MINNESOTA BOARD OF MEDICAL PRACTICE

University Park Plaza • 2829 University Avenue SE Suite 500 • Minneapolis, MN 55414-3246
Telephone (612) 617-2130 • Fax (612) 617-2166 • www.bmp.state.mn.us
MN Relay Service for Hearing Impaired (800) 627-3529

Physician Assistant Advisory Council
Meeting Dates and Deadlines

Upon receipt of your application and documentation, you will be put on the next Council and Board agendas unless you specify a particular Board. It is your responsibility to make sure your file is complete; i.e. verifications, completed application, and documentation have been received by the Board. As a general rule, the application and documentation must be received two weeks prior to the next Council meeting as indicated below.

PA Document Deadline	Council Meeting	Board Meeting
December 6, 2012	December 20, 2012	January 12, 2013
February 7, 2013	February 28, 2013	March 09, 2013
April 05, 2013	April 25, 2013	May 11, 2013
June 07, 2013	June 27, 2013	July 13, 2013
August 07, 2013	August 29, 2013	September 14, 2013
October 10, 2013	October 31, 2013	November 09, 2013
December 5, 2013	December 19, 2013	January 11, 2014

2014 Dates to be Determined

All Physician Assistant Licenses Expire June 30th of Each Year

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PHYSICIAN ASSISTANT
Fact Sheet

History

Physician Assistants were initially registered in Minnesota in 1987 and governed by rules promulgated by the Minnesota Department of Health. Effective 1991, a new law allowed physicians to delegate prescribing authority (excluding controlled substances) to physician assistants who were currently certified by National Commission on Certification of Physician Assistants. In 1995, a law was enacted to replace the rules and thereby enabling the physician assistants to become statutorily legitimate. This law allowed physicians to extend their delegation of authority to controlled substances. The law also shifted more responsibility to the physicians and the physician assistants by eliminating the supervisory agreement protocol and instituting a system whereby a practice setting description is filed with the Board annually along with the evidence of annual review of physician-physician assistant agreement.

A law became effective on August 1, 2009 changing

- Registration to licensure
- Eliminating temporary registration. Temporary licenses are still available to applicants who have passed the NCCPA exam
- Increasing # PAs supervised from 2 to 5
- Practice Setting Description to Notice of Intent to Practice and
- Supervisory Agreement/Delegation/Internal Protocol to Delegation Agreement

Physician Assistant Advisory Council

The Physician Assistant Advisory Council is appointed to advise the Board of Medical Practice on issues regarding physician assistant licensure standards, enforcement of statutes, and complaint review. The Council is composed of three physician assistants, two physicians and two public members.

Title Protection

Nonlicensed individuals are prohibited from using the title *"Physician Assistant," "Licensed Physician Assistant," "Minnesota Licensed Physician Assistant" or "PA," "Orthopedic Physician Assistant-Certified" or "O.P.A.-C."* Physician assistants who elect to place their license on inactive status do not pay renewal fees and shall not practice as a physician assistant. Practicing as a physician assistant with a lapsed license or license on inactive status is grounds for disciplinary action. The Board enforces the requirements of the physician assistant licensure system and provides information to consumers and other interested persons.

Permanent License

The law provides the following requirements for licensure: 1) current certification from National Commission on Certification of Physician Assistants; and 2) is not under current discipline as a physician assistant unless Board considers the condition for licensure.

Temporary License

A temporary license is available to applicants who meet all the requirements for permanent licensure and wish to practice before final approval is granted by the Board.

Notice of Intent to Practice

A Notice of Intent to Practice must be submitted to the Board prior to beginning practice as a PA. Individuals who practice without submitting a Notice shall be subject to disciplinary action unless care is provided during a disaster or emergency. A new Notice must be submitted to the Board when there is a change in primary supervising physician or place of employment. A Notice is required for each place of employment. A revised and updated Notice must be submitted when significant changes (e.g. change in delegated prescribing authority) are made by the physician-PA team. Evidence of review of the Notice of Intent to Practice and Delegation Agreement must be provided to the Board on the renewal form to ensure current practice is reflected.

Physician-Physician Assistant Delegation Agreement

This delegation agreement may or may not have prescribing privileges. To establish eligibility to prescribe, a physician assistant must be: 1) currently licensed with the Board; 2) currently certified by the National Commission on Certification of Physician Assistants; and 3) have a physician-physician assistant delegation agreement with prescribing privileges delegated by the supervising physician in the delegation agreement. The delegation agreement is documentation that a Minnesota licensed physician accepts full medical responsibility for the performance, practice, and activities of a physician assistant in accordance with the role delineation set forth in the delegation agreement. The delegation must be appropriate to the physician assistant's practice, within the physician assistant's training and experience, and services customary to the supervising physician's practice. The delegation agreement must be kept on file at the practice site and reviewed at least annually at PA license renewal time. The supervising physician cannot supervise more than five full-time equivalent physician assistants simultaneously. With the approval of the Board or in a disaster/emergency situation pursuant to Minn. Stat. §147A.23, a supervising physician may supervise more than five full-time equivalent physician assistants simultaneously. Physician assistants may provide services in a practice site geographically remote from the supervising physician. Failure to maintain annually reviewed and updated agreements, internal protocols or prescribing delegation is grounds for disciplinary action.

Continuing Education

Each licensed physician assistant must obtain 50 contact hours of Category 1 continuing education every two years or take the National Commission on Certification of Physician Assistants exam during the last two years as a condition of licensure renewal. Newly licensed physician assistants commence their two year cycle on July 1 immediately following the date licensure was granted.

Renewal Cycle

Licenses must be renewed annually on or before July 1 of each year. Evidence of annual review (e.g. a statement that the review has been completed) of the Notice of Intent to Practice and the Delegation Agreement must accompany the renewal. Renewal notices are sent approximately six weeks prior to expiration. It is the physician assistant's responsibility to keep the Board advised of their current address. The Board is obligated to mail the renewal application to the address on file. Failure to receive the renewal documents does not relieve physician assistants of their renewal obligation. Licenses which have lapsed for two annual renewal cycles are canceled for nonrenewal.

