COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
DEPARTMENT OF PUBLIC HEALTH
BUREAU OF HEALTH PROFESSIONS LICENSURE
BOARD OF REGISTRATION OF PHYSICIAN ASSISTANTS
250 WASHINGTON STREET
BOSTON, MA 02108
800-414-0168
617-973-0806
www.mass.gov/dph/boards/pa

PHYSICIAN ASSISTANT LICENSE APPLICATION INSTRUCTIONS AND CHECKLIST

Please read these instructions carefully. All supporting materials must be submitted to complete an application. Applications will not be reviewed by the Board until all documentation has been received.

General Information About the Application Process:

The Board of Registration of Physician Assistants ("Board") highly recommends that you refrain from accepting a Physician Assistant position in Massachusetts until you are licensed.

Once an application is received by the Board, it takes a **minimum of 3-5 weeks** to review the completed application and determine if any additional information is required. Once complete, applications are processed for the issuance of a license in the order received. Every effort is made to process license applications in a timely manner; however, the Board is unable to expedite the processing of applications.

To facilitate the processing of your application, please ensure that you provide all the information requested**. DO NOT LEAVE BLANKS.** If you are unable to provide the requested information, attach a separate sheet with an explanation. Missing information will delay the processing of your application.

As an applicant, it is your responsibility to ensure that ALL supporting documentation for licensure is sent directly to the Board and to check with the Board on the status of your application.

All requested information must be provided; failure to provide requested information may result in a delay in processing of application. **Incomplete applications will be returned to applicant.**

Complete applications must include the following documents:

☐ Completed application form, signed and dated by the applicant and notarized.

☐ 2x2 passport style color photo; white or off-white background; copies and printer generated photos are not acceptable.

☐ Signed and notarized Criminal Offender Record Information (CORI) Acknowledgement Form obtained from the Board's website.

□ Check or money order payable to the Commonwealth of Massachusetts for $225.00; cash or foreign currency is not accepted.

> **NOTE**: If you hold a Temporary Practice Certificate, you must pay this fee in addition to the fee previously paid for your Temporary Practice Certificate.

□ Official transcripts in signed, sealed envelopes from physician assistant programs/degrees with proof of a bachelor's degree or higher. When requesting official transcripts, please inform each school's registrar that the transcript must be complete and indicate the degree and date conferred in mm/dd/yyyy format.

> **NOTE:** If transcripts have been previously submitted with an application for a Temporary Practice Certificate, they do not need to be resubmitted, if they were submitted within the past 12 months.

□ NCCPA documentation of certification is required. This must be sent directly from NCCPA. On-
line verification is acceptable.

□ Verification of licensure status, in signed, sealed envelopes, or via on-line primary source verification from any state or jurisdiction in which you now or have ever held <u>any</u> professional license or board certification. Verifications must be sent directly to the Board by the state or other jurisdictions.

<u>For Massachusetts licenses only</u>, the Board also accepts printed, self-queries of online verification of licensure from the following: Board of Registration in Dentistry, Board of Registration in Nursing, Board of Registration in Pharmacy, Board of Certification of Community Health Workers, Board of Registration of Genetic Counselors, Board of Registration in Naturopathy, Board of Registration of Nursing Home Administrators, Board of Registration of Perfusionists, Board of Registration of Respiratory Care, Nurses Aid Registration Board and the Office of Emergency Medical Services for EMT, Advanced EMT and Paramedic Certification. Any printed, self-queries of online verification of licensure must be submitted with the application packet.

□ Completed MassHealth Attestation form.

> **NOTE**: If verifications have been previously submitted with an application for a temporary practice certificate, they do not need to be resubmitted if they were issued within the past 12 months.

□ Submission of completed application and fee acknowledges that the applicant understands and agrees to all provisions herein. Applications are void if requirements for physician assistant licensure are not met within one (1) year from the date of Board receipt of this application. <u>All fees are non-refundable and non-transferable</u>.

□ Application must be submitted on single-sided paper.

