it appears on your driver's license, Social Security Card, etc.				
Last Name:		First Name:		Middle Name:
Social Security Number: - -			Maiden Name:	
I certify under penalty of perjury that:				
<input type="checkbox"/> I am a citizen of the United States and I have a valid US Driver License or US State ID. License/State ID Number: _____ State: __				
<input type="checkbox"/> I am a citizen of the United States currently living outside the United States and do not have a valid US Drivers License or US State ID. Please attach a legible copy of your valid passport or other documentation to verify you are a legal citizen of the United States.				
<input type="checkbox"/> I am a non-citizen of the United States, who is lawfully present in the United States and I have a valid US Drivers License or US State ID. License/State ID Number: _____ State: __				
<input type="checkbox"/> I am a non-citizen of the United States, who is lawfully present in the United States and I do not have a valid US Drivers License or US State ID. Please attach a legible copy of your current and valid government issued document showing evidence of authorization to work in the United States.				
<input type="checkbox"/> I am a foreign national not physically present in the United States.				
Mailing Address:				
City:			State:	ZIP:
<input type="checkbox"/> Male	Date of Birth:	Phone #:	E-Mail:	
<input type="checkbox"/> Female				
List all other licenses, registrations, or certifications issued by any state which you now hold or have ever held in any profession. <i>(Use additional sheets if necessary.)</i>				
Profession:		Issuing State:		
License Number:		License Status:	Issue Date:	
Profession:		Issuing State:		
License Number:		License Status:	Issue Date:	
Profession:		Issuing State:		
License Number:		License Status:	Issue Date:	
Profession:		Issuing State:		
License Number:		License Status:	Issue Date:	

DO NOT WRITE IN THIS SECTION - FOR DIVISION USE ONLY

License/Certificate Number: _____

Date License/Certificate Approved/Denied: ___/___/___ by _____

Reason for Denial/Other Comments: _____

Bureau Manager Review: QQ Yes answers or Education or Exam Approve Deny

AFFIDAVIT and RELEASE AUTHORIZATION FOR APPLICANT

1. I certify that am qualified in all respects for the license for which I am applying in this application.
2. I certify that to the best of my knowledge, the information contained in the application and its supporting document(s) is free of fraud, forgery, misrepresentation, omission of material fact; is truthful, correct, and complete; discloses all material facts regarding the applicant; and that I will update or correct the application as necessary, prior to any action on my application.
3. I authorize all persons, institutions, organization, schools, governmental agencies, employers, references, or any others not specifically included in the preceding characterization, which are set forth directly or by reference in this application, to release to the Division of Occupational and Professional Licensing, State of Utah, any files, records, or information of any type reasonably required for the Division of Occupational and Professional Licensing to properly evaluate my qualifications for licensure/certification/registration by the State of Utah.
4. I understand that it is the continuing responsibility of applicants and licensees to read, understand, and apply the requirements contained in all statutes and rules pertaining to the occupation or profession for which you are applying, and that failure to do so may result in civil, administrative, or criminal sanctions.
5. I understand that as holder of a Utah Controlled Substance licensee that I must comply with Utah Code Annotated §58-37f-401(3). This statute requires me to register with the Controlled Substance Database in order to hold a Utah Controlled Substance License.

Name: _____ Position: _____ Signature: _____ Date: _____

PHYSICIAN ASSISTANT SCHOOL *(Use additional sheets if necessary.)*

Name of School:		Dates Attended:		To:
Location:			Date of Graduation:	
Mailing Address:	City:	State:	ZIP:	
Name of School:		Dates Attended:		To:
Location:			Date of Graduation:	
Mailing Address:	City:	State:	ZIP:	
Name of School:		Dates Attended:		To:
Location:			Date of Graduation:	
Mailing Address:	City:	State:	ZIP:	

PROFESSIONAL EXAMINATION REQUIREMENT

NCCPA, Date(s) Taken:

RECORD OF PROFESSIONAL EXPERIENCE

Account for all time periods since graduation from PA school. *(Use additional sheets if necessary.)*

