

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
STATE BOARD OF MEDICINE

RENEWAL APPLICATION – PHYSICIAN ASSISTANT

Full Name

RETURN TO:

Street Address

**State Board of Medicine
PO Box 8414
Harrisburg, PA 17105-8414**

City State Zip Code

Email Address

License Number

Check if appropriate

- ADDRESS CHANGE** – The address above is a new address and not on file with the Board.
- NAME CHANGE** – The name above is not the current name on the licensure records. **(You must submit a photocopy of a legal document verifying name change (i.e., marriage certificate, divorce decree or legal document indicating retaking of a maiden name, etc.))**

Requesting Status Change: Please note, the Board may require licensees who have not actively practiced for four or more years and are requesting reactivation of an expired/inactive license/certification to successfully complete a clinical skills evaluation and/or retraining program. This may delay the reactivation of your license until an approved skills evaluation and/or retraining program has been successfully completed.

- I will not be practicing this profession in Pennsylvania after the expiration date indicated below and request inactive status.
No fee is required. Form must still be completed – questions answered, signed and dated.

SECTION A - THE FOLLOWING LICENSE RENEWAL QUESTIONS MUST BE ANSWERED

YES	NO	<i>If you answered yes to questions 2 through 12, provide details AND attach copies of legal document(s). IF YOU ALREADY REPORTED THE INFORMATION TO THE BOARD PRIOR TO THIS RENEWAL, YOU DO NOT NEED TO REPORT IT AGAIN.</i>
		1. Do you hold or have you ever held a license, certificate, permit, registration or other authorization to practice any health-related profession or occupation in any state or jurisdiction? If you answered yes, provide the profession and state or jurisdiction. LIST: _____
		2. Since your initial application or last renewal, whichever is later, 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. Since your initial application or last renewal, whichever is later, 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. Since your initial application or last renewal, whichever is later, 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. Since your initial application or your last renewal, whichever is later, have you had your DEA registration denied, revoked or restricted?
		8. Since your initial application or your last renewal, whichever is later, have you had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority?
		9. Since your initial application or your last renewal, whichever is later, have you ever had practice privileges denied, revoked, suspended, or restricted by a hospital or any health care facility?
		10. Since your initial application or your last renewal, whichever is later, have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?

YES	NO	<i>If you answered yes to questions 2 through 12, provide details AND attach copies of legal document(s). IF YOU ALREADY REPORTED THE INFORMATION TO THE BOARD PRIOR TO THIS RENEWAL, YOU DO NOT NEED TO REPORT IT AGAIN.</i>
		11. Since your initial application or last renewal, whichever is later, 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 your initial application or your last renewal, whichever is later, 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 <u>filing date</u> and <u>the date you were served</u>. **If you previously reported the complaint to the Board provide the docket number _____
		13. Do you maintain current medical professional liability insurance in the Commonwealth of Pennsylvania? If you answer "No", please provide an explanation or reason for an exemption request.
		14. Have you completed 2 hours of Board-approved continuing education in child abuse recognition and reporting?
		15. Do you hold current certification with the NCCPA?
		16. Please provide the zip code of your primary employer/practice location. This data is being collected for the purpose of identifying healthcare professionals during state emergencies and may be provided to the Pennsylvania Emergency Management Agency for official use only. Zip Code: _____

SPECIAL NOTICE TO ALL HEALTH-RELATED LICENSEES AND FUNERAL DIRECTORS

ACT 31 OF 2014 – INITIAL TRAINING AND CONTINUING EDUCATION IN CHILD ABUSE RECOGNITION AND REPORTING REQUIREMENTS

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.

Additionally, EFFECTIVE WITH THE FIRST LICENSE RENEWAL AFTER JANUARY 1, 2015, all health-related licensees and funeral directors applying for the renewal of a license issued by the Board shall be required to complete at least 2 hours of Board-approved continuing education in child abuse recognition and reporting requirements as a condition of renewal.

Please note that Act 31 applies to all health-related licensees, regardless of whether they are subject to the continuing education requirements of the applicable board.

Approved providers can be found by clicking on the Act 31 Mandated Child Abuse Reporter Training link on the Department's website at www.dos.pa.gov. Act 31 may be reviewed at the following link: <http://www.legis.state.pa.us/cfdocs/Legis/LI/uconsCheck.cfm?txtType=HTM&yr=2014&sessInd=0&smthLwInd=0&act=31>.

