Arizona Regulatory Board of Physician Assistants

1740 W. Adams St. Ste. 4000 Phoenix, AZ 85007-2664

Telephone: 480- 551-2700 Toll Free: 877-255-2212

Website: www.azmd.gov

Attention Applicants

Thank you for your interest in obtaining a license to perform health care tasks in Arizona. We are excited to have the opportunity to work with you and help guide you through the application process.

Our mission is to protect public safety through the judicious licensing, regulation and education of all physician assistants. A license to perform health care tasks in Arizona is a privilege, not a right. Please do not assume that licensure is a mere formality or that granting of a license is automatic. Please give your application the time and attention needed to accurately answer all questions. It is the applicant's responsibility to ensure that the information disclosed on the application is correct.

Once your completed application and fee are received by the Board, your application will be reviewed to determine if all items needed to meet Arizona's Revised Statutes and Rules for licensure have been submitted. Please understand that some of the documentation required for licensure must come from the primary source (third party). This can add time to the licensing process. It is the applicant's responsibility to request the documentation from the primary source to be sent directly to the Board. A checklist is provided with this application packet for your convenience.

Some applications evidencing a history of disciplinary action require in-depth investigation and may require additional time and your cooperation. It may become necessary for an applicant to come to the Board's office in Phoenix for an interview as part of the application process. Additionally, if an investigation is required, your application may go before the full Board for consideration of your application.

We will make every effort to complete the application process as quickly as possible. If you have any questions, please do not hesitate to call or email the Board's office. Our staff is happy to assist you in any way we can.

Again, thank you for your interest in an Arizona physician assistant license.

FOR YOUR INFORMATION

Application Review Process:

Board staff will review your application and determine if all items needed to complete your application have been submitted to the Board. If it is determined that your application has deficient items, Board staff will send you a notice with a list of the items still needed to meet requirements. Please allow 15 days for your application to be reviewed by Board staff before calling and requesting a status update. Correspondence will be sent to your email address provided on the application.

Once all information needed to meet the requirements for licensure have been submitted to the Board, your application will undergo a final review by Board staff to ensure all requirements set forth in the Arizona Revised Statutes and Rules have been met.

Please note: It is the applicant's responsibility to report to the Board any changes that may have occurred during the application process. Failure to report any adverse actions to the Board during the licensure process may result in denial or revocation of your license.

To review the Arizona Revised Statutes and Rules to ensure that you meet the requirements for licensure, please go to www.azpa.gov

32-3208. Criminal charges; mandatory reporting requirements; civil penalty

A. A health professional who has been charged with a misdemeanor involving conduct that may affect patient safety or a felony after receiving or renewing a license or certificate must notify the health professional's regulatory board in writing within ten working days after the charge is filed.

B. An applicant for licensure or certification as a health professional who has been charged with a misdemeanor involving conduct that may affect patient safety or a felony **after submitting the application** must notify the regulatory board in writing within ten working days after the charge is filed.

C. On receipt of this information the regulatory board may conduct an investigation.

D. A health professional who does not comply with the notification requirements of this section commits an act of unprofessional conduct. The health professional's regulatory board may impose a civil penalty of not more than one thousand dollars in addition to other disciplinary action it takes.

E. The regulatory board may deny the application of an applicant who does not comply with the notification requirements of this section.

F. On request a health profession regulatory board shall provide an applicant or health professional with a list of misdemeanors that the applicant or health professional must report.

Checklist for an Initial Physician Assistant License Application

Please do not submit this form with your application. Keep it for your records.