Employer:		Supervisor:		
Mailing Address:	City:	State:	ZIP:	
Phone:	Employed From:		To:	
Practice Type and Specialty:				
Employer:		Supervisor:		
Mailing Address:	City:	State:	ZIP:	
Phone:	Employed From:		To:	
Practice Type and Specialty:				
Employer:		Supervisor:		
Mailing Address:	City:	State:	ZIP:	
Phone:	Employed From:		To:	
Practice Type and Specialty:				
Employer:		Supervisor:		
Mailing Address:	City:	State:	ZIP:	
Phone:	Employed From:		To:	
Practice Type and Specialty:				

IF PRACTICING AS A PHYSICIAN ASSISTANT IN UTAH

Complete the following for each of your practice sites. (Use additional sheets if necessary.)

Supervising Physician’s Name: _____

Supervising Physician’s Utah License Number: _____

Specialty: _____

Number of PAs supervised (including the applicant): Number of FTE PAs: _____

Practice Site(s): _____

Type of Practice: _____

Percent of Direct Supervision: _____

Substitute Supervising Physician’s Name: _____

Specialty: _____

AFFIDAVIT:

I declare under penalty of perjury as follows:

I will be practicing as a physician assistant in Utah. I have completed a “Delegation of Services Agreement” with my supervising physician and have reviewed the agreement with each of my substitute supervising physicians.

A copy of the agreement is on file at each of my Utah practice sites and is available to DOPL upon request.

The agreement defines the working relationship and delegation of duties between me and my supervising physician and includes all of the following: the prescribing of controlled substances; the degree and means of supervision; the frequency and mechanism of chart review; procedures addressing situations outside my scope of practice; and procedures for providing backup for me in emergency situations. The written criteria were jointly developed by me and my supervising physician and by me and any substitute supervising physicians. The agreement permits me to work under the direction or review of my supervising physician(s) to assist in the management of illnesses and injuries common to the physician’s scope of practice.

Signature of Physician Assistant Applicant: _____ Date: ____/____/____

Signature of Supervising Physician: _____ Date: ____/____/____

IF NOT PRACTICING AS A PHYSICIAN ASSISTANT IN UTAH

I declare under penalty of perjury as follows:

I will not be practicing as a Physician Assistant in Utah at this time.

If at any future time I choose to practice in Utah, I agree to complete and submit to DOPL a “Notification of Change” form. I understand that I must receive approval from DOPL before I begin practice with the proposed supervisor(s). I also agree to complete a “Delegation of Services Agreement” consistent with Utah law before I begin my practice in Utah. Said agreement(s) will be on file at my Utah practice site(s).

Signature of Applicant: _____ Date: ____/____/____

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UTAH CONTROLLED SUBSTANCES LAW AND RULES EXAMINATION

This examination is not intended to be difficult. The purpose of the exam is to bring to your attention specific practice issues you need to know in order to avoid violating Utah statute as well as Utah law and rule. If you are uncertain about any of the questions listed below, please refer to the references listed in order to become familiar with Utah's controlled substance prescribing practices.

Utah Controlled Substances Act, 58-37 <http://dopl.utah.gov/laws/58-37.pdf>
Utah Controlled Substances Act Rule, R156-37 <http://dopl.utah.gov/laws/R156-37.pdf>

Answer "True" or "False" for each statement. Submit this completed examination with your application for licensure.


