ATTENTION!

Criminal History Record Checks (CHRC) are required for all applicants. The Board may not reinstate or issue a new license to any applicant, physician or allied health practitioner, if the Board has not received criminal history record information.

The Board recommends that you do not submit your fingerprints for a CHRC earlier than 6 weeks before the date you intend to submit your initial license or reinstatement application to the Board.

The Board is only authorized to retain CHRC information for 90 days. If the CHRC is over 90 days, the applicant will be required to complete a new CHRC.

For detailed instructions on submitting your fingerprints for a CHRC, please read and follow the attached instructions.

MARYLAND BOARD OF PHYSICIANS

Baltimore, Maryland
www.mbp.state.md.us

Notice: Criminal History Records Check Required

Dear Applicant for Initial License or Reinstatement of License:

A full Criminal History Records Check (CHRC) is a qualification of licensure. The Board may not reinstate or issue a new license to any applicant, physician, or allied health practitioner, if the Board has not received criminal history record information.

A CHRC will include both a State and national criminal history records check conducted by the Maryland Department of Public Safety and Correctional Services, Criminal Justice Information System (CJIS) and will be maintained in the Maryland and FBI database for further identification purposes. Applicants have the right to challenge their records, which is discussed in more detail in the FBI NonCriminal Justice Applicant's Privacy Rights notice (https://www.mbp.state.md.us/forms/fbi_privacy_rights.pdf). An applicant for initial licensure or reinstatement shall apply to CJIS for a CHRC and the application shall include:

1. Two complete sets of legible fingerprints taken on forms approved by CJIS and the FBI; and
2. Payment of the required fees.

Timing of CHRCs

The Board recommends that applicants do not submit fingerprints earlier than 6 weeks before the date the applicant/licensee intends to complete the initial license or reinstatement application. The Board is only authorized to retain CHRC information for 90 days. If the CHRC is over 90 days, the applicant will be required to complete a new CHRC.

Fingerprints

A. For Initial Applicants and Reinstatements

All applicants for licensure in Maryland will be required to submit fingerprints for the CHRC. In order to be fingerprinted, the fingerprinting entity will need the following Board specific information:

- CJIS Authorization #: 1600000743
- FBI ORI #: MD 920522Z
- Reason Fingerprinted: Professional License
- Type of Check: Governmental Licensing/ Certification

1. Within Maryland

    a. Go to an authorized location to be fingerprinted prior to mailing in your application to the Board. For a list of electronic fingerprinting locations go to the following website: https://www.dpscs.state.md.us/publicservs/fingerprint.shtml. The Board is not responsible for the list. If there are any concerns about a fingerprinting location, please contact CJIS directly.
    b. Provide the fingerprinting entity the CJIS Authorization number and FBI ORI # provided on page 1 of this letter.
    c. Pay the appropriate fee to the fingerprinting entity.

Once the Board receives the results of the CHRCs, the application process will be completed in accordance to Board regulations and policies.

2. Outside of Maryland

    a. Out-of-state applicants have the option of using a Maryland location for fingerprinting. If a Maryland location is used, follow the instructions above for applicants within Maryland. If a location outside of Maryland is used, follow the instructions below.
    b. Either:
        i. Email CJIS Customer Service at cjis.customerservice@maryland.gov, or
        ii. Call the Central Repository in Baltimore City at 410-764-4501 or toll-free number 1-888-795-0011 to request fingerprint cards.
    c. Have CJIS Authorization and FBI ORI Board #'s available to complete your submission.
    d. Mail the fingerprint card and the associated fee to 6776 Reisterstown Road, Suite 217, Baltimore, Maryland 21215. For overnight mail, use the same address.
    e. Please include a check or money order payable to "CJIS Central Repository." Once the Board receives the results of the CHRCs, the application process will be completed in accordance with the Board's regulations and policies.

Timing of CHRCs

The Board recommends that applicants do not submit fingerprints earlier than 6 weeks before the date the applicant/licensee intends to complete the initial license or reinstatement application. The Board is only authorized to retain CHRC information for 90 days. If the CHRC is over 90 days, the applicant will be required to complete a new CHRC.

Fees:

Fees are required for CJIS to process each criminal background record check request. All fees must be paid by credit card, check or cashier's check in United States currency. The Central Repository cannot accept cash.

Do not send any payment to the Board, as it does not conduct CHRCs. For additional information contact CJIS at 410-764-4501 or visit https://www.dpscs.state.md.us/publicservs/fingerprint.shtml.