If any part of this Fact Sheet conflicts with the rules or laws, the rules or laws take precedence. It is your responsibility to keep up with legislation. Ignorance of laws and regulations is not a defense. Call the Board offices if you have any questions.

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IMPORTANT

E-licensing Surcharge

In 2009, the legislature enacted MN Statute 16E.22 which requires state agencies to collect a temporary surcharge of 10% of no less than $5.00 and no more than $150.00 for the initial license application and license renewal fees for business, commercial, professional, and occupational licenses. These fees must be collected whether the application is made by paper or online and must be collected from July 2009 through June 2015 for the Minnesota Office of Enterprise Technology to fund a statewide electronic licensing system. Since 2009, the Board of Medical Practice has utilized our reserve fund to meet this requirement on our licensee's behalf, but our reserve fund is now depleted and we are obligated by law to collect the surcharge directly from our applicants and licensees.

Effective November 1, 2010, the following fees (including the e-licensing surcharge) must be submitted with the initial application or the application will be returned. The fees below do not include the temporary permit fee. There is no surcharge for a temporary permit.

Profession	Fee*
Acupuncture	$330
Athletic Trainer	$165
Naturopathic Doctor	$385
Physician	$431.20
Physician Assistant	$280.50 with prescribing
	$258.50 without prescribing
Respiratory Therapist	$209
Telemedicine	$192.50
Traditional Midwife	$220

*Includes initial application fee, annual fee, and e-licensing surcharge.

IMPORTANT

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PHYSICIAN ASSISTANT
Instructions

Enclosed is your application for licensure as a Physician Assistant (PA). Please thoroughly review these materials before submitting your application. Any processing fees incurred are your responsibility. The Board reserves the right to reject any outdated applications submitted; therefore, it is recommended that you use the application in a timely manner. Incomplete applicant files will be destroyed after six months of inactivity.

Application

Important: Although it is no longer a requirement for initial licensure, a Notice of Intent to Practice must be submitted to the Board prior to beginning practice as a Physician Assistant.

The following requirements **must be sent directly to the Minnesota Board from the facility/person** completing the form. It is your responsibility to make sure these forms are completed and received by our office.

- **State board verification forms.** These forms must be submitted before your application is complete. The Board must receive separate verification form completed by each state board where you have ever held a health care professional license/registration.
- **Verification of education.** This form must be completed by your PA education program and mailed directly to the Board.
- **Current NCCPA Certification, including scores.** Submit a request online through your personal record at NCCPA or in writing with your name and social security number to NCCPA by email (nccpa@nccpa.net), fax (678-417-8135), or US mail (12000 Findley Road, Suite 200, Duluth, GA 30097).
- **Recommendations** from two health professionals you have worked with during the last 5 years. At least one must be a physician other than supervising physician

In addition to the documentation requirements set forth above, all of the following requirements must be met or the entire application will be returned:

- Non-refundable $280.50 fee (w/prescribing) or $258.50 w/o prescribing ($132 application + $148.50 annual w/prescribing or $126.50 w/o prescribing. The annual fee will be prorated at first renewal. Make checks payable to the **Minnesota Board of Medical Practice.**
- Account for all your time since graduation from high school to the date of application. During continuous years of education, periods of three months or less (summer break) need not be accounted for.
- The name on the application and the name on the certificate must be the same. If there has been a name change, submit a *notarized* copy of the supporting documentation, e.g. marriage license.
- A full face, recent, 2x3" photograph must be affixed as indicated on the application and *notarized* as a true likeness.
- *Notarized* copy of NCCPA certificate.
- Any other information requested by the board.

Supervising Physicians

Licensed PAs are required to work under a supervising physician. PAs cannot practice until a supervising physician has been obtained and a Notice of Intent to Practice form has been submitted to the Board. This document outlines the scope of the PAs practice in regard to physician

supervision, practice sites, and delegation of prescribing authority. Licensed PAs who do not have a Delegation Agreement in place are not permitted to practice. The Delegation Agreement is not submitted to the Board, but must be kept on file at the employment site. A physician can supervise up to five full-time equivalent PAs at one time. With the approval of the Board or in a disaster/emergency situation pursuant to Minn. Stat. §147A.23, a supervising physician may supervise more than five full-time equivalent PAs simultaneously.

Permanent Licensure Process

Applicants are granted permanent licensure by the Board of Medical Practice six times per year at Board meetings. In order to be granted permanent licensure by the Board, the Physician Assistant Advisory Council must first approve your application and recommend approval to the Board. Council meetings are held 3-4 weeks before Board meetings. For an application to be reviewed by the Council, the applicant must meet all application filing deadlines associated with that particular Council meeting date. *These deadline dates are included with your application.* Board meetings are held during every odd-numbered month generally on the second Saturday.

Temporary License ($60 fee)

A temporary license may be requested by an applicant who meets all the requirements for licensure and who wishes to practice before final approval is granted by the Board. In order for a temporary license to be granted, the application for permanent licensure must be complete, and a completed temporary license application form and $60 fee must be received by the Board. A temporary license cannot be issued without the required documentation and fees. The temporary license is valid from the date of approval until the next Board meeting at which a decision is made on the application.

Application Fees

Please be aware that all fees are non-refundable. Fees submitted will not be refunded if it is determined that you are not eligible for licensure.

Permanent Licensure Fee: $280.50 w/prescribing or $258.50 w/o prescribing ($132 application + $148.50 annual w/prescribing or $126.50 w/o prescribing)

This fee must be sent with a completed Application for Licensure form. Applicants who apply for a temporary license must also submit an application for permanent licensure.

Temporary Licensure Fee: $60

This fee must be sent with a completed temporary license application form.

Annual Fee: $148.50 (with prescribing) or $126.50 without prescribing)

To be paid by all licensed physician assistants annually. The first renewal fee will be pro-rated.

How to Apply

If you qualify for licensure and would like an application or if you have specific questions about the application process and would like to talk to someone, please call the Board at 612-617-2130. Address all written correspondence to:

MN Board of Medical Practice – PA Licensure
University Park Plaza
2829 University Ave SE – Suite 500
Minneapolis, MN 55414-3246

Applicants are required to submit written notification to the Board within 30 days of any name or address change. The law takes precedence over any conflicts between these instructions and the law.