<input type="checkbox"/> True <input type="checkbox"/> False	1. A prescription for a schedule II controlled substance may be filled in a quantity not to exceed a 30 day supply.
<input type="checkbox"/> True <input type="checkbox"/> False	2. A prescription for a schedule III or IV controlled substance may be refilled 5 times within a six month period from the issue date of the prescription.
<input type="checkbox"/> True <input type="checkbox"/> False	3. All prescription orders must be signed in ink or indelible pencil to prevent anyone from altering a legitimate prescription.
<input type="checkbox"/> True <input type="checkbox"/> False	4. Licensed prescribing practitioners must make their controlled substance stock and records available to DOPL personnel for inspection during regular business hours.
<input type="checkbox"/> True <input type="checkbox"/> False	5. All records of purchasing, prescribing, and administering controlled substances must be maintained by the licensed prescribing practitioner for at least five years.
<input type="checkbox"/> True <input type="checkbox"/> False	6. The name, address, and DEA registration number of the prescribing practitioner, and the name, address and age of the patient are required to be included on the prescription for a controlled substance.
<input type="checkbox"/> True <input type="checkbox"/> False	7. A controlled substance is taken according to the prescriber's instructions. A refill may be dispensed after 80% of the medication has been consumed.
<input type="checkbox"/> True <input type="checkbox"/> False	8. After the discovery of any theft or loss of a controlled substance, the prescribing practitioner is required to file the appropriate forms with the DEA, report the incidence to the local police, and send copies of the filed DEA forms to DOPL.
<input type="checkbox"/> True <input type="checkbox"/> False	9. The maximum number of controlled substances that can be written on a single prescription form is one.
<input type="checkbox"/> True <input type="checkbox"/> False	10. An emergency verbal prescription order for a schedule II controlled substance requires that the patient be under the continuing care of the prescribing practitioner for a chronic disease, the amount of drug prescribed is limited to what is needed to adequately treat the patient for no more than 72 hours, and a written prescription shall be delivered to the filling pharmacy within 7 working days of the verbal order.
<input type="checkbox"/> True <input type="checkbox"/> False	11. Issuing a prescription for a schedule II or III controlled substance for yourself is considered unprofessional conduct and may result in disciplinary action.
<input type="checkbox"/> True <input type="checkbox"/> False	12. A prescribing practitioner is using a schedule IV controlled substance in the treatment of weight reduction for obesity. The practitioner has completed a medical history of the patient, has performed a complete physical examination, has ruled out contra-indications, and has determined that the health benefits of treatment greatly out-weigh the risks. An informed consent signed by the patient is also required prior to initiating treatment.
<input type="checkbox"/> True <input type="checkbox"/> False	13. The Division will immediately suspend the Utah controlled substance license if the DEA registration is denied, revoked, surrendered, or suspended.
<input type="checkbox"/> True <input type="checkbox"/> False	14. The Division may: refuse to issue a license, refuse to renew a license, or revoke, suspend, restrict, or place on probation the license of an individual who does not register with the controlled substance database and take the controlled substance tutorial and examination.

QUALIFYING QUESTIONNAIRE

Read thoroughly, and answer the questions. Do not leave any question blank.

(Note: If you have formally expunged a criminal record you do not need to disclose that criminal history.)

<input type="checkbox"/> Yes <input type="checkbox"/> No	1. Have you ever applied for or received a license, certificate, permit, or registration to practice in a regulated profession under any name other than the name listed on this application?
<input type="checkbox"/> Yes <input type="checkbox"/> No	2. Have you ever been denied the right to sit for a licensure examination?
<input type="checkbox"/> Yes <input type="checkbox"/> No	3. Have you ever had a license, certificate, permit, or registration to practice a regulated profession denied, conditioned, curtailed, limited, restricted, suspended, revoked, reprimanded, or disciplined in any way?
<input type="checkbox"/> Yes <input type="checkbox"/> No	4. Have you ever been permitted to resign or surrender your license, certificate, permit, or registration to practice in a regulated profession while under investigation or while action was pending against you by any health care profession licensing agency, hospital or other health care facility, or criminal or administrative jurisdiction?
<input type="checkbox"/> Yes <input type="checkbox"/> No	5. Are you currently under investigation or is any disciplinary action pending against you now by any licensing agency?
<input type="checkbox"/> Yes <input type="checkbox"/> No	6. Have you ever had hospital or other health care facility privileges denied, conditioned, curtailed, limited, restricted, suspended, or revoked in any way?
<input type="checkbox"/> Yes <input type="checkbox"/> No	7. Have you ever been permitted to resign or surrender hospital or other health care facility privileges, while under investigation or while action was pending against you by any licensing agency, hospital or other health care