Questions?

Should you have any questions, concerns, or to check the status of a criminal history record information request, please contact the **CJIS Call Center at 410-764-4501 or 1-888-795-0011**, Monday-Friday 8:00 a.m. - 5:00 p.m. The Board cannot assist you in this regard.

***Please do not contact the Board to verify receipt or submit receipts. The Board will receive the electronic CHRC notifications within 3 – 14 days.**

MARYLAND BOARD OF PHYSICIANS

Baltimore, Maryland
410-764-4777
www.mbp.state.md.us

PHYSICIAN ASSISTANT APPLICATION FOR LICENSURE

Dear Applicant:

Attached is an application packet for licensure as a Physician Assistant in Maryland. The application fee is **$225.00** and is **non-refundable.** Please make your check or money order payable to: **Maryland Board of Physicians.**
Mail your application and check to:

Maryland Board of Physicians
P.O. Box 37217
Baltimore, MD 21297

Please **DO NOT** mail or hand deliver your application to the Board office or any other address except the address listed above. Applications mailed or hand delivered to the Board office will be forwarded to the above address. This will delay the processing of your application. **Please note: Federal Express (FEDEX) or UPS do not deliver to post office boxes.**

Applications are processed in order of receipt. **Please allow at least 3 to 6 weeks for the processing of your application.** Board staff will make every effort to process your application as quickly as possible. Incomplete applications and/or failure to submit the required information will delay the processing of your application.

Please do not continuously call your analyst to check on the status of your application. Constant interruptions slow down the process. Generally, within 5 - 7 business days from the receipt of your application, your analyst will contact you if additional documentation is required. Please make sure your contact information is current.

Documents submitted to support your application must come directly from the source. For example, verification of education must come directly from your school. Verification of national certification must come from the national certifying body and verification of other licenses must come from the state board that issued your license.

Board staff will not disclose the status of your application to another party unless you have completed the Third Party Option on page 8 of the application or provided documentation allowing staff to disclose the status to another party. Other parties include family members, friends and future employers, etc.

The Board reviews applications in order of receipt. If your application **is missing information**, you will be contacted by **email** within 10-15 days. The email will list the information that is required to complete your application. You have 60 days to submit the required information. If you do not submit the required information within 60 days of the date of the email, your application will be closed, and a new application and a fee will be required.

The Board's website is updated every 24 hours. You may wish to check the website at *www.mbp.state.md.us* before call-ing the Board to find out if a license was issued to you. When you get to the website, click Search Practitioner Profiles.

We look forward to receiving your completed application and will process it as quickly as possible.

Thank you,

The Allied Health Division
Maryland Board of Physicians

MARYLAND BOARD OF PHYSICIANS

P.O. Box 37217
Baltimore, Maryland 21297
Telephone: 410-764-4775 800-492-6836
www.mbp.state.md.us

APPLICATION FOR LICENSURE OF PHYSICIAN ASSISTANTS

INSTRUCTIONS AND IMPORTANT INFORMATION

If you have been previously licensed in Maryland as a physician assistant, DO NOT USE THIS APPLICATION. Download a copy of the reinstatement application from the Board's website at *www.mbp.state.md.us*. Click on Download Forms.

1. **Name**: If the name on the application form differs from the name on any of your supporting documentation, you must submit a copy of a marriage license, divorce decree, or a court order explaining the change of name. The Board must be notified of any change in your name on a timely basis.

2. **Non-Public Address:** The non-public (home) address will be the location to which the Board directs all correspondence. This address is confidential. Do not use your practice address. **If you change your address prior to being licensed, immediately notify the Board in writing.**

3. **Public Address:** The public (business) address is your address of record, available to the public, and will be posted on your Practitioner Profile on the Board's Website. **If you change your address prior to being licensed, immediately notify the Board in writing.**

4. **Contact Information (Telephones and E-mail Address):** The Board will contact you using the information provided.

5. **Date of Birth:** Health Occupations Article §15-303(a)(3), Annotated Code of Maryland requires applicants to be at least 18 years old. Date of birth will also be used for identification and criminal background checks.

6. **Gender:** Disclosure of Gender is not a requirement of licensure, but the information provided will be used for identification purposes and for criminal background checks only.

7. **Race and Ethnicity:** Disclosure of race or ethnicity is not requirements of licensure, but the information provided will be used for identification purposes and for criminal background checks only.

