



**\*\*\*FOR OFFICE USE ONLY\*\*\***

Application Approved:

License Number:

Issue Date:

Signature of Board Administrator

ID#:

Receipt #:

**Rhode Island  
Board of Licensure of Physician Assistants**

Room 205  
3 Capitol Hill  
Providence, RI 02908-5097

***Instructions and Application For  
License As A***

**Physician Assistant**

by

☐ **Examination**

☐ **Endorsement**

☐ **FCVS** (See instructions on page 2)

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*Applicant - Print Name (First/MI/Last)*

☐ I am also applying for a RI Uniform Controlled Substances Registration (CSR) and I have attached the CSR application to this license application.

**Phone: (401) 222-3855**

**TTY/TDD: (800) 745-5555**

**Fax: (401) 222-2158**

Revised 12/10/2012 jcp

# GENERAL INFORMATION

## Enclosures

The following materials and information should be enclosed within this application packet:

|                                                                   |     |
|-------------------------------------------------------------------|-----|
| Application Process Overview.....                                 | 3   |
| Instructions for Completing Application.....                      | 4   |
| Application Materials                                             |     |
| Application.....                                                  | 5-8 |
| Application Checklist.....                                        | 9   |
| Interstate Verification Form - Other State License(s).....        | 10  |
| RI Uniform Controlled Substances Act Registration Form (CSR)..... | 11  |

## Licensure Requirements

### Applicants

1. Fee of **\$110.00** (or **\$310.00 with CSR**) NOTE: These application fees are **NON-REFUNDABLE**.
2. Recent passport type photograph.
3. License Verification(s) from the state(s) in which applicant holds or has held a license.
4. Official transcript from an accredited School of Physician Assistants.\*
5. Score/Certification sent directly from the National Commission on Certification of Physician Assistants (NCCPA).\*
6. National Practitioner Data Bank Self-Query

### \*FCVS

**IMPORTANT:** *If applicant provides verification of credentials by the **Federation Credentials Verification Service (FCVS)** of the **Federation of State Medical Boards (FSMB)**, requirements 4 and 5 above shall be met and said documentation need not be submitted. An application for verification of credentials by FCVS may be obtained by contacting the Federation of State Medical Boards, toll free at **1-888-ASKFCVS** (1-888-275-3287), or it can be downloaded at the Federation's web site at:*

[http://www.fsmb.org/fcvs\\_physicianassistant.html](http://www.fsmb.org/fcvs_physicianassistant.html)

## Rules and Regulations

To obtain the Rules and Regulations for your profession visit the A-Z list on the Topics & Programs page at the following web site. From the list click on the letter for your profession.

<http://www.health.ri.gov/atoz/>

**NOTE:** **ALL** physician assistant applicants must have a supervising physician who oversees the activities of, and accepts the responsibility for, the medical services rendered by the physician assistant

# APPLICATION PROCESS OVERVIEW

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The licensure process in the State of Rhode Island is conducted by the Rhode Island Department of Health (HEALTH), Office of Medical Licensure & Discipline, and the Rhode Island Board of Licensure of Physician Assistants (Board).

## **Application Process**

In addition to the application, you must submit additional information directly to the Board. All items listed on the “checklist” (page 9) must be submitted for an application to be considered complete. All applications are considered valid for 1 year from the day they are received at HEALTH. If you do not complete the application process and obtain a license within 1 year a new application must be submitted.

Please allow a minimum of 4-6 weeks for the entire licensure process to be completed. If you have malpractice criminal or disciplinary history, in Rhode Island or another state, it can take an additional 2 or 3 months for all pertinent documentation to be received, and a decision to be made regarding issuance of your license.

Licenses will be issued within 7-10 working days following approval of the license. A letter will be mailed within 3 weeks from the date of license approval to the address furnished in the application. You are responsible for notifying the Board office, in writing, if your address changes in the interim. Visit the following website to obtain a change of address form.

<http://www.health.ri.gov/forms/changeofaddress/professions.pdf>

*To obtain your license number prior to receiving your letter, please refer to the HEALTH Licensee Lookup web site:*

<https://healthri.mylicense.com/Verification/>

HEALTH will not, for any reason, accelerate the processing of one applicant at the expense of others. Once completed, the application will be reviewed, and you will be contacted in writing.

Please continue to review the remaining portions of this application packet for instructions and other materials necessary to complete the application.

It is the responsibility of the applicant to arrange for submission of ALL licensure requirements. HEALTH does NOT notify applicants of missing or incomplete documentation.

If you have any questions about this application process, or would like to check on the status of your application, please contact the board staff at (401) 222-3855.

