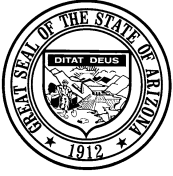

Arizona Regulatory Board of Physician Assistants

9545 East Doubletree Ranch Road • Scottsdale, Arizona 85258-5514
Telephone: 480-551-2700 • Fax: 480-551-2704 • www.azpa.gov

PHYSICIAN ASSISTANT APPLICATION INSTRUCTIONS

An Application for licensure as a physician assistant and the accompanying materials are included with this document. Please read all instructions carefully, noting that it is ***YOUR RESPONSIBILITY*** for ensuring verification of your physician assistant training, PANCE eligibility and experience. Please be sure all documents are forwarded directly to the Licensing Division of the Arizona Regulatory Board of Physician Assistants ("P.A. Board") at the address above. Applicants are required to comply with the current statutes and rules at the time they submit their application and should licensure be granted.

FOR YOUR INFORMATION:
All credentials submitted shall remain the property of the P.A. Board and will not be returned.
An application will not be considered for approval until all requisite forms and supporting documentation are in hand, **which is your responsibility.**
All forms provided in the application must be completed by the appropriate entity and returned directly to the P.A. Board's office.

Failure to submit a completed application within one year from the date of the board's mailing to the applicant of a statement of application deficiencies will result in your application being withdrawn. A complete application includes ***ALL*** forms, documentation, examination scores, verifications, etc., requested by the board, submitted in a form satisfactory to the board. Therefore, an application is not considered complete (even though the application form itself is completed) until ALL of the requested information has been received by the Licensing Division. ***A.R.S. § 32-2522 (G)***

PLEASE NOTE THAT APPLICATION FEES ARE NOT REFUNDABLE.

Your interest in licensure in Arizona is appreciated and the Licensing Division looks forward to working with you to successfully complete this process. Should you have any questions, please do not hesitate to contact the P.A. Board Licensing Division staff at 480-551-2700. Also, for further information you may visit our website at www.azpa.gov

PLEASE NOTE: The Notification of Supervision application is a ***SEPARATE*** application from the Licensure application and requires its own fee of $125.00. A Physician Assistant may not perform health care tasks in Arizona until the Notification of Supervision is approved by the P.A. Board.

In addition to the appropriate completion of this application, the following must be submitted:
(Please see the attached checklist for all documents needed)

1. Evidence of legal name and date of birth: U. S. *Birth Certificate*, U. S. Passport, Naturalization Certificate, Permanent resident card or Visa.

2. Evidence of legal name change other than that shown on documents filed in accordance with #1 above, i.e., marriage certificate.

3. Submit a complete and accurate statement of whereabouts and nature of practice, or other activities from the date of graduation from physician assistant training to the date of application, indicating the exact month and year for each. No period unaccounted for is allowed. Do not attach a Curriculum Vita (CV).

4. Submit all forms included with the application that are applicable and that are listed on the checklist.

5. Submit a check, money order, or the attached payment card authorization for the $125.00 non-refundable application fee. Should your application be approved, you will also be **invoiced for a prorated licensing fee or temporary licensing fee if applicable.**

PHYSICIAN ASSISTANT APPLICATION

(To be completed and signed by applicant. All questions MUST be answered, even if only to indicate "None" or "N/A".)

1. Legal Name: ______________________________
   (Last) (First) (Middle) (Maiden)

2. Office Address (if applicable): ______________________________
   (No.) (Street) (City) (State) (Zip)

3. Physician Assistant Training Program Attended: ______________________________

   Location: ______________________________ Degree Date: ______________

4. In what states or provinces have you ever been granted any licensure as a physician assistant? If more than three, attach separate listing.

   (a) ______________________________
   (State Board) (License No.) (Date Issued) (Status)

   (b) ______________________________
   (State Board) (License No.) (Date Issued) (Status)

   (c) ______________________________
   (State Board) (License No.) (Date Issued) (Status)

5. Have you ever taken the Physician Assistant National Certifying Examination (PANCE) as administered by the National Commission on Certification of Physician Assistants (NCCPA)? YES ☐ NO ☐

   Examination Date: ______________________________
   (Month/Day/Year)

   (If scheduled to take the examination are you requesting a temporary certificate?) YES ☐ NO ☐

   Scheduled Examination Date: ______________________________

6. **Account for,** in chronological order, **all activities since graduation from <u>Physician Assistant Training Program to present.</u>** ALL PERIODS OF TIME INCLUDING MONTH/YEAR MUST BE ACCOUNTED FOR. Attach a separate sheet if necessary. <u>DO NOT</u> ATTACH A CURRICULUM VITA (CV).