□ Retain a copy of the completed application for licensure for your records. **The Board is <u>not</u> able to provide copies of the application.** Employers may require that you provide them with a copy.

□ All submissions and documentation for agenda items must be received by the Board at the close of business on the Monday of the week preceding the scheduled Board meeting. Materials received after the deadline will be reviewed prior to being placed on the agenda for the next scheduled meeting.

*****A Supervising Physician and Work Setting Information form must be on file with the Board within thirty (30) days of beginning employment. Your license may be issued without these forms, though they have been included for your convenience.

NOTE A: If there has been no change in supervising physician[s] and/or work setting[s] since a Temporary Practice Certificate was issued, new forms do not need to be resubmitted.

NOTE B: Multiple supervising physicians and work settings require submission of separate forms for each supervising physician and each work setting.

IMPORTANT INFORMATION:

Pursuant to 263 CMR 3.03 (4), Board regulations state that a physician assistant applicant/registrant must notify the Board in writing of any of the following events within thirty (30) days of their occurrence: change of address of applicant/registrant; change of identity of the applicant/ registrant's employer or employment status of the applicant/registrant; any change in the identity or address of the registered physician supervising the practice of the applicant/registrant; or, the permanent departure of the applicant/registrant from the Commonwealth of Massachusetts.

Failure to update your address may result in failure to receive a license renewal application and expiration of your license. The address of record is where the Board mails your license and any correspondence.

The address printed on your license is a **PUBLIC RECORD** that is available to anyone who requests it. If you are using your home address, you may wish to consider changing this to an office address. Address changes may be done on online at the board's website www.mass.gov/dph/boards/pa or you may obtain a form online to submit to the Board's office.

Answers to many questions may be found on the Board's website. Statutes and regulations governing physician assistant licensure and practice may be found on the website; they are also available for purchase from the State House Bookstore, Massachusetts State House, Room 116, Boston, MA 02108, 617-727-2834.

For further information, please contact the Board office at 1-800-414-0168 or 617-973-0806.

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COMPLETE ALL QUESTIONS

License Application Fee - $225.00

1. Applicant Name:_____
   Last First Middle
   a. Maiden Name/Other Name (if applicable):
   _____
   Last First Middle
2. Temporary Practice Certificate Number (if applicable): _____
3. Address of Record: _____
   No. Street Apt. #
   _____
   City/Town State Zip Code
4. Most Recent Previous Address: _____
   (Different than Address of Record - MUST BE FILLED IN) No. Street Apt. #
   _____
   City/Town State Zip Code
5. Telephone Number(s) Day: _____ Evening: _____ Cell: _____

6. _____/_____/_____ _____
   Date of Birth (mm/dd/yyyy) **Place of Birth** (city/state/country)

   HEIGHT: _____ Feet _____ Inches **EYE COLOR**:_____

   Sex: M F (Circle One) **MOTHER'S MAIDEN NAME**: _____

   Email: _____

7. **SOCIAL SECURITY NUMBER (SSN)** (**disclosure is mandatory**): _____/_____/_____

Pursuant to G.L. c. 30A, s. 13A and G.L. c. 62C, s. 47A, the Bureau of Health Professions Licensure is required to obtain your SSN and forward it to the Massachusetts Department of Revenue. The Department of Revenue will use your SSN to ascertain whether or not you are in compliance with Massachusetts tax laws (G.L. c. 62C, s. 47A) and child support laws (G.L. c. 119A, s.16).

FOR BOARD USE ONLY

Application Number: _____ Receipt Number: _____

License Number __PA_____ Temporary Practice Number: PAT_____

EDUCATION

8. NCCPA Certificate Number: _____ Expiration Date: _____

Applicant must arrange for official written documentation of certification to be sent directly by the NCCPA.

9. PA Program Name/Location: _____

_____

Degree awarded: _____ Date of Graduation:___/___/_____
(mm/dd/yyyy)

Submit official transcript in a signed, sealed envelope. Transcripts may be mailed directly to the Board. Note: If transcripts were previously submitted with an application for a temporary practice certificate, they do not need to be sent a second time.