## **INSTRUCTIONS FOR COMPLETING THE LICENSE APPLICATION**

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Read the following instructions and those throughout the application packet carefully before completing the application. **Only complete applications with the appropriate fee will be accepted.** Failure to submit all required information and appropriate documentation may result in processing delays.

### **General Instructions**

1. Make a copy of the application and forms before you begin in case you make a mistake.
2. Type your information or print in blue or black ball-point pen. HEALTH staff will not make assumptions about illegible information.
3. Provide a response to each section or question; otherwise mark “N/A” for Not Applicable.
4. We suggest that you make a copy of your completed application before submitting it to HEALTH.
5. It is your responsibility to check on the status of your application.

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## **Completing your Application**

1. Complete the application (pages 5-8). You must respond to all components of the application as instructed. If you attach separate pages in continuation of the application, such pages **MUST** clearly indicate the section for which such information is being reported.
2. Make check or money order (in U.S. funds only) for the application fee of **\$110.00** (or **\$310.00 with CSR**) payable to **Rhode Island General Treasurer** and staple it to the upper left-hand corner of the first (Top) page of the application. This application fee **CANNOT BE REFUNDED**, even if the applicant is found ineligible for licensure.
3. Affix a recent **2 X 2 photo** of yourself in the space provided.
4. A completed official transcript **sent directly** from the accredited school of **Physician Assistants** to the Board of Licensure of Physician Assistants (Address below)- OR FCVS. No student copies will be accepted.
5. If you are a new graduate and applying for Graduate Status and your transcript is not yet available, a certified statement may be **sent directly FROM** the Dean or Registrar of the Physician Assistant Program verifying your completion of **ALL GRADUATION REQUIREMENTS**. A completed official transcript must be **sent directly FROM the school** to the Board of Licensure of Physician Assistants as soon as it is available. A license cannot be issued without receipt of an official transcript.
6. Scores, or certification, **sent directly** from the **NCCPA** (Telephone **1-678-417-8100**) to the Board of Licensure of Physician Assistants, OR FCVS.
7. RI Uniform Controlled Substances Act Registration Form (CSR) if applicable (page 11.).
8. **(Endorsement Candidates)**: Please send the license verification form on page 10 to all states in which **applicant** holds or has held a license. Be sure to sign and complete the identifying information on the form. HEALTH must receive these verifications **directly** from the licensing authority in each state.
9. **National Practitioner Data Bank Report**. Submit a "self-query" of the National Practitioner Data Bank (NPDB). The application is a Practitioner Request for Information Disclosure, which can be obtained by calling the NPBD, or downloading it from the NPDB web site.

Phone: 1-800-767-6732  
Web Site: <http://www.npdb-hipdb.com>

You must mail this completed form directly to NPBD. **When you receive a response, send the Board the ORIGINAL, UNOPENED response**. The Board must have this response in order to complete your application so you are encouraged to make this request as soon as possible.
10. Mail the application and documentation to:

**Rhode Island Department of Health  
Board of Licensure of Physician Assistants, Room 205  
3 Capitol Hill  
Providence, RI 02908-5097**



# State of Rhode Island Board of Licensure of Physician Assistants

## Application for License as a Physician Assistant

Refer to the Application Instructions when completing these forms. Type or block print only. Do not use felt-tip pens.

### 1. Name(s)

This is the name that will be printed on your License/Permit/Certificate and reported to those who inquire about your License/ Permit/ Certificate. Do not use nicknames, etc.

Title (i.e., Mr., Mrs., Ms., etc.)

First Name

Middle Name

Surname, (Last Name)

Suffix (i.e., Jr., Sr., II, III)

Maiden, if applicable

Name(s) under which originally licensed in another state, if different from above (First, Middle, Last).

### 2. Social Security Number

 -  - 

U.S. Social Security Number

"Pursuant to Title 5, Chapter 76, of the Rhode Island General Laws, as amended, I attest that I have filed all applicable tax returns and paid all taxes owed to the State of Rhode Island, and I understand that my Social Security Number (SSN) will be transmitted to the Division of Taxation to verify that no taxes are owed to the State."

### 3. Gender

☐

Male

☐

Female

### 4. Date of Birth

Month

Day

 

Year

### 5. Home Address

It is your responsibility to notify the board of all address changes.

1st Line Address (Apartment/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City

Country, If NOT U.S.

 - 

Home Phone

Email Address (Format for email address is Username@domain e.g. applicant@isp.com)

### 6. Business Address (ONLY if it is RELATED to your license.)

It is your responsibility to notify the board of all address changes.