APPLICATION FEE	
☐ Application Fee	The application fee is $125 payable by check or credit card. The application fee must be submitted with the application and is non-refundable.
☐ License Fee	Once your license application is approved, you will be required to pay a prorated licensure issuance fee up to $370. This fee is prorated based on your birth month.
LICENSE APPLICATION	
☐ Completed Application	Provide a complete application, pages 1 - 8. You must complete all questions. If you fail to complete a question, your application will be considered deficient and the processing of your application will be delayed.
EVIDENCE OF LEGAL STATUS	
☐ A photocopy of Your Birth Certificate or Passport	Applicants must provide a photocopy of a Birth Certificate or Passport.
☐ Proof of Immigration status	A list of the documents that are required to be submitted to the Board is included with the application.
☐ Government Issued Photo ID	A copy of a government issued photo ID is required if the proof of legal status does not include a photo. Example: driver license or state I.D.
☐ Evidence of legal name change	Applicant must provide evidence of legal name change, if applicable. Example: Marriage Certificate, court documents showing legal name change.
EDUCATION	
☐ Education Certification Form	The applicant must send the education certification form provided with the application packet, to the program in which the applicant received a physician assistant degree. This form must be completed, signed and sent directly to the Board by the program.
NCCPA EXAMINATION	
☐ NCCPA	Applicants must request a copy of the applicant's certificate of successful completion of the NCCPA examination and the applicant's examination score to be sent directly to the Board from NCCPA.
VERIFICATION OF OTHER STATE LICENSE(S)	
☐ State/Province Licensure Verification	License verification is required to be sent directly to the Board from **each** state or province in which you hold or have held a license. If you obtain a license during the licensure process, you must request the verification to be sent directly to the Board. *The Board accepts verifications from Veridoc.

HOSPITAL AFFILIATIONS/EMPLOYMENT	
☐ Hospital Affiliations/ Employment Verifications	You must request verification(s) of all hospital affiliations and employment for the five years preceding the application to be sent directly to the Board. Each hospital must verify the applicant's affiliation or employment on the hospital's official letterhead or the electronic equivalent.
MALPRACTICE DOCUMENTS	
☐ Malpractice Form	If an applicant has a malpractice settlement or judgment against the applicant within 10 years from the date of the application, the applicant must complete a malpractice form, included with the application packet, for each malpractice settlement or judgment against the applicant. Please do not submit this form if you have not had a malpractice settlement or judgment against you within the last 10 years.
QUESTIONNAIRE AFFIRMATIVE RESPONSES	
☐ Narrative and Supporting Documents	If you answer "yes" to a question on the questionnaire page, please provide the following: • A narrative/explanation of the circumstances that led to the issue disclosed. • Documents to support your narrative. Example: Court documents, Board Orders, etc. *If documents are not provided, this **will** delay the application process. **Please note:** It is the applicant's responsibility to report to the Board any changes that may have occurred during the application process. Failure to report any adverse actions to the Board during the licensure process may result in denial or revocation of your license.
Information requested to be sent directly to the Board can be sent to the following:	
DO NOT EMAIL APPLICATION(S) Email: licensingreport@azmd.gov	Arizona Regulatory Board of Physician Assistants 1740 W. Adams St. Ste. 4000 Phoenix, AZ 85007-2664

ARIZONA REGULATORY BOARD OF PHYSICIAN ASSISTANTS INITIAL LICENSE APPLICATION

1740 W. Adams St. Ste. 4000 Phoenix, AZ 85007-2664

www.azmd.gov; Email: licensingreport@azmd.gov

To be completed and signed by the applicant. All questions MUST be answered, even if only to indicate "None" or "N/A".

Personal Information

1. **First Name:** _____ **Middle Name:** _____ **Last Name:** _____

Other Names Used: _____

2. **Social Security Number:** _____ **3.** **Date of Birth:** _____

4. **State of Birth:** _____ **City of Birth:** _____ **or** **Country of Birth:** _____

Social Security Number, Date of Birth and Place of Birth are Confidential Information - Not for Public Disclosure

Address Information

Practice Address: This is the practice/principal place of your business. The address and phone number provided will appear in the Medical Directory and on the Board's website. **Every physician assistant must have an address available to the public**. If only one address is provided, even if it is your home address, it will be available to the public upon request. If you want your home address to be listed as your practice address on the Board's website, include the address in the practice address field.

5. **Practice/Training Name:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____ ***Practice address not required for licensure**

Home Address: You are **required** to provide a home address, telephone number and your primary email address. Your home address and telephone number will not be released to the public *unless* you fail to provide an office address. Your email address will not be released to the public, but the Board may occasionally send relevant news and information to you via email.