Note: To apply for a DEA number/registration, call 612-344-4100.

APPLICATION FOR PHYSICIAN ASSISTANT LICENSE

MINNESOTA BOARD OF MEDICAL PRACTICE
University Park Plaza
2829 University Avenue SE, Suite 500
Minneapolis, Minnesota 55414-3246
612-617-2130 or www.bmp.state.mn.us

Hearing Impaired-Minnesota Relay Service
Metro Area 297-5353
Outside Metro Area 1-800-627-3529

FOR BOARD USE ONLY

APPLICATION #: _____
CHECK/RECEIPT #: _____
AMT PAID: _____
TEMP LICENSE #: _____
BOARD DATE: _____
LICENSE #: _____

ACCOUNT CODE	AMOUNT
635019 w/pres	
635020 app	
635048 w/o	
635049 tl	
513122 sur	

Date of Application:

MONTH	DAY	YEAR

Instructions to Applicant

1. Enter all dates as Month/Day/Year.
2. Please type or print and answer all questions completely and accurately. Failure to answer all questions completely and accurately, and/or omission or falsification of material facts may be cause for denial of your application, or disciplinary action if you are subsequently licensed by the Board.
3. Have attached forms completed and submitted to our office, where applicable.
4. Read the attached statutes regarding physician assistant licensure.
6. See the attached Licensure Instructions for information regarding fees to be submitted with your application.
7. The name you enter must exactly match the name on your physician assistant certificate or documentation of formal name change must be submitted.
8. The application fee is not refundable.
9. Incomplete applications will be destroyed after six months inactivity.

Your Current Name and Address

Full Legal Name: Last	First	Middle
Street Address:		
City:	State or Province:	Zip Code: / Country:
Home Phone: / Other Phone:	Gender ☐ Male ☐ Female	Other Names:
Social Security or Alien Registration Number:		

Record of Birth

Birthdate (Mo/Day/Year) / /	City of Birth:	State of Birth:	Country of Birth:

NCCPA Certification (*)

Date of Certification (Mo/Day/Year) / /	Certificate Number:	Expiration Date (Mo/Day/Year) / /
Primary Specialty:	Secondary Specialty:	

(*) Attach Notarized Copy of National Commission on Certification of Physician Assistants (NCCPA)

Preliminary Education

Name of High School:	City:	State or Province:	Zip Code:	From Date:	To Date:
Name of College:	Cite:	State or Province:	Zip Code:	From Date:	To Date:
Type of Degree:	Name of Issuing School:	City:	State or Province:	Date Degree Received:	

Physician Assistant Education and Training

Institution	City	State	Zip Code	From Date Month/Day/Year	To Date Month/Day/Year	Degree/ Certificate

Other Education and Training

Institution	City	State	Zip Code	From Date Month/Day/Year	To Date Month/Day/Year	Degree/ Certificate

STATES/PROVINCES/COUNTRIES IN WHICH YOU ARE OR HAVE BEEN LICENSED OR REGISTERED
List all health professional licenses

State/Province/Country	Health Profession	License/Registration Number	Date Issued Month/Day/Year	Exam

Drivers License

State:	License Number:

Activities

List below, in chronological order, all activities including post-graduate training, hospital or clinic affiliations, and period of unemployment. Account for all time since graduation from high school.

From Date	To Date	Position

Name of Facility			
Street Address	City	State	Zip Code

From Date	To Date	Position

Name of Facility			
Street Address	City	State	Zip Code

From Date	To Date	Position

Name of Facility			
Street Address	City	State	Zip Code

From Date	To Date	Position

Name of Facility			
Street Address	City	State	Zip Code

From Date	To Date	Position

Name of Facility:			
Street Address	City	State	Zip Code

From Date	To Date	Position

Name of Facility			
Street Address	City	State	Zip Code

From Date	To Date	Position

Name of Facility			
Street Address	City	State	Zip Code

From Date	To Date	Position

Name of Facility			
Street Address	City	State	Zip Code

Except for questions 1-4, please answer all questions by selecting Yes or No and provide an explanation when requested. Questions 1-4 do not have "No" as an option for confidentiality reasons. If you have a condition addressed by questions 1-4 and you are NOT participating in Health Professionals Services Program (HPSP) for monitoring of the condition, you must answer "Yes" to the applicable questions(s). If you do not have this condition, OR if you are participating in HPSP for monitoring of this condition, do not answer the applicable question(s). For questions 1-2, the terms "impaired" and "limited" include but are not limited to impairments or limitations related to physical, psychological, or emotional disorders or conditions, or chemical dependency or chemical abuse. The purpose and intended us of this information is to enable the Board to determine whether you meet statutory and rule requirements for licensure. This information is classified as private while your application is pending and public after your renewal is granted. Exception: "Yes" answers are confidential during any investigation and private thereafter. This information will NOT be included in the profiling. If responses to questions change during the time your application is pending, you must make the board aware of the new information.

Y

1. Is your cognitive, communicative, or physical ability to engage in the practice as a physician assistant with reasonable skill and safety been impaired or limited in any way? Please describe.

Y N 1a. If yes, are the limitations or impairments reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? Please describe.

Y N 1b. If yes, are the limitations or impairments reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? Please describe.

Y

2. Does your use of alcohol or chemical substances(s), including prescription medications, in any way impair or limit your ability to practice as a physician assistant with reasonable skill and safety? Please describe.

Y

3. Are you engaged in any illegal use of controlled substances including use of illegal controlled substances (e.g. heroin, cocaine) or illegal use of legal controlled substances (i.e. not obtained pursuant to a valid prescription of a licensed health care provider). Please describe.

Y N 3a. If yes, have you taken any steps (i.e. treatment, psychotherapy, participation in a support group) to discontinue or reduce such use? Please describe.

Y N 3b. If yes, are you now participating in a supervised rehabilitation program or professional assistance program which has as a component a monitoring regimen designed to assure that you are not currently engaging in the use of illegal controlled substances? Please describe.