***This address will appear on the Department of Health web site.***

Name of Business/Work Location

1st Line Address (Department/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City

Country, If NOT U.S.

 - 

Business Phone

Extension

State

Postal Code, If NOT U.S.

 - 

Business Fax



### 11. Criminal Convictions

Respond to the question at the top of the section, then list any criminal conviction(s) in the space provided.

If necessary, you may continue on a separate 8½ x 11 sheet of paper.

Have you ever been convicted of a violation, plead Nolo Contendere, or entered a plea bargain to any federal, state or local statute, regulation, or ordinance or are any formal charges pending?

☐ Yes ☐ No

Abbreviation of State and Conviction<sup>1</sup> (e.g. CA - Illegal Possession of a Controlled Substance):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

| Month                |                      | Year                 |                      |
|----------------------|----------------------|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |

### 12. Disciplinary Questions

Check either Yes or No for each question.

NOTE: If you answer "Yes" to any question, you are **required** to furnish complete details, including date, place, reason and disposition of the matter.

- |                                                                                                                                                                                                                                                                                                        |                                                          |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|
| 1. During any Professional/Medical Education, were you ever dismissed, suspended, restricted, put on probation, or otherwise acted against or did you take a leave of absence for medical reasons?                                                                                                     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. During any Professional/Medical Education, were you ever requested to leave or did you leave, temporarily or permanently, prior to completion of training?                                                                                                                                          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. During any training, were you ever dismissed, suspended, restricted, put on probation, or otherwise acted against or did you take a leave of absence for medical reasons?                                                                                                                           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. During any training, were you ever requested to leave or did you leave, temporarily or permanently, prior to completion of training?                                                                                                                                                                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Are there any charges or investigations pending, in any state, against you?                                                                                                                                                                                                                         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Have your staff privileges at any hospital, nursing home, or other health care facility or health care provider or HMO ever been reduced, revoked, or suspended or have you voluntarily surrendered your clinical privileges from any such unit or facility while under investigation in any state? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Have you ever had any disciplinary action(s) taken, or is any pending, against your License to practice medicine, DEA Permit, State Controlled Substances Registration, Medicare Privileges, Medicaid Privileges, or are any complaints pending in any state?                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Have you ever had a membership in a professional society revoked, suspended, or limited in any manner or have you voluntarily withdrawn while under investigation?                                                                                                                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Have you ever failed to pass an examination for licensure?                                                                                                                                                                                                                                          | <input type="checkbox"/> Yes <input type="checkbox"/> No |



**Note:** If you answer "Yes" to any question, you are **required** to furnish complete details, including date, place, reason and disposition of the matter. You may use the space below or, if needed, on a separate sheet of paper.

\_\_\_\_\_  
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### 13. Affidavit of Applicant

Complete this section and sign in the presence of a notary public.

Make sure that you and the notary public have completed all components accurately and completely.

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

I have read carefully 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 denial, suspension or revocation of my license to practice as a Physician Assistant in the State of Rhode Island.

I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Board of Licensure of Physician Assistants of any change in the answers to these questions after this application and this affidavit is signed.

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

\_\_\_\_\_  
Date of Signature (MM/DD/YY)

The foregoing instrument was acknowledged before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_, by \_\_\_\_\_, who is personally known to me or has produced \_\_\_\_\_ as documentation and did / did not take an oath.

\_\_\_\_\_  
Name of Notary (Print, Type or Stamp)

\_\_\_\_\_  
Signature of Notary

\_\_\_\_\_  
Notary No/Commission No.

\_\_\_\_\_  
Commission Expiration Date (MM/DD/YY)

Notary Seal

### 14. Recent Photograph

Securely tape or glue in this square a current 2" x 2" photograph of yourself (alone).

Photographs must be recent, passport type photo, clear, front view, full face without a hat or dark glasses.

Full length photos will not be accepted.



**Write your name on the back of the photograph, and provide the date that the photograph was taken.**

\_\_\_\_\_  
Date of Photograph



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## APPLICATION CHECKLIST

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Please review the following checklist to ensure that all the components of the application process have been satisfied. Some items may not apply.

