ALASKA STATE MEDICAL BOARD

Department of Commerce, Community, and Economic Development
Division of Corporations, Business, and Professional Licensing
(333 Willoughby Street - Ninth Floor)
Post Office Box 110806
Juneau AK 99811-0806
A - K: (907) 465-2756 L - Z: (907) 465-2541
E-Mail: medicalboard@alaska.gov

APPLICATION FOR A LICENSE TO PRACTICE AS A PHYSICIAN ASSISTANT

This packet contains all the documents you will need to apply for a permanent license to practice medicine as a physician assistant in Alaska.

Please read all instructions and information carefully and complete all documents as requested. Please note the following:

- ***Average processing time for a permanent license is from eight to twelve weeks***. Start the process far enough in advance to allow this process to occur. Applications are reviewed in order of receipt in our office. If there are items in the application about which the board requires additional information, or if there is any adverse or derogatory information that comes to light, the review process may take longer.

  Please do not ask us to expedite your application before others received earlier.

- Appropriate fees must accompany applications before initial screening can begin.

- An incomplete application or any unusual circumstances noted in the application may require additional processing time.

- While we understand your desire to conclude this process as quickly as possible, our licensing staff is responsible for reviewing many files and cannot complete the application process if required documents are missing. It is your responsibility to insure those documents are received by our office.

- The application review process is defined by the requirements set forth in state law. The board and its staff must comply with those laws in processing applications.

- The Alaska State Medical Board conducts a thorough evaluation of education, training, employment or work history, malpractice history, and any criminal or disciplinary history. We recommend you do not make commitments for loans, practice start dates, home purchases, etc., based on the expectation of licensure. The board will not accelerate one application over others nor will it forego any elements of its screening process.

Please contact our offices or visit our website for forms or additional information.

907/269-8163 – Anchorage

A – K 907/465-2756 - Juneau *L – Z 907/465-2541 - Juneau*

www.commerce.state.ak.us/occ/pmed.htm

IMPORTANT INFORMATION - PLEASE READ
PHYSICIAN ASSISTANT – CERTIFIED

To practice as a Physician Assistant - Certified, or to use the title, a person must be licensed under regulation 12 AAC 40.400 and authorized to practice under 12 AAC 40.408 by the State Medical Board. ***An approved Collaborative Plan must be on file with the State Medical Board in order to be authorized to practice.***

This packet contains the documents you will need to obtain licensure as a Physician Assistant - Certified in Alaska.
A complete application file must contain the following:

- Complete, notarized application form (6 pages)
- Authorization for Release of Records
- Certified true copy of diploma from an accredited Physician Assistant program (accredited by the Accreditation Review Commission on Education for the Physician Assistant or, before 2001, by its predecessor accrediting agency the American Medical Association's Committee on Allied Health Education and Accreditation)
- Verification of Physician Assistant Program education
- Certified true copy of current certification by the National Commission on Certification of Physician Assistants
- A copy of your current DEA registration certificate
- An approved plan of collaboration with a physician licensed to practice in the State of Alaska
- Verifications of licensure from all states, territories, or provinces where you have ever been licensed
- Clearance report from the Federation of State Medical Boards
- Clearance report from the Drug Enforcement Administration

Fees for initial licensure as a Physician Assistant – Certified

Fees due upon application:
$150 Nonrefundable application fee
$ 50 Temporary permit fee
$200 Permanent license fee
$100 Collaborative plan fee (to establish or change)
$500 Total Due

A certified true copy of your current NCCPA certificate must be maintained in your license file at all times as well as a current copy of your DEA registration. Without those documents, you are not in compliance with regulations and may not practice.

IMPORTANT INFORMATION - PLEASE READ
PHYSICIAN ASSISTANT – GRADUATE

To apply for a license as a Physician Assistant **–** Graduate, you must submit the following documents:

- Complete, notarized application form
- Authorization for Release of Records
- Certified true copy of diploma from an accredited Physician Assistant program (accredited by the Accreditation Review Commission on Education for the Physician Assistant or, before 2001, by its predecessor accrediting agency the American Medical Association's Committee on Allied Health Education and Accreditation)
- Verification of Physician Assistant Program education
- Proof of having been accepted to sit for the NCCPA examination
- An approved Outline for Plan of Collaboration with a physician licensed to practice in Alaska

Fees for a Physician Assistant - Graduate

Fees due upon application:
$ 50 Nonrefundable application fee
$ 50 Temporary permit fee
$100 Collaborative plan fee (to establish or change)
$200 Total Due

It is the responsibility of the Physician Assistant - Graduate to notify the board immediately upon receiving examination results. The graduate permit is valid only until the board receives notice that the applicant either failed to take or failed to pass the NCCPA examination.

Notify the board immediately upon receiving scores for the NCCPA examination. Upon submitting this notification and a certified true copy of the certificate, the applicant must include the $200 biennial registration fee in order to move the license application from Physician Assistant - Graduate to Physician Assistant - Certified status and for issuance of the permanent license. The license must be approved by the board before issuance.

A Physician Assistant - Graduate must be provided with continuous on-site supervision by either a licensed Physician Assistant - Certified or by a physician licensed to practice in Alaska. A Physician Assistant - Graduate **may not** prescribe controlled substances.

OTHER IMPORTANT INFORMATION - ***PLEASE READ***

ADDRESS CHANGES
It is the responsibility of the individual to advise the State Medical Board, Division of Corporations, Business, and Professional Licensing, of any address changes.

ADDRESS OF RECORD
Item 8 of the application asks for your preferred address of record. This is the address to which you would like us to send all communications to you including your permit or license. This is also the address that is available to the public. If you choose to use a third party address such as an employment or staffing agency, we are not responsible for mail reaching you directly.

APPLICATION STATUS UPDATES
Our licensing examiner will send you a written status update upon the initial screening of the application.

CERTIFIED TRUE COPIES
To obtain a certified, true copy, take the original document and a photocopy to a notary public so he/she may compare the original to the photocopy of the document. You or the notary must write**, "I certify this to be a true copy of the original document."** on the photocopy. If you write the statement, have the notary attest the fact by signing and notarizing the document. Each certified true copy must have a notary signature and seal.