SECTION B – VERIFICATION OF INFORMATION

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 Licensee (**Mandatory**): _____ Date: _____

EXPIRATION DATE: →	December 31, 2016
FEE – Payable to "COMMONWEALTH OF PENNSYLVANIA" →	\$40.00
Write your license number on your payment. A \$20.00 fee will be assessed for returned payments.	
LATE FEE – \$5.00 per month, or part of a month will be assessed if postmarked AFTER 12-31-16	
PRACTICING ON AN EXPIRED LICENSE MAY RESULT IN DISCIPLINARY ACTIONS AND ADDITIONAL MONETARY PENALTIES	
TO ENSURE YOU RECEIVE YOUR NEW LICENSE BEFORE IT EXPIRES	
RETURN BY: DECEMBER 1, 2016	

* Required to avoid duplication

* Anonymous & aggregate reporting only



**Commonwealth of Pennsylvania
Department of Health
2016 Survey of Physician Assistants**

IF YOU HAVE ALREADY SUBMITTED YOUR RENEWAL SURVEY ONLINE, DO NOT MAIL THIS SURVEY

The Department of Health, with the support of the Department of State, requests that you complete this survey to assist in understanding and describing the physician assistant workforce. Strict controls are placed upon information when shared for the production of statistical reports and analysis. This information, when released to the public, will be in aggregate form only. To view past physician assistant workforce reports, visit www.health.state.pa.us/workforce. Thank you for your cooperation!

1. Year of birth 2. Sex Male Female 3. Hispanic or Latino origin Yes No
4. Race (Check one) American Indian/Alaska Native Asian Black/African-American
 Native Hawaiian/Other Pacific Islander White/Caucasian Two or more races
 Other _____
5. State of residence (State abbreviation) Non-U.S. (check) 5a. County of Residence (Codes on page 4)
 If you do not practice in Pennsylvania, select 00 for county not in Pennsylvania.
6. Highest physician assistant degree attained? (check one)
 Certificate/diploma/associate Bachelor Master Doctorate
- 6a. In which state did you obtain this degree? (State Abbreviation) Non-U.S. (check)
- 6b. In what year did you obtain this degree?
7. In which state did you complete the majority of your clinical rotations? (State abbreviation) Non-U.S. (check)
8. In which state were you first licensed as a physician assistant? (State abbreviation) Non-U.S. License (check)
- 8a. In what year was your first physician assistant license issued?
9. Enter the code number that best describes the primary specialty area in which you are currently practicing:

Note: All surgical specialties are listed alphabetically under surgery.

- | | | |
|--|--|---------------------------------------|
| 01= Addiction Medicine | 20= Medical Genetics | 39= Psychiatry – child and adolescent |
| 02= Adolescent Medicine | 21= Neonatal-Perinatal Medicine | 40= Psychiatry – forensic |
| 03= Allergy and Immunology | 22= Nephrology | 41= Pulmonary disease |
| 04= Anesthesiology | 23= Neurology | 42= Radiation oncology |
| 05= Cardiovascular Disease | 24= Neuromusculoskeletal Medicine | 43= Radiology |
| 06= Critical Care Medicine | 25= Nuclear Medicine | 44= Rheumatology |
| 07= Dermatology | 26= Obstetrics and Gynecology | 45= Sleep medicine |
| 08= Emergency Medicine | 27= Occupational Medicine | 46= Surgery – general |
| 09= Endocrinology, Diabetes and Metabolism | 28= Oncology | 47= Surgery – colon and rectal |
| 10= Family Medicine/General Practice | 29= Ophthalmology | 48= Surgery – neurological |
| 11= Gastroenterology | 30= Otolaryngology | 49= Surgery – orthopedic |
| 12= Geriatric Medicine | 31= Pathology | 50= Surgery – pediatric |
| 13= Gynecology only | 32= Pediatrics – general | 51= Surgery – plastic |
| 14= Hematology | 33= Pediatrics – subspecialties | 52= Surgery – thoracic and cardiac |
| 15= Hospice and Palliative Medicine | 34= Pharmacology | 53= Surgery – vascular |
| 16= Hospitalist | 35= Physical medicine and rehabilitation | 54= Surgery – other |
| 17= Infectious Diseases | 36= Preventive medicine | 55= Urology |
| 18= Internal Medicine – General | 37= Psychiatry – general | 56= N/A |
| 19= Maternal & Fetal Medicine | 38= Psychiatry – adult | |