### **Board Application**

- ☐ I have read and understand the "Instructions for Completing the Application".
- ☐ I have completed the Rhode Island Board application as instructed (pages 5-8).
- ☐ I have attached the cover page of the application.
- ☐ I have completed Section 13, "**Affidavit of Applicant**", and had the form notarized by a notary public.
- ☐ I have attached a photograph to Section 14, "**Recent Photograph**" as instructed. I have verified that it meets the photograph requirements as stated in the application.
- ☐ I have a **check** or **money order** (preferred), made payable (in U.S. funds only) to the: "**Rhode Island General Treasurer**" in the amount of **\$110.00** (or **\$310.00 with CSR**) and attached it to the upper left-hand corner of the first (Top) page of the application.
- ☐ I have arranged my Board Application materials in the following order.
  1. Fee (attached as instructed).
  2. Board Application (including cover page) and pages 5-8.
  3. Supporting documentation as required. [**Note:** Pages containing additional information in continuation of the Board application **MUST** indicate the section for which the information is being reported.]
- ☐ I have mailed the above application materials directly to the Rhode Island Board of Licensure of Physician Assistants.

### **Required Forms**

- ☐ I have completed and mailed the following forms as instructed.
  1. Interstate Verification Form(s) - Other State License(s), **OR** I have contacted **FCVS**
  2. National Practitioner Data Bank Report (NPDB)

### **Other Documents**

- ☐ I have requested a school transcript and my certification or score (NCCPA) as instructed, **OR** I have contacted **FCVS**.
- ☐ RI Uniform Controlled Substances Act Registration Form (if applicable) CSR Form (page 11.).
- ☐ I have applied to have my credentials verified by the Federation Credentials Verification Service (FCVS).



## Rhode Island Board of Licensure of Physician Assistants

Room 205, 3 Capitol Hill  
Providence, RI 02908-5097  
(401) 222-3855

Substitute forms are not acceptable, copy this form as needed.

### INTERSTATE VERIFICATION FORM - OTHER STATE LICENSE(S)

I am applying for a license to practice as a Physician Assistant in the State of Rhode Island. The Rhode Island Board of Licensure of Physician Assistants requires that the following form be completed by the jurisdiction(s) in which I hold or have held a license. This constitutes authority for you to release all information in your files, favorable or otherwise, directly to the Rhode Island Board of Licensure of Physician Assistants at the above address.

Print/Type Full Name

Signature

Date

Previous Names Used

Social Security Number

Date of Birth

License Number

Date Issued

### THIS SECTION TO BE COMPLETED BY THE PHYSICIAN ASSISTANT BOARD

Physician Assistant Program Completed:

Location:

Graduation Date:

Licensed by Examination?

☐ Yes ☐ No

Applicant has completed and passed the NCCPA Exam:

☐ Yes ☐ No

License Status:

☐ Active ☐ Inactive ☐ Lapsed

Original Date Issued:

Expiration Date:

#### Questions:

1. Has this licensee ever been investigated by your Board?

☐ Yes ☐ No

2. Has this licensee incurred any disciplinary proceedings in your state, or is any action pending?

☐ Yes ☐ No

3. Has the applicant's license ever been denied, surrendered, reprimanded, suspended, revoked or placed on probation?

☐ Yes ☐ No

4. Do you know of any information that may discredit this person?

☐ Yes ☐ No

If you answer "Yes" to questions 1-4, please provide a written explanation below, and attach a copy of all supporting documentation (e.g., Board order, complaint, etc.).

### Certification:

Signature

Date

Type or Print Name

Title

Full Name of Licensing Board

Please Affix  
Board Seal Here

Please return directly to the Board at the above address. Thank you for your prompt cooperation.



Substitute forms are not acceptable - This form may be duplicated as needed.

## Rhode Island Board of Licensure of Physician Assistants

Room 205, 3 Capitol Hill  
Providence, RI 02908-5097  
(401) 222-3855

### Rhode Island Uniform Controlled Substances Act Registration (CSR)

I am applying for a Rhode Island Uniform Controlled Substances Act Registration (CSR). **I understand that there is an additional \$200.00 fee for this Registration Application (NON-REFUNDABLE) and that the check or money order must be made out to the RI General Treasurer.**  
**NOTE: To be issued a RI Controlled Substance Registration you must have a Rhode Island Business Address.**

Print/Type Full Name

Business Name

Current RI PA LicenseNo.