ACTIVITIES	LOCATION	FROM/TO (MONTH/YEAR)
(e.g.) Prepare for PANCE/Vacation	**City/State**	**06/99 to 01/00**

7. Have you ever had any application for any professional license refused or denied by any licensing authority?	YES ☐	NO ☐
8. Have you ever been refused or denied the privilege of taking an examination required for any professional licensure?	YES ☐	NO ☐
9. Have you ever been dropped, suspended, placed on probation, expelled, fined, resigned or been requested to resign from any Physician Assistant Training program or educational program in which you were enrolled?	YES ☐	NO ☐
10. Has any training program taken action against you including probation, restriction, suspension, revocation, modification, accepted resignation, asked you to leave temporarily or permanently?	YES ☐	NO ☐
11. Have you ever voluntarily surrendered any healthcare license?	YES ☐	NO ☐
12. Have you ever had any healthcare license revoked?	YES ☐	NO ☐
13. Have you ever been the subject of disciplinary action or are you currently under investigation with regard to your healthcare license, been sanctioned by any healthcare licensing authority, healthcare association, licensed healthcare facility or healthcare staff of such facility?	YES ☐	NO ☐
14. Have your privileges ever been restricted, terminated, voluntarily or involuntarily resigned or withdrawn by any healthcare licensing authority, healthcare association, licensed healthcare facility or healthcare staff of such facility?	YES ☐	NO ☐
15. Has disciplinary action been taken against you by any licensing agency with regard to any professional license? Including but not limited to restricted, terminated, voluntarily or involuntarily resigned or withdrawn.	YES ☐	NO ☐
16. Are there any pending complaints, investigations, or disciplinary actions against you with any healthcare licensing authority, healthcare association, licensed healthcare facility or healthcare staff of such facility?	YES ☐	NO ☐
17. Have you ever had a registration issued by a controlled substance authority (State or Federal) revoked, suspended, limited, restricted, modified, denied or have you surrendered or given up in lieu of action?	YES ☐	NO ☐
18. Have you ever been charged with or convicted, pardoned or had a record expunged or vacated of a felony, misdemeanor involving moral turpitude? (see explanation below) A "yes" answer is required even if you entered a diversion program.	YES ☐	NO ☐
19. Have you ever been charged with or convicted (including a nolo contendere plea or guilty plea) of a violation of any federal or state drug law(s) or rule(s) whether or not sentence was imposed or suspended?	YES ☐	NO ☐
20. In the last ten (10) years has a judgment or settlement been entered against you in excess of $20,000 as a defendant in a medical malpractice suit? *Please do not report pending malpractice suits or settlements paid not related to a civil action.	YES ☐	NO ☐
21. Have you ever been court martialed or discharged other than honorably from the armed service?	YES ☐	NO ☐
22. Have you ever been terminated from a healthcare position with a city, county, or state government or the Federal government?	YES ☐	NO ☐
23. Have you ever been convicted of insurance fraud or received sanctions, including restrictions, suspension or removal from practice, imposed by any agency of the Federal government?	YES ☐	NO ☐

Note: *In the event the response to any of the questions numbered 7 through 23 is "YES"*, the applicant must file with the application a detailed report concerning the above matters, including any charge, date of such charge, the complete name and address of all bodies of jurisdiction, the result of any hearings, and the disposition of such charge(s). IN ADDITION, the applicant must submit photocopies of any complaints, hearings, settlements or judgments together with copies of patient's hospital and/or office records to the Arizona Regulatory Board of Physician Assistants.

Moral Turpitude includes but is not limited to the following: Armed Robbery, Assault with a Deadly Weapon, Attempted Insurance Fraud, Fabricating and Presenting False Public Claim, False Reporting to Law Enforcement Agency, Falsification of Records of the Court, Forgery, Fraud, Hit & Run, Illegal Sale & Trafficking in Controlled Substances, Indecent Exposure, Kidnapping, Larceny, Mann Act (Federal Commercialization of Women Statute), Misleading Sale of Securities in Connection with Transfer of Real Property, Perjury, Possession of Heroin for Sale/Unlawful Sale or Dispensing Narcotic Drugs, Rape, Shoplifting and Soliciting Prostitution.

