State of Utah

Division of Occupational & Professional Licensing

160 East 300 South, P.O. Box 146741
Salt Lake City, Utah 84114-6741
Telephone (801) 530-6628
www.dopl.utah.gov

PHYSICIAN ASSISTANT NOTIFICATION OF CHANGE

(Note: Microsoft Word users can fill in the blanks, print the form and save it for their records)

*****Please list your full legal name as it appears on your driver's license, Social Security Card, etc.*****

Last Name:	First Name:	Middle Name:
Social Security Number: - -	Maiden Name:	

I certify under penalty of perjury that:

- ☐ I am a citizen of the United States.
- ☐ I am a qualified alien as defined in 8 U.S.C., Sec 1641 who is lawfully present in the United States. I understand that I am required to visit DOPL's offices and present a government issued ID bearing my photo and evidence of one, or both of the following:
  Alien ID Number I-94 Number
- ☐ I am a foreign national not physically present in the United States. *(If you check this item you do not need to respond to the following section.)*

and

- ☐ I have a valid Driver License or State Issued ID State: Number:
- ☐ I do not have a Driver License. I am legally present in the United States, and I understand that the Department of Commerce will verify my legal presence in order to process my application.

Mailing Address:			
City:		State:	ZIP:
☐ Male ☐ Female	Date of Birth:	Phone #:	E-Mail:

PHYSICIAN(S) TO BE REMOVED AS SUPERVISOR(S): Use additional sheets if necessary. The physician(s) listed on this page **will be removed** as supervisor(s).

Supervising Physician's Name:	License Number:
Supervising Physician's Name:	License Number:
Supervising Physician's Name:	License Number:
Substitute Supervisor(s):	
Substitute Supervising Physician's Name:	License Number:
Substitute Supervising Physician's Name:	License Number:
Substitute Supervising Physician's Name:	License Number:

DO NOT WRITE IN THIS SECTION - FOR DIVISION USE ONLY

License/Certificate Number: ____

Date License/Certificate Approved/Denied: ___/___/____ by ______________________________

Reason for Denial/Other Comments: ____

____

LIST ALL SUPERVISING PHYSICIAN(S) TO BE APPROVED: Complete the following for each PRACTICE SITE. *(Use additional sheets if necessary.)*

Primary Supervising Physician's Name:			License Number:
Specialty:	Number of physician assistants being supervised (*including this applicant*):		
Name of Practice Site(s):			
Address of Practice Site(s):			
City:		State:	Zip:
Primary Supervisors Phone Number:	Primary supervisors email:		
Percent of Direct Supervision:	Number of hours working per week:		
Substitute Supervising Physician's Name:			License Number:
Specialty:			
Substitute Supervising Physician's Name:			License Number:
Specialty:			
Substitute Supervising Physician's Name:			License Number:
Specialty:			

Primary Supervising Physician's Name:			License Number:
Specialty:	Number of physician assistants being supervised (*including this applicant*):		
Name of Practice Site(s):			
Address of Practice Site(s):			
City:		State:	Zip:
Primary Supervisors Phone Number:	Primary supervisors email:		
Percent of Direct Supervision:	Number of hours working per week:		
Substitute Supervising Physician's Name:			License Number:
Specialty:			
Substitute Supervising Physician's Name:			License Number:
Specialty:			
Substitute Supervising Physician's Name:			License Number:
Specialty:			

Primary Supervising Physician's Name:			License Number:
Specialty:	Number of physician assistants being supervised (*including this applicant*):		
Name of Practice Site(s):			
Address of Practice Site(s):			
City:		State:	Zip:
Primary Supervisors Phone Number:	Primary supervisors email:		
Percent of Direct Supervision:	Number of hours working per week:		
Substitute Supervising Physician's Name:			License Number:
Specialty:			
Substitute Supervising Physician's Name:			License Number:
Specialty:			
Substitute Supervising Physician's Name:			License Number:
Specialty:			

SUMMARY OF SUPERVISING PHYSICIAN: Please list all of your supervisor(s) to **remain** and to be **approved**. Use additional sheets if necessary.