COMPLETION OF THE APPLICATION FORMS
Help us do a good job processing your application. Type or print legibly all application documents. Read the instructions and give careful thought before answering the questions in the application - remember - you are certifying that the information is truthful and correct. Make sure all notary seals are properly affixed on the application and all documentation has been properly certified as required. Provide all documents requested in the application; incomplete applications will delay processing. Carefully follow the instructions on each form.

Each question in the application must be answered. If necessary, attach separate sheets of paper, labeled with your name and signed by you, for any question for which you have provided a YES response.

Failure to answer all questions completely and accurately, or the omission or falsification of information may be cause for denial of your application or disciplinary action if you are subsequently permitted by the board. WHEN IN DOUBT, DISCLOSE ALL INFORMATION OR CALL OUR OFFICE.

CONFIDENTIALITY:
The contents of licensing files are generally considered public records. If you believe that the additional information you are attaching to explain a "Yes" answer should be considered confidential, state that in the attachment. A request for confidentiality may or may not be granted.

DEA CLEARANCE REPORT
You are required to request a clearance report from the Drug Enforcement Administration for your DEA registration. Use the form provided in this packet and send your request to:

Drug Enforcement Administration
300 5th Avenue, Suite 1300
Seattle WA 98104

If you do not currently hold a DEA registration, you must obtain one before you may be granted prescribing authority. You may obtain an application for the DEA registration by contacting the Seattle office at 888/219-4261 or go to their website at http://www.deadiversion.usdoj.gov/drugreg/index.html for information and application forms. When you are applying for a DEA registration, include a copy of your temporary permit or license from Alaska along with your application.

DENIAL OF APPLICATION
The denial of an application for licensure may be reported to any person, professional licensing board, federal, state, or local government agency, other entity making relevant inquiry or as may be required by law.

FAX DOCUMENTS
Fax copies of documents are **NOT** accepted for documentation or verification in our licensing process. Please do not fax copies of documents.

INITIAL LICENSURE IN SECOND YEAR OF TWO-YEAR CYCLE
If you were initially licensed in the second year of the two-year licensure period, within 12 months of the date of expiration (December 31, even-number years), the applicant will pay the entire license fee. Upon renewal, the applicant will receive a renewal form that pro-rates the licensure fee for the coming licensure period. The applicant will pay one-half of the required license renewal fee at the time of renewal.

If your permanent license was first issued to you after October 1 of the second year of the licensing period, you will pay the initial full license fee. However, your license will be issued showing the expiration date of the next biennial licensing period. (For example, if your initial license was issued October 18, 2000. The normal expiration date for medical licenses is December 31, even-numbered years. Since the license was issued after October 1, the expiration date will automatically be entered as December 31, 2002.)

LICENSE APPLICATION PROCESSING STAFF
If your last name begins with the letters A through K, you may contact your licensing examiner at 907/465-2756.
If your last name begins with the letters L through Z, you may contact your licensing examiner at 907/465-2541.

LICENSE RENEWAL
All medical licenses in Alaska are on a two-year cycle, with all licenses expiring December 31 of even-numbered years. Notification for license renewal is mailed out to license holders of record at least 30 days prior to expiration, usually in late October. You are required by law to keep your current address on file with the division (12 AAC 02.900).

Failure to receive a renewal notice is not considered an excuse for nonrenewal. A physician assistant not intending to practice medicine in Alaska may renew their license in an “inactive” status. If you practice in the state occasionally, you must renew your license in active status. An inactive status license prohibits you from practicing; however, if you wish to reactivate your inactive license, contact the board for instructions.

If a physician assistant does not have a current collaborative plan in place they may still renew their license as active but not authorized to practice. At a later date, when the physician assistant enters into a new collaborative plan, the active license remains in place.

It is illegal to practice medicine in Alaska with an inactive or lapsed license or permit.

LICENSING PROCESS
Submit your complete application to the board with fees and pertinent documents. The licensing examiner assembles the documents for your file and advises the applicant of the application status.

Upon the completion of the application file when all documents have been received from other organizations, the file is forwarded to the board’s administrator who reviews the entire file. At the discretion of the administrator, a temporary permit may be issued (see information under Temporary Permit on page 5 of Application Information).

The complete application file is presented to the board at its next meeting. The board meets four times each year. Following the board’s review and approval, the licensing examiner will issue the permanent license.

Applications will be processed in the order in which they are received in the board’s office. Please insure that you apply well in advance of your need for the permit or license. Board staff will not expedite one application before another.

PAYMENT OF CHILD SUPPORT AND STUDENT LOANS
If the Alaska Child Support Enforcement Division has determined that you are in arrears on child support, or if the Alaska Commission on Post-Secondary Education has determined you are in loan default, you may be issued a nonrenewable temporary license valid for 150 days. Contact Child Support Services at (907) 269-6900 or the Post-Secondary Education office at (907) 465-2962 or 1-800-441-2962 to resolve payment issues.

PERFORMANCE ASSESSMENTS
Regulation 12 AAC 40.430 specifies the nature and frequency of performance assessments to be conducted by collaborating physicians with their physician assistants. Please review that regulation and its requirements. Copies of the statute and regulations may be obtained from the Division of Corporations, Business, and Professional Licensing or from our website.

PERSONAL INTERVIEWS
Applicants for medical licensure in Alaska may be required to have a personal interview either with an individual board member or with the full board. Should an interview be required, you will be notified and an interview scheduled. An interview may be required if, during the processing of your application, a question arises for which the board determines it requires additional information from you.

PLANS OF COLLABORATION
Collaborative plans must be on file with the board no later than 14 days following the effective date (beginning date of employment) of the plan. Both the physician assistant and the collaborating physician must retain copies of their active collaborative plans for their records. There must be **at least one** alternate collaborating physician on each plan. Plans must also be maintained at the practice location and available for public scrutiny.

PRACTICE REGULATIONS
It is the responsibility of the Physician Assistant - Certified to learn the governing regulations under which they must practice. Copies of the statute and regulations may be obtained from the Division of Corporations, Business, and Professional Licensing.