8. **Social Security Number:** Maryland law requires the Board of Physicians to collect Social Security numbers from all persons applying for professional licenses or certificates. Disclosure of your Social Security number is mandatory. The Maryland Board of Physicians is permitted by State or Federal law or regulation to use the Social Security number for the following purposes:

   A. Verification of identity with respect to actions related to your license (Code of Maryland Regulations 10.32.01.);
   B. Administration of the Child Support Enforcement Program (Family Law Article, §10-119.3);
   C. Identification by the Department of Assessments and Taxation of new businesses in Maryland (Health Occupations Article, §1-210);
   D. Verification by the Maryland Medicaid program of licensure and sanctions for providers participating in Medicaid 42 U.S.C. §1396(a)(49); 42 U.S.C. §1396r-2; 42 U.S.C. §1320 a-7).

INSTRUCTIONS AND IMPORTANT INFORMATION CONTINUED

9. **Employment Activities:** Please complete and include all employment history beginning with the date you graduated from an accredited physician assistant educational program.

10. **Verification of Professional Education:** Complete the top portion of the Verification of Professional Education form (PA 1) and forward it to the ARC-PA accredited physician assistant program from which you graduated.

11. **Verification of Education—Bachelor's Degree:** Applicants who graduated from an accredited physician assistant educational program after October 1, 2003 must have a bachelor's degree or its equivalent. They must also complete Part 1 of the Verification of Education Bachelor's Degree form (PA 2) and mail it to the appropriate school official.

12. **National Certification:** Verification of certification from the National Commission on Certification of Physician Assistants (NCCPA). Applicants for licensure as a physician assistant must be currently certified by NCCPA.

13. **Oral and Written Competency in English:** Demonstrate verbal and written competency in the English language by documentation of any of the following:

    a. Graduation from an English-speaking high school or undergraduate school after at least three (3) years of enrollment;

    b. Graduation from an English-speaking professional school; or

    c. Achievement of a passing score of at least 26 on the spoken part **and** 79 on the written part of the Test of English as a Foreign Language (TOEFL).

    To take the test or obtain score reports for the TOEFL, contact the Educational Testing Services at *http://www.ets.org/toefl/contact/region1*. You will be asked to provide a PDF copy of your score report.

14. **Licensure in Other States:** If you have ever held a license, certification or registration to practice as a physician assistant in any state or jurisdiction or in ANY other health care profession in any other states, including Maryland, complete the top portion of the Verification of Other State Licenses form (PA 3) and send it to the licensing board in each state in which you are or have been licensed/certified/ registered. PLEASE check with the applicable state board to see if there is a fee required for this information prior to mailing the form. If you were licensed by the Board of Physicians in another profession, you do not need to complete the PA 3 form.

15. **Character and Fitness Questions:** Answer the Character and Fitness questions "YES" or "NO." If you answer "YES" to any item, please provide a detailed explanation, on a separate sheet of paper, and any supporting documents. If you were discharged from the military, please provide documentation that shows, including, but not limited to, the type of service, date and type of discharge, e.g. DD14. Failure to provide a detailed explanation of a "Yes" response and the required supporting documentation will delay the review process.

16. **Release:** Sign and date the certification. You are giving the Board and Physician Assistant Advisory Committee permission to request additional information to support your application for licensure.

INSTRUCTIONS AND IMPORTANT INFORMATION CONTINUED

17. Optional Third Party Release: If you wish the Board to disclose the status of your application to a third party, complete the third party release statement.

18. Cooperation in an Investigation: Cooperation in an Investigation: You are expected to cooperate fully with any request for information related to your polysomnographic technologist application for licensure.

19. Certification and Passport Quality Photo: Sign and date the certification in the presence of a notary public after you have affixed a recent original passport quality (2" x 2") photo to the application in the space provided.

Supplemental Forms PA1, PA2, and PA3 - Verification of Education (PA1): Complete this form and send it to the institutions where you completed your ARC-PA-accredited physician assistant educational program. **Verification of Education—Bachelor's Degree (PA2):** Complete this form if you did not receive at least a Bachelor's degree as part of your physician assistant education program. **Verification of Other State Licenses (PA3):** Complete this form if you were issued a license/certification/registration as a physician assistant or ANY other health care provider.

FCVS: The Board may accept the Federation Credentials Verification Service (FCVS) for primary source verification of a physician assistant's core credentials. For more information regarding the FCVS, please contact 888-ASK-FCVS (888-275-3287) or www.fsmb.org.