Applicant Name_______________________________, P.A.

CONFIDENTIAL

PHYSICIAN HEALTH PROGRAM

Question	Yes	No
1. **Within the last five years, have you been diagnosed, treated or admitted to a hospital or other facility for the treatment of bi-polar disorder, schizophrenia, paranoia or any psychotic disorder?**	YES ☐	NO ☐
2. **Are you now being treated or have you in the last 5 years been treated for a drug or alcohol addiction or participated in a rehabilitation program?** *If in a confidential program in another state see explanation below.	YES ☐	NO ☐
3. **Do you currently have any disease or condition that interferes with your ability to competently and safely perform the essential functions of your profession, include any disease or condition generally regarded as chronic by the medical community, i.e. (1) behavioral health illness or condition; (2) alcohol or other substance abuse; and/or (3) physical disease or condition, that may presently interfere with your ability to competently and safely perform the essential functions involved in your usual practice?** See below for definition of ability to practice medicine**.**	YES ☐	NO ☐

In the event you answer YES to any of the above questions, you must file with the application a detailed written narrative statement concerning the above matter(s), including the name of healthcare providers and treatment centers where you were treated, along with the discharge summary of your treatment and progress. If you are currently participating or have participated in the past 5 years pursuant to a confidential agreement or order in a program for the treatment and rehabilitation of physician assistants impaired by alcohol, drug abuse or for other issues, please submit a copy of the agreement/order along with a compliance reports from the state monitoring programs

FAILURE TO PROPERLY ANSWER THESE QUESTIONS CAN RESULT IN BOARD DISCIPLINARY ACTION, INCLUDING REVOCATION OR DENIAL OF A LICENSE.

Ability to practice medicine is to be construed to include all of the following:

1. **The cognitive capacity to make appropriate clinical diagnoses and exercise reason medical judgments and to learn and keep abreast of medical developments;**
2. **The ability to communicate those judgments and medical information to patients and other healthcare providers, with or without the use of aids or devices, such as a voice amplifier; and**
3. **The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.**

(THIS SECTION INTENTIONALLY LEFT BLANK)

Applicant Name______________________________, P.A.

The applicant ____
(Print or type Name)

being first duly sworn upon his oath deposes and says that I am the person above described and identified; that I have not engaged in any of the acts prohibited by the statutes of the State of Arizona, particularly those acts set forth in the Rules and Regulations of the Board. I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentality's (local, state, federal or foreign) to release directly to the Arizona P.A. Board, all information, files, records requested by the P.A. Board in connection with the processing of this application. I further authorize the P.A. Board to release to the organizations, individuals and groups listed above any information which is material to my application. I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. I am the lawful holder of all credentials submitted and that the credentials submitted were not procured by fraud or misrepresentation or any mistake of which I am aware. Should I furnish false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my License to perform health care tasks as a physician assistant in the State of Arizona.

☐ I am a U.S. Citizen or U.S. National (If this box is checked please submit with your application a copy of one of the listed approved supporting documents listed in the "Arizona Statement of Citizenship and Alien Status for State Public Benefits" i.e. U. S. Birth Certificate, U.S. Passport, etc.)

☐ I am NOT a U. S. Citizen or U.S. National (If this box is checked you must download, complete and submit with your application "Arizona Statement of Citizenship and Alien Status for State Public Benefits" form along with a copy of one of the listed approved supporting documents i.e. Permanent Registration Card or Visa.

Signature of Applicant: ____________________________ Date: __________________

ARIZONA LAW REQUIRES AN APPLICANT WHO HAS BEEN CHARGED WITH A FELONY OR A MISDEMEANOR INVOLVING CONDUCT THAT MAY AFFECT PATIENT SAFETY AFTER SUBMITTING THE APPLICATION TO NOTIFY THE ARIZONA REGULATORY BOARD OF PHYSICIAN ASSISTANTS WITHIN 10 DAYS AFTER THE CHARGE IS FILED. ARIZONA REVISED STATUTE (A.R.S.) §32-3208 (SEE WEBSITE UNDER *Physician Assistant Center – Reportable Misdemeanors* FOR LIST OF REPORTABLE MISDEMEANORS – ALL FELONIES ARE REPORTABLE.)

