



APPLICATION FOR PHYSICIAN ASSISTANT

Completion of this application form is necessary for consideration for licensure. Disclosure of this information is voluntary; however, failure to disclose all requested information may result in this form not being processed and may subsequently result in denial of this application.

Please type or print. When space provided is insufficient, attach additional pages. You may reproduce these blank forms as needed. Please make sufficient copies of all forms before you begin.

Are you requesting a Temporary Permit? (Temporary Permits are not issued to applicants by endorsement). Y [] N []

1. Indicate your full legal name. If your name is different from that shown on your documentation you must submit a copy of the legal document of name change.

Full Name: _____
first middle last suffix

Other names used, including maiden name: _____

2. Include residence, mailing and e-mail address. Residence address may not be a Post Office Box, except qualified participants under the Safe At Home Act, K.S.A. 75-451 et seq. may use substitute residential and mailing addresses.

Residence Address: _____
street city county state zip

Mailing Address: _____
public information street city county state zip

E-mail: _____

3. Daytime phone number (include area code): _____

4. Identification. Disclosure of your social security number is required by federal mandates set forth in 42 U.S.C.S. § 666(a)(13). K.S.A. 74-148(a) provides that every application by an individual for a professional license shall require the applicant's social security number. K.S.A. 4-139 requires disclosure of your social security number upon request to the Kansas director of taxation. Your social security number may be provided for child support enforcement actions, to the Kansas director of taxation, for reporting disciplinary actions to the National Practitioner Data Bank-Health Integrity and Protection Data Bank (NPDB-HIPDB) as required by 45 C.F.R. §§ 61.1 et seq. Disclosure of your social security number is voluntary for disclosure to other state regulatory agencies, testing and examination vendors, law enforcement agencies, and other private federations and associations involved in professional regulation. Such disclosure is for identification purposes only. Your social security number will not be released for any other purpose not permitted by law.

Date of Birth: _____ Place of Birth: _____ Sex: M [] F []
city state/jurisdiction country

Social Security/Tax ID. No: _____ NPI (National Provider Identifier): _____ NPI Not Applicable: []

Are you a U.S. Citizen? Y [] N [] If you answered NO, are you (check one):

- A qualified alien (as defined in 8 U.S.C.A. § 1641). []
A nonimmigrant under the Immigration and Nationality Act (8 U.S.C.A. § 1101 et seq). []
An alien who is paroled into the United States under 8 U.S.C.A. § 1182(d)(5) for less than one year. []
A foreign national, not physically present in the United States. []
Other: _____

5. List all Board of Certification (NCCPA) attempts. Enclose a certified copy of your NCCPA certification.

I have not yet tested. Date scheduled to sit for the examination: _____

Date _____ Passed _____ Number of attempts for intital testing.

6. List all post secondary schools you have attended, even those from which you did not graduate in chronological order. Attach an additional sheet if necessary. Enclose or send only the official and final transcript showing the degree awarded required for licensure. Do not provide additional education transcripts.

School Name: _____

Address: _____
street city state zip country

Attendance Dates: _____ To _____ Degree: _____
month year month year

School Name: _____

Address: _____
street city state zip country

Attendance Dates: _____ To _____ Degree: _____
month year month year

7. List all employment/professional activity during the past five years. Account for all time and explain all gaps in professional activity. Attach an additional sheet if necessary.

I have not been employed during the past five years.

Employer: _____ Job description/Title _____

Address: _____ Dates: From _____ To _____
street city state

Employer: _____ Job description/Title _____

Address: _____ Dates: From _____ To _____
street city state

Employer: _____ Job description/Title _____

Address: _____ Dates: From _____ To _____
street city state

8. List all states, countries or jurisdictions in which you are currently or have been licensed, registered or certified in any health care profession. Attach an additional sheet if necessary. You must complete the attached *Licensure Verification* form and forward to all Boards or similar entities in which you have held any health care license, registration or certification. Some entities charge a fee for this information. Contact the entity to determine their requirements.

I have never been licensed, registered or certified in another state, country or jurisdiction.