PRACTICING IN ALASKA
For information on physician assistant practice opportunities, you may wish to contact:

Alaska Academy of Physician Assistants
4450 Cordova Street – Suite 110
Anchorage AK 99503
Office Phone 800/478-8684 or 907/646-0588
Fax Phone 907/562-8641
Email: info@akapa.org

PROCESSING TIME
Processing time for a physician assistant permit varies. Among other variables, processing time largely depends on the time it takes for other agencies and organizations to return required documents to us. We cannot predict how long it will take to complete your application. For planning purposes, **submit your application 8 to 12 weeks in advance** of your anticipated work date. If you have not received your permit before you come to Alaska, please call our office to check on your status. **Do not report to work without a permit in hand.**

SOCIAL SECURITY REQUIREMENT
Alaska Statute 08.01.060(b) requires an applicant for an occupational license to provide a United States social security number. Applicants who are foreign citizens and are unable to obtain a social security number must contact the licensing examiner for instructions.

STALE DOCUMENTS
If during the license application process certain documents become older than six months from the date the document was received in our office, that document is considered to be stale and must be resubmitted. Affected documents include the application, verifications of licensure from other licensing jurisdictions, the DEA clearance report, and the FSMB Board Action Data Bank report.

TELEPHONE QUERIES ABOUT STATUS OF APPLICATIONS
We have a very small staff and work hard to process applications as quickly as possible. Unnecessary telephone calls to our offices delay processing. If we must spend time answering numerous telephone queries, application processing time is affected. Because of the huge volume of telephone calls regarding the status of applications and because of privacy issues, **we must restrict our telephone responses to the applicant only**. We will not discuss your application with others. If you are concerned about your application being received in our office, mail it "certified – return receipt requested." You will have a verification of delivery returned to you by the post office.

TEMPORARY PERMIT
Temporary permits are issued only to physician assistants applying for a new license in Alaska. After your application for a permanent license is complete, it is forwarded to the board's executive administrator. Following her review, she may authorize the issuance of a temporary permit. Since the board only meets four times each year, the temporary permit is a courtesy to you to allow you to practice until the next board meeting when your file will be considered. The permit will be mailed to you at the address you specify in your application. Should a personal interview be required, the temporary permit may be issued at the conclusion of the interview.

WEBSITE ADDRESS
The Division of Corporations, Business, and Professional Licensing maintains a website where you may check to see if your license or permit has been issued. You may also download forms from the medical board's website at www.commerce.state.ak.us/occ/pmed.htm.

WITHDRAWAL OF APPLICATIONS
The board permits the withdrawal of an application that it has not yet considered at a board meeting. Should you wish to withdraw your application, please submit a request for withdrawal in writing stating the reason for the withdrawal. Such requests must be received before the first time the board reviews and considers the application. Once the board has been presented the application, it cannot be withdrawn. All withdrawals are reported to the Federation of State Medical Boards stating the reason for the withdrawal.

"YES" RESPONSES
A "Yes" response in the application does not mean your application will be denied. If you have responded "Yes" to any question in the application, additional time will be required for the gathering and assessment of pertinent information. **You can expedite this process by providing with your application complete explanations and documentation for any "Yes" responses.**

APPLICATIONS WILL BE PROCESSED IN THE ORDER IN WHICH THEY ARE RECEIVED IN THE BOARD OFFICE. PLEASE INSURE THAT YOU APPLY WELL IN ADVANCE OF YOUR NEED FOR THE PERMIT. BOARD STAFF WILL NOT EXPEDITE ONE APPLICATION OVER ANOTHER.

HELP US TO HELP YOU:

1 First and foremost: **apply far enough in advance to allow for application processing**.

2 If you are concerned about your application being received in our office, mail it Certified - Return Receipt.

3 If you wish to expedite processing as much as you can, send all your verification request forms out via overnight mail and include a return overnight mail envelope addressed to the licensing examiner for the organization's use.

4 Insure the application is complete when you submit it and provide any necessary explanations with the application.

5 Provide complete explanation for any "Yes" responses. Also provide any supporting documents you may have for any "Yes responses.

6 Provide a brief description for any malpractice claims describing the allegation, the nature of the case, your level of involvement, and the resolution of the case.

7 If you are notified in our status letter that documents are still outstanding, please follow up with the responding agencies before calling our office.

QUESTIONS? CALL

A – K 907/465-2756 L – Z 907/465-2541

PHYSICIAN ASSISTANT APPLICATION CHECKLIST

A complete application must contain the following:

- ❑ Complete, notarized application form with photograph (6 pages)
- ❑ Explanations for any 'yes' responses in application
- ❑ Fees
- ❑ Authorization for Release of Records
- ❑ Certified true copy of diploma from an accredited Physician Assistant program (accredited by the American Medical Association's Committee on Allied Health Education and Accreditation)
- ❑ Verification of Physician Assistant Program education
- ❑ Certified true copy of current certification by the National Commission on Certification of Physician Assistants
- ❑ A copy of your current DEA registration certificate
- ❑ An approved plan of collaboration with a physician licensed to practice in the State of Alaska
- ❑ Verifications of licensure from all states, territories, or provinces where you have ever been licensed as any health care professional
- ❑ Clearance report from the Federation of State Medical Boards
- ❑ Clearance report from the Drug Enforcement Administration

- ❑ **The collaborative plan must be on file with the board no later than 14 days from the beginning date of the plan. To avoid potential problems, please submit the plan in advance of reporting to work if possible.**

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Office Use Only

APPLICATION FOR PHYSICIAN ASSISTANT

Please check one of the following and submit the required fees.

☐ Physician Assistant – Certified
$150 Nonrefundable application fee
$ 50 Temporary permit fee
$200 Permanent license fee
$100 Collaborative plan fee
$500 Total Due

☐ Physician Assistant – Graduate
$ 50 Non refundable application fee
$ 50 Temporary permit fee
$100 Collaborative plan fee
$200 Total due

PART I PERSONAL IDENTIFICATION INFORMATION

(Type or Print Legibly)

1	Full Legal Name (Last, First, Middle)	Last	First	Middle
2	Other Names Used (Incl. Maiden Name)			
3	Legal Name Changes (Provide copy of documents)			
4	Date of Birth	Mo Day Year / /	Place of Birth (City, State/Country):	Sex: ☐ M ☐ F
5	Full Practice Address	Facility Name and Mailing Address (Include street address if using post office box)		
		City	State	Zip Code
6	Full Residence Address	Mailing Address (Include street address if using post office box)		Duration at this address: Yrs: Mos:
		City	State	Zip Code
7	Telephones	Area Code/Phone Work:	Area Code/Phone Home:	
8	Preferred Address of Record (See Address of Record information.)	☐ Use **Practice** Address	☐ Use **Residence** Address	
9	E-Mail Address (Optional)			
10	Previous License or Permit In ALASKA?	☐ NO ☐ YES	If YES, when and what type: Year:_____ ☐ Graduate ☐ Permanent License	

APPLICANT: As required by state law, please provide your Social Security Number in the space below. It is considered CONFIDENTIAL Information and is not for public disclosure.

