Regular Mailing Address
STATE BOARD OF OSTEOPATHIC MEDICINE
P.O. BOX 2649
HARRISBURG, PA 17105-2649
Email: st-osteopathic@pa.gov

Courier Delivery Address
STATE BOARD OF OSTEOPATHIC MEDICINE
2601 NORTH THIRD STREET
HARRISBURG, PA 17110
717-783-4858

APPLICATION FOR LICENSURE AS A PHYSICIAN ASSISTANT

This application can be used for licensure under the State Board of Osteopathic Medicine only. A licensee under the State Board of Osteopathic Medicine may only be supervised by a licensed osteopathic physician (DO). **If you wish to be supervised by an allopathic physician (MD), you must become licensed under the State Board of Medicine.**

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.

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.

Section 9.1(a) of ABC-MAP* requires that all prescribers or dispensers, as defined in Section 3 of ABC-MAP, applying for licensure/approval complete at least 4 hours of Board-approved education consisting of 2 hours in pain management or the identification of addiction and 2 hours in the practices of prescribing or dispensing of opioids. Applicants seeking licensure/approval on or after July 1, 2017, must document, within one year from issuance of the licensure/ approval, that they completed this education either as part of an initial education program, a stand-alone course from a Board-approved course provider, or a continuing education course from an approved continuing education provider. The 4 hours of Board-approved education needs to be completed only once. See the Board's website for the Opioid Education Forms and additional information.

*The Achieving Better Care by Monitoring All Prescriptions Program Act (ABC-MAP) (Act 191 of 2014, as amended) is available on the Legislature's website at:
http://www.legis.state.pa.us/cfdocs/Legis/LI/uconsCheck.cfm?txtType=HTM&yr=2014&sessInd=0&smthLwInd=0&act=191

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.).

PLEASE ALLOW AT LEAST 60 DAYS FOR PROCESSING

APPLICANTS MUST COMPLETE THE FOLLOWING:

1.	Submit the $30 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.	Complete the Verification of Education and send to the physician assistant program where you graduated. **The program must send the completed form directly to the Board**.
3.	The Board requires that you have obtained a minimum of a Baccalaureate/Bachelor's Degree. If you have obtained a Baccalaureate Degree or higher from the physician assistant program, a transcript is **NOT** required. However, if a school different from the physician assistant program granted the degree, arrange for this school to submit a transcript directly to the Board. The transcript must indicate the degree that was awarded.
4.	Contact the National Commission on Certification of Physician Assistants, Inc. (NCCPA) and arrange for your exam scores to be sent directly to the Board.

5.	Attach a Curriculum Vitae listing **all** periods of employment or unemployment (i.e. child rearing, research, etc.) from graduation from physician assistant program to present. The list must be in chronological order, include the month and year and indicate the state/territory in which the employment occurred.
6.	Contact the state board office(s) where you hold or have ever held a license, certificate, permit, registration or other authorization to practice a health-related profession 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.
7.	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.** You should make a copy for your records.
8.	Applicants may also use the FCVS credentials verification service through the Federation of State Medical Boards to verify their education and examination scores. **The Board will accept FCVS if primary source verification is provided. However, you will need to meet all Pennsylvania licensure requirements.** Additional documents are required by the Board that are **NOT** included in the FCVS report but are listed in items #5-7 of the application instructions. It is the applicant's responsibility to ensure that these additional documents are provided to the Board as outlined in the application instructions.
9.	All applications must be submitted to the Board office by mail with original signatures. Faxed/emailed applications are not accepted.

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APPLICATION FOR LICENSURE AS A PHYSICIAN ASSISTANT

Licensure Fee: Submit the $30 fee, check or money order, made payable to the "Commonwealth of Pennsylvania." **FEES ARE NOT REFUNDABLE.** **Check or money order must be in "US funds**." **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 of payment.

*****IMPORTANT EDUCATION CHANGES EFFECTIVE JANUARY 1, 2004*****

Act 160 of 2002 requires that candidates for initial licensure after January 1, 2004 obtain a baccalaureate or higher degree from a college or university and must complete not less than 60 clock hours of didactic instruction in pharmacology or other related courses.