State/Country/Jurisdiction	License, Registrant, Certificate no.	Status	Issue Date
_____	_____	_____	_____
_____	_____	_____	_____

Applicant Name: _____
(please print or type)

9. Recommendation by a peer that has known the applicant for a minimum of 1 year.

I _____, a licensed and practicing physician assistant in the state of _____
(name, please print) (state name)

affirms that _____ has been known to me for _____ year(s), and that applicant, to
(name of applicant)

the best of my knowledge is an ethical practioner, is of good professional character, and not addicted to the use of alcohol or narcotic drugs.

signature

address

date

city, state and zip

10. Certificate of Professional School (Post Secondary School)

It is herby certified that _____ attended _____,
(name) (schools name)

in _____ beginning _____ with a completion date of _____
(city and state) (date) (date)

during which time the applicant pursued and completed all requirments for the program of Physician Assistant according to the standards of accreditation prevailing at the time. It is further certified that the applicant received the following degree: _____
(specify degree, certificate, letter of certification or other)

(signature of President, Registrar, Dean, Director of Course)

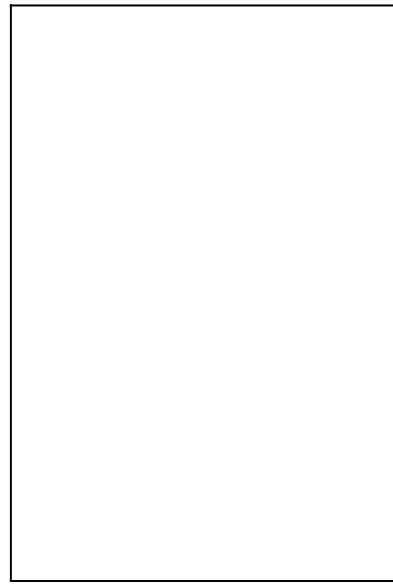
date

Name of School

School Seal
(if no school seal, statement must be notarized by the school)

11. Photo.

Attach a **2"x 3" wallet size photograph** of applicant with head and shoulder areas only. The photograph must have been taken within 90 days prior to date of application. Proof photographs, negatives, copies of photographs, poor quality, photographs cut from books, newspaper articles, or passport photos are **NOT** accepted.



Applicant Name: _____
(please print or type)

12. Please answer each of the following questions by putting a check in the appropriate box. All “yes” answers MUST be thoroughly explained in detail on a separate signed page. You are required to furnish complete details including date, place, reason and disposition of the matter and attach all relevant documentation. All information received will be checked accordingly to verify the truth and veracity of your answers. It is imperative that you honestly and fully answer all questions, regardless of whether you believe the information requested is relevant. If you are unsure of your response to a particular question, check the “yes” box and submit the appropriate form if required. Your responses on your application are evaluated as evidence of your candor and honesty. A honest “yes” answer to a question on your application is not definitive as to the Boards' assessment of your present moral character and fitness, but a dishonest “no” answer is evidence of a lack of candor and honesty, which may be definitive on the character and fitness issue. Please be advised that a false response to any of these questions may be grounds for denial of licensure and reported to the appropriate data banks. If a question is not applicable, then check the “no” box.