Applicant's Social Security Number _____

11. **Military Service**

Have you ever been in the armed forces? ☐ Yes ☐ No

If YES, branch of service: _____ Date of commission: _____

Date and Type of Discharge: _____

Locations where you served: _____

PART II EDUCATION

12. Identify the physician assistant program you completed. If you attended more than one program, list all.

Name of Institution	Location	Degree/Certificate Earned	Date Awarded (Mo/Yr)

13. Other than as a physician assistant, have you attended or completed any other education for any of the professions in the healing arts?

Name of Institution	Location	Degree/Certificate Earned	Date Awarded (Mo/Yr)

If necessary, continue to list on a separate sheet of paper labeled with your name and signed by you.

PART III PROFESSIONAL ACTIVITIES

14. **Professional Licensure** Please list all states, territories, provinces, or foreign countries in which you hold or have ***ever*** held a license as a physician assistant or any other health care professional. Include instructional or training permits. ***Failure to list all jurisdictions may result in disciplinary sanctions or denial.***

	Location (state, territory, etc.)	License No.	Type of License (PA, RN, PT,etc.)	Date Issued	Current Status (Active, Lapsed, etc.)
1					
2					
3					
4					
5					

If necessary, continue to list on a separate sheet of paper labeled with your name and signed by you.

15. **Work History** Please provide a chronological listing of your work history to the present date with no more than a 60-day gap in time. Include all work, both medical and non-medical, since graduation from high-school, or college if appropriate. **Please explain any gap in time of more than sixty (60) days.**

	Date (MM/YYYY)	Location (City, State, or Other Country)	Activity
Fr			
To			
Fr			
To			
Fr			
To			

Applicant Name:	**Application Date:**

Work History continued

	Date (MM/YYYY)	Location (City, State, or Other Country)	Activity
Fr			
To			
Fr			
To			
Fr			
To			
Fr			
To			
Fr			
To			
Fr			
To			
Fr			
To			
Fr			
To			
Fr			
To			

If necessary, continue to list on a separate sheet of paper labeled with your name and signed by you.

16. **Medical Malpractice History**

Have you ever had any claims of malpractice filed against you? ☐ No ☐ Yes

If Yes, please list all claims of malpractice filed against you below. Include all settlements, judgments, awards, and claims, even if no money was paid. For each case listed below, provide an explanation and documentation. Provide your explanation on a separate sheet of paper labeled with your name, and signed by you; include a brief description regarding the nature of the case, the allegations, and your response to the allegations. *Letters from attorneys or insurance carriers **may not** be substituted for this required explanation*. Documentation includes a copy of the order for settlement, dismissal, or removal from the case, or other documentation to support your explanation. Please do not send all of the motions or filings for the case.

Case Number	Date of Case (Mo/Yr)	Jurisdiction (State, etc.)	Nature of Allegation	Amount of Settlement Paid on Your Behalf
1				
2				
3				
4				
5				

If necessary, continue to list on a separate sheet of paper labeled with your name and signed by you.

Applicant Name:	**Application Date:**

SPECIAL INSTRUCTIONS FOR PARTS IV AND V

In responding to the questions in Parts IV and V below, please check the appropriate box next to each question. A "Yes" response to a question does not automatically result in a denial of license application. **For each "Yes" response to any question, you must provide an explanation and documentation.** Provide your explanation on a separate sheet of paper labeled with your name, and signed by you; include full details, dates, locations, type of action, organizations or parties involved, and specific circumstances. When in doubt about your response, disclose and provide the explanation requested. Please answer parts A and B of each question. Documentation includes copies of court orders, charging documents, board or license actions, etc.

CONFIDENTIALITY

The contents of licensing files are generally considered public records. If you believe that the additional information you are attaching to explain a "yes" answer should be considered confidential, state that in the attachment. A request for confidentiality may or may not be granted.

PART IV DISCIPLINARY HISTORY

IMPORTANT! *PLEASE READ BEFORE ANSWERING THE DISCIPLINARY HISTORY QUESTIONS*

For the purposes of this application, the word "discipline" is used. There are many forms of disciplinary actions that may be imposed by organizations, schools, programs, licensing authorities, and other agencies. Such disciplinary actions may include but not be limited to: Suspension, Surrender, Revocation, Probation, Academic Probation, Reprimand, Censure, Restricted License, Limited License, Conditioned License, or Letters of Counseling, Concern, Advice, Warning, Caution, Admonishment, Reprimand, etc. Please include non-reported disciplinary actions. Failure to disclose past history may be grounds for disciplinary sanctions.

WHEN IN DOUBT, DISCLOSE AND EXPLAIN.

17a.	☐ No	☐ Yes	Have you ever been convicted of a crime (felony or misdemeanor) in any jurisdiction of the United States, including military, or any international jurisdiction?
17b.	☐ No	☐ Yes	Is any such action pending?
18a.	☐ No	☐ Yes	Have you ever been charged with a crime (felony or misdemeanor) in any jurisdiction of the United States, including military, or any international jurisdiction that did not result in acquittal or dismissal?
18a.	☐ No	☐ Yes	Is any such action pending?
19a.	☐ No	☐ Yes	Relating to the practice of medicine, has there ever been a finding of, or have you ever been found guilty of, professional misconduct, unprofessional conduct, incompetence, or negligence, by any jurisdiction of the United States, including military, or any international jurisdiction?
19b.	☐ No	☐ Yes	Is any such action pending?
20a.	☐ No	☐ Yes	Relating to the practice of medicine, have you ever had charges filed against you alleging professional misconduct, unprofessional conduct, incompetence, or negligence, in any jurisdiction of the United States, including military, or any international jurisdiction?
20b.	☐ No	☐ Yes	Is any such action pending?