FOR P.A. BOARD STAFF USE ONLY - DO NOT WRITE IN THIS SPACE			
Date Application received:	______________	Inquiry Number:	__ ______________
Date application processed:	______________	Processed by:	______________
Date of Temporary approval:	______________	Approved by:	______________
Date Temporary License Issued:	______________	Temporary License No.:	______________
Date of Regular approval:	______________	Approved by:	______________
Date Regular License Issued:	______________	Regular License No.:	______________

ARIZONA REGULATORY BOARD OF PHYSICIAN ASSISTANTS
9545 E. Doubletree Ranch Road, Scottsdale, Arizona 85258, Ph: 480-551-2700, Fax: 480-551-2704

TEMPORARY LICENSE CHECKLIST

If you are registered with the N.C.C.P.A. for the examination and you are applying for a ***TEMPORARY LICENSE***, please submit only those items listed below.

Applications submitted without the application fee will not be accepted or processed until the fee has been received. Your application cannot be approved until ***ALL*** documentation has been received.

Failure to submit a completed application within one year from the date of the mailing by the board of a statement to the applicant of the deficiencies in the application pursuant to subsection E, will result in your application being withdrawn. ***A.R.S. § 32-2522(G)***

Application fees are non-refundable.

The following items are to be completed and forwarded to the board.

- ☐ $125.00 Application Fee (Upon approval you will be also invoiced the $50.00 Temporary licensing fee)
- ☐ Completed Application
- ☐ Birth Certificate/Passport/Marriage License/Legal Name Change Documents
- ☐ Home Address, Phone Number & Social Security Number Form (for our records only)
- ☐ Temporary License Agreement Form
- ☐ Affidavit
- ☐ Detailed written narrative statement if you answered YES to any questions on the application, and accompanying documentation. (Including Malpractice form if applicable)

The applicant must forward the following enclosed forms to the appropriate entity for completion.

(When completed by the entity, these are to be sent directly to the Arizona Regulatory Board of Physician Assistants.)

- ☐ Request a letter from the N.C.C.P.A. sent directly to the P.A. Board that you are eligible for and registered to take the Physician Assistant National Certifying Examination (PANCE).
- ☐ Form 1 to be completed and submitted by your P.A. Program

If you are approved for a Temporary Certificate you will be invoiced the $50 temporary fee.

Upon passing the examination you can request permanent licensure and you will be invoiced the pro-rated licensure fee.

ARIZONA REGULATORY BOARD OF PHYSICIAN ASSISTANTS
9545 E. Doubletree Ranch Road, Scottsdale, Arizona 85258, Ph: 480-551-2700, Fax: 480-551-2704

REGULAR LICENSE CHECKLIST

If you are applying for a ***REGULAR LICENSE***, please submit all items listed below.

Applications submitted without the application fee will not be accepted or processed until the fee has been received. Your application cannot be approved until ***ALL*** documentation has been received.

Failure to submit a completed application within one year from the date of the mailing by the board of a statement to the applicant of the deficiencies in the application pursuant to subsection E, will result in your application being withdrawn.
A.R.S. § 32-2522(G)

Application fees are non-refundable.

The following items are to be completed and forwarded to the board.

☐ **$125.00** Application Fee (Upon approval you will be invoiced a pro-rated initial licensing fee up to $100.00)

☐ Completed Application

☐ Copy of Birth Certificate/Passport/Marriage License/Legal Name Change Documents

☐ Employment List of all physician assistant employment held since graduation or during the past five years

☐ Home Address, Phone Number & Social Security Number Supplement Form

☐ Affidavit

☐ Detailed written narrative statement if you answered YES to any question on the application and accompanying documentation. (Including Malpractice form if applicable)

The applicant must forward the following enclosed forms to the appropriate entity for completion. (If applicable)
(When completed by the entity, these are to be sent directly to the Arizona Regulatory Board of Physician Assistants.)

☐ Medical Agency of Employment Form/Supervising Physician Form to be completed by all employers listed on the Employment List;

☐ Form I to be completed and submitted by your P.A. Program;

☐ Authorize the N.C.C.P.A. to release your Physician Assistant National Certifying Examination (PANCE) scores directly to the P.A. Board.