- 9a. Did you complete or are you currently completing a post-graduate physician assistant residency program in your primary specialty area? Yes No N/A
- 9b. In which state are you primarily practicing your primary specialty area? (State abbreviation)
 Non-U.S. (check) N/A
- 9c. In which county are you primarily practicing your primary specialty area? (Codes on page 4) N/A
 If you do not practice in Pennsylvania, select 00 for a county not in Pennsylvania.
- List any other counties in which you practice your primary specialty area. (Codes on page 4)
- 9d. 9e.
10. In the past 12 months, did you volunteer your services as a physician assistant in Pennsylvania? Yes No
11. In the past 12 months, did you provide direct patient care in a safety net facility in Pennsylvania, including volunteer hours?
 Note: for the purposes of this survey, a safety net provider includes the following: free health clinic, Federally Qualified Health Center (FQHC), Federally Qualified Health Center Look-Alike (FQHC-LA) or certified rural health clinic (RHC).
 Yes No
12. What is your current employment status? (Select the best fitting category)
- | | | |
|---|--|--|
| <input type="checkbox"/> Employed in health care (direct, indirect) | <input type="checkbox"/> Unemployed, disabled | <input type="checkbox"/> Unemployed, seeking work in health care |
| <input type="checkbox"/> Employed, not in health care | <input type="checkbox"/> Unemployed, not seeking work in health care | <input type="checkbox"/> Retired |

If employed in health care, continue to question 13.

If employed, not in health care, unemployed or retired, you have finished the survey. Thank you!

13. Which organization best describes the employer you work for the most hours each week? (Check one)
- | | | |
|--|---|---|
| <input type="checkbox"/> Consulting/contractual/Locum Tenens | <input type="checkbox"/> Insurance | <input type="checkbox"/> Urgent care center/clinic |
| <input type="checkbox"/> Group practice | <input type="checkbox"/> Pharmaceutical company | <input type="checkbox"/> University/academic center |
| <input type="checkbox"/> Government – federal/state/local | <input type="checkbox"/> Private practice – employee | <input type="checkbox"/> Other – independent organization |
| <input type="checkbox"/> Hospital | <input type="checkbox"/> Private practice – full/part owner | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Health system | <input type="checkbox"/> Public health organization – federal/state/local | <input type="checkbox"/> N/A |
14. Which setting best describes where you work the most hours each week? (Check one)
- | | | |
|---|---|--|
| <input type="checkbox"/> Academic institution | <input type="checkbox"/> Hospital – inpatient | <input type="checkbox"/> Office/clinic – multi specialty |
| <input type="checkbox"/> Ambulatory surgical facility | <input type="checkbox"/> Hospital – outpatient | <input type="checkbox"/> Public Health – federal/state/local |
| <input type="checkbox"/> Business/industry/insurance | <input type="checkbox"/> Long-term care center | <input type="checkbox"/> Research laboratory |
| <input type="checkbox"/> Correctional facility | <input type="checkbox"/> Nursing home | <input type="checkbox"/> Urgent care/convenient care |
| <input type="checkbox"/> Emergency department | <input type="checkbox"/> Office/Clinic – Solo practice | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Home health | <input type="checkbox"/> Office/Clinic – Single specialty | |
| <input type="checkbox"/> Hospital – federal/state | <input type="checkbox"/> Office/Clinic – Free/no charge | |
15. Are you currently providing clinical or direct patient care on a regular basis? Yes No >> **if 'Yes,' skip to question 16**
- 15a. How many years has it been since your provided clinical or direct patient care?
 Less than 2 years 2 to less than 5 years 5 to less than 10 years 10+ Years

16. Indicate number of hours you spent in Pennsylvania during a typical week in the past 12 months on each activity below:
 Note: For purposes of this survey, direct patient care includes the amount of time a physician assistant spends directly with patients in a medical setting; including time spent on patient record keeping and patient specific office work. This would also include 'on call' hours if the physician assistant is required to remain in a medical facility.

- | | |
|---|--|
| 16a. <input type="text"/> <input type="text"/> Administration | 16b. <input type="text"/> <input type="text"/> Research |
| 16c. <input type="text"/> <input type="text"/> Teaching/education | 16d. <input type="text"/> <input type="text"/> Clinical or direct patient care |

If you responded with zero hours of 'clinical or direct patient care,' you have finished the survey. Thank you!