	facility, or criminal or administrative jurisdiction?
<input type="checkbox"/> Yes <input type="checkbox"/> No	8. Is any action related to your conduct or patient care pending against you now at any hospital or health care facility?
<input type="checkbox"/> Yes <input type="checkbox"/> No	9. Have you ever had rights to participate in Medicaid, Medicare, or any other state or federal health care payment reimbursement program denied, conditioned, curtailed, limited, restricted, suspended, or revoked in any way?
<input type="checkbox"/> Yes <input type="checkbox"/> No	10. Have you ever been permitted to resign from Medicaid, Medicare, or any other state or federal health care payment reimbursement program while under investigation or while action was pending against you by any licensing agency, hospital, or other health care facility, or criminal or administrative jurisdiction?
<input type="checkbox"/> Yes <input type="checkbox"/> No	11. Is any action pending against you now by Medicaid, Medicare, or any other state or federal health care payment reimbursement program?
<input type="checkbox"/> Yes <input type="checkbox"/> No	12. Have you ever had a federal or state registration to sell, possess, prescribe, dispense, or administer controlled substances denied, conditioned, curtailed, limited, restricted, suspended or revoked in any way by either the federal Drug Enforcement Administration or any state drug enforcement agency?
<input type="checkbox"/> Yes <input type="checkbox"/> No	13. Have you ever been permitted to surrender your registration to sell, possess, prescribe, dispense, or administer controlled substances while under investigation or while action was pending against you by any health care profession licensing agency, hospital or other health care facility, or criminal or administrative jurisdiction?
<input type="checkbox"/> Yes <input type="checkbox"/> No	14. Is any action pending against you now by either the Federal Drug Enforcement Administration or any state drug enforcement agency?
<input type="checkbox"/> Yes <input type="checkbox"/> No	15. Have you been named as a defendant in a malpractice suit?
<input type="checkbox"/> Yes <input type="checkbox"/> No	16. Have you ever had office monitoring, practice curtailments, individual surcharge assessments based upon specific claims history, or other limitations, restrictions or conditions imposed by any malpractice carrier?
<input type="checkbox"/> Yes <input type="checkbox"/> No	17. Have you ever had any malpractice insurance coverage denied, conditioned, curtailed, limited, suspended, or revoked in any way?
<input type="checkbox"/> Yes <input type="checkbox"/> No	18. If you are licensed in the occupation/profession for which you are applying, would you pose a direct threat to yourself, to your patients or clients, or to the public health, safety, or welfare because of any circumstance or condition?
<input type="checkbox"/> Yes <input type="checkbox"/> No	19. Have you ever been declared by any court of competent jurisdiction incompetent by reason of mental defect or disease and not restored?
<input type="checkbox"/> Yes <input type="checkbox"/> No	20. Have you been terminated, suspended, reprimanded, sanctioned, or asked to leave voluntarily from a position because of drug use or abuse within the past five (5) years?
<input type="checkbox"/> Yes <input type="checkbox"/> No	21. Have you ever had a documented case in which you were involved as the abuser in any incident of verbal, physical, mental, or sexual abuse?
<input type="checkbox"/> Yes <input type="checkbox"/> No	22. Are you currently using or have you recently (<i>within 90 days</i>) used any drugs (<i>including recreational drugs</i>) without a valid prescription, the possession or distribution of which is unlawful under the Utah Controlled Substances Act or other applicable state or federal law?
<input type="checkbox"/> Yes <input type="checkbox"/> No	23. Do you currently have any criminal action pending?
<input type="checkbox"/> Yes <input type="checkbox"/> No	24. Have you pled guilty to, no contest to, entered into a plea in abeyance or been convicted of a misdemeanor in any jurisdiction within the past ten (10) years? Motor vehicle offenses such as driving while impaired or intoxicated must be disclosed but minor traffic offenses such as parking or speeding violations need not be listed.
<input type="checkbox"/> Yes <input type="checkbox"/> No	25. Have you ever pled guilty to, no contest to, or been convicted of a felony in any jurisdiction?
<input type="checkbox"/> Yes <input type="checkbox"/> No	26. Have you, in the past ten (10) years, been allowed to plea guilty or no contest to any criminal charge that was later dismissed (<i>i.e. plea-in-abeyance or deferred sentence</i>)?
<input type="checkbox"/> Yes <input type="checkbox"/> No	27. Have you ever been incarcerated for any reason in any federal, state or county correctional facility or in any correctional facility in any other jurisdiction or on probation/parole in any jurisdiction?
<input type="checkbox"/> Yes <input type="checkbox"/> No	28. Has any owner, officer, manager, pharmacist, pharmacy technician or medical practitioner associated with or employed by the applicant ever had a license, certificate, permit, registration to practice a regulated profession denied, conditioned, curtailed, limited, restricted, suspended, revoked, reprimanded, or disciplined in any way?
	<p>If you answered “yes” to any of the above questions, enclose with this application complete information with respect to all circumstances and the final result, if such has been reached. If you answered “yes” to Questions 23, 24, 25, 26, 27, 28 or 29 you must submit a complete narrative of the circumstances that occurred for EACH and EVERY conviction, plea in abeyance, and/or deferred sentence. You must also attach copies of all applicable police report(s), court record(s), and probation/parole officer report(s).</p> <p>If you are unable to obtain any of the records required above, you must submit documentation on official letterhead from the police department and/or court indicating that the information is no longer available.</p> <p>If you have formally expunged a criminal record as evidenced by a court order signed by a judge, you do not need to disclose that criminal history. Expungement orders must be sent to the Bureau of Criminal Identification and the FBI to enable the expungement to be completed and the criminal history eliminated from the records.</p> <p>A “Yes” answer does not necessarily mean you will not be granted a license; however, DOPL may request additional documentation if the information submitted is insufficient.</p>