Part IV Disciplinary History Questions continued

21a. ☐ No ☐ Yes Has any hospital or other health care facility disciplined, restricted, or terminated your professional training, employment, or privileges, or investigated a complaint or accusation regarding your practice (except for late medical records)?

21b. ☐ No ☐ Yes Is any such action pending?

22a. ☐ No ☐ Yes Have you ever voluntarily or involuntarily resigned or withdrawn from professional training, from employment, or your privileges from any hospital or other health care facility to avoid the imposition of disciplinary sanction, restriction, or termination?

22b. ☐ No ☐ Yes Is any such action pending?

23a. ☐ No ☐ Yes Have you ever been disciplined by a medical school or post-graduate training program? (Including Academic Probation) *See important information block on discipline on page 4.*

23b. ☐ No ☐ Yes Is any such action pending?

24a. ☐ No ☐ Yes Have you ever had a license to practice medicine disciplined by any authority including a state medical board or a military authority (except for late medical records)?
(If you are unsure about your response to this question, please refer to the instructions and definitions for this section on page 4 of this application above. When in doubt, disclose and explain.)

24b. ☐ No ☐ Yes Is any such action pending?

25a. ☐ No ☐ Yes Have you ever been under investigation by any medical licensing jurisdiction or authority?
(If you are unsure about your response to this question, please refer to the instructions and definitions for this section on page 4 of this application above. When in doubt, disclose and explain.)

25b. ☐ No ☐ Yes Is any such action pending?

26a. ☐ No ☐ Yes Have you ever had a medical license application denied by any medical licensing jurisdiction or authority?

26b. ☐ No ☐ Yes Is any such action pending?

27a. ☐ No ☐ Yes Have you ever voluntarily or involuntarily withdrawn an application for a license to practice medicine in any United States jurisdiction or any international jurisdiction?

27b. ☐ No ☐ Yes Is any such action pending?

28a. ☐ No ☐ Yes Have you ever voluntarily or involuntarily surrendered or suspended your license to practice medicine in any United States jurisdiction or any international jurisdiction?

28b. ☐ No ☐ Yes Is any such action pending?

29a. ☐ No ☐ Yes Have you ever voluntarily or involuntarily agreed to any limitations, restrictions, or conditions to your license to practice medicine?

29b. ☐ No ☐ Yes Is any such action pending?

30a. ☐ No ☐ Yes Has your employment by a clinic, hospital, or other health care organization ever been terminated involuntarily or voluntarily as a result of an actual or potential investigation or as grounds for disciplinary proceedings?

30b. ☐ No ☐ Yes Is any such action pending?

PLEASE READ THESE QUESTIONS CAREFULLY BEFORE YOU RESPOND.

If you respond 'yes' to any question, please attach a complete explanation to your application. Failure to disclose past history may be grounds for disciplinary sanctions.

WHEN IN DOUBT, DISCLOSE AND EXPLAIN.

PART V PERSONAL HISTORY

Please refer to Special Instructions on page 4. For the purposes of the questions in this section, the following phrases or words are defined:

"Ability to Practice Medicine" includes, but is not limited to, the cognitive capacity to make appropriate clinical diagnoses and exercise reasonable medical judgments and to learn and keep abreast of medical developments; the ability to communicate those judgments and medical information to patients and other health care providers with or without the use of aids or devices, such as voice amplifiers; and the physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids of devices, such as corrective lenses or hearing aids.

"Medical Condition" includes physiological, mental, or psychological conditions or disorders, such as, but not limited to, orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

"Chemical Substance(s)" any natural or synthetic chemical substance, alcohol, drugs, or medications, including those chemical substances taken pursuant to a valid prescription for legitimate medical purpose and in accordance with the direction(s) of the prescribing physician, as well as those used illegally.

"Controlled Substances" means any substance as defined in either Alaska Statute 11.71.900 or the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C.A. Section 801 et seq. (Public Law 91-513) and any subsequent amendment(s).

"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application; rather, "currently" means recently enough so that the event, condition, behavior, impairment, limitation, etc., may have an ongoing impact on the applicant's ability to practice medicine in a competent manner.

"Illegal Drug Use" means the use of an illegally obtained controlled substance or dangerous drug; the term "illegal drug use" also means the use of a legally obtained controlled substance or dangerous drug which is not taken in accordance with the directions of the licensed physician who prescribed the controlled substance or dangerous drug.

31.	☐ No	☐ Yes	Are you currently experiencing any medical condition or disorder that impairs your judgment or that otherwise affects your ability to practice medicine in a safe and competent manner?
32.	☐ No	☐ Yes	Since completing your postgraduate training, have you ever been physically or mentally unable to practice medicine for a period of sixty (60) days or more?
33.	☐ No	☐ Yes	Are you currently the subject of any civil investigation or court process relating to your ability to practice in a safe and competent manner?
34.	☐ No	☐ Yes	Have you ever been diagnosed with, been treated for, or do you currently have pedophilia, exhibitionism, or voyeurism, or any other sexual behavior disorder? (Please note that "sexual behavior disorder" does **not** include sexual preference.)
35.	☐ No	☐ Yes	Are you currently engaged in the illegal use of any drug, whether by ingestion, inhalation, injection, or any other method?
36.	☐ No	☐ Yes	Have you used or are you currently using any chemical substance(s), legal or illegal, that in any way impaired or limited, or is currently impairing or limiting, your ability to practice medicine in a safe and competent manner?
37.	☐ No	☐ Yes	Have you ever been voluntarily or involuntarily committed or confined to any facility for mental health care?

Part V Personal History Questions Continued

38. ☐ No ☐ Yes Have you ever been diagnosed with, treated for, or do you currently have (check the appropriate condition):

☐ Bipolar Disorder	☐ Depressive Neurosis	☐ Kleptomania
☐ Hypomania	☐ Any Dissociative Disorder	☐ Pyromania
☐ Schizophrenia	☐ Any Psychotic Disorder	☐ Delirium
☐ Depression	☐ Any Organic Mental Disorder	☐ Paranoia

☐ Seasonal Affective Disorder

☐ Any condition requiring chronic medical or behavioral treatment

39. ☐ No ☐ Yes Have you ever taken, or are you currently taking, any chemical substance for any of the disorders listed in question 38 above?

