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

Physician Assistant

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 lawful presence 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

Do not leave any question blank.

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, resigned, or surrendered while under investigation, or otherwise **disciplined in any way**?

2. ☐ Yes ☐ No Do you CURRENTLY have **any criminal action active or pending**?

3. ☐ Yes ☐ No WITHIN THE PAST 10 YEARS, have you pled **guilty** to, **no contest** to, entered into a **plea in abeyance,** or been **convicted** of **a misdemeanor** in any jurisdiction?

4. ☐ Yes ☐ No Have you EVER pled **guilty** to, **no contest** to, entered into a **plea in abeyance**, or been **convicted** of a **felony** in any jurisdiction?

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 2,3, or 4 you must submit the following for EACH and EVERY incident:

- personal account of the incident
- 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.

NOTE:

- **DISCLOSE** charges that were later held in abeyance, diverted, reduced, or dismissed.
- **DISCLOSE** motor vehicle offenses such as driving while impaired or intoxicated. But you do not need to disclose minor traffic offenses such as parking or speeding violations.
- You do **not need to disclose** juvenile offenses, unless you were tried as an adult.
- **DISCLOSE** if you are restricted from possession, purchase, transfer, or ownership of a firearm or ammunition (even if your restriction is based on a non-reportable juvenile conviction).
- You do **not need to disclose** legally expunged or sealed criminal history incidents.

For more information, see DOPL's criminal history FAQs.

PROFESSIONAL LICENSES

List all other licenses, registrations or certification issued by any state which you now hold or have ever held in any profession. *(Use additional sheets if necessary.)*

Profession: _____ **License Number:** _____

Issuing State: _____ **License Status:** _____ **Issue Date:** _____

Profession: _____ **License Number:** _____

Issuing State: _____ **License Status:** _____ **Issue Date:** _____

If you identified a physician assistant license above, please answer the following:

☐ Yes ☐ No After obtaining the license(s) above, have you engaged in at least one year of experience in the state, district, or territory of the United States where the license was issued?

Note: If you answer yes to the question above, please see the checklist at the end of this application or our website for instructions on applying by endorsement.

MEDICAL 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. Have your rights, privileges, and/or participation ever been denied, conditioned, curtailed, limited, restricted, suspended or revoked in any way by:

☐ Yes ☐ No a hospital or health care facility
☐ Yes ☐ No Medicaid, Medicare or any other state or federal health care payment reimbursement program
☐ Yes ☐ No the Federal Drug Enforcement Administration or any state drug enforcement agency
☐ Yes ☐ No malpractice insurance coverage
☐ Yes ☐ No other entity: _____

2. Have you ever been permitted to resign or surrender any rights, privileges and/or participation while under investigation or while action was pending against you from:

☐ Yes ☐ No a hospital or health care facility
☐ Yes ☐ No Medicaid, Medicare or any other state or federal health care payment reimbursement program
☐ Yes ☐ No the Federal Drug Enforcement Administration or any state drug enforcement agency
☐ Yes ☐ No malpractice insurance coverage
☐ Yes ☐ No other entity: _____

3. Is any action pending against you now by:

☐ Yes ☐ No a hospital or health care facility
☐ Yes ☐ No Medicaid, Medicare or any other state or federal health care payment reimbursement program
☐ Yes ☐ No the Federal Drug Enforcement Administration or any state drug enforcement agency
☐ Yes ☐ No malpractice insurance coverage
☐ Yes ☐ No other entity: _____

4. ☐ Yes ☐ No Have you been named as a defendant in a malpractice suit?

5. ☐ Yes ☐ No Have you ever had office monitoring, practice curtailments, individual surcharge assessments based upon specific claims history, or other limitation, restrictions or conditions imposed by any malpractice carrier?

If you answered **"Yes"** to question 4 you must submit a complete narrative of the circumstances and a National Practitioner Data Bank report outlining all professional liability claims made against your license and any settlements paid by or on your behalf. *NPDB website: http://www/npdb.hrsa.gov.*

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.

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 I may need a written delegation of services agreement or a written consultation and referral plan for prescribing controlled substances as outlined in statute.

3. I understand that there may be additional continuing education requirements for those who hold a controlled substance license.

4. I understand it is required that I hold a valid Federal Drug Enforcement Administration (DEA) registration.

Signature of Applicant: _____ Date _____

Note: *In addition to signing this affidavit, you must complete the items listed on the OPTIONAL CONTROLLED SUBSTANCE LICENSE checklist at the end of this application.*

AFFIDAVIT OF PRACTICE

Complete only one of the supervision options below:

***Option 1:* To be completed by applicants who will be practicing in Utah upon approval of this change.**

You must complete a separate form for each primary supervisor. If more than two substitute supervisors, please attach a separate sheet with the name and license number of each additional supervisor.

Applicant's Name: _____

Supervising Physician: _____ **License Number:** _____

Telephone Number: _____ **Email:** _____

Substitute Supervising Physician: _____ **License Number:** _____

Substitute Supervising Physician: _____ **License Number** _____

Total Number of PAs supervised (including the applicant)**:** _____ **Full-Time Equivalent:** _____

Percentage of Direct Supervision for this applicant: _____

We, the undersigned, declare under penalty of perjury we have completed a "Delegation of Services Agreement" that meets the requirements of R156-70a-501 and have reviewed the agreement with each substitute supervising physician. A copy of the agreement is on file at each of the PAs Utah practice sites and will be made available to DOPL upon request.

Signature of Applicant: _____ Date _____

Signature of Supervisor: _____ Date: _____

***Option 2:* To be completed by applicants who will not immediately begin practice in Utah.**

I declare under penalty of perjury that 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).

