

**Regular Mailing Address**  
**STATE BOARD OF MEDICINE**  
 P.O. BOX 2649  
 HARRISBURG, PA 17105-2649  
 Email: [st-medicine@pa.gov](mailto:st-medicine@pa.gov)

**Courier Delivery Address**  
**STATE BOARD OF MEDICINE**  
 2601 NORTH THIRD STREET  
 HARRISBURG, PA 17110  
 717-783-1400/717-787-2381

## APPLICATION FOR LICENSURE AS A PHYSICIAN ASSISTANT

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

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**

### INSTRUCTIONS FOR APPLICANTS WHO HOLD NCCPA CERTIFICATION

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 in a sealed official school envelope.**
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 in an official school envelope. 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 in an official envelope.
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 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.

7.	Provide an official notification of information (Self Query) from the National Practitioner Data Bank. Please refer to the NPDB website for additional information. <b>When you receive the "Response to your Self Query," forward the entire report directly to the Board Office.</b> <u>You should make a copy for your records.</u>
8.	Applicants may also use the FCVS credentials verification service through the Federation of State Medical Boards to verify their education and examination scores. <b>The Board will accept FCVS if primary source verification is provided. However, you will need to meet <u>all Pennsylvania licensure requirements.</u></b> Additional documents are required by the Board that are <b>NOT</b> 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.

## INSTRUCTIONS FOR TEMPORARY PERMIT APPLICANTS

Applicants must be scheduled to take the first available NCCPA examination after graduation from the physician assistant program. <b><u>Temporary permits will expire within 12 months of issuance or upon failure of the NCCPA examination, whichever occurs first.</u></b> Temporary permit holders must practice under direct supervision and may not prescribe/dispense drugs.	
1.	Submit the \$30 fee, check or money order, made payable to the "Commonwealth of Pennsylvania." <b><u>FEES ARE NOT REFUNDABLE.</u></b> <b><u>Check or money order must be in "US funds."</u></b> <b>Note:</b> 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.
2.	Complete the Verification of Education and send to the physician assistant program where you graduated. <b>The program must send the completed form directly to the Board in a sealed official school envelope.</b>
3.	The Board requires that you have obtained a minimum of a Baccalaureate/Bachelor's Degree. If you have obtained a Baccalaureate/Bachelor's Degree or higher from the physician assistant program, a transcript is <b>NOT</b> 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 in an official school envelope. The transcript must indicate the degree that was awarded.
4.	After taking the NCCPA examination, contact the National Commission on Certification of Physician Assistants, Inc. (NCCPA) and arrange for your examination scores to be sent directly to the Board in an official envelope. When the Board receives your passing examination scores, your temporary permit will automatically be transmitted to a license. Please note, an additional fee will not be required to complete the transfer.
5.	Attach a Curriculum Vitae listing <b>all</b> 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.	Applicants may also use the FCVS credentials verification service through the Federation of State Medical Boards to verify their education and examination scores. <b>The Board will accept FCVS if primary source verification is provided. However, you will need to meet <u>all Pennsylvania licensure requirements.</u></b> An additional document required by the Board that is <b>NOT</b> included in the FCVS report but is listed in items #5 of the application instructions. It is the applicant's responsibility to ensure that this additional document is provided to the Board as outlined in the application instructions.
7.	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.

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## APPLICATION FOR LICENSURE AS A PHYSICIAN ASSISTANT

- Check to indicate that you desire a temporary permit. Temporary permits are only available to new graduates who have not yet taken the PANCE examination. **A temporary permit is valid for 1 year from date of issuance or upon failure of the examination, whichever occurs first.**

**Temporary permit and 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)

<b>NAME:</b>	Last:	First:	Middle:
<b>ADDRESS:</b>	Street:		
City:	State:	ZIP:	
<b>DATE OF BIRTH:</b>	Month	Day	Year
<b>PHONE NUMBER:</b>	<b>SOCIAL SECURITY NUMBER:</b>		
<b>EMAIL ADDRESS:</b>			

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."

<b>NAME OF SUPERVISOR:</b>	Last	First	Middle
<b>LICENSE NUMBER OF SUPERVISOR:</b>	MD _____		

<b>EDUCATION</b>					
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<b>NAME OF SCHOOL:</b>		<b>GRADUATION DATE:</b>	Month	Day	Year
<b>ADDRESS OF SCHOOL:</b>					
<b>Did you receive at least a Baccalaureate/Bachelor's Degree from the physician assistant program?</b>				Yes	No
<b>If you answered 'No', list below the name and address of the program that issued the Baccalaureate Degree.</b>					
<b>NAME OF SCHOOL:</b>		<b>GRADUATION DATE:</b>	Month	Day	Year
<b>ADDRESS OF SCHOOL:</b>	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 certified 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 profession or occupation in any state or jurisdiction? <b>If you answered yes, provide the profession and state or jurisdiction.</b> <b>LIST:</b> _____		
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	Have you been the subject of a civil malpractice lawsuit? <b>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.</b>  <b>**If you previously reported the complaint to the Board provide the docket number below:</b> _____		

## 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**

**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**

<b>NAME:</b>	Last:	First:			Middle:			
<b>ADDRESS:</b>	Street:							
City:				State:			ZIP:	
<b>DATE OF BIRTH:</b>	Month	Day	Year	<b>SOCIAL SECURITY NUMBER:</b>				
<b>NAME OF SCHOOL:</b>								
<b>DATES OF ATTENDANCE:</b>	<b>FROM:</b>	Month	Day	Year	<b>TO:</b>	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 in an official school envelope.

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

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

<b>NAME OF PROGRAM:</b>							
<b>ADDRESS:</b>	Street						
City:			State:			ZIP:	
<p>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.</p>							
<b>DEGREE AWARDED:</b>				<b>GRADUATION DATE:</b>	Month	Day	Year

<b>SIGNATURE OF PROGRAM DIRECTOR:</b>	_____						
<b>DATE:</b>	Month	Day	Year	<p>Upon completion, school must return this completed form directly to the Pennsylvania State Board of Medicine in an official school envelope.</p> <p align="center"><b>DO NOT RETURN THIS FORM TO THE APPLICANT</b></p>			
(Seal of School)							

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