Licensure and Renewal: If your application is approved, you will receive an approval letter containing the license number assigned to you, the original date of licensure and expiration, and a license. Regardless of the date of initial licensure, your license will expire on June 30th of the first odd year following the date on which you are initially licensed. You will have to renew your license if you plan to continue practicing in Maryland. The renewal notice will be sent at least 30 - 60 days prior to the expiration of your license to the most current address on file with the Board. **You will be required to renew your license on-line by June 30th of every odd year whether or not you receive the renewal notice.**

DELEGATION AGREEMENTS

Licensure alone does not permit a physician assistant (PA) to practice in Maryland. A delegation agreement must be completed and filed with the Board. The PA may begin practicing once the Board receives the delegation agreement and acknowledges receipt. The delegation agreement fee is $200.00. Go to the Board's website at *www.mbp.state.md.us/forms/della.pdf* to download this form.

PRACTICING AS A PHYSICIAN ASSISTANT: A person may not practice, attempt to practice, or offer to practice as a physician assistant in Maryland unless licensed to practice by the Board. A person may not represent or imply to the public by title or by description of services, methods or procedures that the person is a physician assistant unless licensed by the Board to practice as a physician assistant. A physician assistant may not perform or attempt to perform or offer to perform any delegated acts beyond the scope of the license or beyond the scope of an approved delegation agreement on file with the Board.

Please keep a copy of your application.

Maryland Board of Physicians

Check One:

☐ Initial Licensure

☐ Reinstatement

Name of Profession: _____

ATTENTION

If You Are a Veteran, Service Member or Military Spouse

PLEASE REVIEW AND COMPLETE BEFORE PROCEEDING

*"**Veteran**" means a former service member who was discharged from active duty under circumstances other than dishonorable within one year before the date on which the application for license, certificate, or registration is submitted.*

*"**Veteran**" does not include an individual who has completed active duty and has been discharged for more than one year before the application for a license, certification, or registration is submitted.*

*"**Military Spouse**" means the spouse of a service member or veteran,*

"Military Spouse" includes a surviving spouse of:

* *A veteran; or*
* *A service member who died within one year before the date on which the application for license, certification, or registration is submitted.*

*"**Service Member**" means an individual who is an active duty member of:*

* *The Armed Forces of The United States*
* *A reserve component of the Armed Forces of the United States; or*
* *The National Guards of any state*

Complete ONLY if You Meet the Following Criteria

Check the appropriate box.

☐ Service Member — Currently serving in the U.S. Armed Forces, a reserve component of the Armed Forces or National Guards of any state. **Provide supporting documentation.**.

☐ Veteran — Discharged from active military duty under circumstances other than dishonorable within the one year of submitting the application. **Provide supporting documentation.**

☐ Military Spouse: ***Check the appropriate box***

- ☐ Spouse is a Veteran. **Provide supporting documentation.**
- ☐ Spouse was a service member who died within one year before the date of submitting the application. **Provide supporting documentation.**
- ☐ Spouse is a Service Member currently serving in the U.S. Armed Forces, a reserve component of the Armed Forces or National Guards of any state. **Provide supporting documentation.**

_____ _____

Name of Applicant (PRINT) Military Branch

PHYSICIAN ASSISTANT
LICENSURE APPLICATION
01/2021

MARYLAND BOARD OF PHYSICIANS
P.O. Box 37217 • Baltimore, MD 21297
Telephone: 410-764-4777 Toll Free: 800-492-6836

FOR BANK USE ONLY
Date _____
Check Number _____
Amt Paid _____
Name Code _____
App ID: 09
Fee: $225

PHYSICIAN ASSISTANT APPLICATION FOR LICENSURE

Please print legibly or type the required information. Do not leave any item unanswered.

1. Your Complete Current Legal Name: As listed on your U.S. birth/marriage certificate, U.S. passport, or most recent document issued by the INS.

Last name and generational indicator (Jr., Sr., II, III, etc.): Complete name you would like to appear on your License.