UTAH PHYSICIAN ASSISTANT LAW AND RULES EXAMINATION

The reference listed after each question is provided to assist you in selecting your response. The examination is not intended to be difficult. The purpose of the exam is to bring to your attention specific practice issues you need to know in order to avoid violating Utah law and rule. If you are uncertain about any of the questions listed below, please refer to the reference listed in order to become familiar with your Utah physician assistant practice.

Physician Assistant Act, 58-70a - <http://dopl.utah.gov/laws/58-70a.pdf>
Physician Assistant Practice Act Rules, R156-70a - <http://dopl.utah.gov/laws/R156-70a.pdf>

Answer “True” or “False” for each statement. Submit this completed examination with your application for licensure.

<input type="checkbox"/> True <input type="checkbox"/> False	1. A physician can supervise only 4 full time equivalent (FTE) Physician Assistants.
<input type="checkbox"/> True <input type="checkbox"/> False	2. A physician assistant’s full time equivalent (FTE) is equal to 2080 hours of staff time for a one-year period.
<input type="checkbox"/> True <input type="checkbox"/> False	3. A supervising physician and his physician assistant have been working together for three months. The supervising physician must review and cosign sufficient numbers of patient charts and medical records to ensure that the patient’s health, safety, and welfare will not be adversely compromised..
<input type="checkbox"/> True <input type="checkbox"/> False	4. A physician assistant, while practicing, shall wear an identification badge indicating his/her license classification, and not represent his/herself as a physician to the patient.
<input type="checkbox"/> True <input type="checkbox"/> False	5. In accordance with a Delegation of Services Agreement, in order for a physician assistant to prescribe or administer a controlled substance, a physician assistant must: <ul style="list-style-type: none"> • hold a Utah controlled Substance license and a DEA registration. • prescribe or administer the controlled substance within the prescriptive practice of the supervising physician and also within the delegated prescribing delineation. • have the supervising physician cosign any medical record of a prescription of a Schedule II or III controlled substance. • sign the prescription in ink and include his own DEA number on the prescription form.
<input type="checkbox"/> True <input type="checkbox"/> False	6. Unlawful conduct includes engaging in practice as a physician assistant while not under the supervision of a supervising physician or substitute, supervising physician.
<input type="checkbox"/> True <input type="checkbox"/> False	7. Unprofessional conduct includes failing to maintain a Delegation of Services Agreement that accurately reflects current practices at the practice site.
<input type="checkbox"/> True <input type="checkbox"/> False	8. Unprofessional conduct includes providing sample medications to a patient that does NOT have a legitimate medical need for it.
<input type="checkbox"/> True <input type="checkbox"/> False	9. A physician assistant who violates the unlawful conduct provision may be found guilty of a third degree felony.
<input type="checkbox"/> True <input type="checkbox"/> False	10. A physician assistant who violates the unlawful conduct provision may be found guilty of a Class A misdemeanor.
<input type="checkbox"/> True <input type="checkbox"/> False	11. A physician assistant may provide medical services under the following conditions: <ul style="list-style-type: none"> • if the services fall within the physician assistant’s scope of skill and competence • if the services are provided in the Delegation of Services agreement with the supervising physician • if the supervising physician provides the same services
<input type="checkbox"/> True <input type="checkbox"/> False	12. A physician assistant holding a temporary license may work only under the direct supervision of a supervising physician
<input type="checkbox"/> True <input type="checkbox"/> False	13. A temporary license may be granted to a physician assistant who has met all of the licensing requirements except for passing the examination component.
<input type="checkbox"/> True <input type="checkbox"/> False	14. A physician assistant may NOT independently bill a patient for services rendered.
<input type="checkbox"/> True <input type="checkbox"/> False	15. Documentation of completed qualified continuing professional education may be provided by submitting to the Division copies of certificates from sponsoring agencies, transcripts of participation on applicable letterhead, or a copy of current national certification by NCCPA.
<input type="checkbox"/> True <input type="checkbox"/> False	16. As a condition for licensure renewal, each physician assistant must have completed 40 hours of continuing professional education during each two-year licensure cycle.
<input type="checkbox"/> True <input type="checkbox"/> False	17. The minimum length of time that records documenting completion of qualified continuing professional education must be kept after the two-year period to which the records pertain is 4 years.
<input type="checkbox"/> True <input type="checkbox"/> False	18. A temporary license may only be issued for a maximum of 120 days.
<input type="checkbox"/> True <input type="checkbox"/> False	19. A temporary license may not be renewed or extended.
<input type="checkbox"/> True <input type="checkbox"/> False	20. The supervising physician cannot be an employee of the physician assistant that s/he supervises.