6. **Home Address:** _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Mobile:** _____

Primary Email Address: _____ ***required**

Mailing Address: If no address is provided, all Board correspondence will be sent to your practice address.
Please note: You are required to notify the Board in writing within 30 days of any change in address or phone number.

7. **Mailing Address:** _____ **City:** _____ **State:** _____ **Zip:** _____

☐ Same as Practice Address ☐ Same as Home Address

PLEASE NOTE: *You are required to notify the Board in writing within 30 days of any change in office or home address and telephone number. A.R.S. 32-2527(B). There is a fine of $100 for failure to report change of address.*

In addition to your primary e-mail address provided on page one of this application, please indicate if you would like to designate/authorize an individual or prospective employer, beside yourself, to receive status updates on your application. Please note: If a substantive review/investigation is required during the application process, the applicant will be required to provide additional authorization, in writing, for the third party to receive status updates concerning the substantive review.

Name | Phone# | E-mail

8. Other State Certifications, Registrations, or Licenses

Please list all states and provinces in which you have been certified, registered, or licensed as a physician assistant., including the certificate, registration, or license number, and current status. If more than 5, attach a separate listing. If a license is pending or was not issued, so state. **If none, please indicate "Not Applicable".**

State Board:	Certificate, Registration, or License No.:	Status:

9. Education

Physician Assistant Training Program:

Address: **Location:** **Degree Date:**

Date of Physician Assistant National Certifying examination [PANCE or most recent recertifying examination (PANRE)]:

Have you, within the last three years before the date of the application, completed 45 hours in pharmacology or clinical management of drug therapy or are you certified by a national commission on the certification of physician assistants or its successor? ☐ Yes ☐ No

10. Continuous Practice

Have you been in continuous practice as a physician assistant for the past 10 years (or since graduating from PA school?)

If you answer "No", please explain any lapses in practice. (e.g. preparing for PANCE, waiting for licensure, etc.)

☐ **Yes** ☐ **No**

Explanation:

First Name: **Last Name:**

11. Questionnaire

1.	Have you had an application for a certificate, registration, or license refused or denied by any licensing authority? If so, provide an explanation.	☐ Yes ☐ No
2.	Have you had the privilege of taking an examination for a professional license refused or denied by any entity? If so, provide an explanation.	☐ Yes ☐ No
3.	While attending an approved program, have you ever had any action taken against you by the program including but not limited to having resigned or been requested to resign, been suspended or expelled from, been placed on probation, or been fined while enrolled in an approved program in a medical school or a postsecondary educational program? If so, provide an explanation.	☐ Yes ☐ No
4.	Have you ever had a health professional license suspended or revoked, or have you ever surrendered a health professional license or had any other disciplinary action taken against your health professional license? If so, provide an explanation.	☐ Yes ☐ No
5.	Are you currently under investigation by any health profession regulatory authority, health care association, licensed health care institution, or are there any pending complaints or disciplinary actions against you? If so, provide an explanation.	☐ Yes ☐ No
6.	Have you ever had any action taken against your privileges, including termination, resignation, or withdrawal by a health care institution or health profession regulatory authority? If so, provide an explanation.	☐ Yes ☐ No
7.	Have you ever had a federal or state authority take any action against your authority to prescribe, dispense, or administer controlled substances including revocation, suspension, denial, or whether you ever surrendered such authority in lieu of any of these action? If so, provide an explanation.	☐ Yes ☐ No
8.	Have you ever been charged with, convicted of, pled guilty to, or entered into a plea of no contest to a felony or misdemeanor involving moral turpitude or been pardoned or had a record expunged or vacated? If so, provide an explanation.	☐ Yes ☐ No
9.	Have you ever been charged with or convicted of a violation of any federal or state drug statute, rule, or regulation, regardless of whether a sentence was or was not imposed? If so, provide an explanation.	☐ Yes ☐ No
10.	Have you, within the last 10 years from the date of the application, had a judgment or a settlement entered against you in a medical malpractice suit? If so, provide an explanation.	☐ Yes ☐ No
11.	Have you ever been court-martialed or discharged other than honorably from any branch of military service? If so, provide an explanation.	☐ Yes ☐ No
12.	Have you ever been involuntarily terminated from a health professional position, resigned, or been asked to leave a health care position? If so, provide an explanation.	☐ Yes ☐ No
13.	Have you ever been convicted of insurance fraud or received a sanction, including limitation, suspension, or removal from practice, imposed by any state or the federal government? If so, provide an explanation.	☐ Yes ☐ No