Signature of Applicant: _____ Date _____

TEMPORARY LICENSE (OPTIONAL)

Temporary licensure is an optional license available for applicants who have not previously passed the PANCE only. Please see the checklist at the end of this application for additional instructions.

Applicant's Name: _____

Name of Clinic: _____

Supervising Physician: _____ **License Number:** _____

Clinic Address: _____

Street/PO Box *City* *State/Zip*

Telephone Number: _____ **Email:** _____

To be completed by the applicant:

I hereby certify that I will not practice until I have been granted a temporary license, and will cease practice upon the expiration of the license. Once the temporary license has been issued, I will only practice under the direct supervision of my supervising physician or substitute supervising physician as outlined in UCA 58-70a-306 (2)(c)

Signature of Applicant: _____ **Date** _____

To be completed by the supervising physician:

I certify that I am licensed in good standing and will provide direct supervision to the above named applicant as outlined in UCA 58-70a-306 (2)(c). I understand that I am responsible for their activities and services performed, and that once issued their temporary license to practice is valid for only 120 days. I understand that the applicant cannot work without a valid temporary license, either before it is issued or after it expires.

Signature of Supervisor: _____ Date: _____

Certification of Completion of Physician Assistant Education

This form may be used in lieu of transcripts to document completion of an approved PA program. It must be completed by an official representative of the school and bear the schools official seal. Additionally, it must be sent directly from the school to DOPL or sealed in an envelope bearing the school's stamp/seal on the envelope flap and submitted with your application. If the form is presented to DOPL unsealed, it will be rejected.

APPLICANT INFORMATION

To be completed by the applicant.

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

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

EDUCATION

To be completed by the Accredited Physician Assistant Program Official Representative

Name of Institution: _____

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

Telephone Number _____ **Email:** _____

Accrediting Body: _____ **Accreditation Date:** _____

I attest that the above named applicant attended this physician assistant program from:

Start Date: _____ End Date: _____
MM/DD/YYYY *MM/DD/YYYY*

and graduated on: _____
MM/DD/YYYY

Signature of Official Program Representative: _____

Printed Name: _____ **Title:** _____

Signed and the school seal affixed this _____ day of _____, 20_____.

{School Seal}

PHYSICIAN ASSISTANT
DELEGATION OF SERVICES AGREEMENT

A Delegation of Services Agreement must be maintained at each practice site. It does not need to be submitted with your application. It consists of written criteria jointly developed by all parties involved 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.

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

Name of Establishment: _____

Supervisor: _____ **License Number:** _____

Substitute Supervisor: _____ **License Number:** _____

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

Telephone Number _____ **Email:** _____

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.

List the process by which this supervision will be accomplished, including how supervision will be accomplished when the supervising physician is on vacation:

_____

_____

_____

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

_____

_____

_____

List the process and degree of onsite supervision:

_____

_____

_____

FREQUENCY AND MECHANISM OF QUALITY REVIEW

List the method for quality review of the supervising physician.

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 professional.

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 how situations outside the physician assistant's scope of practice will be handled.

EMERGENCY SITUATIONS

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

Signature of Physician Assistant: _____ **Date:** _____

Signature of Supervisor: _____ **Date:** _____

NOTE: A copy of this "Delegation of Services Agreement" is required to be available at the practice site(s). The agreement needs to accurately reflect current practices. You do not need to submit this document to DOPL unless requested.

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.

Your application is classified as a public record and may be available for inspection by the public, except with regard to the release of information which is sub-classified as controlled, private, or protected under the Government Records Access and Management Act or restricted by other law.

ALL APPLICANTS

The following items are required to complete your application:

- ☐ $180.00 non-refundable application processing fee, made payable to "DOPL".
- ☐ Supporting documentation for any "yes" answers provided on either of the qualifying questionnaires.

LICENSURE BY APPLICATION

If applying for **Licensure by Application**, *in addition* to the items required for all applicants, you must submit:

- ☐ Documentation of meeting the education requirements. Submit one of the following:
  - Official transcripts documenting a degree from a physician assistant school accredited by the Accreditation Review Commission of Education for the Physician Assistant (ARC-PA). **NOTE:** Transcripts are considered "official" when they are sent directly from the school to DOPL or sealed in an envelope bearing the school's stamp/seal on the envelope flap.
    OR
  - Certification of Completion of Physician Assistant Education form found in this application.
- ☐ Request official documentation from NCCPA of a passing score on the PANCE or PANRE be sent directly to DOPL. Please contact NCCPA via their website, www.nccpa.net.

LICENSURE BY ENDORSEMENT

If you are currently licensed in *good standing* as a physician assistant in a state, territory, or district of the United States deemed equivalent to a Utah license and have at least one year of licensed experience, you may apply for **Licensure by Endorsement**. *In addition* to the items required by all applicants, you must submit the following:

- ☐ Official verification, showing active licensure in good standing for at least one year, from a jurisdiction designated by the Division as equivalent to Utah. Please see our website for additional information regarding approved states.
  Note: If your state is not deemed equivalent for purposes of endorsement, you may be able to use experience gained outside of the state to document the requirements for Initial Licensure above.

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.

OPTIONAL TEMPORARY LICENSURE

If you meet all the requirements for licensure but have not yet passed the PANCE, you *may* apply for temporary licensure. In addition to the items required for all applicants, you must submit the following:

- ☐ $50.00 non-refundable Temporary Physician Assistant application fee.
- ☐ Completed "Temporary License" section of this application.

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