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REQUEST FOR VERIFICATION OF LICENSE

(Use this form to verify licensure from another state, if applicable.)

TO BE COMPLETED BY THE APPLICANT:

Complete the first section of the form and submit it to a state in which you are **currently** licensed as a physician assistant. Request that the verifying state complete the form and mail it directly to DOPL or return it to you for submission with your application.

Last Name:	First Name:	Middle Name:	
Maiden Name:	Social Security Number: - -		
Mailing Address:	City:	State:	ZIP:
Date of Birth:	E-Mail:	Date of Graduation:	
I am requesting licensure in the State of Utah as a Physician Assistant .			
I am/have been licensed in your state under the name:		License nr in your state is/was:	
I have enclosed the necessary license verification fee in the amount of \$			
Signature of Applicant:			

TO BE COMPLETED BY THE VERIFYING AGENCY:

Please furnish the information requested, sign and verify the document, and mail it directly to DOPL, or place the completed form in a sealed envelope and provide it to the applicant in person or by mail. The applicant will include the sealed verification of licensure with his/her Utah application. Thank you.

Name of Verifying State: _____

Name of Licensee (*as it appears in verifying state's records*): _____

Classification of License Issued: _____

License Number: _____ Current Status: _____

Original Date of Licensure: ___/___/___ Expiration Date: ___/___/___

Continuously Licensed:

Yes No, please explain: _____

Licensed By:

Exam, Type: _____ Date: ___/___/___

Endorsement: from what state? _____

Examination Scores: _____

Education Required for Licensure: _____

Disciplinary Action or Pending Disciplinary Action:

No Yes, please provide certified copies of all Petitions, Orders, etc.

Signature: _____

Title: _____

Agency: _____

Date: ___/___/___

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PHYSICIAN ASSISTANT TEMPORARY LICENSE REQUEST

TO BE COMPLETED BY THE APPLICANT:			
Last Name:	First Name:	Middle Name:	
Maiden Name:	Social Security Number: - -		
Mailing Address:	City:	State:	ZIP:
Date of Birth:	Date Taking Certifying Exam:	Date Employment to Begin:	
Supervising Physician:			Phone:
Mailing Address:	City:	State:	ZIP:
Clinic Location:			Phone:
Mailing Address:	City:	State:	ZIP:
I hereby certify that I will not practice until I have been granted a temporary license. Once the temporary license has been issued, I will only practice under the direct supervision of my supervising physician or substitute supervising physician.			
Signature of Applicant:			Date of Signature

