



UTAH DEPARTMENT OF COMMERCE

Division of Professional Licensing

Physician Assistant Specializing in Mental Health Care

APPLICANT INFORMATION

Full Legal Name: _____
First Middle Last

All Previous Legal Names: _____

Other DOPL Licenses Held: _____

SSN:* _____ Date of Birth: _____ Gender: Male Female
* If you don't have a social security number, please follow the instructions on the last page.

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

City: _____ State: _____ Zip: _____

Phone: (_____) _____ - _____ Email: _____

Note: All Division notices and communication will be sent to this 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

I certify that to the best of my knowledge, the information contained in the application and all supporting document(s) are true and correct, and 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.

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 Department of Commerce, State of Utah, any files, records, or information of any type reasonably required for the Department to properly evaluate my qualifications for licensure/certification/registration by the State of Utah.

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.

I understand that I am responsible to update the Department of any changes relating to my application/license/certification/registration.

I understand that if the application is not complete at the time of submission, it will delay approval and could result in a denial.

I declare under criminal penalty under the law of Utah that this application is true and correct.

Signature of Applicant: _____ Date: _____



QUALIFYING QUESTIONNAIRE

Do not leave any question blank.

DOPL may request additional documentation if the information submitted is insufficient.

- 1. 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. Do you CURRENTLY have any criminal action active or pending?
3. 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. 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.

Please DISCLOSE the following:

- charges that were later held in abeyance (plea in abeyance), diverted, reduced, or dismissed.
motor vehicle offenses such as driving while impaired or intoxicated.
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:

- minor traffic offenses such as parking or speeding violations.
juvenile offenses, unless you were tried as an adult.
legally expunged or sealed criminal history incidents.

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



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.

NATIONAL PROVIDER IDENTIFIER (NPI)

Your NPI: _____



Completion of Clinical Practice

Each supervisor must complete a separate form. Make additional copies as needed.

APPLICANT INFORMATION (TO BE COMPLETED BY THE APPLICANT)

Full Legal Name: _____
First Middle Last

Address: _____ City: _____ State: _____ Zip: _____

License Number: _____ State of Issue: _____ PANCE pass Date: _____

EMPLOYMENT INFORMATION: (TO BE COMPLETED BY THE SUPERVISOR)

Name of Establishment: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (_____) _____ – _____ Email: _____

Dates of Supervision: _____ to _____ Total Clinical hours? _____

Were any of the hours identified above completed as part of an approved education program in mental health?

Yes No If YES, number of hours completed as part of the program: _____

ATTESTATION:

I certify that I am (select one):

- a mental health therapist who has been trained in and has at least two years of practice experience in psychotherapy
- a physician who is board certified in psychiatry

I certify that I supervised the above named applicant while completing the clinical training hours identified on this form. I further certify that the supervision provided and the collaborative clinical practice met the requirements of Utah Code § [58-70a-307](#), [58-70a-501.1](#), and [58-70a-501.2](#).

I declare under criminal penalty under the law of Utah that this application is true and correct.

Signature of certifying individual: _____ Date: _____

Relationship to Applicant: _____

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.

If you do not have a valid Social Security number, you must submit your Individual Taxpayer Identification Number (ITIN), Alien Registration Number (A-number), or a copy of an unexpired government issued passport from your country of residence and an intent-to-hire letter from a Utah based employer ([Utah Code § R156-1-301](#)). Submission of the above documents may require additional documents to demonstrate lawful presence ([Utah Code § 63G-12-402 \(3\)\(k\)](#)).

ALL APPLICANTS

The following items are required to complete your application:

- If you do not hold a Utah Physician Assistant license, you must submit a complete application for Utah licensure. Applications may be submitted [online](#) or with the [Utah Physician Assistant Application Form](#).
- Documentation of meeting the education requirements. Submit official transcripts documenting completion of one of the following:
 - an accredited doctorate level academic program for physician assistants approved by the division in collaboration with the board;
 - a post-graduate certificate program for physician assistants to practice within psychiatric and mental health care that is approved by the division in collaboration with the board; or
 - a post-graduate residency in psychiatry and additional clinical practice or coursework in accordance with requirements approved by the division in collaboration with the board.
- A copy of your current Certification of Added Qualification in Psychiatry issued by the [NCCPA](#).
- A "Completion of Clinical Practice" form found in this application from each clinical practice supervisor, documenting at least 10,000 hours of clinical practice that meets the requirements of Utah Code [58-70a-501.1 \(4\)](#).

Submit completed application to the Division:

By US Postal Service:

**Division of Professional Licensing
PO BOX 146741
Salt Lake City, UT 84114-6741**

By in-person or express delivery:

**Division of Professional Licensing
Heber M Wells Building, 1st Floor
160 E 300 S
Salt Lake City, UT 84111**

If you have questions, please contact the Division at 801-530-6628 or by email at B1@Utah.gov.