

Regular Mailing Address
STATE BOARD OF MEDICINE
STATE BOARD OF OSTEOPATHIC MEDICINE
P.O. BOX 2649
HARRISBURG, PA 17105-2649
717-783-1400/717-787-2381
Email: st-medicine@pa.gov
st-osteopathic@pa.gov

Courier Delivery Address
STATE BOARD OF MEDICINE
STATE BOARD OF OSTEOPATHIC MEDICINE
2601 NORTH THIRD STREET
HARRISBURG, PA 17110

APPLICATION FOR A TEMPORARY GRADUATE PERFUSIONIST LICENSE

1.	TEMPORARY GRADUATE PERFUSIONIST LICENSE - \$50 – Submit the appropriate fee via check or money order, made payable to the "Commonwealth of Pennsylvania." FEES ARE NOT REFUNDABLE. Note: A processing fee of \$20 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment. Your cancelled check is your receipt.
2.	If documents will be submitted to the Board under a name different from your present name, submit a copy of the legal document evidencing the name change (i.e., marriage license, divorce decree, naturalization, etc.).
3.	Applicant must be at least 18 years of age.
4.	You may not practice in the Commonwealth of Pennsylvania until the Pennsylvania State Board of Medicine or State Board of Osteopathic Medicine has issued a license and you have obtained professional liability insurance.
<p>PLEASE NOTE: If a pending application is older than one year from the date submitted and the applicant wishes to continue the application process, the Board shall require the applicant to submit a new application including the required fee. In order to complete the application process, many of the supporting documents associated with the application cannot be more than six months from the date of issuance.</p> <ul style="list-style-type: none"> • Graduate of an accredited perfusionist program and waiting to take or waiting for the results of the ABCP's exam. • A temporary graduate perfusionist license will expire 2 years after the date of issuance and may not be renewed OR upon notification from the ABCP of failure of the exam, whichever occurs first. • A temporary graduate perfusionist must be supervised by a perfusionist holding a current license in Pennsylvania. 	
5.	Complete pages 1 and 2 of the application and submit to the Board with the appropriate fee.
6.	Complete Section 1 of the Verification of Perfusion Education and forward to your program for completion of Section 2. The program must return the completed verification <u>directly</u> to the Board in an official envelope.
7.	The Bureau of Professional and Occupational Affairs (BPOA), in conjunction with the Department of Human Services (DHS), is providing notice to all health-related licensees and funeral directors that are considered "mandatory reporters" under section 6311 of the Child Protective Services Law (CPSL) (23 P.S. § 6311), as amended, that EFFECTIVE JANUARY 1, 2015, all persons applying for issuance of an initial license shall be required to complete 3 hours of DHS-approved training in child abuse recognition and reporting requirements as a condition of licensure. Please review the Board website for further information on approved CE providers. Once you have completed a course, the approved provider will electronically submit your name, date of attendance, etc., to the Board. Child Abuse Continuing Education Providers Information can be found here.
8.	Contact the ABCP or other Nationally-recognized accrediting agency approved by the Board, and request official verification that you are eligible and have applied to sit for the certification examination be sent <u>directly</u> to the Board.
9.	Provide proof of professional liability insurance coverage through self-insurance, personally purchased insurance or insurance provided by your employer for the minimum amount of \$1,000,000.00 per occurrence or claims made. This proof of insurance/certificate must include your name and indicate that you are covered under this policy while performing perfusion services in the Commonwealth of Pennsylvania.
10.	ALL APPLICANTS must provide an official notification of information (Self Query) from the National Practitioner Data Bank. Please refer to the NPDB website for additional information. When you receive the "Response to your Self Query," forward the entire report directly to the Board Office. <u>You should make a copy for your records.</u>

11.	Contact the state board office(s) where you hold or have ever held a license, certificate, permit, registration or other authorization to practice a profession or occupation and request letters of good standing. The letter must include the following: license issue and expiration date, license status (current or expired) and disciplinary standing. The letter(s) of good standing must be sent directly to the Board.
12.	Attach a current Curriculum Vitae listing <u>all</u> periods of employment or unemployment (i.e., child rearing, etc.) from graduation from school to present. The list must be in chronological order, include the month and year, and indicate the state/territory in which the employment occurred.