Y

4. Have you within the past five years been advised by your treating physician that you have a mental, physical, or emotional condition, which, if untreated, would be likely to impair your ability to practice as a physician assistant with reasonable skill and safety? If you answer this question 'yes'', please answer the following:

Y N 4a. With regard to any condition referenced above, are you being treated so that such impairment is avoided?

Y N 4b. With regard to any condition referenced above, are you in compliance with the recommended treatment?

Y N 4c. With regard to any condition referenced above, has your treating physician advised you that you are able to practice as a physician assistant with reasonable skill and safety?

4d. Please explain._____

4e. Identify your treating physician._____

Y N

5. Have you ever been diagnosed as having or have you been treated for pedophilia, exhibitionism, voyeurism, or other sexual behavior disorders? Please describe.

Y N

6. Have you ever been the subject of an investigation by any Federal, State, or Local agency having jurisdiction over controlled substances? If so, give particulars.

Y N	7. Have you ever been denied a registration/certification/licensure or the privilege of taking a physician assistant certifying examination or has a conditioned registration/certificate/license ever been issued to you by any state board or other licensing authority? If so, give particulars.
Y N	8. Has your license/registration/certificate to practice as a physician assistant in any state or country ever been voluntarily or involuntarily (i.e. by State Board Order or any other form of disciplinary action) revoked, suspended, restricted, or conditioned by a State Board or other licensing authority? If so, give particulars.
Y N	9. Have you ever been notified of any investigations by any state board, physician assistant society, certifying authority or any health facility of any complaints against you relative to the practice as a physician assistant, or have you been reprimanded or censured by any physician assistant society or licensing board? If so, give particulars.
Y N	10. Have you ever been a defendant in any malpractice lawsuits, had any malpractice settlement, or have any pending? If so, give a detailed clinical explanation of each case as well as documentation of outcome (insurance papers or court documents).
Y N	11. Have you ever been denied, restricted, or revoked staff affiliations with a hospital, nursing home, clinic, or other health care facility? If so, give particulars.
Y N	12. Have there been any criminal charges filed against you? This includes charges of disorderly conduct, assault or battery, or domestic abuse, whether the charges were misdemeanor, gross misdemeanor, or felony. This also includes any offenses which have been expunged or otherwise removed from your record by executive pardon. If so, give particulars including the date of conduct, state and local jurisdiction in which the charges were filed.
Y N	13. Have there been any charges of Driving While Intoxicated (DWI) or Driving Under the Influence (DUI) or other impaired driving offenses involving alcohol or other chemicals filed against you? If so, give particulars, including the date of conduct, state and local jurisdiction in which the charges were filed, a detailed explanation of the incident and consequences, results of a CD evaluation, current drinking habits, and court documents.

RIGHTS OF SUBJECTS OF DATA

This information is requested by the Minnesota Board of Medical Practice. The purpose and intended use of this information is to enable the Board to determine whether you meet statutory and rule requirements for licensure. The information is classified as private while your application is pending or if your application is denied, and as public if your license is granted. You are required to submit this information. Your application will not be processed without it and the form will be returned to you for completion. This information may be used as the basis for further investigation by the Board into your qualifications. Under some circumstances, the information could become available to other agencies or persons authorized by law to have access. Attach a separate page for detailed explanations, when appropriate. Failure to answer all questions completely and accurately, and/or omission or falsification of material facts may be cause for denial of your application, or disciplinary action if you are subsequently licensed by the Board.

Affidavit of Applicant:

State of: _____

County of: _____

I, _____, swear that I am the person described and identified; that I have not engaged in any of the acts prohibited by the statutes of Minnesota: that I am the person named in the diploma, which accompanies this application; that I am the lawful holder of said diploma; that said diploma was procured in the regular course of instruction and examination without fraud or misrepresentation.

I hereby authorize all educational institutions, hospitals, medical institutions or organizations, clinics, my references, personal physicians, employers (past and present), business and professional associates (past and present), all Governmental agencies and instrumentalities (local, state, federal or foreign) to release to this licensing Board any information, files, or records including (but not limited to) transcripts, medical records, personnel files, and any information, favorable or otherwise, the Board may require for its evaluation of my professional, ethical, and physical qualifications for licensure in Minnesota.

I hereby release, discharge, and exonerate the Board, its agents, and representatives, and any person furnishing information to the Board from any and all liability of every nature and kind arising out of the furnishing of oral information or of documents, records, or other information to the Board.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension or revocation of my license to practice as a physician assistant in Minnesota. I understand that I am required to update my application with pertinent information to cover the time period between date of application and date approved by the Board.

Sworn to before me this _____ day of _____ , _____ . _____

Signature of Applicant

_____

Signature of Notary Public

My Commission Expires: _____

Certification of Identification
(Certification of Notary Public is required.)

Paste a recent photo, front-view passport-type photo in this square

I certify that on the date set forth below, the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document. Sworn to before me by the applicant

on this _____ day of _____ , _____.

Notary Seal

Signature of Notary Public _____

Expiration Date _____ / _____ / _____

_____

Signature of Applicant

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BUSINESS ADDRESS

Effective August 1, 2012, Minn. Stat. §214.073 requires licensees to provide their primary business address at the time of initial application and all subsequent renewals. Your primary business address is public and you are required to submit it for application purposes. Your license will not be issued without it unless you check the box below certifying that you are not currently in the workforce related to your practice.

Facility name _____

Street _____

City _____State_____ Zip_____

☐ I certify that I am not currently in workforce related to my practice, and I don't have a business address related to my practice.

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PHYSICIAN ASSISTANT
Verification of Physician Assistant Education

This form is for certification of physician assistant education and must be completed and **mailed by the facility directly to the Minnesota Board of Medical Practice**. Any processing fees are the applicant's responsibility. The applicant's signature authorizes release of information, favorable or otherwise, directly to the Board.