First name and middle name:

(If applicable, please check a box and complete below) ☐Complete Maiden Name OR ☐Complete Former Name

Stop! **If any credential you submit bears a name other than your current legal name as listed above, or if you have been licensed in another state under any name other than your current legal name, sign and date an attachment which includes each different name, an explanation of why the name differs from your current legal name, and a copy of the legal document to support the name change.**

2. Non-Public Address: The non-public (home) address will be the location to which the Board directs all correspondence. This address is confidential.
Do not use your practice address.
Street Address: **(Do NOT use a P.O. Box) If you change your address prior to being licensed, immediately notify the Board in writing.**

City State Zip Code

3. Public Address: The public (business) address is your address of record, available to the public, and will be posted on your Practitioner Profile on the Board's Website.
Street Address: **If you change your address prior to being licensed, immediately notify the Board in writing.**

City State Zip Code

4. Telephone(s): Home Office:

Cell/Pager: E-mail Address:

5. Date of Birth: Month Day Year

6. Gender: ◯ Male ◯ Female

7. Race: Check all that apply ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ White

Ethnicity: ◯ Hispanic or Latino ◯ Not Hispanic or Latino

8. U.S. Social Security Number:

For Board Use Only	License Number:		Expiration Date:	
	Date Issued:			
	Licensed By: _____			

9. Chronology of Employment Activities: Beginning with the date you completed your Physician Assistant Program, list employment activities as a PA. Also list any other health related employment. Explain any lapse over 1 year in which you were not employed. Please write N/A below if the statements do not apply to you.

Graduation Date from PA Program:
Month: __________ Year: ___________

Employment activities after graduation from Physician Assistant Program

month	year		month	year	
		TO			**Activity/Position:**
Name and telephone of Supervisor:					**Name and Address of Employer:**
month	year		month	year	
		TO			**Activity/Position:**
Name and telephone of Supervisor:					**Name and Address of Employer:**
month	year		month	year	
		TO			**Activity/Position:**
Name and telephone of Supervisor:					**Name and Address of Employer:**
month	year		month	year	
		TO			**Activity/Position:**
Name and telephone of Supervisor:					**Name and Address of Employer:**
month	year		month	year	
		TO			**Activity/Position:**
Name and telephone of Supervisor:					**Name and Address of Employer:**
month	year		month	year	
		TO			**Activity/Position:**
Name and telephone of Supervisor:					**Name and Address of Employer:**
month	year		month	year	
		TO			**Activity/Position:**
Name and telephone of Supervisor:					**Name and Address of Employer:**
month	year		month	year	
		TO			**Activity/Position:**
Name and telephone of Supervisor:					**Name and Address of Employer:**

If you will need more space this page allows, please photocopy this for your use or attach a separate sheet. Please sign and date each sheet you attach.

10. EDUCATIONAL PROGRAM: Please complete this section and send the attached **Verification of Professional Education (PA 1)** to your Physician Assistant program.

_____

Name of School/Program

_____/_____/_____ _____

Graduation Date **Degree and Type (Bachelor's, Master's, Certificate)**

_____

Street Address

_____

City **State** **Zip Code**

_____

Telephone Number, including area code

11. EDUCATION: BACHELOR'S DEGREE (Applicants who graduated after October 1, 2003 from an approved physician assistant educational program, must have a Bachelor's degree. Complete this section and the attached Verification of Education form if you did not receive at least a Bachelor's degree from your physician assistant training program.)

_____

NAME OF SCHOOL **DEGREE** **DATE GRADUATED: MM/DD/YYYY**

_____

STREET ADDRESS **CITY** **STATE** **ZIP CODE**

12. National Certification: List the date and certification number.

NCCPA certificate number _____

Certification Date _____/_____/_____

13. ORAL AND WRITTEN COMPETENCY IN ENGLISH (Check one)

◯ I graduated from an English-speaking high school or undergraduate school after at least three (3) years of enrollment;*

Name of high school: _____

City and state of high school: _____

** Please provide a copy of your high school and/or undergraduate school transcript.*

◯ I graduated from an English-speaking professional school; or

◯ I achieved a passing score of at least 26 on the spoken part of the TOEFL **and** 79 on the written part of the TOEFL.**

*** Please attach a PDF copy of your score report to the application.*

14 a. Licensure as a Physician Assistant. List all states or other jurisdictions in which ever held a license/certificate/ registration to practice as a Physician Assistant. Please complete and mail the attached **Verification of Other State Licenses** form **(PA 3)** to the appropriate state board(s). If you have never been licensed as a Physician Assistant, write N/A here _____.

State	License #	Category (PA)	Year Issued	Expiration Date

14 b. Licensure as another health care practitioner. List all states or other jurisdictions in which ever held a license/ certificate/registration to practice in ANY other health occupation. Please complete and mail the attached **Verification of Other State License(s)** form **(PA 3)** to the appropriate state board(s). If you have never been licensed in any other health occupation, write N/A here _____.