TO BE COMPLETED BY SUPERVISING PHYSICIAN:	
Name: _____	
Address: _____	
City: _____	State: _____ Zip: _____
Telephone: _____	Utah License Number: _____
Signature of Supervisor: _____	Date of Signature: ____/____/____

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PHYSICIAN ASSISTANT DELEGATION OF SERVICES AGREEMENT

KEEP THIS ON SITE AT YOUR FACILITY

<p>A Delegation of Services Agreement is to be maintained at each practice site and is to be available to DOPL upon request. It consists of written criteria jointly developed by a physician assistant's supervising physician and any substitute supervising physicians and the physician assistant that permits a physician assistant, working under the direction or review of the supervising physicians, to assist in the management of illnesses and injuries common to the physician's scope of practice.</p>					
Last Name:		First Name:		Middle Name:	
Mailing Address:		City:		State:	ZIP:
Utah License Number of Physician Assistant:					
Supervising Physician:				Utah License Number:	
Substitute Supervising Physician:				Utah License Number:	
Substitute Supervising Physician:				Utah License Number:	
Substitute Supervising Physician:				Utah License Number:	
Name of Facility:					
Mailing Address:		City:		State:	ZIP:
Name of Facility:					
Mailing Address:		City:		State:	ZIP:
Name of Facility:					
Mailing Address:		City:		State:	ZIP:

YOU MUST SUBMIT A COMPLETED COPY OF THIS DELEGATION OF SERVICES AGREEMENT WITH YOUR APPLICATION.

YOU DO NOT NEED TO SUBMIT AN UPDATED COPY OF THE DELEGATION OF SERVICES AGREEMENT WHEN YOU HAVE A CHANGE TO YOUR SUPERVISING PHYSICIAN

DEGREE AND MEANS OF SUPERVISION:

The supervising Physician shall provide supervision to the physician assistant to adequately serve the health care needs of the practice population and ensure that the patient's health, safety, and welfare will not be adversely compromised. A physician assistant holding a temporary license may work only under 100% direct supervision.

<p>List the method of immediate consultation whenever the physician assistant is not under the direct supervision of the supervising physician:</p>

<p>List the process and degree of onsite supervision:</p>

List the method of supervision when the supervising physician is on vacation:

FREQUENCY AND MECHANISM OF CHART REVIEW:

List the method for chart review and co-signatures of the supervising practitioner for supervision. Include the process for chart review and co-signatures required:

PRESCRIBING OF CONTROLLED SUBSTANCES:

A physician assistant may prescribe or administer an appropriate controlled substance if the physician assistant holds a current Utah controlled substance license covering the appropriate schedules of controlled substances and a current DEA registration covering the appropriate schedules of controlled substances; the prescription or administration of the controlled substance is within the prescriptive practice of the supervising practitioner and also within the delegated prescribing stated in the delegation of services agreement; and the supervising practitioner co-signs any medical chart record of a prescription of a Schedule 2 or Schedule 3 controlled substance made by the physician assistant.

In order to prescribe controlled substances, the physician assistant must have obtained his or her own controlled substance license and DEA registration. The physician assistant may not use his or her supervising physician's controlled substance licenses or DEA registrations.

Please define the process for the physician assistant prescribing controlled substances and expectations:

SCOPE OF PRACTICE:

Please define procedures addressing situations outside the physician assistant's scope of practice:

EMERGENCY SITUATIONS:

List procedures for providing backup support for the physician assistant in emergency situations:

ADDITIONAL CONSIDERATIONS RELATING TO THE PRACTICE:

List any additional items, procedures, and expectations pertinent to the physician assistant at your site:

Signature of Physician Assistant: _____

Signature Date: ____/____/____

Signature of Supervising Physician: _____

Signature Date: ____/____/____

Signature of Substitute Supervising Physician: _____

Signature Date: ____/____/____

NOTE: It is “unprofessional conduct” under the Physician Assistant Practice Act to fail to maintain at the practice site(s) a “Delegation of Services Agreement” that accurately reflects current practices; or to fail to make the “Delegation of Services Agreement” available to DOPL for review upon request.

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NCCPA Request and Authorization for Release of Information

Please type or print. Duplicate as needed.