Print Name: ____ SS#:____________________

Signature:____ Date:______________

Date of Degree(mo/day/yr)____________________ Degree Received________________
* *

The School completes the following information:

It is hereby certified that:____
(Name of Applicant)

Matriculated in:____
(Name of School)

Program located at: ____
(City/State of School)

And received a diploma conferring:_________________________ On:_______________
(Degree) (Mo/Day/Year

Program accredited by: (check one)

___ Commission on Allied Health Education and Accreditation (CAHEA), Commission on Accreditation of Allied Health Education Programs (CAAHEP), or a successor agency
___ Accreditation Review Committee on Education for the Physician Assistant (ARC-PA)
___ Other (explain)______________________

Any disciplinary action? Yes*______ No______

Any derogatory information on file? Yes*______ No______

President, Secretary Dean, Registrar

School Seal**

Print Name:____________________________

Signature:_____________________________

Title: ________________________________

Date: _________________________________

Phone: ____________ Fax_______________

***Please** attach letter of explanation.
****If there is no seal, attach letter of explanation on letterhead.
5/09

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PHYSICIAN ASSISTANT
Verification of NCCPA Certification

This form is for verification of National Commission on Certification of Physician Assistants (NCCPA) certification. Complete the top portion of this form and mail to the NCCPA. **<u>This form must be mailed directly by the NCCPA to the Minnesota Board of Medical Practice</u>**. Any fees are the applicant's responsibility. The applicant's signature authorizes release of information, favorable or otherwise, directly to the Board. Alternatively, you may request a verification online from NCCPA. See Instructions.

Print Your Name: ______________________________SS#: _____________________

Signature: ___________________________________ Date: _______________________

* *
*

The NCCPA completes the following information:

It is hereby certified that: ____
(Name of Applicant)

Was issued a certification by the National Committee on Certification of Physician Assistants (NCCPA) on:

____
(Month / Day / Year)

Expiration date is: ____
(Month / Day / Year)

Any disciplinary action?: Yes*______ No ______

Print name:_________________________

Seal** Signature: __________________________

Title: _______________________________

Date: _______________________________

*If yes, please attach letter of explanation.
**If there is no seal, attach letter of explanation on letterhead. 5/09

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PHYSICIAN ASSISTANT
Verification of Licensure/Registration

This form is for verification of all physician assistant and other health care professional licenses or registrations from every board issuing any type of license including training and temporary permit even if license is not current. **Each Board completing the form must mail directly to the Minnesota Board of Medical Practice.** Any fees are the applicant's responsibility. The applicant's signature authorizes release of information, favorable or otherwise, directly to the Board.

Print Your Name:____________________________SS#: ____________________

Signature: ____________________________ Date: ________________________

* *

The State Board completes the following information:

It is hereby certified that: ____
(Name of Applicant)

Date of birth: ____
(Month / Day / Year)

Was issued license/registration number: ________________________________

By: ______________________________ On:______________________________
(State) (Month / Day / Year)

Expiration date is:____
(Month / Day / Year)

Issued on the basis of: ____

Disciplinary action ever initiated, pending, or invoked? Yes*______ No______

Ever voluntarily relinquished license? Yes*______ No ______

State Seal**

Print name: ________________________

Signature: ________________________

Title: ____________________________

Date: ____________________________

*If yes, please attach letter of explanation.
**If there is no seal, attach letter of explanation on letterhead.
5/09

MINNESOTA BOARD OF MEDICAL PRACTICE
University Park Plaza • 2829 University Avenue SE Suite 500 • Minneapolis, MN 55414-3246
Telephone (612) 617-2130 • Fax (612) 617-2166 • www.bmp.state.mn.us
MN Relay Service for Hearing Impaired (800) 627-3529

PHYSICIAN ASSISTANT
Recommendation Form

This form must be completed and mailed directly to the Minnesota Board of Medical Practice by two persons with whom applicant has worked with during the last five years. At least one must be a physician or osteopath other than a supervisor of the applicant. The applicant's signature authorizes release of information, favorable or otherwise, directly to the Board.

Print Applicant Name____

Signature__________________________________ Date_______________________

* *

THE PERSON SERVING AS A REFERENCE COMPLETES THE FOLLOWING INFORMATION:

RECOMMENDATION FOR: (Print name of Applicant)______________________________

1. How long have you known the applicant?______________________________

2. What has been the nature of your relationship with the applicant?___________

   ____

3. How would you characterize the moral and professional conduct of the applicant?____

4. Would you recommend the applicant for approval for licensure for the practice as a physician assistant?____

   ____

5. Place a checkmark by the word(s) which best describe this applicant.

   A. Clinical Skills: ______Marginal* ______Fully Meets Standards

   B. Any indication of chemical dependency? ______Yes* ______No

   C. Any indication of malprescribing: ______Yes* _____No

   ***Please attach letter of explanation**

* *

Completed By:

Printed Name_________________________________ Signed____________________

Health Profession__________________________ License #________ State________

Date____________ Phone#______________ Fax_____________ Email____________

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PHYSICIAN ASSISTANT
Recommendation Form

<u>This form must be completed and mailed directly to the Minnesota Board of Medical Practice by two persons</u> with whom applicant has worked with during the last five years. At least one must be a physician or osteopath other than a supervisor of the applicant. The applicant's signature authorizes release of information, favorable or otherwise, directly to the Board.

Print Applicant Name____

Signature_______________________________ Date_____________________

* *

THE PERSON SERVING AS A REFERENCE COMPLETES THE FOLLOWING INFORMATION:

RECOMMENDATION FOR: (Print name of Applicant)____________________________

1. How long have you known the applicant?____________________________

2. What has been the nature of your relationship with the applicant?___________

   ____

3. How would you characterize the moral and professional conduct of the applicant?____

4. Would you recommend the applicant for approval for licensure for the practice as a physician assistant?____

   ____

5. Place a checkmark by the word(s) which best describe this applicant.

   A. Clinical Skills: ______Marginal* ______Fully Meets Standards

   B. Any indication of chemical dependency? ______Yes* ______No

   C. Any indication of malprescribing: ______Yes* _____No

   ***Please attach letter of explanation**

* *

Completed By:

Printed Name______________________________ Signed____________________

Health Profession__________________________ License #________ State________

Date____________ Phone#______________ Fax_____________ Email____________

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Treating Physician Statement

Applicant: Applicants who have a medical condition during the last five years which, if untreated, would be likely to impair their ability to practice with reasonable skill and safety must have their treating physician complete this form. A treating physician is the physician who diagnosed and provides or provided treatment for the condition and includes the current treating physician.