Supervising Physician's Name:

☐ Primary ☐ Substitute ☐ Current/Remaining

Supervising Physician's Name:

☐ Primary ☐ Substitute ☐ Current/Remaining

Supervising Physician's Name:

☐ Primary ☐ Substitute ☐ Current/Remaining

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Supervising Physician's Name:

☐ Primary ☐ Substitute ☐ Current/Remaining

Supervising Physician's Name:

☐ Primary ☐ Substitute ☐ Current/Remaining

AFFIDAVIT FOR SUPERVISING PHYSICIAN(S) *(Use additional sheets if necessary.)*	
I declare under penalty of perjury as follows: 1. I certify as a Supervising Physician, I have reviewed the types of supervision with the Physician Assistant. 2. I certify as a Supervising Physician, I have reviewed the frequency and mechanism of chart review with the Physician Assistant including the cosigning of all medical chart records of Schedule 2 or Schedule 3 prescriptions. 3. I certify as a Supervising Physician, I have reviewed the prescribing and administering of controlled substances including the cosigning of all medical chart records of Schedule 2 or Schedule 3 prescriptions with the Physician Assistant. 4. I certify as a Supervising Physician, I have reviewed my Scope of practice including my specialty with the Physician Assistant. 5. I certify as a Supervising Physician, I have reviewed the proper emergency procedures with the Physician Assistant. 6. I certify as a Supervising Physician, I have reviewed any additional considerations relating to the practice with the Physician Assistant. 7. I certify as a Supervising Physician, I have completed a "Delegation of Services Agreement" with the Physician Assistant. 8. I certify as a Supervising Physician, a copy of the Delegation of Services Agreement is on file at each of my Utah practice sites and is available to DOPL upon request.	
Signatures of all primary supervisors to be approved:	
Primary Supervising Physician Name: Primary Supervising Physician Signature:	Date:
Primary Supervising Physician Name: Primary Supervising Physician Signature:	Date:
Primary Supervising Physician Name: Primary Supervising Physician Signature:	Date:
Primary Supervising Physician Name: Primary Supervising Physician Signature:	Date:
Primary Supervising Physician Name: Primary Supervising Physician Signature:	Date:
Primary Supervising Physician Name: Primary Supervising Physician Signature:	Date:
Primary Supervising Physician Name: Primary Supervising Physician Signature:	Date:

AFFIDAVIT FOR THE PHYSICIAN ASSISTANT	
I declare under penalty of perjury as follows: 1. I certify as a Physician Assistant, I have reviewed the types of supervision with the Supervising Physician. 2. I certify as a Physician Assistant, I have reviewed the frequency and mechanism of chart review with the Supervising Physician including the cosigning of all medical chart records of Schedule 2 or Schedule 3 prescriptions 3. I certify as a Physician Assistant, I have reviewed the prescribing and administering of controlled substances including the cosigning of all medical chart records of Schedule 2 or Schedule 3 prescriptions with the Supervising Physician. 4. I certify as a Physician Assistant, I have reviewed my Scope of practice including my specialty with the Supervising Physician. 5. I certify as a Physician Assistant, I have reviewed the proper emergency procedures with the Supervising Physician. 6. I certify as a Physician Assistant, I have reviewed any additional considerations relating to the practice with the Supervising Physician. 7. I certify as a Physician Assistant, I have completed a "Delegation of Services Agreement" with the Supervising Physician. 8. I certify as a Physician Assistant, a copy of the Delegation of Services Agreement is on file at each of my Utah practice sites and is available to DOPL upon request.	
PA Applicant Name: PA Applicant Signature:	Date:

NOTE: It is "unlawful conduct" under the Physician Assistant Practice Act to practice as a Physician Assistant if you are not under the supervision of a supervising Physician or substitute supervising Physician.