NOTE: In the event that the response to any of the questions is "Yes", you must file an explanation and submit photocopies of any corresponding documents. Failure to properly answer these questions can result in Board disciplinary action, including revocation or denial of license.

Moral Turpitude includes but is not limited to: Armed Robbery, Assault with a Deadly Weapon, Attempted Insurance Fraud, Embezzlement, Fabricating and Presenting False Public Claims, False Reporting to Law Enforcement Agency, Falsification of Records of the Court, Forgery, Fraud, Hit & Run, Illegal Sale and Trafficking in Controlled Substances, Indecent Exposure, Kidnapping, Larceny, Mann Act (Federal Commercialization of Women Statute), Misleading Sale of Securities in Connection with Transfer of Real Property, Perjury, Possession of Heroin for Sale/Unlawful Sale or Dispensing Narcotic Drugs, Rape, Shoplifting, Theft and Soliciting Prostitution.

First Name: _____ **Last Name:** _____

12. Confidential Question

1. Have you received treatment within the last five years for use of alcohol or a controlled substance, prescription-only drug, or dangerous drug or narcotic or a physical, mental, emotional, or nervous disorder or condition that currently affects your ability to exercise the judgment and skills of a medical professional? If so, provide the following:

☐ Yes ☐ No

A.) A detailed description of the use, disorder, or condition; and

B.) An explanation of whether the use, disorder, or condition is reduced or ameliorated because you receive ongoing treatment and if so, the name and contact information for all current treatment providers and for all monitoring or support programs in which you are currently participating.

C.) A copy of any public or confidential agreement or order relating to the use, disorder, or condition, issued by a licensing agency or health care institution within the last five years, if applicable.

The purpose of the confidential question is to allow the Board to determine the applicant's current fitness to perform health care tasks. The mere fact of treatment, monitoring or participation in a support group is not, in itself, a basis of which admission is denied; the Board routinely licenses individuals who demonstrate personal responsibility and maturity in dealing with fitness issues. The Board encourages those applicants who may benefit from assistance to seek it. The Board may limit or deny licensure to applicants whose ability to function is impaired in a manner relevant to the practice of medicine at the time the licensing decision is made or to applicants who demonstrate a lack of candor by their responses. This is consistent with the public purpose that underlies the licensing responsibilities assigned to the Arizona Regulatory Board of Physician Assistants and to the applicants seeking licensure.

NOTE: In the event that the response to any of the questions is "Yes", you must file an explanation and submit photocopies of any corresponding documents. Failure to properly answer these questions can result in Board disciplinary action, including revocation or denial of license.

13. Citizenship Attestation

Proof of Citizenship: Effective January 1, 2008, based on Federal and State laws, all applicants must provide evidence that the applicant is lawfully present in the United States, pursuant to A.R.S. § 41-1080 and A.A.C. R4-16-201(C)(1) require documentation of citizenship or alien status for licensure. If the documentation does not demonstrate that the applicant is a United States citizen, national, or a person described in specific categories, the applicant will not be eligible for licensure in Arizona.

☐ **I am a U.S. Citizen or U.S. National.**	If this box is checked, please submit documentation as stated on the Statement of Citizenship form (also review the application checklist).
☐ **I am NOT a U.S. Citizen or U.S. National.**	If this box is checked, please submit documentation as stated on the Statement of Citizenship form (also review the application checklist).

First Name: _____ **Last Name:** _____

14. Hospital Affiliations/Medical Employment Verification

Please list all hospital affiliations and medical employment within the past five (5) years. This form must be completed.