Treating Physician: Complete and mail this form directly to the Minnesota Board of Medical Practice. This form is also available on our website.

Applicant's Printed Name_____

Applicant's Date of Birth (Mo/Day/Yr)_____ Health Profession_____

I hereby authorize you, my treating physician, to disclose my medical records to the Minnesota Board of Medical Practice. I hereby release, discharge, and exonerate the Board, its agents, and representatives, and any person furnishing information to the Board from any and all liability of every nature and kind arising out of the furnishing oral information or documents, records, or other information to the Board.

Signed_____ Date_____

Nature of medical condition including diagnosis and significant symptoms

Date first saw patient: _____ **Date last saw patient:** _____

Has the applicant been compliant with treatment? (If no, please explain)
☐ Yes ☐ No

What medications is the applicant taking for this condition?

If this medical condition was untreated, would it be likely to impair the applicant's ability to practice with reasonable skill and safety? (If yes, please explain) ☐ Yes ☐ No

Should the condition be monitored? (If yes, please explain) ☐ Yes ☐ No

Treating Physician (print name)_____

Signature_____ Date_____

Phone_____ Fax_____

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PHYSICIAN ASSISTANT
Temporary License Request

A temporary license is available for physician assistants who have applied for permanent licensure and have complied with all requirements and wish to practice prior to the next Board meeting at which the application would be considered. Upon request, temporary license will be issued after eligibility for licensure has been established and the credentialing and verification process has been completed. This process usually takes several weeks. The Board may, at its discretion, issue a temporary license under the above conditions. A temporary license is valid only until the next Board meeting at which a decision is made on the application.

Applicants requesting a temporary license must complete this form and submit a non-refundable $60 fee. This fee is in addition to the application and permanent license fees. Please make checks payable to the Minnesota Board of Medical Practice.

Name_____
(Please Print)

Temporary license will be used at the following proposed practice location:

_____
(Hospital/Clinic)

_____
(Street)

_____
(City/State/Zip Code)

Professional telephone number: _____
(Including Area Code)

Anticipated date of commencing practice at proposed practice location:

_____
(Mo/Day/Yr)

Mailing address for temporary license:

_____

_____

_____

_____

Physician Assistant

Notice of Intent to Practice

(formerly Practice Setting Description)

MINNESOTA BOARD OF MEDICAL PRACTICE
University Park Plaza • 2829 University Avenue SE, Suite 500
Minneapolis, Minnesota 55414-3246
612-617-2130 or www.bmp.state.mn.us
Hearing Impaired-Minnesota Relay Service
Metro Area 297-5353
Outside Metro Area 1-800-627-3529

Month	Day	Year

Instructions

1. This form must be completed and submitted to the Board prior to beginning practice as a PA. Individuals who practice without submitting a Notice shall be subject to disciplinary action unless care is provided during disaster or emergency.
2. Complete all parts of the application. Incomplete Notices will not be accepted. Type or print for clarity.
3. The address and phone number listed is public information.
4. Physicians may only delegate prescribing authority to the extent of their own authority. PAs should review the physician's license status by searching their Professional Profile on the Board's website.
5. A supervising physician shall not supervise more than five full-time equivalent PAs simultaneously without the approval of the Board except when responding to disaster situations under Minn. Stat. 147A.23.
6. A new Notice must be submitted to the Board when there is a change in primary supervising physician or place of employment. A Notice is required for each place of employment.
7. A revised and updated Notice must be submitted when significant changes (e.g. change in delegated prescribing authority) are made by the physician-PA team. Evidence of review of the Notice of Intent to Practice and Delegation Agreement must be provided to the Board on the renewal form to ensure current practice is reflected.

Identification

Physician Assistant's Name (first,middle,last) _____

Business Address_____City, State, Zip_____

License #_____ Specialty_____DEA#_____ Phone_____ Email_____

Primary Supervising Physician(first,middle,last) _____

Business Address_____City, State, Zip_____

License #_____ Specialty_____ DEA #_____ Phone_____ Email_____

Current Delegation Agreement is on file at the following location:_____

Date expected to commence practicing_____

Does this Notice replace a previous Notice? If so, what is the name of primary supervising physician and termination date?_____

Prescribing Privileges

Supervising physicians may delegate to physician assistants who meet the criteria in Minn. Stat. §147A.18 Subd 1, the authority to prescribe, dispense and administer legend drugs, controlled substances, and medical devices. The supervising physician is responsible for determining if the PA is qualified and knowledgeable to prescribe the medications delegated. It is recommended the PA be provided with a list of medications for their use. The supervising physician may alter medications on the list at any time without board approval as long as the physician understands and determines the PA is qualified and knowledgeable in the use of these medications. The physician is ultimately responsible for the prescriptive practice of the PA.

Expiration Date of NCCPA Certification (must be current in order to prescribe) _____

Delegated Prescribing Authority (check one)

☐ No, this PA does not qualify under Chapter 147A and/or I do not wish to delegate such authority.

☐ Not yet, this PA does not currently qualify under Chapter 147A. Once this PA is NCCPA certified and has a temporary permit or license, I wish to delegate prescribing, dispensing and administering privileges.

☐ Yes, this PA qualifies under Chapter 147A PA Practice Act and I wish him/her to have prescribing, dispensing, and administering privileges.

PRACTICE SITES

Specify each practice location and indicate the type of patient care setting which best describes each practice site. Indicate the approximate percentage of time spent in each setting, and type(s) of supervision provided for each location.

Please Note: A physician assistant may be employed in more than one practice, and thus may have more than one Delegation Agreement in effect. The practice sites listed here should only include those pertinent to this specific physician-physician assistant Delegation Agreement.