If you are approved for licensure you will be invoiced the pro-rated licensure fee which is in addition to the application fee.

ARIZONA REGULATORY BOARD OF PHYSICIAN ASSISTANTS
9545 E. Doubletree Ranch Road, Scottsdale, Arizona 85258, Ph: 480-551-2700, Fax: 480-551-2704

HOME ADDRESS AND SOCIAL SECURITY SUPPLEMENT FORM

P.A. APPLICANT'S FULL NAME: ______________________________

BIRTHDATE: ____________________ **SOCIAL SECURITY NO:** ____________________

PLACE OF BIRTH: ______________________________
(City) *(State)* *(Country)*

HOME ADDRESS: ______________________________
(Street Address)

____
(City) *(State)* *(Zip Code)*

HOME TELEPHONE NUMBER: ( ) ____________________

MOBILE TELEPHONE NUMBER: ( ) ____________________

E-MAIL ADDRESS: ______________________________

MAILING ADDRESS: ______________________________
(Street Address)

____
(City) *(State)* *(Zip Code)*

A.R.S. §32-2527(A): **In accordance with this statute, a residential address is not available to the public *unless* it is the only address of record.**

CONFIDENTIAL INFORMATION – NOT FOR PUBLIC KNOWLEDGE

ARIZONA REGULATORY BOARD OF PHYSICIAN ASSISTANTS
9545 E. Doubletree Ranch Road, Scottsdale, Arizona 85258, Ph: 480-551-2700, Fax: 480-551-2704

AGREEMENT FOR TEMPORARY LICENSURE PURSUANT TO *A.R.S. §32-2524(F)*

Pursuant to ***A.R.S. §32-2524(F),*** this voluntary agreement is made between ________________________, P.A., and the Arizona Regulatory Board of Physician Assistants ("P.A. Board").

P.A. ____________________________, holder of Temporary License no. ___________ agrees and stipulates with the P.A. Board that he/she shall perform health care tasks under his/her Temporary License only at the same geographic work site where his/her supervising physician sees patients.

Any violation of this order constitutes unprofessional conduct as defined by ***A.R.S. §32-2501(18)(ee)*** and may result in disciplinary action pursuant to ***A.R.S. §32-2551***.

Arizona Regulatory Board
of Physician Assistants

[S E A L]

____
Lisa Wynn, B.S.
Executive Director

____
Physician Assistant's Signature

Date: ______________________________

Date: ______________________________

Executed copy mailed this ___________ day of
____________________, 200_ to the P.A.

____
P.A. Board Staff Member

ARIZONA REGULATORY BOARD OF PHYSICIAN ASSISTANTS
9545 E. Doubletree Ranch Road, Scottsdale, Arizona 85258, Ph: 480-551-2700, Fax: 480-551-2704

AFFIDAVIT

STATE OF ___________________________________)

COUNTY OF _________________________________)

I hereby certify that I have completely read, and will abide by the **ARIZONA REVISED STATUTES** pursuant to Chapter 25, and the **RULES AND REGULATIONS** pursuant to Chapter 17, governing the certification of physician assistants and the performance of health care tasks in the State of Arizona.

Dated this ___________ day of ____________________, 20__________.

____

(Print or Type full Name of Physician Assistant)

____

(Signature of Physician Assistant)

NOTARY:

Sworn to before me this _____________ day of ______________, 20__________

____

(Notary Signature)

My Commission Expires On: ___________________________________.

ARIZONA REGULATORY BOARD OF PHYSICIAN ASSISTANTS

9545 E. Doubletree Ranch Road, Scottsdale, Arizona 85258, Ph: 480-551-2700, Fax: 480-551-2704

FORM I – PHYSICIAN ASSISTANT TRAINING PROGRAM CERTIFICATION

Part of the application for certification as a physician assistant in the State of Arizona requires this form to be completed by the physician assistant training program where the physician assistant applicant received training as a physician assistant. The physician assistant applicant must forward this form for completion by an officer of the physician assistant training program which granted the physician assistant's degree.

I hereby authorize the release of all information in your files, favorable or otherwise, directly to: The Arizona Regulatory Board of Physician Assistants, 9545 E. Doubletree Ranch Road, Scottsdale, Arizona 85258.