☐ **Check here if you have not held medical employment for the past 5 years.**

☐ **Check here if you have not held hospital affiliations within the past 5 years.**

a. Name: _____ From: _____ To: _____

Address: _____ City: _____ State: _____ Zip: _____

Position Held: _____ ☐ **Hospital Affiliation** ***and/or*** ☐ **Medical Employment**

b. Name: _____ From: _____ To: _____

Address: _____ City: _____ State: _____ Zip: _____

Position Held: _____ ☐ **Hospital Affiliation** ***and/or*** ☐ **Medical Employment**

c. Name: _____ From: _____ To: _____

Address: _____ City: _____ State: _____ Zip: _____

Position Held: _____ ☐ **Hospital Affiliation** ***and/or*** ☐ **Medical Employment**

d. Name: _____ From: _____ To: _____

Address: _____ City: _____ State: _____ Zip: _____

Position Held: _____ ☐ **Hospital Affiliation** ***and/or*** ☐ **Medical Employment**

e. Name: _____ From: _____ To: _____

Address: _____ City: _____ State: _____ Zip: _____

Position Held: _____ ☐ **Hospital Affiliation** ***and/or*** ☐ **Medical Employment**

First Name: _____ **Last Name:** _____

15. Attestation

I attest that all of the information contained in this application and accompanying evidence or other credentials submitted are true and correct. I attest the credentials submitted with the application were procured without fraud or misrepresentation or any mistake of which I am aware, and that I am the lawful holder of the credentials. I authorize the release of any information from any source requested by the Board necessary for initial and continued licensure in this state.

Signature of Applicant: Date:

First Name: **Last Name:**

16.

ARIZONA STATEMENT OF CITIZENSHIP OR ALIEN STATUS FOR STATE PUBLIC BENEFITS

Professional License and Commercial License
Arizona Regulatory Board of Physician Assistants

PA License Applicants

Title IV of the federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (the "Act"), 8 U.S.C. § 1621, provides that, with certain exceptions, only United States citizens, United States non-citizen nationals, non-exempt "qualified aliens" (and sometimes only particular categories of qualified aliens), nonimmigrants, and certain aliens paroled into the United States are eligible to receive state, or local public benefits. With certain exceptions, a professional license and commercial license issued by a State agency is a State public benefit.

Arizona Revised Statutes § 41-1080 requires, in general, that a person applying for a license must submit documentation to the license agency that satisfactorily demonstrates the applicant's presence in the United States is authorized under federal law.

Directions: All applicants must complete Sections I, II, and IV. Applicants who are not U.S. citizens or nationals must also complete Section III.

Submit this completed form and a copy of one or more document(s) from the attached "Evidence of U.S. Citizenship, U.S. National Status, or Alien Status" with your application for license or renewal . If the document you submit does not contain a photograph, you must also provide a government issued document that contains your photograph. You must submit supporting legal documentation (i.e. marriage certificate) if the name on your evidence is not the same as your current legal name.

SECTION I – APPLICANT INFORMATION

APPLICANT'S NAME (Print or Type)

TYPE OF APPLICATION (Check one) ☐ INITIAL APPLICATION ☐ RENEWAL

TYPE OF LICENSE/CERTIFICATION (Check one)

☐ PA Application

SECTION II – CITIZENSHIP OR NATIONAL STATUS DECLARATION

Are you a citizen or national of the United States? ☐ Yes ☐ No

If Yes, indicate place of birth:

City of Birth: **State (or equivalent):** **Country or Territory:**

If you answered **Yes**, 1) Attach a photocopy of a document from the attached list, section A. Documents from List B also apply to U.S. Citizens, but submission of a List B document does not negate the requirement to submit a copy of an item from List A.

Name of document:

2) Go to Section IV.

If you answered **No**, you must complete Section III and IV.

SECTION III – ALIEN STATUS DECLARATION

To be completed by applicants who are not citizens or nationals of the United States. Please indicate alien status by checking the appropriate box. Attach a copy of a document from the attached list, section A. Additionally, submit an item from the attached list section C or other document as evidence of your status.

Name of document provided:

Qualified Alien Status (8 U.S.C.§§ 1621(a)(1),-1641(b) and (c))

OVER

☐ 1. An alien lawfully admitted for permanent residence under the Immigration and Nationality Act (INA).