Setting Codes
C = Office/Clinic
UC = Urgent Care Center
H = Hospital
ER = Hospital Emergency Room
LT = Long Term Care Facility
OO = Outpatient Other
HO = Hospital Other

Supervision Codes:
OS = On-Site
TC = Telecommunications
O = Other, please specify

PRIMARY PA PRACTICE SITE	SETTING	% OF PRACTICE	SUPERVISION	PHONE #	
STREET ADDRESS		CITY		STATE	ZIP CODE
OTHER PA PRACTICE SITE	SETTING	% OF PRACTICE	SUPERVISION	PHONE #	
STREET ADDRESS		CITY		STATE	ZIP CODE
OTHER PA PRACTICE SITE	SETTING	% OF PRACTICE	SUPERVISION	PHONE #	
STREET ADDRESS		CITY		STATE	ZIP CODE
OTHER PA PRACTICE SITE	SETTING	% OF PRACTICE	SUPERVISION	PHONE #	
STREET ADDRESS		CITY		STATE	ZIP CODE
OTHER PA PRACTICE SITE	SETTING	% OF PRACTICE	SUPERVISION	PHONE #	
STREET ADDRESS		CITY		STATE	ZIP CODE

ATTEST

A. Physician Assistant

I hereby certify that I have reviewed and understand the current laws pertaining to physician assistants and fully understand my responsibilities and that I have a physician-physician assistant Delegation Agreement in force and on file at the practice site.

PA Name (Printed) ______________________________________ PA Signature______________________________________

License # ____ Date____

B. Primary Supervising Physician

I hereby certify that I have reviewed and understand the current laws pertaining to physician assistants. I have reviewed and understand the physician-physician assistant Delegation Agreement between the physician assistant and myself. I have reviewed and agree to abide by the terms of the Notice of Intent to Practice, Delegation Agreement, and applicable state laws and rules. I agree to provide adequate supervision and to accept full medical responsibility for medical care rendered by the physician assistant named above.

Physician Name (Printed) _________________________________ Physician Signature_________________________________

License # ____ Date____

Physician – Physician Assistant

Delegation Agreement

(formerly Supervising Agreement)

MINNESOTA BOARD OF MEDICAL PRACTICE
University Park Plaza • 2829 University Avenue SE, Suite 500
Minneapolis, Minnesota 55414-3246
612-617-2130 or www.bmp.state.mn.us
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Metro Area 297-5353
Outside Metro Area 1-800-627-3529

Month	Day	Yeav

Instructions

1. Complete all parts of the Delegation Agreement. Any part that does not apply, mark "N/A" for clarity of the PAs intended scope of practice.
2. Primary and alternate supervising physicians must review and understand the current Minn. Stat. §147A regarding PA licensure, practice, supervision, and delegation of prescribing.
4. Supervising physicians may only delegate prescribing within their license authority and to a PA who is currently NCCPA certified.
5. The Delegation Agreement must be kept on file at the practice site and reviewed at least annually at PA license renewal time. **Do not submit to the board unless requested.**

Identification

Physician Assistant's Name (first,middle,last) _____

Signature_____ License #_____ Specialty_____

Primary Supervising Physician(first,middle,last) _____

Signature_____ License #_____ Specialty_____

Physician Supervision

Minn. Stat. §147A.01 Subd. 21 defines **Supervising physician** as "a Minnesota licensed physician who accepts full medical responsibility for the performance, practice, and activities of a physician assistant under agreement as described in section 147A.20. The supervising physician who completes and signs the delegation agreement may be referred to as the primary supervising physician. A supervising physician shall not supervise more than five full-time equivalent physician assistants simultaneously. With the approval of the board, or in a disaster or emergency situation pursuant to section 147A.23, a supervising physician may supervise more than five full-time equivalent physician assistants simultaneously."
Minn. Stat. §147A.01 Subd. 22 defines **Supervision** as "overseeing the activities of, and accepting responsibility for, the medical services rendered by a physician assistant. The constant physical presence of the supervising physician is not required so long as the supervising physician and physician assistant are or can be easily in contact with one another by radio, telephone, or other telecommunication device. The scope and nature of the supervision shall be defined by the individual physician-physician assistant delegation agreement."

Manner by which supervision will be accomplished. (A narrative description is acceptable).

Review of services provided by the physician assistant shall be accomplished by (choose one or more):

___ On site review ___ Telecommunication ___ Other:

Annual Delegation Agreement Review

Primary Physician Initials_____ Date_____	Primary Physician Initials_____ Date_____
Physician Assistant Initials Date	Physician Assistant Initials Date
Primary Physician Initials_____ Date_____	Primary Physician Initials_____ Date_____
Physician Assistant Initials_____ Date_____	Physician Assistant Initials_____ Date_____

Practice Sites

Practice locations are specified on the Notice of Intent to Practice, which is submitted to the Board. A copy of this submission should be kept at the practice site. Any changes in the practice site(s) associated with this Delegation Agreement should be indicated on an amended Notice, which must be submitted to the Board.

Delegation of Medical Services

As stated in Minn. Stat. §147A.09 Subd. 1, physician assistants shall practice medicine only with physician supervision. Physician assistants may perform those duties and responsibilities as delegated in the physician-physician assistant Delegation Agreement maintained at the address of record by the supervising physician and physician assistant, including the prescribing, administering, and dispensing of medical devices and drugs, excluding anesthetics, other than local anesthetics, injected in connection with an operating room procedure, inhaled anesthesia and spinal anesthesia.

Patient services must be limited to services within the training or experience of the physician assistant, services customary to the practice of the supervising physician, services delegated by the supervising physician, and services within the parameters of the laws, rules and standards of the facilities in which the physician assistant practices.

Orders of physician assistants shall be considered the orders of their supervising physicians in all practice-related activities, including, but not limited to, the ordering of diagnostic, therapeutic, and other medical services.

The Supervising Physician should indicate below the patient services s/he chooses to delegate to the physician assistant. Indicate "yes" for those delegated or "no" for each item. Attach a separate sheet, if necessary, and cite this below.

☐ No ☐ Yes 1. Take patient histories and develop medical status reports

☐ No ☐ Yes 2. Perform physical examinations

☐ No ☐ Yes 3. Interpret and evaluate patient data

☐ No ☐ Yes 4. Order or perform diagnostic procedures

☐ No ☐ Yes 5. Order or perform therapeutic procedures

☐ No ☐ Yes 6. Provide instructions regarding patient care, disease prevention, and health promotion

☐ No ☐ Yes 7. Assist the supervising physician in patient care in the home and in health care facilities

☐ No ☐ Yes 8. Create and maintain appropriate patient records

☐ No ☐ Yes 9. Transmit or execute specific orders at the direction of the supervising physician

☐ No ☐ Yes 10. Prescribe, administer, and dispense drugs, controlled substances and medical devices in accordance with section 147.18 and chapter 151 per Delegation Agreement.