- (a) Yes No Have you ever been dropped, suspended, expelled, fined, placed on probation, allowed to resign, requested to leave temporarily or permanently, or otherwise had action taken against you by any professional training program prior to completing the training?
- (b) Yes No Have you ever had any application for any professional license refused or denied by any licensing authority?
- (c) Yes No Have you ever been refused or denied the privilege of taking an examination required for any professional licensure?
- (d) Yes No Have you ever been warned, censured, disciplined, had admissions monitored, had privileges limited, suspended, revoked or placed on probation, or have you ever involuntarily or voluntarily (to avoid disciplinary action or investigation) resigned or withdrawn from any licensed hospital, nursing home, clinic or other health care facility in which you have trained, including but not limited to residency or postgraduate training programs, or otherwise been a staff member, been a partner or held privileges?
- (e) Yes No Have you ever been denied staff membership with any licensed hospital, nursing home, clinic or other health care facility?
- (f) Yes No Have you ever been requested to resign, withdraw or otherwise terminate your position with a partnership, professional association, corporation or other practice organization, either public or private?
- (g) Yes No Have you ever voluntarily surrendered any professional license?
- (h) Yes No Has any licensing authority ever limited, restricted, suspended, revoked, censured or placed on probation or had any other disciplinary action taken against any professional license you have held?
- (i) Yes No Have you ever been notified or requested to appear before a licensing or disciplinary agency?
- (j) Yes No To your knowledge, have any complaints (regardless of status) ever been filed against you with any licensing agency, professional association, hospital, nursing home, clinic or other health care facility?
- (k) Yes No Has any professional association imposed any disciplinary action against you?
- (l) Yes No Within the past 2 years, have you used any alcohol, narcotic, barbiturate, or other drug affecting the central nervous system, or other drug which may cause physical or psychological dependence, either to which you were addicted or upon which you were dependent?
- (m) Yes No Within the past 2 years, have you been diagnosed or treated for any physical, emotional or mental illness or disease, including drug addiction or alcohol dependency, which limited your ability to practice the healing arts with reasonable skill and safety?
- (n) Yes No Within the past 2 years, have you used controlled substances, which were obtained illegally or which were not obtained pursuant to a valid prescription order or which were not taken following the directions of a licensed health care provider?

- (o) Yes No Have you ever practiced your profession while any physical or mental disability, loss of motor skill or use of drugs or alcohol, impaired your ability to practice with reasonable safety?
- (p) Yes No Do you presently have any physical or mental problems or disabilities which could affect your ability to competently practice your profession?
- (q) Yes No Have you ever been denied a Drug Enforcement Administration (DEA) or state bureau of narcotics or controlled substance registration certificate or been called before or warned by any such agency or other lawful authority concerned with controlled substances?
- (r) Yes No Have you ever surrendered your state or federal controlled substances registration or had it revoked, suspended, or restricted in any way?
- (s) Yes No Have you ever been notified of any charges or complaints filed against you by any licensing or disciplinary agency?
- (t) Yes No Have you ever been arrested? Do not include minor traffic or parking violations or citations except those related to a DUI, DWI or a similar charge. You must include all arrests including those that have been set aside, dismissed or expunged or where a stay of execution has been issued.
- (u) Yes No Have you ever been charged with a crime, indicted, convicted of a crime, imprisoned, or placed on probation (a crime includes both Class A misdemeanors and felonies)? You must include all convictions including those that have been set aside, dismissed or expunged or where a stay of execution has been issued.
- (v) Yes No Have you ever been court martialled or discharged dishonorably from the armed services?
- (w) Yes No Have you ever been a defendant in a legal action involving professional liability (malpractice), or had a professional liability claim paid in your behalf, or paid such claim yourself?
- (x) Yes No Have you ever been denied provider participation in any State Medicaid or Federal Medicare Programs?
- (y) Yes No Have you ever been terminated, sanctioned, penalized, or had to repay money to any State Medicaid or Federal Medicaid Programs?

Additional information, reference question letter and include date, place, reason and disposition of the matter. Attach all relevant legal documentation.

13. Oath must be signed by applicant and notarized.

I, _____, being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents. 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 the state of Kansas and may subject me to a fine not exceeding \$10,000 and term of imprisonment not exceeding 5 years of each violation (K.S.A. 21-3805).

Signature of Applicant

SEAL

Sworn to before me this _____ day of _____ 20 _____

Notary Public

Commission Expires

14. Fee of \$200.00. An additional \$30.00 is required if a tempoary license is requested.

Make the fee payable to: Kansas State Board of Healing Arts or charge by credit/debit card using the attached authorization form.

235 SW TOPEKA BLVD., TOPEKA, KS 66603

Voice: 785-296-7413 Toll Free: 888-886-7205 Fax: 785-296-0852 Website: www.ksbha.org

Applicant Name: _____
(please print or type)



Authorization and Release

Must be signed by applicant and notarized.