State of Utah
DIVISION OF OCCUPATIONAL & PROFESSIONAL LICENSING

160 East 300 South, P.O. Box 146741
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PHYSICIAN ASSISTANT NOTIFICATION OF CHANGE NOT PRACTICING IN UTAH

(Note: Microsoft Word users can fill in the blanks, print the form and save it for their records)

*****Please list your full legal name as it appears on your driver's license, Social Security Card, etc.*****

Last Name:	First Name:	Middle Name:
Social Security Number: - -	Maiden Name:	

I certify under penalty of perjury that:

- ☐ I am a citizen of the United States.
- ☐ I am a qualified alien as defined in 8 U.S.C., Sec 1641 who is lawfully present in the United States. I understand that I am required to visit DOPL's offices and present a government issued ID bearing my photo and evidence of one, or both of the following:
  Alien ID Number　　I-94 Number
- ☐ I am a foreign national not physically present in the United States. *(If you check this item you do not need to respond to the following section.)*

and

- ☐ I have a valid Driver License or State Issued ID　State:　Number:
- ☐ I do not have a Driver License. I am legally present in the United States, and I understand that the Department of Commerce will verify my legal presence in order to process my application.

Mailing Address:			
City:		State:	ZIP:
☐ Male ☐ Female	Date of Birth:	Phone #:	E-Mail:

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:	Issuing State:	
License Number:	License Status:	Issue Date:
Profession:	Issuing State:	
License Number:	License Status:	Issue Date:
Profession:	Issuing State:	
License Number:	License Status:	Issue Date:

IF NOT PRACTICING AS A PHYSICIAN ASSISTANT IN UTAH

I declare under penalty of perjury as follows:

I will not be practicing as a Physician Assistant in Utah at this time.

If at any future time I choose to practice in Utah, I agree to complete and submit to DOPL a "Notification of Change" form. I understand that I must receive approval from DOPL before I begin practice with the proposed supervisor(s). I also agree to complete a "Delegation of Services Agreement" consistent with Utah law before I begin my practice in Utah. Said agreement(s) will be on file at my Utah practice site(s).

Signature of Applicant:	Date:

NOTE: It is "unlawful conduct" under the Physician Assistant Practice Act to practice as a Physician Assistant if you are not under the supervision of a supervising Physician or substitute supervising Physician.

PHYSICIAN ASSISTANT NOTIFICATION OF CHANGE
Application Instructions and Information

Mandatory Attachment Check List *(Applications with incomplete attachments will not be considered and may be denied.)*	
☐	Fill out Personal information section.
☐	List all physicians to be removed as Supervisors or statement all current physicians will remain as supervisors.
☐	List **ALL** physicians to remain or be added
☐	Obtain **ALL PRIMARY** supervisors signatures, dates, and personally sign and date form
☐	**Not practicing in Utah:** Fill in form on page 5, sign, and date.

1. **Social Security Number:** Your social security number is classified as a private record under the Utah Government Records Access and Management Act. If an SSN is not provided, the application is incomplete and may be denied.

2. **Address of Record:** The address you provide on this application will be your address of record. You are responsible to directly notify DOPL of any change to your address of record.

3. **Laws and Rules:** You are required to understand Utah laws and rules pertaining to your practice. The following laws and rules are available on the Internet at www.dopl.utah.gov:

4. **Controlled Substance License:** You must hold a Utah controlled substance license **AND** a federal DEA registration to administer, possess, or prescribe a controlled substance in your practice in Utah.

5. **DEA Registration:** For DEA registration information, contact the Drug Enforcement Administration, Salt Lake District Office, 348 East South Temple, Salt Lake City, UT 84088. Telephone (801) 524-4389.

6. **Acceptable Forms of Payment:** Licensure fees can be paid by check or money order, made payable to "DOPL." Cash and debit/credit cards (*American Express, MasterCard, and Visa*) are also accepted in person at DOPL's main office – but not over the telephone.

7. **Mail Complete Application to:**

   By U.S. Mail
   Division of Occupational & Professional Licensing
   P.O. Box 146741
   Salt Lake City, Utah 84114-6741

   By Delivery or Express Mail
   Division of Occupational & Professional Licensing
   160 E 300 S, 1st Floor Lobby
   Salt Lake City, UT 84111-2305

8. **Telephone Numbers:** (801) 530-6628
   (866) 275-3675 – Toll-free in Utah