VERIFICATION OF OTHER LICENSES/BOARD CERTIFICATIONS

10. **LIST BELOW ALL OTHER PROFESSIONAL LICENSES AND BOARD CERTIFICATIONS EVER HELD; INCLUDE ALL STATES AND JURISDICTIONS**

☐ **I DO NOT CURRENTLY HOLD AND HAVE NEVER HELD ANY PROFESSIONAL LICENSE OR CERTIFICATION IN ANY STATE OR JURISDICTION.**

Issuing State/Jurisdiction	Profession	License/Certification Number

Applicants must arrange for official documentation of current license status from each state or jurisdiction to be sent directly to the Board in a signed, sealed envelope or via on-line primary source verification.

<u>For Massachusetts licenses only</u>, the Board also accepts printed, self-queries of online verification of licensure from the following: Board of Registration in Dentistry, Board of Registration in Nursing, Board of Registration in Pharmacy, Board of Certification of Community Health Workers, Board of Registration of Genetic Counselors, Board of Registration in Naturopathy, Board of Registration of Nursing Home Administrators, Board of Registration of Perfusionists, Board of Registration of Respiratory Care, Nurses Aid Registration Board and the Office of Emergency Medical Services for EMT, Advanced EMT and Paramedic Certification. Any printed, self-queries of online verification of licensure must be submitted with the application packet

QUESTIONS

IF YOU ANSWER "YES" TO ANY OF THE FOLLOWING QUESTIONS PLEASE ATTACH A SEPARATE SHEET EXPLAINING THE CIRCUMSTANCES.

An applicant for employment <u>or for housing or an occupational or professional license</u> with a sealed record on file with the commissioner of probation may answer 'no record' with respect to an inquiry herein relative to prior arrests, criminal court appearances or convictions. An applicant for employment <u>or for housing or an occupational or professional license</u> with a sealed record on file with the commissioner of probation may answer 'no record' to an inquiry herein relative to prior arrests or criminal court appearances. In addition, any applicant for employment <u>or for housing or an occupational or professional license</u> may answer 'no record' with respect to any inquiry relative to prior arrests, court appearances and adjudications in all cases of delinquency or as a child in need of services which did not result in a complaint transferred to the superior court for criminal prosecution.

11. Have you ever been denied a license, or ever withdrawn or attempted to withdraw an application, for any professional license in the United States or any country or foreign jurisdiction?

Yes □ No □

12. Has any licensing or certification board, government authority, hospital or health care facility or professional association located in the United States or any country or foreign jurisdiction taken any disciplinary action against you?

Yes □ No □

13. Are you the subject of any pending disciplinary action by any licensing or certification board, government authority, hospital or health care facility or professional association located in the United States or any country or foreign jurisdiction?

Yes □ No □

14. Have you ever voluntarily surrendered or resigned any professional license or board certification in the United States or any country or foreign jurisdiction?

Yes □ No □

15. Have you ever been arrested, charged, arraigned, indicted, prosecuted, convicted or been the subject of any criminal investigation or any court proceeding in relation to any criminal violation? Do not report minor violations for which a fine of $250 or less was imposed.

Yes □ No □

16. Have you ever been court martialed or other than honorably discharged from the armed services (military) of the United States or of any country or foreign jurisdiction?

Yes □ No □

RELEASE

I hereby authorize all hospitals, institutions, credentialing agencies, organizations, personal physicians, employers (past and present), business and professional associates (past and present), and all government agencies and entities (local, state, federal, or foreign) to release to the Board of Registration of Physician Assistants any information, files or records requested by the Board in connection with the processing of my application. I further authorize the Board of Registration of Physician Assistants to release information contained in this application in association with its processing.

AFFIDAVIT OF APPLICANT

To the best of my knowledge and belief, I have filed all state tax returns and paid all state taxes required by state law and do not owe child support.