I, _____, hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present) and all government agencies (local, state, federal or foreign) to release to the Kansas State Board of Healing Arts or its successors any information, files or records requested by the Board in connection with this application. I further authorize the Kansas State Board of Healing Arts or its successors to release to the organizations, individuals, or groups listed above any information which is material to this application or any subsequent licensure.

Signature of Applicant

Sworn to before me this _____ day of

_____ 20 _____

Notary Public

SEAL

_____ Commission Expires



GENERAL INFORMATION AND INSTRUCTIONS

Physician Assistant

Please visit <http://www.ksbha.org/statutes/booklets/physicianassistant.pdf> for all information governing a Physician Assistant License.

Please read the following information very carefully. This information is vital to the successful completion of your application. Often your questions are covered in this form. Please allow two (2) weeks after the submission of the application before contacting our office. Do not make a commitment to any work dates prior to being licensed.

All applicants are considered on an individual basis. You may be requested to submit information or documents in addition to the requirements mentioned herein before the application will be deemed complete. It is highly recommended you make and keep copies, for your records, of all items submitted for review. In addition, when mailing you may want to request a delivery confirmation to confirm your application has been received at the Kansas State Board of Healing Arts. The Board accepts the use of the Federation Credentials Verification Service (FCVS) to primary source verify core credentials. Contact FCVS at 888-ASK-FCVS or www.fsmb.org/fcvs.html.

Kansas application fees must be submitted with the application, are **NOT** refundable and will be processed upon receipt. The Kansas application fee is \$200.00 and the temporary permit fee is an additional \$30.00. Make checks payable to KSBHA. Checks returned for any reason by the payer's financial institution must be replaced by a money order, certified check, or credit card and include a \$30.00 processing fee. To pay by debt or credit card please complete the credit card authorization form.

Temporary permits are not issued to applicants by endorsement. One (1) temporary permit may be issued by the Board to applicants who meet all the requirement as required under K.S.A. 65-28a07 and amendments thereto. Temporary Permits expire one (1) year after the date of issue or certification.

You must submit any change of address to the Board. Please visit our website to complete the "Change of Address" form.

Portions of the application may be copied and sent to the appropriate place to be completed and mailed directly to the Kansas Board of Healing Arts.

Licenses/Certificates expire December 31 and are renewed annually. License renewal will be required of all receiving a permanent license prior to October 1.

CHECK LIST

Did you complete the following?

<u>ALL</u> questions answered on the application	Certified copy of the NCCPA Certification
Request official & final transcript submitted by the post secondary school	Signature of recommendation #9
Request verification from states, countries or jurisdictions if applicable	Post secondary school signature and seal #10
Documentation to any "yes" answers to #12	Notarize and sign Oath #13
Head and shoulder photograph (size: 2X3 taken within 90 days of application)#11	Notarize and sign Release Form
Application and Temporary permit payment if applicable	Complete and sign protocol

revised 3-3-10, kl

235 SW TOPEKA BLVD., TOPEKA, KS 66603

Voice: 785-296-7413 Toll Free: 888-886-7205 Fax: 785-296-0852 Website: www.ksbha.org



STATE VERIFICATION FORM

Send to all states in which a license or registration has ever been issued. Verification fees may be applicable and are the applicant's responsibility. Please contact individual boards to confirm fees. The applicant should complete the top section. The official state board should complete the bottom section and return directly to the Kansas State Board of Healing Arts.

I, hereby authorize and request the state Board of [] having control of any documents, records and other information pertaining to me to furnish to the Kansas State Board of Healing Arts information including documents and/or records regarding charges or complaints filed against me or my license/registration; formal, informal, pending, closed or any other pertinent information.

