

**Regular Mailing Address**  
**STATE BOARD OF MEDICINE**  
**P.O. BOX 2649**  
**HARRISBURG, PA 17105-2649**  
**Email: [st-medicine@pa.gov](mailto:st-medicine@pa.gov)**

**Courier Delivery Address**  
**STATE BOARD OF MEDICINE**  
**2601 NORTH THIRD STREET**  
**HARRISBURG, PA 17110**  
**717-783-1400/717-787-2381**

## APPLICATION FOR LICENSURE AS A PHYSICIAN ASSISTANT

This application can be used for a temporary permit or licensure under the State Board of Medicine only. A temporary permit holder or licensee under the State Board of Medicine may only be supervised by a licensed allopathic physician (MD). **If you wish to be supervised by an osteopathic physician (DO), you must become certified under the State Board of Osteopathic Medicine.**

**PLEASE NOTE:** If this application is not completed **within six months**, updates of certain sections and/or supporting documents will be required. If the application has not been completed within one year from the date it was received, applicants will be required to submit a new application (**another application processing fee**) and supporting documents, as necessary.

If documents will be submitted to the Board under a name different from your present name, submit a copy of the legal document evidencing the name change (i.e., marriage license, divorce decree, naturalization, etc.).

**PLEASE ALLOW AT LEAST 60 DAYS FOR PROCESSING**

### INSTRUCTIONS FOR APPLICANTS WHO HOLD NCCPA CERTIFICATION

1. Submit the \$30 fee via check or money order, made payable to the "Commonwealth of Pennsylvania." **FEES ARE NOT REFUNDABLE.** Note: A processing fee of \$20 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment. Your cancelled check is your receipt.
2. Complete the Verification of Education and send to the physician assistant program where you graduated. **The program must send the completed form directly to the Board in a sealed official school envelope.**
3. The Board requires that you have obtained a minimum of a Baccalaureate/Bachelor's Degree. If you have obtained a Baccalaureate Degree or higher from the physician assistant program, a transcript is **NOT** required. However, if a school different from the physician assistant program granted the degree, arrange for this school to submit a transcript directly to the Board in an official school envelope. The transcript must indicate the degree that was awarded.
4. Contact the National Commission on Certification of Physician Assistants, Inc. (NCCPA) and arrange for your exam scores to be sent directly to the Board in an official envelope.
5. Attach a Curriculum Vitae listing **all** periods of employment or unemployment (i.e. child rearing, research, etc.) from graduation from physician assistant program to present. The list must be in chronological order, include the month and year and indicate the state/territory in which the employment occurred.
6. Contact the state board office(s) where you hold or ever held licensure/certification to practice as a physician assistant or other health care practitioner and request letters of good standing. The letter must include the following: license issue and expiration date, license status (current or expired) and disciplinary standing. The letter(s) of good standing must be sent directly to the Pennsylvania Board from each state board office in an official board envelope.
7. **ALL APPLICANTS** must provide an official notification of information (Self Query) from the National Practitioner Data Bank/Healthcare Integrity and Protection Data Bank. Please refer to the NPDB-HIPDB website for additional information. **When you receive the "Response to your Self Query," forward the entire report directly to the Board Office. You should make a copy for your records.**
8. All applications must be submitted to the Board office by mail with original signatures. Faxed/emailed applications are not accepted.

## INSTRUCTIONS FOR TEMPORARY PERMIT APPLICANTS

Applicants must be scheduled to take the first available NCCPA examination after graduation from the physician assistant program. **Temporary permits will expire within 12 months of issuance or upon failure of the NCCPA examination, whichever occurs first.** Temporary permit holders must practice under direct supervision and may not prescribe/dispense drugs.