☐ No ☐ Yes 11. For physician assistants not delegated prescribing authority, administering legend drugs and medical devices following prospective review for each patient by and upon direction of the supervising physician.

☐ No ☐ Yes 12. Function as an emergency medical technician with permission of the ambulance service and in compliance with section 144E.127 and ambulance service rules adopted by the Emergency Medical Services Regulatory Board.

☐ No ☐ Yes 13. Initiate evaluation and treatment procedures essential to providing an appropriate response to emergency situations.

☐ No ☐ Yes 14. Perform and sign the documentation for Department of Transportation exams

☐ No ☐ Yes 15. Perform and sign the documentation for school bus driver exams

☐ No ☐ Yes 16. Request diagnostic or therapeutic radiologic procedures (including but not limited to x-rays, CT scans, MRI scans, ultrasound, nuclear imaging studies)

☐ No ☐ Yes 18. Certify a patient's eligibility for a disability parking certificate under section 169.345, subdivision 2

☐ No ☐ Yes 19. Assist in surgery

☐ No ☐ Yes 20. Provide medical authorization for the immediate detention on a 72 hour hold for a patient in danger of causing injury to self or others in accordance with 253B.05, subdivision 2

☐ No ☐ Yes 21. Order or perform diagnostic procedures, including the use of radiographic imaging systems in accordance with Minnesota Rules 2007, Chapter 4732;

☐ No ☐ Yes 22. Order or perform therapeutic procedures with the use of ionizing radiation in accordance with Minnesota Rules 2007, Chapter 4732;

☐ No ☐ Yes 23. Other (please specify) _____

☐ see addendum dated:

Delegation of Prescriptive Practice

Supervising physicians may delegate to physician assistants who meet the criteria in Minn. Stat. §147A.18 Subd 1, the authority to prescribe, dispense and administer legend drugs, controlled substances, and medical devices. The supervising physician is responsible for determining if the PA is qualified and knowledgeable to prescribe the medications delegated. The supervising physician may alter medications at any time by updating the Delegation Agreement without Board approval as long as the physician understands and determines the PA is qualified and knowledgeable in the use of these medications. The physician is ultimately responsible for the prescriptive practice of the PA.

The supervising physician(s) hereby delegate the following prescriptive practice to the physician assistant (choose one)

___ No prescriptive practice (go to page 4)

___ This PA may prescribe, dispense, or administer as indicated below:

A. Medication categories. Exceptions may be listed for any category at right.

□ No □ Yes 01 Anesthetics (note Minn. Stat. §147A.09 Subd.1) ..... _____

□ No □ Yes 02 Antiinfectives..... _____

□ No □ Yes 03 Antineoplastics & Immunosuppressants ..... _____

□ No □ Yes 04 Cardiovascular Medications..... _____

□ No □ Yes 05 Autonomic & Central Nervous System Drugs ..... _____

□ No □ Yes 06 Dermatological Drugs ..... _____

□ No □ Yes 07 Diagnostic Agents ..... _____

□ No □ Yes 08 Ear – Nose - Throat Medications ..... _____

□ No □ Yes 09 Endocrine Medications ..... _____

□ No □ Yes 10 Gastrointestinal Medications..... _____

□ No □ Yes 11 Immunologicals & Vaccines ..... _____

□ No □ Yes 12 Musculoskeletal Medications ..... _____

□ No □ Yes 13 Nutritional Products, Blood Modifiers & Electrolytes _____

□ No □ Yes 14 Obstetrical & Gynecological Medications ..... _____

□ No □ Yes 15 Ophthalmic Medications ..... _____

□ No □ Yes 16 Respiratory Medications ..... _____

□ No □ Yes 17 Urological Medications..... _____

B. Controlled Substances

□ No □ Yes 18 schedule V ..... _____

□ No □ Yes 19 schedule IV ..... _____

□ No □ Yes 20 schedule III ..... _____

□ No □ Yes 21 schedule II ..... _____

C. Medical Devices

□ No □ Yes 22 ..... _____

Review of Delegated Prescribing

147A.18 Subd. 1.(b) states: "Supervising physicians shall retrospectively review the prescribing, dispensing, and administering of legend and controlled drugs and medical devices by physician assistants, when this authority has been delegated to the physician assistant as part of the delegation agreement between the physician and the physician assistant. The process and schedule for the review must be outlined in the physician-physician assistant delegation agreement."

Indicate the process for review of delegated prescribing. (choose all that apply, or provide a narrative if desired).

___ Review a representative sample of patient care notes.

___ Audit of medical records.

___ Case discussion between supervising physician and physician assistant.

___ Other:

Indicate the schedule for review. (choose one)

___ daily ___ weekly ___ monthly ___ quarterly ___ other (specify):

ATTEST

A. Physician Assistant

I hereby certify that I have reviewed and understand the current laws pertaining to physician assistants and fully understand my responsibilities and that I have a physician-physician assistant Delegation Agreement in force and on file at the practice site.

PA Name (Printed) _____ PA Signature_____

License # _____ Date_____

B. Primary Supervising Physician

I hereby certify that I have reviewed and understand the current laws pertaining to physician assistants. I have reviewed and understand the physician-physician assistant Delegation Agreement between the physician assistant and myself. I have reviewed and agree to abide by the terms of the Notice of Intent to Practice, Delegation Agreement, and applicable state laws and rules. I agree to provide adequate supervision and to accept full medical responsibility for medical care rendered by the physician assistant named above.

Physician Name (Printed) _____ Physician Signature_____

License # _____ Date_____

C. Alternate Supervising Physicians

I have reviewed and understand the physician-physician assistant Delegation Agreement between the physician assistant and the primary supervising physician named above. When acting as the supervising physician, I agree to adequately supervise and to accept full medical responsibility for medical care rendered by the physician assistant named above.

☐ Refer to separate listing(s) dated:

Name	License #	Signature	Date	Phone #	DEA #