☐ 2. An alien who is granted asylum under Section 208 of the INA.

☐ 3. A refugee admitted to the United States under Section 207 of the INA.

☐ 4. An alien paroled into the United States for at least one year under Section 212(d)(5) of the INA.

☐ 5. An alien whose deportation is being withheld under Section 243(h) of the INA.

☐ 6. An alien granted conditional entry under section 203(a)(7) of the INA as in effect prior to April 1, 1980

☐ 7. An alien who is a Cuban/Haitian entrant.

☐ 8. An alien who has, or whose child or child's parent is a "battered alien" or an alien subject to extreme cruelty in the United States.

Nonimmigrant Status (8 U.S.C. § 1621(a)(2))

☐ 9. A nonimmigrant under the Immigration and Nationality Act [8 U.S.C § 1101 et seq.]. Nonimmigrants are persons who have temporary status for a specific purpose. See 8 U.S.C § 1101(a)(15).

Alien Paroled into the United States For Less Than One Year (8 U.S.C. § 1621(a)(3))

☐ 10. An alien paroled into the United States for less than one year under Section 212(d)(5) of the INA.

Other Persons (8 U.S.C § 1621(c)(2)(A) and (C)

☐ 11. A nonimmigrant whose visa for entry is related to employment in the United States, or

☐ 12. A citizen of a freely associated state, if section 141 of the applicable compact of free association approved in Public Law 99-239 or 99-658 (or a successor provision) is in effect [Freely Associated States include the Republic of the Marshall Islands, Republic of Palau and the Federate States of Micronesia, 48 U.S.C. § 1901 et seq.];

☐ 13. A foreign national not physically present in the United States.

Otherwise Lawfully Present

☐ 14. A person not described in categories 1-13 who is otherwise lawfully present in the United States.

Please NOTE: The federal Personal Responsibility and Work Opportunity Reconciliation Act may make persons who fall into this category ineligible for licensure. See 8 U.S.C. § 1621(a).

SECTION IV - DECLARATION

All applicants must complete this section.

I declare under penalty of perjury under the laws of the State of Arizona that the answers and evidence I have given are true and correct to the best of my knowledge.

APPLICANT'S SIGNATURE: _____ TODAY'S DATE: _____

ARIZONA REGULATORY BOARD OF PHYSICIAN ASSISTANTS
1740 W. Adams St. Ste. 4000 Phoenix, AZ 85007-2664
Phone: 480-551-2700 Fax: 480-551-2704

PHYSICIAN ASSISTANT TRAINING PROGRAM CERTIFICATION

Part of the application for certification as a physician assistant in the State of Arizona requires this form to be completed by the physician assistant training program where the physician assistant applicant received training as a physician assistant. The physician assistant applicant must forward this form for completion by an officer of the physician assistant training program which granted the physician assistant's degree. This completed form can then be faxed or mailed to the Board.

I hereby authorize the release of all information in your files, favorable or otherwise, directly to: The Arizona Regulatory Board of Physician Assistants, 1740 W. Adams St. Ste. 4000 Phoenix, AZ 85007-2664

Physician Assistant Signature: _____ Physician Assistant Name: _____

To Be Completed by the Physician Assistant Training Program:

This is to certify that _____ *(name of applicant)*

was granted the degree of _____ on _____

Dates attended; from _____ to _____

1. Was the student ever required to repeat any segment of training?	☐ Yes	☐ No
2. Were any actions, restrictions, limitation (including probation or academic probation) taken while the student was participating in your training program?	☐ Yes	☐ No
3. Was the student ever counseled regarding his/her performance or behavior in your training program?	☐ Yes	☐ No

If you answered "Yes" to any of the above questions, please provide a brief explanation.

Signature: _____

Name and Title : _____ *(Seal of Training Program)*

(if none, indicate so)

P.A. Program Name: _____

Address : _____

Phone: _____ Fax: _____ Date: _____

ARIZONA REGULATORY BOARD OF PHYSICIAN ASSISTANTS
1740 W. Adams St. Ste. 4000 Phoenix, AZ 85007-2664
Phone: 480-551-2700 Fax: 480-551-2704

MALPRACTICE FORM

The applicant must complete this form for **each** malpractice settlement or judgment in the last ten (10) years. If more than one case, please make copies of this form and return with required documents.