1. Submit the \$30 fee, check or money order, made payable to the "Commonwealth of Pennsylvania." **FEES ARE NOT REFUNDABLE. Check or money order must be in "US funds."** **Note:** A processing fee of \$20 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment. Your cancelled check is your receipt of payment.
2. Complete the Verification of Education and send to the physician assistant program where you graduated. **The program must send the completed form directly to the Board in a sealed official school envelope.**
3. The Board requires that you have obtained a minimum of a Baccalaureate/Bachelor's Degree. If you have obtained a Baccalaureate/Bachelor's Degree or higher from the physician assistant program, a transcript is **NOT** required. However, if a school different from the physician assistant program granted the degree, arrange for this school to submit a transcript directly to the Board in an official school envelope. The transcript must indicate the degree that was awarded.
4. After taking the NCCPA examination, contact the National Commission on Certification of Physician Assistants, Inc. (NCCPA) and arrange for your examination scores to be sent directly to the Board in an official envelope. When the Board receives your passing examination scores, your temporary permit will automatically be transmitted to a license. Please note, an additional fee will not be required to complete the transfer.

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## APPLICATION FOR LICENSURE AS A PHYSICIAN ASSISTANT

- Check to indicate that you desire a temporary permit. Temporary permits are only available to new graduates who have not yet taken the PANCE examination. **A temporary permit is valid for 1 year from date of issuance or upon failure of the examination, whichever occurs first.**

**Temporary permit and Licensure Fee:** Submit the \$30 fee, check or money order, made payable to the "Commonwealth of Pennsylvania." **FEES ARE NOT REFUNDABLE. Check or money order must be in "US funds."** **Note:** A processing fee of \$20 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment. Your cancelled check is your receipt of payment.

**\*\*\*IMPORTANT EDUCATION CHANGES EFFECTIVE JANUARY 1, 2004\*\*\***

Act 160 of 2002 requires that candidates for initial licensure after January 1, 2004 obtain a baccalaureate or higher degree from a college or university and must complete not less than 60 clock hours of didactic instruction in pharmacology or other related courses.

### TO BE COMPLETED BY APPLICANT

(Please print or type)

<b>NAME:</b>	Last:	First:	Middle:
<b>ADDRESS:</b>	Street:		
City:	State:	ZIP:	
<b>DATE OF BIRTH:</b>	Month	Day	Year
<b>PHONE NUMBER:</b>	<b>SOCIAL SECURITY NUMBER:</b>		
<b>EMAIL ADDRESS:</b>			

If your supporting documents are listed under another name or names, please list below:

\_\_\_\_\_

Last First Middle

If you know the name of your supervisor, please provide the name and license number below. The supervisor is required to submit a separate application for registration as a supervising physician. In order for you to begin practicing, this application must also be approved. If you do not have a supervisor at this time, write "None."

<b>NAME OF SUPERVISOR:</b>	Last	First	Middle
<b>LICENSE NUMBER OF SUPERVISOR:</b>	MD _____		

EDUCATION					
<b>NAME OF SCHOOL:</b>		<b>GRADUATION DATE:</b>	Month	Day	Year
<b>ADDRESS OF SCHOOL:</b>					
<b>Did you receive at least a Baccalaureate/Bachelor's Degree from the physician assistant program?</b>				Yes	No
<b>If you answered 'No', list below the name and address of the program that issued the Baccalaureate Degree.</b>					
<b>NAME OF SCHOOL:</b>		<b>GRADUATION DATE:</b>	Month	Day	Year
<b>ADDRESS OF SCHOOL:</b>	Street				
	City	State		Zip	

## LEGAL QUESTIONS

**You must answer the following questions.** If you answer "YES" to #2 through #8, provide complete details on a separate sheet as well as certified copies of relevant documents. **Sign and date below.**