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Check the Board under which you are applying to be licensed:

- State Board of Medicine State Board of Osteopathic Medicine

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APPLICANT INFORMATION
 (Please Print or Type)

NAME:		Last			First			Middle		
ADDRESS*:		Street								
City							State		ZIP	
DATE OF BIRTH:		Month	Day	Year	SOCIAL SECURITY NUMBER:					
EMAIL ADDRESS:				TELEPHONE NUMBER:						

If your supporting documents are listed under another name or names, please list below:

Last	First	Middle
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NAME OF PERFUSIONIST EDUCATION PROGRAM:													
ADDRESS OF PROGRAM:													
DATE OF ATTENDANCE:		FROM			TO			DATE OF GRADUATION					
		Month	Day	Year				Month	Day	Year	Month	Day	Year
DATE AMERICAN BOARD OF CARDIOVASCULAR PERFUSION (ABCP) EXAM TAKEN (If applicable):							Month		Day		Year		
NAME/LICENSE NO. OF SUPERVISING PA PERFUSIONIST:					Last			First			PA License No.		
SUPERVISOR'S SIGNATURE:													

LEGAL QUESTIONS

You must answer the following questions. If you answer "YES" to #2 through #12, provide complete details on a separate sheet as well as certified copies of relevant documents. **Sign and date below.**

		Yes	No
1.	Do you hold or have you ever held a license, certificate, permit, registration or other authorization to practice a profession or occupation in any state or jurisdiction? If you answered yes, provide the profession and state or jurisdiction. Please do not abbreviate the profession. _____		
2.	Have you had disciplinary action taken against a professional or occupational license, certificate, permit, registration or other authorization to practice a profession or occupation issued to you in any state or jurisdiction or have you agreed to voluntary surrender in lieu of discipline?		
3.	Do you currently have any disciplinary charges pending against your professional or occupational license, certificate, permit or registration in any state or jurisdiction?		
4.	Have you withdrawn an application for a professional or occupational license, certificate, permit or registration, had an application denied or refused, or for disciplinary reasons agreed not to apply or reapply for a professional or occupational license, certificate, permit or registration in any state or jurisdiction?		
5.	Have you been convicted (found guilty, pled guilty or pled nolo contendere), received probation without verdict or accelerated rehabilitative disposition (ARD), as to any criminal charges, felony or misdemeanor, including any drug law violations? Note: You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.		
6.	Do you currently have any criminal charges pending and unresolved in any state or jurisdiction?		
7.	Have you ever had your DEA registration denied, revoked or restricted		
8.	Have you ever had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority?		
9.	Have you ever had practice privilege denied, revoked, suspended, or restricted by a hospital or any health care facility?		
10.	Have you ever been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?		
11.	Do you currently engage in, or have you ever engaged in, the intemperate or habitual use or abuse of alcohol or narcotics, hallucinogenics or other drugs or substances that may impair judgment or coordination?		
12.	Have you been the subject of a civil malpractice lawsuit? If yes, please submit a copy of the entire Civil Complaint, which must include the filing date and the date you were served. Submit a statement which includes complete details of the complaints that have been filed against you. **If you previously reported the complaint to the Board provide the docket number _____		

SIGNED STATEMENT

NOTICE: Disclosing your Social Security Number on this application is mandatory in order for the State Boards to comply with the requirements of the Federal Social Security Act pertaining to Child Support Enforcement, as implemented in the Commonwealth of Pennsylvania at 23 Pa. C.S. § 4304.1(a). At the request of the Department of Human Services, the licensing boards must provide to the Department of Human Services information prescribed by the Department of Human Services about the licensee, including the social security number. In addition, Social Security Numbers are required in order for the Board to comply with the reporting requirements of the U.S. Department of Health and Human Services, National Practitioner Data Bank.

I verify that this application is in the original format as supplied by the Department of State and has not been altered or otherwise modified in any way. I am aware of the criminal penalties for tampering with public records or information under 18 Pa. C.S. Section 4911. I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa. C.S. § 4904 (relating to unsworn falsification to authorities) and may result in the suspension, revocation or denial of my license, certificate, permit or registration.

Signature of Applicant

Date

Printed Name of Applicant

PENNSYLVANIA STATE BOARD OF MEDICINE or OSTEOPATHIC MEDICINE

VERIFICATION OF PERFUSION EDUCATION

SECTION 1 – TO BE COMPLETED BY APPLICANT

NAME:	Last	First	Middle

NAME OF PERFUSION PROGRAM:	
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ADDRESS:	City	State	ZIP

Submit the verification of medical education form to your perfusion program and request the program return the completed form directly to the board in an official envelope.

SECTION 2 – TO BE COMPLETED BY DEAN OR REGISTRAR OF PERFUSION PROGRAM

NAME OF PERFUSION PROGRAM:	
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NAME OF STUDENT:	Last	First	Middle

DATE STUDENT BEGAN TO ATTEND THIS PROGRAM:	Month	Day	Year

DATE OF GRADUATION:	Month	Day	Year

I CERTIFY THAT ALL OF THE INFORMATION LISTED ABOVE IS CORRECT

SIGNATURE OF DEAN/REGISTRAR:	
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DATE:	Month	Day	Year

Upon completion, program must return this completed form directly to the Pennsylvania State Board of Medicine in an official envelope.

(Seal of Program)

DO NOT RETURN THIS FORM TO THE APPLICANT

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