Full Name: []
Other Names Used (if applicable): [] Date of Birth: [] / [] / []
License or Registration No.: [] Issue Date: [] / [] / []
Profession: []
Signature: _____ Date: _____

Full Name of licensee or registrant: []
License or Registration No.: [] Status: []
Issue Date: [] / [] / [] Expiration Date: [] / [] / []
License Method: [] School: []

DISCIPLINARY ACTIONS:

Is the applicant currently the subject of a pending investigation by a licensing or disciplinary authority in your state? [] Yes [] No [] Unable to Divulge

Have formal disciplinary proceedings been initiated against the applicant or applicant's license or registration by a disciplinary authority in your state? [] Yes [] No [] Unable to Divulge

Comments []

Signature _____
Title _____
State Board of _____
Date _____

(SEAL)



**PHYSICIAN ASSISTANT'S RESPONSIBLE PHYSICIAN
and DRUG PRESCRIPTION PROTOCOL**

Please enter required information, including signatures.

Physician Assistant's Name: _____

License Number: _____

Responsible Physician's Name:: _____

License Number: _____

1. Description of the physician's practice and way in which the physician assistant is to be utilized (please include the routine duties of the physician assistant, the type of practice, and the practice setting):

2. Practice locations, including hospitals, at which the physician assistant will routinely perform acts constituting the practice of medicine and surgery:

3. I understand the responsible physician will always be available for communication with the physician assistant within 30 minutes during the performance of patient service by the physician assistant.

4. I understand that failure to adequately direct and supervise the physician assistant in accordance with Physician Assistant Licensure Act, or rules and regulations adopted under such statutes by the board, would constitute grounds for revocation, suspension, limitation or censure of the responsible physician's license to practice medicine and surgery in the state of Kansas.

5. I understand a current copy of this form shall be provided to the Board office and maintained at the usual practice locations of the responsible physician and that any changes or amendments thereto will be provided to the board within 10 days.
6. The signature of a designated physician who shall routinely provide direction and supervision to the physician assistant in the temporary absence of the responsible physician is required:

Name of Designated Physician: _____

License Number: _____

Signature of Designated Physician

Date

7. Indicate the procedures to be followed to notify the designated physician upon such temporary absence of the responsible physician:

A Drug Prescription Protocol as authorized by the responsible physician must be submitted to the Board for the physician assistant to prescribe drugs or request, receive, sign for and distribute to patients professional samples. Further, in no case shall the scope of the authority of the physician assistant to prescribe drugs, exceed the normal and customary practice of the responsible physician in the prescribing of drugs. To prescribe controlled substances, the physician assistant must register with the Drug Enforcement Administration.

The physician assistant is authorized to prescribe controlled substances as follows:

	NONE	ALL	ALL EXCEPT Specify below
Schedule II and II-N	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Schedule III and III-N	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Schedule IV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Schedule V	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Exceptions:

INFORMATION PERTAINING TO DEA REGISTRATION	YES	NO
Responsible physician has a current DEA number?	<input type="checkbox"/>	<input type="checkbox"/>
Physician assistant has a current DEA number?	<input type="checkbox"/>	<input type="checkbox"/>
Responsible physician and physician assistant have DEA registrations for prescribing of controlled substances in all schedules?	<input type="checkbox"/>	<input type="checkbox"/>

If the answer is "no" to any of the above, please provide explanation:

The physician assistant is authorized to prescribe **non-controlled** drugs as follows:

	NONE Within Class	ALL Within Class	ALL Except Specify Below
Analgesics (non-narcotic)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anthelmintics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antifungals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antihistamines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antihypertensives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antinauseants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antispasmodics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bronchodilators	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Contraceptives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cough Suppressants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decongestants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diuretics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Expectorants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Estrogens	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Progesterone Preparations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhoidal Preparations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Injectables	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skeletal Muscle Relaxants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Topical Ophthalmic Preparations, Except Steroids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Otic Preparations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginitis Preparations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vitamins and Minerals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Topical Preparations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Steroids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anti-Anxiety and Anti-Depressants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (SPECIFY BELOW)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other/Exceptions:

The physician assistant's authority to request, receive and sign for professional samples and to distribute professional samples to patients is identical to the physician assistant's authority to prescribe non-controlled substances, except:

I have carefully read the questions in the foregoing request form and have answered them completely, and I declare under penalty of perjury that my answers and all statements contained herein are true and correct.

Signature of Responsible Physician

Signature of Physician Assistant

Date

Date