First Name: _____ **Last Name:** _____

Provide a detailed clinical narrative regarding each malpractice case(s). Include name of patient, age, sex, date of occurrence and location (include address). Do not omit the answers to these questions or make reference to attached documents for answers. This section must be completed with your own description that includes all of the facts requested above. *NOTE:* HIPAA regulations do not prevent you from responding and providing the requested information. Please include a separate sheet of paper if you require more room for your narrative. **Please provide a copy of the plaintiff's complaint and copy of the judgment or settlement agreement for each case.**

NARRATIVE:

1. Amount of settlement or judgment: _____ **2. Date of judgment or settlement:** _____

3. Amount of settlement or judgment attributed to you: _____

4. Has this case been investigated or reviewed by any State Medical Board? ☐ Yes ☐ No

If answer is "Yes" , **request that a letter of resolution from the State Medical Board to be sent directly to us.**

I certify that the information which I have provided is correct to the best of my knowledge.

Signature of Applicant: _____ Date: _____

Evidence of U.S. Citizenship, U.S. National Status, or Alien Status

License Application Types: Locum Tenens, Pro Bono, Teaching, Education Permit, Post Graduate, or Physician's Assistant

You must submit supporting legal documentation (e.g. marriage certificate) if the name on your evidence is not the same as your current legal name.

Citizens must submit one of the documents in list A. If applicable, citizens shall also submit a document from list B, but this does not negate the requirement to submit an item from list A. A copy of a government issued photo ID is required if the proof of legal status does not include a photo.

Non-citizens must provide one item from both lists A and C.

List A (Applicable to both citizens and non-citizens)

1. A photocopy of a birth certificate.

Or

2. A photocopy of a passport.

List B

1. A United States certificate of naturalization.
2. A United States certificate of citizenship.
3. A tribal certificate of Indian blood.
4. A tribal or Bureau of Indian Affairs affidavit of birth.

List C (Applicable to non-citizens only)

1. An Arizona driver license issued after 1996 or an Arizona non-operating identification license.
2. A driver license issued by a state that verifies lawful presence in the United States. This must be accompanied with a statement by the state issuing entity that the state verifies legal status prior to issuing the license.
3. A foreign passport with a United States Visa.
4. An I-94 form with a photograph.
5. A United States Citizenship and Immigration Services employment authorization document or refugee travel document.
6. Any other license that is issued by the federal government, any other state government, an agency of this state or political subdivision of this state that requires proof of citizenship or lawful alien status before issuing the license.

PAYMENT CARD AUTHORIZATION

First Name _____ Last Name _____

PHYSICIAN ASSISTANT APPLICATION PROCESSING FEE $125

Type of Card: ☐ **Visa** ☐ **Mastercard** ☐ **Amex**

Card Number: | | | | | | | | | | | | | | | | |

(No dashes between numbers)

Expiration Date: _____

Name as Shown on Payment Card: _____

Billing Address of Cardholder: _____ **City:** _____ **State:** _____ **Zip:** _____
(Required)

Office Phone: _____

Mailing Address of Cardholder: _____ **City:** _____ **State:** _____ **Zip:** _____
(If different from billing address)

Cardholder Signature: _____ **Date:** _____
(Required)

The Arizona Regulatory Board of Physician Assistants will **only** accept credit card payment via mail (USPS, FedEx, UPS, or any other mail carrier). Any credit card information received via any other method will not be processed and will be destroyed.

Please complete and return this form *with your license application and all necessary documents.* Return the application and payment form (credit card form, check or money order) to the address listed below

Mail to: **Arizona Regulatory Board of Physician Assistants**
1740 W. Adams St. Ste. 4000
Phoenix, AZ 85007-2664

Note: At the time the application is approved an additional prorated fee will be required up to $370. This is in addition to your $125 application fee and will cover your license through the next renewal period.