

# North Dakota State Board of Medical Examiners

CITY CENTER PLAZA, 418 E. BROADWAY AVE., SUITE 12, BISMARCK, ND 58501

PHONE (701) 328-6500, FAX (701) 328-6505

## APPLICATION FOR PHYSICIAN ASSISTANT LICENSURE

DATE RECEIVED

FEES RECEIVED

Date \_\_\_\_\_

### 1. BIOGRAPHICAL INFORMATION

- A. Name \_\_\_\_\_  
(First) (Middle) (Maiden) (Last)
- B. Business Address \_\_\_\_\_  
\_\_\_\_\_  
(city) (state) (zip)  
Business Phone ( \_\_\_\_ ) \_\_\_\_\_
- C. Home Address \_\_\_\_\_  
\_\_\_\_\_  
(city) (state) (zip)  
Home Phone ( \_\_\_\_ ) \_\_\_\_\_
- D. E-mail Address \_\_\_\_\_
- E. Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
mm dd yyyy
- F. Place of Birth \_\_\_\_\_
- G. Height \_\_\_\_\_
- H. Weight \_\_\_\_\_
- I. Color of Eyes \_\_\_\_\_
- J. Color of Hair \_\_\_\_\_
- K. Identifying Marks \_\_\_\_\_  
\_\_\_\_\_
- L. Social Security # \_\_\_\_\_
- M. DEA Registration # \_\_\_\_\_

### 2. INTENDED PLACE OF PRACTICE

- A. Name and address of hospital, clinic, or office where you intend to practice \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- B. Anticipated starting date \_\_\_\_\_
- C. Are you applying for a permanent license or a locum tenens permit? \_\_\_\_\_  
(Locum tenens permits may be issued for a period not exceeding three months.)

### 3. CERTIFICATION INFORMATION

- A. Have you passed the certifying exam administered by the National Commission on Certification of Physician Assistants (NCCPA)?  
Yes \_\_\_\_\_ No \_\_\_\_\_ Date \_\_\_\_\_ Certification # \_\_\_\_\_  
(Attach a notarized copy of your certificate)
- B. Have you been certified (or recertified) by the NCCPA within the past six (6) years? Yes \_\_\_\_\_ No \_\_\_\_\_
- C. Is your certification by the NCCPA currently valid? Yes \_\_\_\_\_ No \_\_\_\_\_

### 4. LICENSURE INFORMATION

- A. Have you ever been licensed or registered as a physician assistant in another state? \_\_\_\_\_  
If yes, list states and license/registration number(s) \_\_\_\_\_  
\_\_\_\_\_

5. EDUCATION

HIGH SCHOOL \_\_\_\_\_

CITY \_\_\_\_\_ STATE/COUNTRY \_\_\_\_\_

COLLEGE \_\_\_\_\_

ADDRESS \_\_\_\_\_

DATES OF ATTENDANCE \_\_\_\_\_

DEGREE \_\_\_\_\_ DATE \_\_\_\_\_

COLLEGE \_\_\_\_\_

ADDRESS \_\_\_\_\_

DATES OF ATTENDANCE \_\_\_\_\_

DEGREE \_\_\_\_\_ DATE \_\_\_\_\_

6. PHYSICIAN ASSISTANT EDUCATION/TRAINING

INSTITUTION \_\_\_\_\_

ADDRESS \_\_\_\_\_

DATES OF ATTENDANCE \_\_\_\_\_

DEGREE \_\_\_\_\_ DATE \_\_\_\_\_

INSTITUTION \_\_\_\_\_

ADDRESS \_\_\_\_\_

DATES OF ATTENDANCE \_\_\_\_\_

DEGREE \_\_\_\_\_ DATE \_\_\_\_\_

7. OTHER EDUCATION/TRAINING (specify nature, location, dates, degrees)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

8. ACTIVITIES SINCE GRADUATION

List in chronological order all professional activities since graduation from PA training, including any postgraduate training, hospital or clinic affiliations and periods of unemployment. Account for all time.

FROM MONTH/YEAR	TO MONTH/YEAR	LOCATION AND COMPLETE ADDRESS	POSITION


9. **SUPERVISING PHYSICIAN:**

List in chronological order every supervising physician for whom you have worked as a physician assistant during the past ten years. Include a complete and current address for each physician. (Please attach an addendum if necessary.)

NAME	ADDRESS

10. **PERSONAL DATA**

All information received in this section will be verified. If any question is answered YES, a full explanation must be furnished on a separate sheet and attached to this form. That explanation shall be considered a part of this application. Applicants should be aware that the Board routinely receives information from other states and from national sources about actions taken against licenses or registration of physician assistants.