______________________________ (Physician Assistant Signature) ______________________________ (Printed/Typed Physician Assistant Name)

To Be Completed by the Physician Assistant Training Program:

This is to certify that ______________________________________ was granted the degree of

______________________________________ on________________, 20______.

Dates attended ___________________ to ______________________
(Month/Day/Year) (Month/Day/Year)

NOTE: IF THE ANSWER IS YES TO ANY OF THE QUESTIONS, PLEASE ATTACH A WRITTEN EXPLANATION

1. Was the student ever required to repeat any segment of training? Yes ☐ No ☐
2. Were any actions, restrictions, limitation (including probation or academic probation) taken while the student was participating in your training program? Yes ☐ No ☐
3. Was the student ever counseled regarding his/her performance or behavior in your training program? Yes ☐ No ☐
4. Were the student's final evaluations in every category rated satisfactory and/or above? Yes ☐ No ☐
   If No, please attach a photocopy of the evaluation and a written explanation.
5. Did the student have any medical condition which in any way impairs or limits his/her ability to safely practice any type of health care tasks within the scope of the physician assistant? Yes ☐ No ☐

   Ability to practice medicine is to be construed to include all of the following:
   1. The cognitive capacity to make appropriate clinical diagnoses and exercise reason medical judgments and to learn and keep abreast of medical developments;
   2. The ability to communicate those judgments and medical information to patients and other healthcare providers, with or without the use of aids or devices, such as a voice amplifier; and
   3. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

Signature:____________________________________

Name & Title:_________________________________ **[SEAL OF TRAINING PROGRAM]**
(If none, indicate so)

P.A. Program Name:_____________________________

Address:_____________________________________

____ **Date**: __________________

ARIZONA REGULATORY BOARD OF PHYSICIAN ASSISTANTS
9545 E. Doubletree Ranch Road, Scottsdale, Arizona 85258, Ph: 480-551-2700, Fax: 480-551-2704

MEDICAL AGENCY OF EMPLOYMENT/SUPERVISING PHYSICIAN FORM

Part of the application for certification as a physician assistant in the State of Arizona requires that this form be completed by ALL current and past Medical Agencies/Supervising Physicians where the applicant is or has been employed as a physician assistant for the past five (5) annual years.

MEDICAL AGENCY OF EMPLOYMENT/SUPERVISING PHYSICIAN: I hereby authorize the release of all information in your files, favorable or otherwise, directly to: The Arizona Regulatory Board of Physician Assistants, State of Arizona, 9545 E. Doubletree Ranch Road, Scottsdale, Arizona 85258.

______________________ (Physician Assistant Signature)

______________________ (Printed/Typed Physician Assistant Name)

TO BE COMPLETED BY THE MEDICAL AGENCY OF EMPLOYMENT/SUPERVISING PHYSICIAN

NAME AND ADDRESS OF MEDICAL AGENCY/SUPERVISING PHYSICIAN: ______________________

____

____

Dates of Employment: From: ______________ To: ______________

Names, locations and dates of each hospital/office/clinic wherein the physician assistant was/is assigned: ______________

____

____

1. Were any actions, restrictions, limitations (including probation) taken while in your employment? Yes ☐ No ☐
2. List of healthcare tasks delegated to PA : ______________________
   ____
3. Were any limitations imposed on such health care tasks? Yes ☐ No ☐ If Yes, please explain: ______________
   ____
4. Were any health care tasks ever removed or restricted? Yes ☐ No ☐ If Yes, please explain: ______________
   ____
5. Derogatory information, if any: ______________________
   ____
6. Names of other medical agencies of employment or supervising physicians, if known (list name, city and state):
   1. ______________________
   2. ______________________
   3. ______________________

Signed: ______________________

Name & Title: ______________________

Medical Agency/Supervising Physician: ______________________

____

Address: ______________________

____

[SEAL OR STAMP]
(If none, indicate so)

Date: ______________

ARIZONA REGULATORY BOARD OF PHYSICIAN ASSISTANTS

9545 E. Doubletree Ranch Road, Scottsdale, Arizona 85258, Ph: 480-551-2700, Fax: 480-551-2704

PHYSICIAN ASSISTANT EMPLOYMENT LIST

APPLICANTS: List all current and/or previous employment with medical agencies/supervising physicians, i.e., physician assistant placement group, private practice, hospital, clinic, etc., for the past five (5) years, and return this form with your application.