I understand that the Board is certified by the Massachusetts Criminal History Systems Board for access to Criminal Offender Record Information (CORI), including conviction and pending criminal case data. As an applicant for a license to practice as a Physician Assistant, I understand that a CORI check may be conducted by the Board for conviction and pending criminal case information only and that the CORI results will not necessarily disqualify me.

I understand that I am responsible for reading and understanding the laws and regulations governing practice as a licensed Physician Assistant in Massachusetts and I hereby agree to comply with such laws and regulations.

I understand that this application for licensure as a Physician Assistant shall be deemed no longer valid if requirements for full licensure as a Physician Assistant are not met within one (1) year from the date of Board receipt. I also understand that fees are non-refundable and non-transferable.

I certify, under the pains and penalties of perjury, that the information I have provided pursuant to this application for licensure is truthful and accurate. I understand that any failure to provide truthful and accurate information in connection with this application for licensure may be grounds for the Board of Registration of Physician Assistants to deny issuance of a license; to suspend or revoke a license issued to me; and to deny renewal of a license issued to me, all in accordance with Massachusetts law.

APPLICANT SIGNATURE _____ DATE _____

PRINT NAME _____

Attach a recent passport photo (2x2)

NOTARY NAME: _____

COMMISSION EXPIRES: _____

INCLUDE A NONREFUNDABLE FEE OF $225.00 (CHECK OR MONEY ORDER) PAYABLE TO THE COMMONWEALTH OF MASSACHUSETTS

[Notary Seal]

ATTESTATION PAGE

Mandatory Registration(s): The Affordable Care Act[1] requires physician assistants and certain other providers to enroll in MassHealth as a condition of licensure. Specifically, each PA must enroll as a Nonbilling Provider (also known as an Ordering Referral and Prescribing (ORP) provider). Consequently, when applying for initial PA licensure, an individual must first fully complete and submit to MassHealth an application to be a Nonbilling Provider. For more information go to: https://www.mass.gov/how-to/how-to-enroll-to-be-a-masshealth-orp-provider

MassHealth will accept your application even though you have not yet received your Massachusetts Physician Assistant license and put it in a "pending" status. If you have submitted the application form to MassHealth, you may attest below that you have "submitted a thoroughly completed nonbilling provider application and signed provider contract to MassHealth" on this application.

After you have obtained your Massachusetts Physician Assistance license, contact MassHealth and MassHealth will change your application status from "pending" to "enrolled."

☐ I am aware and have submitted a thoroughly completed application to be a fully participating provider or non-billing provider and a signed provider contract to MassHealth on _____, _____ pursuant to M.G.L. c. 112, s. 9(f)

☐ I consent to the Bureau of Health Professions Licensure and the Massachusetts Executive Office of Health and Human Services, and its enrollment vendor, to obtain, read, copy and share with each other information regarding my MassHealth application and enrollment status and professional licensure status.

http://www.mass.gov/eohhs/provider/insurance/masshealth/aca/aca-section-6401enrollment-information.html

☐ I am aware that if I am or become a licensed prescriber, pursuant to M.G.L. c. 94C §24(a), I must utilize MassPAT each time I prescribe a Schedule II-III opioid or benzodiazepines.

☐ Once I have obtained my Physician Assistant License and registered for MassPat, I consent to the Bureau of Health Professions Licensure and the Massachusetts Prescription Monitoring Program to obtain, read, copy and share with each other information regarding my MassPAT enrollment status and professional licensure status

https://www.mass.gov/service-details/masspat-use-requirements

Mandatory Training(s):

[1] *See also* M.G.L.c. 112 § 9F

If you have not completed the one-time courses listed below, you must complete the course to satisfy initial licensure/ license renewal requirements.

☐ I am a prescriber who is aware of the required training and I have completed mandatory training for all ***prescribers*** **i**n Pain Management pursuant to M.G.L. c. 94C §18(e). I completed the training and received a certificate of completion on: _____, _____. [Note: it is the responsibility of licensees to retain copies of certificates to be provided to the Board upon request at any time].

