UTAH DEPARTMENT OF COMMERCE
Division of Professional Licensing

Restricted Associate Osteopathic Physician and Surgeon

APPLICANT INFORMATION

Clear Form

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. ☐ 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.

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.

PROFESSIONAL LICENSES

List all other licenses, registrations or certifications 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:** _____

Profession:_____ **License Number:** _____

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

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

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 to qualify for controlled substance prescription privileges, my collaborative practice arrangement must authorize prescription privileges for Schedule III through V controlled substances.
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.

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: _____

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

Phone: (_____) _____ – _____ Email: _____

Alternate Contact: _____

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

Phone: (_____) _____ – _____ Email: _____

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: _____

FEDERATION CREDENTIALS VERIFICATION SERVICE (FCVS)

I received notification from FSMB on _____ that my FCVS packet was complete. Initial: _____

RESTRICTED ASSOCIATE OSTEOPATHIC PHYSICIAN LIMITATIONS

I certify that,

1. I have successfully completed a program of professional education, having received an earned degree of Doctor of Osteopathic Medicine from an AOA accredited program.
2. I have successfully completed steps 1 & 2 of the United States Medical Licensing Examination, the Comprehensive Osteopathic Medical Licensing Examination, or equivalent steps of another board-approved medical licensing examination, within the immediately preceding two years *and* no more than three years past the date of graduation listed on my official transcript.
3. I am NOT currently enrolled in, nor have I completed, a residency program.

I understand that,

1. I must enter into a collaborative practice arrangement, approved by the Division, before I can practice medicine in Utah; and if I fail to do so, my license will be canceled after six months.
2. I understand that my Restricted Associate Osteopathic Physician and Surgeon license will only be valid in Utah. I acknowledge that a Restricted Associate Osteopathic Physician and Surgeon license is not eligible for compact license privileges.

I have reviewed and I certify that I will abide by *all* of the laws and rules that govern the practice of my profession, including, but not limited to:

58-68—Utah Osteopathic Medical Practice Act
R156-68—Utah Osteopathic Medical Practice Act Rule
58-37—Utah Controlled Substances Act
R156-37—Utah Controlled Substance Act Rule

I attest to all these under criminal penalty under the law of Utah.

Signature of Applicant: _____ Date: 6/22/2024

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 Admin. 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

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 their website at Verification your FCVS Report is currently in process with FSMB.

  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, possessing, 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.*

Deliver completed application to:

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

UTAH DEPARTMENT OF COMMERCE
Division of Professional Licensing

Restricted Associate Osteopathic Physician Collaborative Practice Agreement

A complete collaborative practice agreement consists of these written criteria, jointly developed by all parties involved, that permits an associate physician, working under the direction or review of a collaborating physician, to provide primary care services, and any additional pages.

Collaboration duration from _____ to _____.

RESTRICTED ASSOCIATE OSTEOPATHIC PHYSICIAN INFORMATION

Name: _____ _____ _____
First *Middle* *Last*

Home Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ – _____ Email: _____

Specialty/Board Certification(s): _____

COLLABORATING PHYSICIAN INFORMATION

Name: _____ _____ _____ License # _____
First *Middle* *Last*

Home Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ – _____ Email: _____

Specialty/Board Certification(s): _____

Total number of restricted physicians associated with collaborating physician: _____

ESTABLISHMENT INFORMATION

If there are additional practice sites, please attach a complete list of all locations.
***Note:** a physical copy of the complete **Collaborative Practice Agreement** must be available at all locations*

Establishment Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ – _____ Email: _____

The Collaborative Practice Agreement must adhere to requirements listed in the Utah Osteopathic Medical Practice Act, Utah Code§ 58-68-807 and the Utah Osteopathic Medical Practice Act Rule, Utah Administrative Code§ R156-68-807. It is the responsibility of all parties involved to familiarize themselves with the law.

A complete collaborative practice agreement, including all additional sheets, must be maintained at each practice site. Any change, amendment, update, or correction to this collaborative practice agreement must be submitted to the Division within 10 days of the changes.

Restricted Associate Osteopathic Physician Collaborative Practice Agreement

MANNER OF COLLABORATION

Specify the manner of collaboration including how the collaborating physician and the associate physician shall maintain geographic proximity and engage in collaborative practice consistent with each professional's skill, training, education, and competence.
(attach additional pages if necessary)

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

Restricted Associate Osteopathic Physician Collaborative Practice Agreement

List procedures for providing oversight of the associate physician during the absence, incapacity, infirmity, or emergency of the collaborating physician.
(attach additional pages if necessary)

Please define procedures addressing how situations outside the associate physician's scope of practice will be handled.
(attach additional pages if necessary)

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

Restricted Associate Osteopathic Physician Collaborative Practice Agreement

Describe the associate physician's controlled substance prescriptive authority Schedule III through V, and provide a comprehensive list of all of the controlled substances the collaborating physician authorizes the associate physician to prescribe *(attach additional pages if necessary):*

Describe your plan establishing educational methods and programs that the associate physician shall complete throughout the duration of the collaborative practice arrangement that will facilitate the advancement of the associate physician's medical knowledge and abilities.
(attach additional pages if necessary)

A copy of the entire Collaboration Agreement, including all additional pages, is required to be available at the practice site(s). The agreement must accurately reflect current practices.

MANNER OF COLLABORATION

I understand that a collaborating physician is responsible, at all times, for the oversight of the activities of, and accepts responsibility for, the primary care services rendered by the associate Physician. I understand that before rendering any health care services the Division must approve this collaborative practice arrangement contract. As a signatory to this agreement, I will maintain required licensure and any required DEA registration and comply with the laws, rules, standards, and ethics of the profession.

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

Signature of Associate Physician: _____ Date: _____

Signature of Collaborating Physician: _____ Date: _____