If you have been in the military since graduating from a P.A. Program, do not have an Agency of Employment/Supervising Physician form completed. Have your Commanding Officer submit a letter providing the dates of active duty and anticipated date of release, along with a summary of your duties.

Physician Assistant Applicant's Name:______________________________________

Agency/Supervising Physician Name:______________________________________

____

Address:______________________________________

____

(CITY) *(STATE)* *(ZIP)*

Dates of Employment: FROM:__________________**TO:**__________________

Agency/Supervising Physician Name:______________________________________

____

Address:______________________________________

____

(CITY) *(STATE)* *(ZIP)*

Dates of Employment: FROM:__________________**TO:**__________________

Agency/Supervising Physician Name:______________________________________

____

Address:______________________________________

____

(CITY) *(STATE)* *(ZIP)*

Dates of Employment: FROM:__________________**TO:**__________________

Agency/Supervising Physician Name:______________________________________

____

Address:______________________________________

____

(CITY) *(STATE)* *(ZIP)*

Dates of Employment: FROM:__________________**TO:**__________________

(THIS FORM MAY BE COPIED IF THERE ARE ADDITIONAL EMPLOYERS)

ARIZONA REGULATORY BOARD OF PHYSICIAN ASSISTANTS
9545 E. Doubletree Ranch Road, Scottsdale, Arizona 85258, Ph: 480-551-2700, Fax: 480-551-2704

MALPRACTICE ADDENDUM

The applicant must complete this form for each malpractice settlement or judgment in the last ten (10) years. If more than one case, please make copies of this form and return with required documents. Please report only the settlement of a civil action.

Applicant Name ____, P.A.

1. **On a separate sheet of paper type your full name and provide a detailed clinical narrative regarding each malpractice case(s). Include name of patient, age, sex, date of occurrence and location (include address). Do not omit the answers to these questions or make reference to attached documents for answers. This section must be completed with your own description that includes all of the facts requested above. *NOTE:* HIPAA regulations do not prevent you from responding and providing the requested information.**

2. **What was the amount and date of the judgment or settlement?**___________________________________
   Amount Date

3. **Amount of judgment or settlement attributed to you**____

4. **Has this case been investigated or reviewed by any State Medical Board?** ☐ Yes ☐ No
   If answer is "Yes", request letter of resolution from State Medical Board be sent directly to us. You do not need to attach the documents listed below if the case has been investigated or reviewed by any State Medical Board.

You are required to attach the following for each case:

- ❑ **Copy of plaintiff's complaint**
- ❑ **Copy of Judgment or Settlement Agreement**
- ❑ **Copy of complete set of medical records including x-rays or diagnostic films**

*** X-rays and diagnostic films must be included. Your application cannot be processed without them.**

I certify that the information which I have provided is correct to the best of my knowledge.

____ __________________________________
Signature **Date**

Your application is not administratively complete until all documents are received.

Arizona Regulatory Board of Physicians Assistants

PAYMENT CARD AUTHORIZATION

PHYSICIAN ASSISTANT LICENSE APPLICATION FEE

Payment for: ____PA

☐ **Physician Assistant Application Fee $125**

Type of Card: ☐ **Visa** ☐ **MasterCard** ☐ **American Express**

Card #: ☐☐☐☐-☐☐☐☐-☐☐☐☐-☐☐☐☐

Expiration Date: ☐☐-☐☐ **(MM-YY)**

Name as Shown on Payment Card: ____

Billing Address of Cardholder:
(Required)

Street Address: ____

City: ______________________________ **State:** ____________________ **Zip:** _____________

Phone Number of Cardholder: ________________________
(Required)

Mailing Address of Cardholder: (If different from billing address):

Street Address: ____

City: ______________________________ **State:** _______________ **Zip:** _____________

Signature of Cardholder: ____________________________________ **Date:** ____________________

Please complete and return this form with your *Regular license application* if paying by credit card.
(If you fax your fee payment, please ***DO NOT*** *mail in the original form as you may be charged a second time. Thank you!)*

Fax Number: 480-551-2704

Mailing Address: Arizona Regulatory Board of Physician Assistants, 9545 E. Doubletree Ranch Road, Scottsdale, AZ 85258