Signature

Business Address

Business Telephone

Date

Business Fax

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        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| <p>Complete this application for registration to prescribe controlled substances in the State of Rhode Island</p> <p>A CSR is not required if there will be no controlled substances prescriptions prescribed in this state.</p> <p>The CSR is renewed at the same time as the professional license is renewed.</p> <p><b>NOTE:</b><br/>Read Important Information on the bottom of this application.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <p>The Rhode Island Uniform Controlled Substances Act can be accessed at the following web Site:<br/><b><a href="http://www.rilin.state.ri.us/Statutes/Title21/21-28/index.htm">www.rilin.state.ri.us/Statutes/Title21/21-28/index.htm</a></b></p> <hr/> <p style="text-align: center;"><b>Drug Schedule (Check all that apply)</b></p> <p style="text-align: center;"><input type="checkbox"/> Schedule II    <input type="checkbox"/> Schedule III    <input type="checkbox"/> Schedule IV    <input type="checkbox"/> Schedule V</p> <hr/> <p><b>A Copy of the DEA Registration must be provided to the Physician Assistant Board within 60 Days of its issuance by the DEA.</b> The DEA Registration must be issued to your Rhode Island Practice Address in order for it to be valid. If you are relocating from another state, you need to apply for a DEA Registration that is specific to Rhode Island. See The bottom of this form for information on how to contact DEA.*</p> <hr/> <p>All Applicants MUST answer the following:</p> <p>A. Has the applicant been convicted of, or entered a plea of nolo contendere to a violation of any state or federal law relating to manufacturing, distributing, possessing, prescribing, administering or dispensing of drugs presently defined as controlled substances under Chapter 21-28, General Laws of Rhode Island? <span style="float: right;"><input type="checkbox"/> Yes    <input type="checkbox"/> No</span></p> <p>B. Has the registration application or registration of the applicant, corporation, firm, partner, or officer of the applicant been surrendered, revoked, suspended or denied under any law of the United States or of any state relating to drugs presently defined as controlled substances under Chapter 21-28 of the General Laws of Rhode Island, or is such action pending? <span style="float: right;"><input type="checkbox"/> Yes    <input type="checkbox"/> No</span></p> <p style="text-align: center;"><b>If you answered "Yes" to question "A" or "B" attach an explanation to this form.</b></p> |
| <p style="text-align: center;"><b>Important Information</b></p> <p>Issuance of a Rhode Island Controlled Substances Registration is contingent upon registration by the U.S. Drug Enforcement Administration. If denied a "DEA Registration", the Rhode Island Controlled Substances Registration becomes <b>"VOID"</b>. Licensed drug facilities and licensed practitioners with prescriptive privileges, cannot dispense, possess, store or ship controlled substances in or into the State of Rhode Island without a valid drug facility or professional license. Rhode Island Controlled Substances Registration (CSR), and a federal Drug Enforcement Administration (DEA) Registration. Practitioners may only prescribe, dispense, possess, and store controlled substances within their particular "scope of practice". "Controlled Substances" for purposes of this application, means a prescription drug in Schedules II through V, pursuant to the Rhode Island Uniform Controlled Substances Act, and 21 CFR 1300 of the Federal Code of Regulations. Schedule I drugs are used by researchers, and require the submission of a protocol.</p> <p>Without a Rhode Island CSR, and federal DEA Registration, licensed drug facilities, and practitioners with prescriptive privileges, may dispense or possess non-controlled prescription medications under its facility or professional license. A CSR will not be granted to an applicant whose BOARD licensure application is "pending" in this state.</p> <p>A Rhode Island Controlled Substances Registration must be obtained prior to applying for the DEA Registration. Federal regulations require that applicants comply with individual state requirements prior to issuance of a DEA Registration. Once the CSR is issued, applicants must apply to the U.S. Drug Enforcement Administration for a federal registration using that agency's DEA Form 224 (New Application for Retail Pharmacy, Hospital/Clinic, Practitioner, Teaching Institution, or Mid-Level Practitioner). Applicants may apply on-line for the DEA Registration at the following web site: <a href="http://www.deadiversion.usdoj.gov/drugreg/reg_apps/index.html">www.deadiversion.usdoj.gov/drugreg/reg_apps/index.html</a></p> <p>*You can also receive an application, or check the status of a pending DEA Registration by contacting the Drug Enforcement Administration at the following location:<br/>Registration Unit, US Drug Enforcement Administration, JFK Federal Building, 15 New Sudbury Street, Boston, MA 02203-0131, Telephone (888) 272-5174.</p> <p style="text-align: center;"><b>NOTE:</b></p> <ul style="list-style-type: none"><li>- Schedules II, III, and IV of section 21-28-2.08 will become void unless dispensed within thirty (30) days of the original date of the prescription.</li><li>- Prescriptions in schedules III, IV and V cannot be written for more than one hundred (100) dosage units and not more than one hundred (100) dosage units maybe dispensed at one time. For purposes of this section, a dosage unit shall be defined as a single capsule, tablet or suppository, or not more than one (1) teaspoon of an oral liquid.</li><li>- Prescriptions in schedule II may be written for up to a 30-day supply, with a maximum of two hundred and fifty (250) dosage units, as determined by the prescriber's directions for use of the medication.</li></ul> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |