State of Utah
Department of Commerce
Division of Occupational and Professional Licensing

Official Use Only
Number: _____
Date Approved/Denied: _____
Approved/Denied By: _____

Restricted Associate Osteopathic Physician and Surgeon

APPLICANT INFORMATION

Full Legal Name: _____
First *Middle* *Last*

All Previous Legal Names: _____

Other DOPL Licenses Held: _____

SSN: _____ **Date of Birth:** _____ **Gender:** ☐ Male ☐ Female

Address: _____
Street Address (including Apt/Unit/Ste #) and/or PO Box

_____
City *State* *ZIP Code*

Phone: _____ **Email:** _____

Please Select ONE:

- ☐ I am a United States citizen OR a non-citizen of the United States who is lawfully present.
- ☐ I am a foreign national not physically present in the United States.
- ☐ None of the above, please explain: _____

Driver License or State ID Card: _____
State of Issue *License Number* *Expiration Date*

NOTE: If you do not hold a US Driver License or a US State ID, you must present a legible copy of your current and valid government issued document(s) showing evidence of authorization to work in the United States.

AFFIDAVIT AND RELEASE

1. I certify that I 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 all supporting document(s) are true and correct, 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, organizations, governmental agencies, or any others not specifically listed, 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 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 I am applying, and that failure to do so may result in civil, administrative, or criminal sanctions.
5. I certify that I do not currently pose a direct threat to myself, to my clients, or to the public health, safety or welfare because of any circumstance or condition.
6. I understand that I am responsible to update the Division of any changes relating to my license/certification/registration.

Signature of Applicant: _____ Date: _____

QUALIFYING QUESTIONNAIRE

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

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.

1.	☐ Yes ☐ No	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?
2.	☐ Yes ☐ No	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 professional licensing agency or criminal or administrative jurisdiction?
3.	☐ Yes ☐ No	Are you currently under investigation or is any disciplinary action pending against you now by any local, state or federal licensing, enforcement or regulatory agency?
4.	☐ Yes ☐ No	Have you ever been declared by any court to be incompetent by reason of mental defect or disease and not restored?
5.	☐ Yes ☐ No	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?
6.	☐ Yes ☐ No	Have you been terminated, suspended, reprimanded, sanctioned, or asked to leave voluntarily from a position because of drug or alcohol use or abuse within the past five (5) years?
7.	☐ Yes ☐ No	Are you currently using or have you recently (within 90 days) used any drugs (including recreational drugs) without a valid prescription, the possession or distribution of which is unlawful under applicable state or federal laws?
8.	☐ Yes ☐ No	Have you ever unlawfully used any drugs for which you have not successfully completed, or are not now participating in a supervised drug rehabilitation program, or for which you have not otherwise been successfully rehabilitated?
9.	☐ Yes ☐ No	Do you currently have any criminal action pending?*
10.	☐ Yes ☐ No	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? *
11.	☐ Yes ☐ No	Have you ever pled guilty to, no contest to, or been convicted of a felony in any jurisdiction?*
12.	☐ Yes ☐ No	Have you ever been incarcerated for any reason in any correctional facility (domestic or foreign) in any jurisdiction or on probation/parole in any jurisdiction?*

***NOTE:* Charges that were later dismissed and motor vehicle offenses such as driving while impaired or intoxicated must be disclosed; however, minor traffic offenses such as parking or speeding violations need not be listed.**

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 **9,10,11** or **12** you must submit the following for **EACH** and **EVERY** incident:

- Personal account of the incident(s)
- police report(s)
- court record(s)
- probation/parole officer report(s)

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.

UTAH CONTROLLED SUBSTANCE AFFIDAVIT (OPTIONAL)

If you are applying for a controlled substance license, you must read and sign the affidavit below.

1. I have reviewed and understand that I must abide by the additional laws and rules that govern the practice of my profession as it pertains to controlled substances.
2. I understand that there may be additional continuing education requirements for those who hold a controlled substance license.
3. I understand it is required that I hold a valid Federal Drug Enforcement Administration (DEA) registration.

Signature of Applicant: _____ Date _____

Note: Please see the checklist for additional instructions.

DESIGNATION OF CONTACT PERSON FOR ACCESS TO MEDICAL RECORDS

You must provide both a primary and alternate contact person for access to medical records. *This information is considered public information.*

Primary Contact: _____ Telephone: _____

Address: _____

Street Address (including Apt/Unit/Ste #) and/or PO Box *City* *State* *Zip*

Alternate Contact: _____ Telephone: _____

Address: _____

Street Address (including Apt/Unit/Ste #) and/or PO Box *City* *State* *Zip*

***Note**: If a hospital, clinic or other facility is the owner of your patient's medical records, the facility's records department may be listed as the primary contact. All applicants must still list a second, unique contact.*

Please identify the method of notifying patients of location of records: (check all that apply):

☐ Phone ☐ Mail ☐ In Person ☐ Other: _____

APPLICATION CHECKLIST AND INSTRUCTIONS

This checklist is for your convenience, you do not need to include it with your application.
NOTE: Incomplete applications will be denied.

As the applicant, you are responsible for submitting a complete application. We will not process your application until we receive all required items as explained on the checklist below. If your application packet is not complete within one month of filing, we will consider it abandoned and deny your application. Please do not submit your application until all items are available (e.g. FCVS released to Utah, verification for other states received).

ALL APPLICANTS

All applicants are required to submit the following items to complete the application:

- ☐ $210.00 non-refundable application processing fee, made payable to "DOPL".
- ☐ Supporting documentation for any "yes" answers provided on the "Qualifying Questionnaire".
- ☐ Request an application packet from Federation Credentials Verification Service (FCVS). FCVS may be contacted via phone at 1-888-ASK-FCVS or via their website at www.fsmb.org/fcvs.html . **You must have received an email from FSMB with notice that the FCVS packet has been released to Utah prior to submitting this application.**
- ☐ Complete the "Collaborative Practice Agreement"

OPTIONAL CONTROLLED SUBSTANCE LICENSE

If your practice in the state of Utah will include administering, possession or prescribing of controlled substances, you must apply for a Utah Controlled Substance License by submitting the following:

- ☐ $100.00 non-refundable application processing fee, made payable to "DOPL".
- ☐ Complete the "Utah Controlled Substance Affidavit" found in this application.

***NOTE:** In addition to the Utah Controlled Substance License, you must hold a valid Federal Drug Enforcement Administration (DEA) registration.

Submit the above items with your completed application to:

In person or via express delivery:
Division of Occupational and Professional Licensing
Heber M Wells Building, 1st Floor Lobby
160 E 300 S
Salt Lake City, UT 84111

US Postal Service:
Division of Occupational and Professional Licensing
PO BOX 146741
Salt Lake City, UT 84114-6741

Restricted Associate Osteopathic Physician Collaborative Practice Agreement

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A collaborative practice agreement must be maintained at each practice site. The collaborative practice agreement must be submitted with your application. A new collaborative practice agreement must be submitted within 10 days of any changes. The collaborative practice agreement consists of written criteria jointly developed by all parties involved that permits an associate physician, working under the direction or review of the collaborating physicians.

Full Legal Name: _____
First *Middle* *Last*

Address: _____
Street Address (including Apt/Unit/Ste #) and/or PO Box

_____
City *State* *ZIP Code*

Phone: _____ **Email:** _____

SUPERVISOR INFORMATION

If there are additional practice sites use additional forms.

Name of Establishment: _____

Establishment Address: _____
Street/PO Box *City* *State/Zip*

Telephone Number _____ **Email:** _____

Collaborating Physician: _____ **License Number:** _____

Collaborating Physician Specialty/Board Certification(s) _____

Associate Physician Specialty/Board Certification(s) _____

Collaborating Physician Home Address: _____
Street/PO Box City *State/Zip*

Collaboration Duration: _____ **Total Number of Associate Physicians:** _____
Start Date *End Date*

MANNER OF COLLABORATION

Specify the manner of collaboration including how the collaborating physician and the associate physician shall engage in collaborative practice consistent with each professional's skill, training, education, and competence.

_____

_____

_____

_____

Specify the manner of collaboration including how the collaborating physician and the associate physician shall maintain geographic proximity.

_____

_____

List procedures for providing oversight of the associate physician during the absence, incapacity, infirmity, or emergency of the collaborating physician.

List how the two months of practice with the collaborating physician will be completed and recorded. Note this requirement must be completed prior to the associate physician practicing in a setting where the collaborating physician is not continuously present.

Prior to prescribing a controlled substance list how the 120 hours of practice with the collaborating physician will be completed and recorded. Note this requirement must be completed before the associate physician is permitted to prescribe any controlled substances when the collaborating physician is not on-site.

PRACTICE IN A MEDICALLY UNDERSERVED AREA

Describe how you are providing primary care services to medically underserved populations or medically underserved areas.

CHART REVIEW

List the method for quality review of the associate physician's charts.
A minimum of 10% of the charts documenting the associate physician's delivery of health care services and a minimum of 20% of the charts in which the associate physician prescribes a controlled substance.

CONTROLLED SUBSTANCES

An associate physician may prescribe or administer an appropriate controlled substance if the associate physician holds a current Utah controlled substance and a current DEA registration covering the appropriate schedules of controlled substances.

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

List of the controlled substances the collaborating physician authorizes the associate physician to prescribe.

Document that the authorization to prescribe the controlled substances is consistent with the education, knowledge, skill, and competence of the associate physician and the collaborating physician.

ADDITIONAL CONSIDERATIONS

Please define procedures addressing how situations outside the associate physician's scope of practice will be handled.

A copy of this "Collaboration Agreement" is required to be available at the practice site(s). The agreement needs to accurately reflect current practices.

Signature of Associate Physician: _____ **Date:** _____

Signature of Collaborating Physician: _____ **Date:** _____