40. ☐ No ☐ Yes Have you ever been adjudicated or declared incompetent or been the subject of an incompetency proceeding?

If you have checked "Yes," to any question above, please attach a detailed explanation.

PART VI SWORN STATEMENT

I hereby certify that I am the person herein named subscribing to this application. I have read the complete application, and I know the full content thereof. **I declare, under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct.** I am the lawful holder of the credential of physician assistant - certified as prescribed by this application, and that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted were procured without fraud or misrepresentation or any mistake of which I am aware and that I am the lawful holder thereof. I further certify that the photograph that appears below is a true likeness of myself taken within the past 60 days.

I understand that any falsification or misrepresentation of any item or response in this application, or any attachment hereto or falsification or misrepresentation of credentials to support this application, is sufficient grounds for denying, revoking, or otherwise disciplining a license or permit to practice medicine in the state of Alaska.

I carefully read all the instructions in the application including the instructions under Part IV, Disciplinary History, on page 4 of this application. ☐ **Yes**

Applicant Signature_____ ***Date***_____

You must sign and date this application in front of the notary public. Applicant signature date and notary public date must be the same.

Affix a ***Recent*** Passport Type Photograph Here

NOTE: Notary Seal Must Overlie A Portion of the Photograph.

SUBSCRIBED AND SWORN TO before me, a Notary Public, in and for the State of _____.
this _____day of _____, 20____.

Notary Signature_____
My commission expires:_____

WARNING: Alaska Statute 11.56.210 states that any person who knowingly or intentionally furnishes false or fraudulent information in this application is subject to imprisonment for not more than one year, a fine of not more than $5,000, or both.

ALASKA STATE MEDICAL BOARD

MED

Department of Commerce, Community, and Economic Development
Division of Corporations, Business, and Professional Licensing
(333 Willoughby Street - Ninth Floor)
Post Office Box 110806
Juneau AK 99811-0806
A - K: (907) 465-2756 L - Z: (907) 465-2541
E-mail: medicalboard@alaska.gov

Office Use Only

AUTHORIZATION FOR RELEASE OF RECORDS

TO WHOM IT MAY CONCERN:

I, _____, residing at
(Please print full name)
_____, hereby authorize the
(Please print full address)

Alaska Division of Corporations, Business, and Professional Licensing and its investigators to examine my medical and dental records, employment and education records including all training which pertains to my medical practice, and any records pertaining to litigation, judgments, suits, and/or settlements, and any law enforcement records pertaining to me and discuss them with persons having possession of them. I also expressly permit and authorize the release of any and all such records pertaining to me to the Alaska Division of Corporations, Business, and Professional Licensing and its investigators. This release also applies to all records that pertain to credentialing records at facilities at which I have applied for or held privileges to practice medicine.

I authorize the Division to discuss my records with persons or organizations that are considered appropriate by the Division in connection with an official investigation, and to provide copies of my records to those persons or organizations deemed appropriate by the Division.

This release also applies to any documents or records which contain information pertaining to psychiatric, psychological, drug, or alcohol evaluation, counseling, diagnosis or treatment received by me and which were prepared or made in conjunction with, or under the authority or guidance of any local, state, or federal law which relates to psychiatric, drug or alcohol evaluation, diagnosis or treatment, including all information previously identified, collected, or stored under the authority of any state or federal law, including 42 CFR Part 2.

I request that upon presentation of this release, or a Certified True Copy thereof, that you provide copies of those records to the Division and/or its investigators, and/or representatives of the Office of the Attorney General of the State of Alaska.

This authorization expires one (1) year from the date of my signature below.

_____ _____
Signature of Applicant Date

_____ _____
Home Phone Number Work Phone Number

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VERIFICATION OF LICENSURE – PHYSICIAN ASSISTANT OR OTHER HEALTH CARE PROFESSIONAL

Instructions to the Applicant: Please complete Part I below and forward a copy of this form to **all** states, territories, or other countries' licensing jurisdictions where you have **ever** been licensed, including as any other health care professional. Copy this form as needed. Please type or print legibly.

PART I

Full Name (Last, First, Middle)	Maiden or Other Names Used:		Date of Birth (MM/DD/YYYY)
Mailing Address	City	State	Zip
Physician Assistant Program Attended	Location		Year of Graduation
Signature of Applicant			Date of Signature

FOLLOWING TO BE COMPLETED BY STATE BOARD OR OTHER LICENSING JURISDICTION ONLY

Instructions to the licensing agency: Please complete Part II below for the physician assistant identified above and return this document directly to the Alaska State Medical Board.

PART II

LICENSING JURISDICTION		**LICENSE NUMBER**	
INITIAL ISSUE DATE		**EXPIRATION DATE**	
BASIS OF LICENSURE (FLEX, USMLE, etc.)		**CURRENT LICENSE STATUS**	

1	Has this applicant ever been the subject of an investigation by a licensing or disciplinary authority in your state or jurisdiction?	☐ No	☐ Yes
2	Is any such investigation pending?	☐ No	☐ Yes
3	Have formal disciplinary proceedings been initiated against this applicant or the applicant's license by a licensing or disciplinary authority in your state or jurisdiction?	☐ No	☐ Yes
4	Is any such action pending?	☐ No	☐ Yes
5	Has this applicant's license ever been suspended, revoked, disciplined, restricted, warned, placed on probation, or in any other manner limited by a licensing or disciplinary authority in your state?	☐ No	☐ Yes
6	To your knowledge, is there any derogatory information regarding this applicant?	☐ No	☐ Yes

_____ _____
Signed by Date

(Board Seal)

_____ _____
Printed Name Title

ALASKA STATE MEDICAL BOARD

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VERIFICATION OF PHYSICIAN ASSISTANT PROGRAM EDUCATION

Instructions to the Applicant: Type or print legibly. Complete Part I below and send to the program/school from which you received your physician assistant diploma or certificate.