If you are a prescriber and have not completed the mandatory prescriber training required for licensure renewal, for your convenience, please see the links to Pain Management courses below. Please refer to the Board of Registration of Physician Assistants website at: https://www.mass.gov/how-to/renew-your-physician-assistant-license for more details on licensure renewal requirements.

Course Names:

_____

☐ I am aware and have completed mandatory training on domestic and sexual violence pursuant to M.G.L.c. 112 §264. I completed the training and received a certificate of completion on _____, _____.

Course Name:

_____

https://www.mass.gov/service-details/domestic-and-sexual-violence-integration-initiatives

☐ I have completed a one-time course of training and education in the diagnosis, treatment and care of patients with cognitive impairments, including, but not limited to, Alzheimer's disease and dementia.

Please note: There is no prescribed course of number of education hours for this training. If you received any training or education in your academic program, through professional staff development, conferences, seminars or continuing education in the diagnosis, treatment and care of patients with cognitive impairments at any time, then you meet the requirements of the training}**.**

Yes ☐ No ☐

Course Name:

_____

This training and education requirement must be taken by November 7, 2022.

Please note: **The Board of Registration of Physician Assistants** request applicants to submit copies of their pre-requisite training certificates with the initial application only.

☐ I hereby certify that the information herein is true to the best of my knowledge.
Signed under the pains and penalties of perjury:

Print Name: _____

Signature: _____ Date:_____

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https://www.mass.gov/orgs/bureau-of-health-professions-licensure

BOARD OF REGISTRATION OF PHYSICIAN ASSISTANTS

CHANGE IN SUPERVISING PHYSICIAN

Complete this form and submit it to the Board within 30 days if you are:

If you are reporting changes in more than one work setting, you must complete and submit a separate form for each supervising physician in each work setting.

Please check the appropriate box:

- ❒ Adding a new supervisory physician
- ❒ Replacing your current supervising physician
- ❒ Adding an additional supervising physician
- ❒ Terminating a supervising physician
- ❒ Change of Work Setting Information

Section I : Physician Assistant Information

Name : _____
Last First Middle License #

Address : _____
Number Street City/Town State Zip

Section II : Change Request Information

_____ **Adding new supervising physician:**

New Supervising Physican: _____
Last First MI License #

Facility Name :_____

Facility Type : ❒ Office ❒Clinic ❒Hospital ❒Othe r : _____

Employment Type : ❒ Full-Time ❒Part-Time ❒Per Diem ❒Other:_____

Address : _____
Street City State Zip

Effective Date: _____

_____ **Replacing supervising physician:**

Previous Supervising Physician: _____
Last First MI License #

Terminaition Date: _____

New Supervising Physician : _____

Facility Name :_____

Facility Type : ❒ Office ❒Clinic ❒Hospital ❒Othe r : _____

Employment Type : ❒ Full-Time ❒Part-Time ❒Per Diem ❒Other:_____

Address : _____
Street City State Zip

Effective Date: _____

_____ **Adding additional supervising physician:**

New Supervising Physican: _____
Last First MI License #

Facility Name :_____

Address : _____
Street City State Zip

Facility Type : ❒ Office ❒Clinic ❒Hospital ❒Othe r : _____

Employment Type : ❒ Full-Time ❒Part-Time ❒Per Diem ❒Other:_____

Effective Date: _____

_____**Terminating a supervising physician:**

Physician Name: _____
Last First MI License #

Termination Date: _____

Clinical setting : Please check all areas of practice that apply:

❒ Administration ❒ General Surgery
❒ Adolescents ❒ Occupational Health
❒ Clinical Research ❒ Pediatrics

❒ Emergency Medicine
❒ Education
❒ Internal Medicine
❒ General Medicine
❒ Primary Care
❒ Obstetrics/Gynecology
❒ Other (Please Specify)
_____

Section III : To be filled out by Supervising Physician

If you answer YES to any of the questions below, please submit a separate sheet with a detailed explanation.