State	License #	Category (EMT; Nurse, etc).	Year Issued	Expiration Date

15. Character and Fitness Questions (Check either **YES** or **NO**) Please answer questions "a" through "q" on pages 5 and 6.

	YES	NO	
a.	◯	◯	Has a state licensing or disciplinary board (including Maryland), a comparable body in the armed services or the Veterans Administration, ever denied your application for licensure, reinstatement, or renewal?
b.	◯	◯	Has a state licensing or disciplinary board (including Maryland), a comparable body in the armed services or the Veterans Administration, ever taken action against your license? Such actions include, but are not limited to, limitations of practice, required education admonishment or reprimand, suspension, probation or revocation.
c.	◯	◯	Has any licensing or disciplinary board in any jurisdiction (including Maryland), a comparable body in the armed services or the Veterans Administration, ever filed any complaints or charges against you or investigated you for any reason?
d.	◯	◯	Have you ever withdrawn your application for a medical license or other health professional license?
e.	◯	◯	Has a hospital, related health care institution, HMO, or alternative health care system ever investigated you or ever brought charges against you?
f.	◯	◯	Has a hospital, related health care institution, HMO, or alternative health care system ever denied your application; failed to renew your privileges, including your privileges as a resident; or limited, restricted, suspended, or revoked your privileges in any way?
g.	◯	◯	Have you ever pleaded guilty or *nolo contendere* to any criminal charge, been convicted of a crime, or received probation before judgment because of a criminal charge?
h.	◯	◯	Have you ever committed an offense involving alcohol or controlled dangerous substances to which you pled guilty or *nolo contendere*, or for which you were convicted or received probation before judgment? Such offenses include, but are not limited to, driving while under the influence of alcohol or controlled dangerous substances.
i.	◯	◯	Are there any charges pending against you in any court of law, are you currently under arrest, released pending trial with or without bond, or is there an outstanding warrant for your arrest?
j.	◯	◯	Do you currently have any condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or a physical, mental, emotional, or nervous disorder or condition) that in any way affects your ability to practice your profession in a safe, competent, ethical, and professional manner?

Important: The Board recognizes that licensees encounter health conditions, including those involving career fatigue, burnout, mental health, and substance use disorders, just as their patients and other healthcare providers do. The Board expects its licensees to address their health concerns and ensure patient safety. Voluntary options may include seeking medical care, self-limiting the licensee's practice, or voluntarily self-referring to the Maryland Healthcare Professionals Program (MHPP) a program that provides assistance to healthcare professionals dealing with potentially impairing conditions in a private, non-disciplinary setting while protecting both the confidentiality of the participant and the safety of the public.

k.	◯	◯	Have any malpractice claims or other claims for money damages ever been filed against you? Include past claims as well as any claim that is now pending, has been dismissed, has been settled, or which has resulted in a damages award against you or your medical practice.

If you answered "YES" to any question, on a separate sheet of paper, please provide a signed and dated detailed explanation and attach appropriate supporting documents. Failure to provide documentation and a signed and dated explanation will delay the processing of your application.

Continue to Page 6 for questions "l" through "q"

15a. Character and Fitness Questions Continued (Check either **YES** or **NO)**

	YES	NO	
l.	◯	◯	Are you in default of a service obligation that you incurred by receiving State or Federal funds for your medical education?
m.	◯	◯	Have you ever failed to make arrangements to satisfy State or Federal loans that financed your medical education?
n.	◯	◯	Has your employment or contractual relationship with any hospital, HMO, other health care facility, health care provider, institution, armed services, or the Veterans Administration ever been terminated for disciplinary reasons?
o.	◯	◯	Have you ever voluntarily resigned or terminated a contract with any hospital, HMO, other health care facility, health care provider, institution, armed services or the Veterans Administration while under investigation by that institution for disciplinary reasons?
p.	◯	◯	Have you ever surrendered your license or allowed it to lapse while you were under investigation by any licensing or disciplinary board of any jurisdiction, any entity of the armed services or the Veterans Administration?
q.	◯	◯	Have you ever been dishonorably discharged from any military service of the U.S. Government? If so, attach a copy of your military discharge documentation that includes type of service, date of discharge, and type of discharge.

»»» **If you answered "YES" to any question, on a separate sheet of paper, please provide a signed and dated detailed explanation and attach appropriate supporting documents.**

Failure to provide documentation and a signed and dated explanation will delay the processing of your application.

