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. Online 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 any professional license or board certification. Verifications must be sent directly to the Board by the state or other jurisdictions.

Completed MassHealth Attestation form.

An official Physician Assistant Information Profile from the Federation of State Medical Boards’ Federation Credentials Verification Service (FCVS) may be submitted in lieu of transcripts and NCCPA documentation. If you are registered with FCVS and are using this service for your application, please inform the Board. For more information about the FCVS Profile, visit the FCVS web site at www.fsmb.org.

**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. All fees are non-refundable and non-transferable.

Application must be submitted on single-sided paper.

Retain a copy of the completed application for licensure for your records. The Board is not 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 online at the board’s website [www.mass.gov/dph/boards/pa](http://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.
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. 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_________________
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.

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<th>Issuing State/Jurisdiction</th>
<th>Profession</th>
<th>License/Certification Number</th>
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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 online primary source verification.
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.

APPLICATION FOR PHYSICIAN ASSISTANT LICENSE
BOARD OF REGISTRATION OF PHYSICIAN ASSISTANTS
Revised • 3-2018

PAGE 6 OF 14
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 _______________________________________

Notary Name: ______________________________

Commission Expires: ________________________

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

[Notary Seal]
Mandatory Registration(s):

☐ 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 pursuant to M.G.L. c. 94C §24(a), I must utilize MassPAT each time I prescribe a Schedule II-III opioid and when prescribing a benzodiazepine or DPH Schedule IV-VI for the first time. I registered with MassPAT effective_______, ______.

☐ 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):

☐ I am aware and have completed mandatory training for all prescribers on 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].

Course Name: _________________________________________________________________

https://www.mass.gov/how-to/renew-your-physician-assistant-license

☐ 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: ____________________________________________________________________

☐ 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: ________________
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 Physician: _________________________________________________
Last  First  MI   License #
Facility Name : ________________________________
Facility Type : ☐ Office   ☐ Clinic   ☐ Hospital   ☐ Other : ________________
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 #
Termination Date: __________________________________________

New Supervising Physician: ____________________________________________________

Facility Name: ________________________________________________________________

Facility Type: ☐ Office  ☐ Clinic  ☐ Hospital  ☐ Other: ___________________________

Employment Type:  ☐ Full-Time  ☐ Part-Time  ☐ Per Diem  ☐ Other: ___________________

Address: _________________________________________________________________ Street  City  State   Zip

Effective Date: ______________________________

Adding additional supervising physician:

New Supervising Physician: ___________________________________________________ Last  First  MI  License #

Facility Name: ________________________________________________________________

Address: _________________________________________________________________ Street  City  State   Zip

Facility Type: ☐ Office  ☐ Clinic  ☐ Hospital  ☐ Other: ___________________________

Employment Type:  ☐ Full-Time  ☐ Part-Time  ☐ Per Diem  ☐ Other: ___________________

Effective Date: ______________________________

Terminating supervising physician:

Physician Name: ________________________________________________________________ Last  First  MI  License #
Termination Date: _________________
Clinical setting: Please check all areas of practice that apply:

☐ Administration
☐ Adolescents
☐ Clinical Research
☐ Emergency Medicine
☐ Education
☐ Internal Medicine
☐ General Medicine

☐ General Surgery
☐ Occupational Health
☐ Pediatrics
☐ 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, notwithstanding 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 online 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.
Federation Credentials Verification Service (FCVS)

Federation Credentials Verification Service (FCVS) was established in September 1996 to provide a centralized, uniform process for state medical boards to obtain a verified, primary source record of a physician's core medical credentials.

This service is designed to lighten the workload of credentialing staff and reduce duplication of effort by gathering, verifying and permanently storing the physician's and/or physician assistant's credentials in a central repository at the Federation of State Medical Board’s offices.

FCVS obtains primary source verification of medical education, postgraduate training, examination history, board action history, board certification and identity. This repository of information allows a physician and/or physician assistant to establish a confidential, lifetime professional portfolio with FCVS which can be forwarded, at the physician's request, to any state medical board that has established an agreement with FCVS, hospital, health care or any other entity.

FCVS Physician Assistant

Applicants who complete the verification process establish a permanent, lifetime portfolio of primary-source verified credentials allowing quick, easy and inexpensive access to medical credentials. These documents can be used throughout the applicant's career for state licensure, hospital privileges, employment and professional memberships.

Contact: www.fsmb.org