Have you [the supervising physician] been disciplined [as defined by the Board of Registration in Medicine regulations] by any government authority, hospital or health care facility or professional medical association [international, national or local] within the past ten years from the date of this application?
_____Yes _____ No

Within the last ten years from the date of this application, have you ever had staff privileges, employment or appointment in a hospital or health care institution denied, suspended or revoked?
_____ Yes _____ No

Within the last ten years from the date of this application, have you ever resigned from a medical staff in lieu of disciplinary action or has any quality assurance committee suggested any form of corrective action concerning your practice?
_____ Yes _____ No

I understand that, not withstanding any other provisions of law, a physician assistant may perform medical services when such services are rendered under my supervision. Such supervision shall be in conformance with Board regulations at 263 CMR 5.04 and 5.05.

_____
Print Name

_____ _____
Signature of Supervising Physician Date

A MA Board of Registration in Medicine Physician Profile must be attached. Profiles are available on line at www.massmedboard.org. Send the profile and the completed form to the MA Board of Physician Assistants at the address above. Make a copy for your records. You will not receive confirmation of receipt by the board.

MassHealth Enrollment Requirement

Providers listed below must submit this form with your license application/renewals

Section 6401 of the Affordable Care Act requires that, for MassHealth services that must be ordered, referred or prescribed, the provider who ordered, referred or prescribed the service must be enrolled with MassHealth in order for the claim for the service to be payable.

The following provider types are eligible to order, refer or prescribe services for MassHealth members and, under state law, must apply to enroll with MassHealth at least as ordering and referring (nonbilling) providers in order to obtain and maintain state licensure. **Providers who are already enrolled with MassHealth have already met the requirement and do not need to take further action.**

Certified nurse midwife	Pharmacist (if authorized to prescribe)
Certified registered nurse anesthetist	Physician (including interns and residents)
Clinical nurse specialist	Physician assistant
Dentist	Podiatrist
Licensed independent clinical social worker	Psychiatric clinical nurse specialist
Nurse practitioner	Psychologist
Optometrist	

MassHealth has created a Nonbilling Provider Application for providers in provider types that are **not** eligible to enroll as fully participating providers. **This application can also be used by providers who are eligible to enroll in MassHealth as fully participating providers but who choose not to at this time.**

Providers who wish to apply to enroll as nonbilling providers must download the materials from the MassHealth website at http://www.mass.gov/eohhs/provider/insurance/masshealth/aca/aca-section-6401enrollment-information.html and send their completed and signed Nonbilling Provider Application and Nonbilling Provider Contract by mail to the MassHealth Customer Service Center (CSC) at:

MassHealth Customer Service Center
Attn: Provider Enrollment and Credentialing
PO Box 121205
Boston, MA 02112-1205

Dentists must submit their materials to:

MassHealth Dental Program
Attn: Provider Enrollment and Credentialing

P.O. Box 2906
Milwaukee, WI 53201-2906

Providers who enroll with MassHealth as nonbilling providers via the Nonbilling Provider Application are not fully participating MassHealth providers and are not eligible to submit claims to MassHealth.

Providers who have questions, or, if eligible, would like to request a fully participating provider application should contact the MassHealth Customer Service Center at 1-800-841-2900 with any questions or, if eligible, to request a fully participating provider application.

You must complete this section and sign below in order for your license application/renewal to be processed

___ I am already enrolled with MassHealth as a nonbilling provider

OR

___ I have submitted a thoroughly completed nonbilling provider application and signed provider contract to MassHealth

By signing this form, you are providing your consent for the Massachusetts Boards of Registration and, where relevant, their supervising state agencies and the Massachusetts Executive Office of Health and Human Services, and where relevant, its provider enrollment vendor, to obtain, read, copy, and share with each other information regarding your MassHealth application and enrollment status and Massachusetts licensure status.

I certify under the pains and penalties of perjury that the information on this form has been reviewed and signed by me, and is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

By: _____ (Signature)

Name: _____ (Printed Legal Name of Provider)

NPI: _____

Primary Service Location Address: _____

_____

Date: _____