RELEASE AND CERTIFICATION

16. Release:

I agree that the Maryland Board of Physicians (the Board) and the Physician Assistant Advisory Committee may request any information necessary to process my application for initial licensure as a physician assistant in Maryland from any person or agency, including but not limited to the NCCPA, former and current employers, government agencies, the National Practitioners Data Bank, Federation of State Medical Boards, hospitals and other licensing bodies, and I agree that any person or agency may release to the Board the information requested. I also agree to sign any subsequent releases for information that may be requested by the Board. I authorize the Maryland Board of Physicians to release any information or document pertaining to any disciplinary action against my license as a physician assistant to my supervising physician.

Applicant's Name (Printed) _____ Applicant's Signature _____ Date _____

17. (OPTIONAL) Third Party Release: Although the Board encourages you to complete all aspects of your application on your own, if you plan to use an intermediary to receive information about the status of your application, please complete this release.

The Maryland Board of Physicians may release any information pertaining to the status of my application to the following person:

Name: _____

Phone: _____ Applicant's Signature _____ Date _____

18. Cooperation in an Investigation: I agree that I will cooperate fully with any request for information or with any investigation related to my practice as a licensed physician assistant in the State of Maryland, including the subpoena of documents or records.

During the period in which my application is being processed, I shall inform the Board within 30 days of any change to any answer I originally gave in this application, any arrest or conviction, any change of address or any action that occurs based on accusations that would be grounds for disciplinary action under Md. Code Ann., Health Occ. § 15-314.

Applicant's Signature _____ Date _____

19. Certification: To be completed by the applicant in the presence of a notary public after the applicant's picture has been attached below.

I certify that I have personally reviewed all responses to the items in this application and that the information I have given is true and correct to the best of my knowledge and that any false information provided as part of my application may be cause for the denial of my application. I also certify that I am thoroughly familiar with the Statute (MD. Code Ann., Health Occ. 15-101 et seq.) and Code of Maryland Regulations (COMAR) 10.32.03 which govern the practice of Physician Assistants in Maryland.

Applicant's Signature _____ Date _____

STATE OF _____

CITY/COUNTY OF _____

I HEREBY CERTIFY that on this _____ day of _____ , 20 _____ , before me, _____,
Name of Notary

a Notary Public of the State and City/County aforesaid, personally appeared the Applicant, _____ whose
(Applicant's Name)

whose likeness is identifiable as that of the person in the photograph attached to this application and who

who has made oath in due form of law that signing the foregoing application was his/her voluntary act and

deed.

AS WITNESS my hand and notorial seal. _____
Notary Public

My Commission expires: _____ SEAL

APPLICANT:

PASTE YOUR PASSPORT-QUALITY PHOTO HERE BEFORE NOTARIZING

COPIES OF PHOTOS ARE NOT ACCEPTABLE

STOP! Completed application and check for $225 must be mailed to Maryland Board of Physicians, P.O. Box 37217, Baltimore, Maryland 21297
DON'T FORGET TO KEEP A COPY OF YOUR APPLICATION!

Physician Assistants

Supplemental Forms

PA 1—Verification of Professional Education (Accredited PA Educational Program)

PA 2—Verification of Education—Bachelor's Degree

(Effective October 1, 2003, applicants who graduated from an accredited physician assistant education program, must have a bachelor's degree or its equivalent. If you did not receive a bachelor's degree or higher from the physician assistant training program you graduated from, please complete the attached verification form and send it the institution that awarded your bachelor's degree or its equivalent.)

PA 3—Verification of Other State Licenses

PA 1
Verification of PA Education Supplemental Form

MARYLAND BOARD OF PHYSICIANS
4201 Patterson Avenue ■ P.O. Box 2571
Baltimore, Maryland 21215-0095
Telephone: 410-764-4777 800-492-6836
www.mbp.state.md.us

For Board Use Only
Program accredited?
_____ _____
Y N
Date verified _____

VERIFICATION OF PROFESSIONAL EDUCATION FOR PHYSICIAN ASSISTANT LICENSURE

Part 1

APPLICANT: Complete Part 1 and send to the institution where you completed your Physician Assistant program.

Name: _____
Last name and generational indicator (Jr., Sr., II, III, etc.) First name Middle name Maiden Name

Date of Birth: _____/_____/_____ Social Secuity Number: _____- _____ - _____
mm dd yyyy

Professional School of Graduation: _____

Attended from: _____ to _____

Date of Graduation: _____ Degree Received: _____
mm/yyyy

Applicant's Signature: _____ Date: _____

Part 2

REGISTRAR, DEAN, PRINCIPAL or OTHER AUTHORIZED OFFICIAL: Please complete this form and mail it to the above address.