	Yes	No
A. Have you ever been rejected for membership by or requested to appear before any professional physician assistant organization?.....	<input type="checkbox"/>	<input type="checkbox"/>
B. Have you ever been denied the privilege of taking a PA certifying exam?.....	<input type="checkbox"/>	<input type="checkbox"/>
C. Have you ever been denied a PA license or registration?.....	<input type="checkbox"/>	<input type="checkbox"/>
D. Have you ever been denied staff affiliation with a hospital, nursing home, clinic or other health care facility?.....	<input type="checkbox"/>	<input type="checkbox"/>
E. Have you ever been warned, censured, disciplined, limited, suspended, put on probation or requested to withdraw from a hospital, nursing home, clinic, or other health care facility?.....	<input type="checkbox"/>	<input type="checkbox"/>
F. Has any licensing, certifying, or registering authority censured, limited, suspended or revoked a license, certification or registration you held, or that you now hold?.....	<input type="checkbox"/>	<input type="checkbox"/>
G. Have you ever voluntarily surrendered a physician assistant or other professional license, certificate or registration?....	<input type="checkbox"/>	<input type="checkbox"/>
H. Have you ever been investigated by any licensing, certifying, registering or disciplinary authority?.....	<input type="checkbox"/>	<input type="checkbox"/>
I. Have you ever been notified that any charges or complaints have been filed against you by any licensing, certifying, registering or disciplinary authority?.....	<input type="checkbox"/>	<input type="checkbox"/>
J. Do you currently have or within the past five years have you had a dependency on the use of alcohol or drugs which impaired or does impair your ability to practice medicine competently?.....	<input type="checkbox"/>	<input type="checkbox"/>
K. Within the past five years have you been admitted to any hospital or other inpatient care facility for any physical, mental, or emotional condition?.....	<input type="checkbox"/>	<input type="checkbox"/>
L. Within the past five years, have you engaged in the excessive or habitual use of alcohol or illegal drugs or received any treatment for alcoholism or excessive or illegal drug use?.....	<input type="checkbox"/>	<input type="checkbox"/>
M. Have you ever been arrested for, charged with, or convicted of a crime?.....	<input type="checkbox"/>	<input type="checkbox"/>
N. Have you ever been a defendant in a legal action involving professional liability (malpractice) or had a professional liability claim paid on your behalf or paid such claim yourself?.....	<input type="checkbox"/>	<input type="checkbox"/>
O. Within the past five years have you had any physical, mental, or emotional condition which impaired or does impair your ability to practice medicine safely and competently?.....	<input type="checkbox"/>	<input type="checkbox"/>

11. AGREEMENT TO UPDATE APPLICATION INFORMATION

By signing this section of the North Dakota Board of Medical Examiners license application form, I agree that:

If any of the information supplied on this application form changes, or becomes inaccurate or incomplete before I am granted a license to practice medicine in North Dakota, I will immediately provide the corrected information to the North Dakota Board of Medical Examiners.

Failure to provide such corrected information to the Board will constitute the use of a fraudulent, deceitful, dishonest, or immoral practice in connection with the North Dakota licensing requirements and will, therefore, be a violation of Sec. 50-03-01-11, of the North Dakota Administrative Code, which will subject me to disciplinary action or denial of licensure.

\_\_\_\_\_  
SIGNATURE OF APPLICANT

12. AFFIDAVIT

I, \_\_\_\_\_, being first duly sworn, depose and say that I am the person referred to in the foregoing application and the supporting documents attached hereto.

I have carefully read the questions in this application and have answered them completely, without reservation of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice as a physician assistant in the State of North Dakota.

Furthermore, I hereby authorize all hospitals, clinics, institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present) and all government agencies (local, state, federal or foreign) to release to the North Dakota State Board of Medical Examiners any information which is material to this application or any subsequent registration, certification or licensure.

\_\_\_\_\_  
SIGNATURE OF APPLICANT

\_\_\_\_\_  
DATE

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_

\_\_\_\_\_  
NOTARY PUBLIC

(SEAL)

My Commission expires \_\_\_\_\_, 20\_\_\_\_\_

13. PRIMARY SUPERVISING PHYSICIAN

I hereby inform the North Dakota State Board of Medical Examiners that I am the Primary Supervising Physician for the physician assistant who is submitting this application. Accordingly, I acknowledge that I understand the following:

Because I am the primary supervising physician, I will be held accountable to the Board of Medical Examiners for the actions of the physician assistant. This accountability includes those circumstances in which the physician assistant is actually performing services for another supervising physician.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_

\_\_\_\_\_  
PRIMARY SUPERVISING PHYSICIAN

14.