		Yes	No
1.	Do you hold or have you ever held a license, certification, or registration (active or inactive, current or expired) to practice any health care profession in any jurisdiction, state, country or territory? <b><u>If yes, list the jurisdiction(s) here:</u></b>		
2.	Have you withdrawn an application for a license, certificate or registration, had an application for a license denied or refused, or for any disciplinary reason agreed not to reapply for a license, certificate or registration in any profession in any state or jurisdiction?		
3.	Have you had disciplinary action taken against your license, certificate or registration issued to you in any profession in any other state or jurisdiction?		
4.	Have you been convicted, found guilty or entered a plea of nolo contendere, or received probation without verdict or accelerated rehabilitative disposition (ARD) as to any felony or misdemeanor, including any drug law violations, or do you have any criminal charges pending and unresolved in any state or jurisdiction? You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.		
5.	Have you ever been arrested for criminal homicide, aggravated assault, sexual offenses or drug offenses in any state, territory or country?		
6.	Have you had practice privileges denied, revoked or restricted in a hospital or other health care facility?		
7.	Are you, or have you ever been, addicted to the intemperate use of alcohol or to the habitual use of narcotics or other habit-forming drugs? <b>Note: You may answer "NO" if you are currently a participant in or have successfully completed the requirements of the Pennsylvania Department of State Professional Health Monitoring Program.</b>		

## VERIFICATION

Note that disclosing your social security number on this application is mandatory in order for the State Board of Medicine to comply with the requirements of the federal Social Security Act pertaining to child support enforcement, as implemented in the Commonwealth of Pennsylvania at 23 Pa. C.S. 4304.1(a). In order to enforce domestic child support orders, the Commonwealth's licensing boards must provide to the Department of Public Welfare information prescribed by DPW about the licensee, including the social security number. Additionally, disclosing the number is mandatory in order for this board to comply with the reporting requirements of the federal National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank. Reports to the NPDB/HIPDB must include the licensee's social security number.

I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa. C.S. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my license or certificate. I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Pennsylvania State Board of Medicine any information, files or records requested by the Board.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Applicant

**PENNSYLVANIA STATE BOARD OF MEDICINE**

**VERIFICATION OF GRADUATION FROM A PHYSICIAN ASSISTANT PROGRAM**

Complete Section 1 of this page and forward to the college or university where you completed your physician assistant program.

**SECTION 1 – TO BE COMPLETED BY APPLICANT**

<b>NAME:</b>		Last:		First:		Middle:	
<b>ADDRESS:</b>		Street:					
City:			State:			ZIP:	
<b>DATE OF BIRTH:</b>		Month	Day	Year	<b>SOCIAL SECURITY NUMBER:</b>		
<b>NAME OF SCHOOL:</b>							
<b>DATES OF ATTENDANCE:</b>		<b>FROM:</b>	Month	Day	Year	<b>TO:</b>	Month Day Year

Submit the verification of physician assistant education form to your school and request the school return the completed form directly to the board in an official school envelope.

**THIS FORM MAY NOT BE COMPLETED/SUBMITTED TO THE BOARD PRIOR TO GRADUATION**

**SECTION 2 – TO BE COMPLETED BY DIRECTOR OF PHYSICIAN ASSISTANT PROGRAM**

<b>NAME OF PROGRAM:</b>							
<b>ADDRESS:</b>		Street					
City:			State:			ZIP:	
I CERTIFY THAT THE ABOVE-NAMED INDIVIDUAL HAS SUCCESSFULLY COMPLETED THE PHYSICIAN ASSISTANT PROGRAM, WHICH INCLUDED AT LEAST 60 CLOCK HOURS OF DIDACTIC INSTRUCTION IN PHARMACOLOGY OR OTHER RELATED COURSE. THE SCHOLASTIC STANDING AND PRACTICAL PERFORMANCE WERE SATISFACTORY DURING THE COURSE OF STUDY COMPLETED.							
<b>DEGREE AWARDED:</b>					<b>GRADUATION DATE:</b>		Month Day Year

<b>SIGNATURE OF PROGRAM DIRECTOR:</b>				_____			
<b>DATE:</b>		Month	Day	Year	<p>Upon completion, school must return this completed form directly to the Pennsylvania State Board of Medicine in an official school envelope.</p> <p><b>DO NOT RETURN THIS FORM TO THE APPLICANT</b></p>		
(Seal of School)							

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