PART I

Full Name (Last, First, Middle)	Maiden or Other Names Used:	Date of Birth (MM/DD/YYYY) / /
Mailing Address	City	State Zip
Signature of Applicant		Date of Signature

Full Program/School Name _____

Location _____

FOLLOWING TO BE COMPLETED BY PROGRAM/SCHOOL STAFF ONLY

Instructions to the Medical School: Please complete Part II below and return this document **directly** to the Alaska board at the letterhead address.

PART II

Exact Date on Program/School Diploma or Certificate: _____

During this physician assistant's education, was he/she ever investigated by the program/school or disciplined by the program/school for any reason? Disciplinary actions include but are not limited to being placed on probation, issued a letter of reprimand, censured, suspended, restricted, or otherwise disciplined.

☐ No ☐ Yes

If you responded "Yes" to this question, please provide a detailed explanation of the action and the reason for the action on a separate sheet of paper attached to this form signed and dated by the person whose signature appears below.

Signed _____

(SEAL, If Applicable)

Printed Name _____

Title _____

Date _____

Physician Assistant Collaborative Plan

MED

INSTRUCTIONS:

Received by Division:

1 **Complete all parts of the plan** – print legibly or type. Incomplete plans will not be accepted.
2 Include the $100 Collaborative Plan fee with this form.
3 Attach a copy of the PA's current NCCPA certificate.
4 Attach a copy of the PA's valid DEA registration.
5 Attach a copy of the collaborating physician's valid DEA registration.
6 Attach a detailed curriculum vitae for the PA, if applicable, for remote site practice (see remote site information below).
7 Mail the completed plan ***with all attachments*** to the State Medical Board. PO Box 110806, Juneau AK 99811-0806. (Keep a complete copy for your practice records.)
8 **IT IS YOUR RESPONSIBILITY TO INSURE THAT THIS DOCUMENT IS FILED IN A TIMELY MANNER AND THAT IT IS COMPLETE WHEN FILED.**

**** * INCOMPLETE PLANS WILL BE RETURNED AND NOT PROCESSED *****

PHYSICIAN ASSISTANT:_____ **PHYSICIAN:**_____

Complete only for Physician Assistant practice in remote sites.

REMOTE SITE: Location of physician assistant's practice is more than 30 miles by road from physician's primary office.

Physician Assistants with less than two years of full-time clinical experience:
- Must work 160 hours in direct patient care under the direct and immediate supervision of the primary collaborating physician or an alternate.
- The first 40 hours must be completed before going to the remote site practice; the remaining 120 hrs must be completed within 90 days of going to the remote site practice.

____ Hours of supervision will commence as soon as this plan is approved and prior to practicing at the remote site. The completed Verification of Hours of Supervision form will be sent to the State Medical Board immediately upon completion of the required hours. **[Physician: Initial this statement if applicable.]**

- OR -

Physician assistants with more than two years of full-time clinical experience:
- Must attach a detailed curriculum vitae which describes the education, skills, and experience sufficient to meet the needs and demands of the remote site practice.

Upon my careful review, as primary collaborating physician, it is my opinion that the previous experience of the physician assistant documented in the attached curriculum vitae has adequately prepared and qualified this individual to work at the remote site practice location identified in this plan.

Primary Collaborating Physician Signature _____

IMPORTANT REGULATIONS (See Booklet for Complete Regulations Language)

PERFORMANCE AND ASSESSMENT OF PRACTICE, 12 AAC 40.430: It is understood by the physician and the physician assistant that a periodic method of assessment is or will be established which will include the physician's evaluation of physician assistant's work performance which means evaluation of medical care and clinic management. Please refer to the full regulation for the frequency of assessments required. It is further understood that documentation of such periodic assessments may be audited by the State of Alaska at any time.

COMMUNICATIONS WITH SENSORY-IMPAIRED PATIENTS, 12 AAC 40.980(A)(4): A method is or will be devised whereby a physician assistant's level of education and professional training are communicated to patients who may be blind, deaf, or otherwise impaired.

IDENTIFICATION OF PHYSICIAN ASSISTANT, 12 AAC 40.460: It is understood that the physician assistant will wear on his/her clothing a nameplate identifying them as a "Physician Assistant-Certified" and shall display a sign at the place of employment which posts current state licensure and that documents of the Physician Assistant's education and plan of collaboration are available for inspection.

PRESCRIPTIVE AUTHORITY, 12 AAC 40.450:

Prescribing Schedules II, III, IV, and V [12 AAC 40.450(c)] The physician assistant named in this plan may, with a valid DEA registration, write a prescription for a schedule II, III, IV, or V controlled substance medication with primary collaboration physician's approval.

Prescribing Authority May Not Exceed Physician's Authority, 12 AAC 40.450(d): The PA's prescriptive authority may not exceed that of the collaborating physician's prescriptive authority.

Obtaining Controlled Substance Supplies, 12 AAC 40.450(e): The physician assistant named in this plan may use the physician assistant's own DEA registration number to request, receive, order, or procure controlled substance supplies from a pharmaceutical distributor, warehouse, or other entity only with primary collaboration physician's approval.

Prescribe, Order, Administer, or Dispense Non-Controlled Medications, 12 AAC 40.450(f): The physician assistant named in this plan may prescribe, order, administer, or dispense a medication that is not a controlled substance only with primary collaboration physician's approval.

ALASKA STATE MEDICAL BOARD

Physician Assistant Collaborative Plan

Physician Assistant

_____
Name (Please Print)

_____
Address

_____
City, State, Zip

License No. _____ PA: Is this a change of address?: _____

Work Phone_____

Home Phone_____

Email Address _____

Primary Collaborative Physician

_____
Name (Please Print)

_____
Address

_____
City, State, Zip

License No. _____

Work Phone _____

Email Address_____

Alternate Physician #1

Name_____
Address_____
_____
License No. _____ Wk Phone_____
Alternate Signature_____

Alternate Physician #2

Name_____
Address_____
_____
License No. _____ Wk Phone_____
Alternate Signature_____

(Attach addendum form 08-4226 (e) with additional alternates if needed.)

PRACTICE INFORMATION

Specific Location: _____
Practice at any location not specified in this plan is not authorized.