I hereby certify that the above-named individual graduated from this institution on: _____
Date of Graduation (mm/yyyy)

The individual graduated with a(n):

☐ Associate's Degree ☐ Certificate ☐ Bachelor's Degree ☐ Master's Degree ☐ Other:_____
(specify)

in _____. The program was accredited by: _____
Educational Program ARC-PA, CAAHEP, CAHEA, etc.

_____ _____
Printed Name of Authorized Official Name of Institution

_____ _____ _____
Title of Authorized Official Telephone Number Fax Number

_____ _____
Signature of Authorized Official Date

SEAL

OF THE

INSTITUTION

PA 2
Verification of Education—
Bachelor's Degree
Supplemental Form

MARYLAND BOARD OF PHYSICIANS
4201 Patterson Avenue ■ P.O. Box 2571
Baltimore, Maryland 21215-0095
Telephone: 410-764-4777 800-492-6836
www.mbp.state.md.us

VERIFICATION OF EDUCATION
BACHELOR'S DEGREE

Part 1

APPLICANT: On October 1, 2003 or later, if you did not receive at least a Bachelor's degree as part of your physician assistant education program, you must complete Part 1 and send to the institution that issued your Bachelor's degree.

Name: _____
Last name and generational indicator (Jr., Sr., II, III, etc.) First name Middle name Maiden Name

Date of Birth: _____/_____/_____ Social Secuity Number: _____- _____ - _____
mm dd yyyy

Professional School of Graduation: _____

Attended from: _____ to _____

Date of Graduation: _____ Degree Received: _____
mm/yyyy

Applicant's Signature: _____ Date: _____

Part 2

REGISTRAR, DEAN, PRINCIPAL or OTHER AUTHORIZED OFFICIAL: Please email this form to: mdh.mbpcredentials@maryland.gov

I hereby certify that the above-named individual graduated from this institution on: _____
Date of Graduation (mm/yyyy)

The individual graduated with a(n):

☐ Associate's Degree ☐ Certificate ☐ Bachelor's Degree ☐ Master's Degree ☐ Other:_____
(specify)

in _____.
Educational Program

_____ _____
Printed Name of Authorized Official Name of Institution

_____ _____ _____
Title of Authorized Official Telephone Number Fax Number

_____ _____
Signature of Authorized Official Date

SEAL

OF THE

INSTITUTION

PA 3
Verification of Licensure in Other States Supplemental Form

MARYLAND BOARD OF PHYSICIANS
4201 Patterson Avenue ■ P.O.Box 2571
Baltimore, Maryland 21215-0095
Telephone: 410-764-4777 800-492-6836
www.mbp.state.md.us

VERIFICATION OF OTHER STATE LICENSES

Part 1

APPLICANT: Complete and sign Part 1 and send a copy of this form to each state board that ever issued you a license/ certificate/registration to practice as a Physician Assistant. Also use this form to send to each state board, including Maryland, that ever issued you a license/certification/registration to practice as ANY other health care practitioner. Please copy this form if you need to send it to more than one state board.

License Type: _____

State of Licensure: _____ License Number: _____

Date: _____ Expiration Date: _____

Name: _____
(Print) Last (Generational Indicator, Jr., III) First Middle Maiden

Social Security No. : _____ Date of Birth: _____/_____/_____

Professional School of Graduation: _____ Year: _____

Signature: _____ Date: _____

Part 2

AUTHORIZED OFFICIAL OF STATE MEDICAL BOARD: Please certify the following information regarding the above-listed individual and send this form directly to the Maryland Board of Physicians at the above address.

_____ _____ _____
License Number Date Issued Expiration Date

Is/was the license in good standing? ☐ **Yes** ☐ **No**

If not in good standing is/was it: ☐ **reprimanded** ☐ **suspended** ☐ **revoked** ☐ **surrendered**

Was the license administratively revoked, suspended, or surrendered because the licensee did not renew? ◯ **Yes** ◯ **No**

If yes, please explain: _____

_____

Other Derogatory Information or Pending Charges: _____

_____

_____ _____
Printed Name of Authorized Official Direct Telephone Number

_____ _____
Title of Authorized Official Printed Name of State

_____ _____
Signature of Authorized Official Date

State Board Seal