TO BE COMPLETED BY APPLICANT

(Please print or type)

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

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

Last First Middle

If you know the name of your supervisor, please provide the name and license number below. The supervisor is required to submit a separate application for registration as a supervising physician. In order for you to begin practicing, this application must also be approved. If you do not have a supervisor at this time, write "None."

NAME OF SUPERVISOR:	Last	First	Middle
LICENSE NUMBER OF SUPERVISOR:	OS _____		

EDUCATION					
NAME OF SCHOOL:		**GRADUATION DATE:**	Month	Day	Year
ADDRESS OF SCHOOL:	Street				
	City	State		Zip	
Did you receive at least a Baccalaureate/Bachelor's Degree from the physician assistant program?				Yes	No
If you answered 'No", list below the name and address of the program that issued the Baccalaureate Degree.					
NAME OF SCHOOL:		**GRADUATION DATE:**	Month	Day	Year
ADDRESS OF SCHOOL:	Street				
	City	State		Zip	

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 copies of relevant documents.

		Yes	No
1	Do you hold or have you ever held a license, certificate, permit, registration or other authorization to practice a health-related profession in any state or jurisdiction? **If you answered yes, provide the profession and state or jurisdiction.** **LIST**: _____		
2	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?		
3	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?		
4	Do you currently have any disciplinary charges pending against your 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 practice privileges denied, revoked, suspended, or restricted by a hospital or any health care facility?		
8	Have you had your DEA registration denied, revoked or restricted?		
9	Have you had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority?		
10	Have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?		
11	Have you 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	Since May 19, 2002, 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 below:** _____		

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. § 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 OSTEOPATHIC MEDICINE

VERIFICATION OF GRADUATION FROM A PHYSICIAN ASSISTANT PROGRAM

Complete Section 1 of this page and forward to the college or university where you completed your physician assistant program.

SECTION 1 – TO BE COMPLETED BY APPLICANT

NAME:	Last:	First:	Middle:
ADDRESS:	Street:		
City:		State:	Zip:

DATE OF BIRTH:	Month	Day	Year	**SOCIAL SECURITY NUMBER:**			
NAME OF SCHOOL:							

DATES OF ATTENDANCE:	**FROM:**	Month	Day	Year	**TO:**	Month	Day	Year

Submit the verification of physician assistant education form to your school and request the school return the completed form directly to the Board.

THIS FORM MAY NOT BE COMPLETED/SUBMITTED TO THE BOARD PRIOR TO GRADUATION

SECTION 2 – TO BE COMPLETED BY DIRECTOR OF PHYSICIAN ASSISTANT PROGRAM

NAME OF PROGRAM:					
ADDRESS:	Street				
City	State	Zip			
DEGREE AWARDED:		**GRADUATION DATE:**	Month	Day	Year

This program included 2 hours of education in pain management or the identification of addiction. YES ____ NO ____

This program included 2 hours of education in the practices of prescribing or dispensing of opioids. YES ____ NO ____

I CERTIFY THAT THE ABOVE-NAMED INDIVIDUAL HAS SUCCESSFULLY COMPLETED THE PHYSICIAN ASSISTANT PROGRAM, WHICH INCLUDED AT LEAST 60 CLOCK HOURS OF DIDACTIC INSTRUCTION IN PHARMACOLOGY OR OTHER RELATED COURSE. THE SCHOLASTIC STANDING AND PRACTICAL PERFORMANCE WERE SATISFACTORY DURING THE COURSE OF STUDY COMPLETED. I FURTHER CERTIFY THAT ALL OF THE INFORMATION LISTED ABOVE IS CORRECT.

SIGNATURE OF PROGRAM DIRECTOR:				
DATE:	Month	Day	Year	

Upon completion, school must return this completed form directly to the Pennsylvania State Board of Osteopathic Medicine.

DO NOT RETURN THIS FORM TO THE APPLICANT

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