Remote site: ☐ Yes (see page 1) ☐ No

EFFECTIVE DATE OF PLAN

Beginning Date of Employment): _____
******Plan must be filed with the board NO LATER THAN 14 days from this date.******

PRESCRIPTIVE AUTHORITY

*(**Doctor** to check boxes for authority to be granted.)*

☐ 12 AAC 40.450 (c) Prescribe, order, administer, and dispense schedules II, III, IV, and V drugs
☐ 12 AAC 40.450 (d) PA's prescriptive authority does not exceed physician's prescriptive authority
☐ 12 AAC 40.450 (e) May procure controlled substance supplies
☐ 12 AAC 40.450 (f) Prescribe, order, dispense, administer non-controlled drugs
☐ I do not wish to have any prescriptive authority under this plan.

Requirements of Law The physician assistant will work only within the agreed scope of practice with the primary physician. All parties to this plan agree to comply with the provisions of all statutes and regulations relating to the physician assistant's practice of medicine in Alaska.

_____
Signature, Physician Assistant **Date**

NOTARY
SUBSCRIBED AND SWORN before me, a Notary Public in and for the state of Alaska, this _____ day of _____, _____.

_____
Notary Public
My commission expires_____

(Notary Seal)

_____
Signature, Primary Collaborating Physician **Date**

NOTARY
SUBSCRIBED AND SWORN before me, a Notary Public in and for the state of Alaska, this _____ day of _____, _____.

_____
Notary Public
My commission expires_____

(Notary Seal)

**** * Incomplete Plans Will Be Returned and Not Processed * ****

ADDENDUM TO COLLABORATIVE PLAN

Physician Assistant	Primary Collaborating Physician

Instructions: Print or type. If you have more than two alternate collaborating physicians for a collaborative plan, use this form to add additional alternate collaborating physicians and attach to the plan between the PA-C and the physician shown above.

ALTERNATE COLLABORATING PHYSICIAN'S STATEMENT

I hereby certify that I am familiar with the statutes and regulations of the State of Alaska governing the activities and responsibilities of a collaborating physician and that I will fulfill those responsibilities in this collaborative agreement in the absence of the primary collaborating physician. In entering into this agreement as alternate collaborating physician, I accept professional or employer liability to patients of the physician assistant for whom malpractice is adjudged. I have retained a copy of this agreement for my records. I will also maintain and make available for audit by the State of Alaska any performance assessment records which are generated as a result of this collaborative agreement in my capacity as alternate collaborating physician.

1

Signature				Date
Printed Name				AK License No.
Address	City	State	Zip	Telephone

2

Signature				Date
Printed Name				AK License No.
Address	City	State	Zip	Telephone

3

Signature				Date
Printed Name				AK License No.
Address	City	State	Zip	Telephone

4

Signature				Date
Printed Name				AK License No.
Address	City	State	Zip	Telephone

ALASKA STATE MEDICAL BOARD

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Department of Commerce, Community, and Economic Development
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Juneau AK 99811-0806
A - K: (907) 465-2756 L - Z: (907) 465-2541
E-Mail: medicalboard@alaska.gov

Office Use Only

PHYSICIAN ASSISTANT
BOARD ACTION DATA BANK INQUIRY

Applicant: Please complete the identifying information below. Type or print legibly.

YOU MUST MAIL THIS REQUEST FORM TO:

Federation of State Medical Boards
400 Fuller Wiser Rd., Suite 300
Euless TX 76039-3855

NAME _____ DATE OF BIRTH _____
(Last, First, Middle) (MM/DD/YYYY)

CURRENT ADDRESS _____

_____

PA PROGRAM/ SCHOOL ATTENDED _____ YEAR OF GRAD./COMPLETION_____

FOLLOWING TO BE COMPLETED BY THE FEDERATION OF STATE MEDICAL BOARDS

Board Action Data Bank Staff: Please search the data bank for any record of this practitioner. Please forward your report to the medical board at the letterhead address.

FOR FEDERATION USE ONLY

ALASKA STATE MEDICAL BOARD

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PHYSICIAN ASSISTANT - CERTIFIED
VERIFICATION OF HOURS OF SUPERVISION

INSTRUCTIONS: In accordance with 12 AAC 40.410 (e and f), physician assistants must complete 160 hours of direct and immediate supervised work before practicing at a remote location. Please complete this form and return to the address above. **You must hold a valid permit before working.**

PHYSICIAN ASSISTANT	COLLABORATING PHYSICIAN
Name (Last, First, MI)	Name (Last, First, MI)
Address	Address
City/State/Zip	City/State/Zip
Telephone:	Telephone:

DOCUMENTED HOURS OF SUPERVISED WORK

Date	No. Hrs	Date	No. Hrs	Date	No. Hrs	Date	No. Hrs

Total Hours Submitted:_____

_____ _____

Signature, Physician Assistant Date Signature, Collaborating Physician Date

ALASKA STATE MEDICAL BOARD

Department of Commerce, Community, and Economic Development
Division of Corporations, Business, and Professional Licensing
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Juneau AK 99811-0806
A - K: (907) 465-2756 L - Z: (907) 465-2541
E-mail: medicalboard@alaska.gov

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Office Use Only

VERIFICATION OF STATUS OF DEA REGISTRATION

Instructions to the Applicant: Type or print legibly. Please complete Part I below and mail to the DEA.

PART I

Full Name (Last, First, Middle)	Maiden or Other Names Used:		Date of Birth (MM/DD/YYYY)
Mailing Address	City	State	Zip
Address Where DEA Registered			DEA Registration No.
Signature of Applicant			Date of Signature

MAIL THIS REQUEST FORM TO: Drug Enforcement Administration
Attn: Diversion Unit
300 5th Avenue, Suite 1300
Seattle, WA 98104

FOR DEA USE ONLY

Instructions to the DEA staff: Complete Part II below. Please search your records and advise if there is any derogatory information on file against this physician. Please return this form directly to the State Medical Board at the letterhead address.

PART II

1. Has this applicant ever surrendered (for cause) or had a federal controlled substance registration revoked, suspended, restricted or denied? ☐ No ☐ Yes
2. Is any such investigation pending? ☐ No ☐ Yes

DEA Comments: _____

_____

_____

_____

_____