Mail completed form directly to:

NCCPA
12000 Findley Road, Suite 200
Duluth GA 30097

Section 1: Identification

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Daytime Telephone: (____) _____ - _____ Social Security Number: _____ - _____ - _____

Section 2: Exam Information

Indicate for which exam and examination period you're requesting information. (Only one request per form.)

- PANCE (Physician Assistant National Certifying Exam)
 PANRE (Physician Assistant National Recertifying Exam)
 Pathway II
 Surgery Exam

Year: _____ Spring Fall

Section 3: Information Request

Indicate the nature of this request and the person or agency to which it should be sent.

- Eligibility letter, verifying that you are eligible for and registered to take the above exam
 Pending letter, verifying that you have taken the above exam and are waiting scores
 Exam results

(Complete only if different from above.)

Name: _____

Agency: _____

Address: _____

City: _____ State: _____ Zip: _____

Want us to send the information via fax? If so, please provide the fax number here: (____) _____ - _____

Section 4: Signature and Authorization

Each state licensing authority sets its own rules and regulations. NCCPA strives to stay up-to-date on individual state regulations. We will send the required information, which may consist of current scores and/or score history, to the agency listed above in accordance with the information on state requirement on file with NCCPA.

I acknowledge that I read and understand the above statement and authorize NCCPA to release all information required by the agency listed above.

(signature)

(date)

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PHYSICIAN ASSISTANT

Attachment Check List <i>(Applications with incomplete attachments will not be considered and may be denied.)</i>	
<input type="checkbox"/>	Complete and submit the Controlled Substance Law and Rule Examination included with this application.
<input type="checkbox"/>	Complete Utah Physician Assistant Law and Rules Exam <i>(take-home, submit with application)</i>
<input type="checkbox"/>	Complete and submit the Qualifying Questionnaire <i>(submit with application)</i>
<input type="checkbox"/>	Complete and submit a copy Delegation of Services Agreement <i>(Submit with application. The original must be posted at each site you provide services.)</i>
<input type="checkbox"/>	Submit an official transcript from a Physician Assistant school accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA), which includes your date of graduation and degree earned. Have the school send the transcript directly to DOPL. You may also have the school send the transcript to you for inclusion with your application so long as it is in a sealed envelope, bearing the school's stamp/seal on the envelope flap
<input type="checkbox"/>	NCCPA, Date(s) Taken: ___/___/___
Submit application Fees	
<input type="checkbox"/>	Physician Assistant <i>(\$180.00 Non Refundable Application Fee)</i> Controlled Substance <i>(\$100.00 Non Refundable Application Fee)</i> Physician Assistant Temporary <i>(\$50.00 Non Refundable Application Fee)</i>

1. **Social Security Number:** Your social security number is classified as a private record under the Utah Government Records Access and Management Act. If an SSN is not provided, the application is incomplete and may be denied.
2. **Address of Record:** The address you provide on this application will be your address of record. You are responsible to directly notify DOPL of any change to your address of record.
3. **Laws and Rules:** You are required to understand Utah laws and rules pertaining to your practice. The following laws and rules are available on the Internet at www.dopl.utah.gov:
4. **Controlled Substance License:** You must hold a Utah controlled substance license **AND** a federal DEA registration to administer, possess, or prescribe a controlled substance in your practice in Utah.
5. **DEA Registration:** For DEA registration information, contact the Drug Enforcement Administration, Salt Lake District Office, 348 East South Temple, Salt Lake City, UT 84088. Telephone (801) 524-4389.
6. **Acceptable Forms of Payment:** Licensure fees can be paid by check or money order, made payable to "DOPL." Cash and debit/credit cards (*American Express, MasterCard, and Visa*) are also accepted in person at DOPL's main office – but not over the telephone.
7. **Mail Complete Application to:**

By U.S. Mail	Division of Occupational & Professional Licensing P.O. Box 146741 Salt Lake City, Utah 84114-6741
By Express Mail or In Person	Division of Occupational & Professional Licensing 1 st Floor Lobby 160 E 300 S Salt Lake City UT 84111-2305

8. **Telephone Numbers:** (801) 530-6628
(866) 275-3675 – Toll-free in Utah