17. What type of physician primarily supervises you? MD DO

18. In the past 6 months, have you utilized language interpretive services to patients? (Languages other than English)
 Yes No >> **If 'No,' skip to question 19.**

18a. In which languages did you utilize language interpretive service to patients? (Check all that apply)

- Arabic Chinese French German Hindi Italian
 Korean Russian Sign Language Spanish Urdu Other_____

For questions 19-21, please consider your use of health information technology (HIT) to find, send, and receive clinical information in the past 6 months. Exclude the use of HIT for administrative (i.e. billing) functions and for electronic prescribing. Note that for questions 20 and 21, HIT does not include faxing.

19. Do you routinely use HIT to find clinical information about your patients?

Yes No >> **if 'No,' skip to question 20**

19a. If yes, which kinds of clinical information do you use HIT to find? (Check all that apply)

- Care gaps per recommended guidelines (i.e., preventive care, immunizations, etc.) Clinical lists (i.e., problems, allergies, clinical notes) Prescription drug history via state monitoring system
 Images Lab results Recent admits/discharges
 Recent office visits

19b. If yes, the ability to electronically find information has:

- Improved my practice Hindered my practice Made no difference in my practice

20. Do you routinely use HIT to send clinical information (such as that included in 19a.)?

Yes No >> **if 'No,' skip to question 21.**

20a. If yes, who is the typical recipient of clinical information?

- Patient Other clinician Both

20b. If yes, the ability to electronically send clinical information has:

- Improved my practice Hindered my practice Made no difference in my practice

21. Do you routinely use HIT to receive clinical information (such as that included in 19a.)?

Yes No >> **if 'No,' skip to question 22.**

21a. If yes, who is the typical sender of clinical information?

- Patient Other clinician Both

21b. If yes, the ability to electronically receive clinical information has:

- Improved my practice Hindered my practice Made no difference in my practice

22. In the Past 6 months, have you provided care through the use of telehealth technology?

Yes No >> **if 'No,' skip to question 23.**

22a. If yes, In what capacity was the telehealth service provided? (Check one)

- Provider to patient Provider to patient and provider to provider Other_____

22b. If yes and provided to a patient, where is the patient receiving the telehealth service located? (Check all that apply)

- Academic/medical school Hospital Urgent care/convenient care
 Ambulatory surgical facility Long-term care center Other_____
 Correctional facility Nursing home
 Home Office/clinic

23. In the past 12 months, how **satisfied** were you with your medical career?

- Very satisfied Satisfied Dissatisfied Very dissatisfied

24. Overall, how **satisfied** are you with your medical career?

- Very satisfied Satisfied Dissatisfied Very dissatisfied



25. What is the greatest source of your professional **satisfaction**? (Check one)

- | | | |
|---|--|--|
| <input type="checkbox"/> Career growth | <input type="checkbox"/> Patient relationships | <input type="checkbox"/> Teaching opportunities |
| <input type="checkbox"/> Decision making autonomy | <input type="checkbox"/> Staff relationships | <input type="checkbox"/> N/A — completely dissatisfied |
| <input type="checkbox"/> Financial reasons – salary/income/benefits | <input type="checkbox"/> Patient care | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Intellectual challenge | <input type="checkbox"/> Practice environment | |
| | <input type="checkbox"/> Religious/philosophical | |

26. What is the greatest source of your professional **dissatisfaction**? (Check one)

- | | | |
|---|---|---|
| <input type="checkbox"/> Administrative burden | <input type="checkbox"/> Lack of available leisure time | <input type="checkbox"/> Staff relationships |
| <input type="checkbox"/> Decision making autonomy | <input type="checkbox"/> Limited time spent with patients | <input type="checkbox"/> N/A — completely satisfied |
| <input type="checkbox"/> Health information technology | <input type="checkbox"/> Oversight | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Insurance coverage | <input type="checkbox"/> Patient relationships | |
| <input type="checkbox"/> Financial reasons – salary/income/benefits | <input type="checkbox"/> Practice environment | |
| | <input type="checkbox"/> Practice restrictions | |

27. How long have you practiced as a physician assistant in Pennsylvania?

- Less than 3 years 3 to less than 6 years 6 to less than 11 years 11 to less than 16 years 16+ years

28. How much longer do you anticipate practicing as a physician assistant in Pennsylvania?

- Less than 3 years 3 to less than 6 years 6 to less than 11 years 11 to less than 16 years 16+ years

29. How much longer do you anticipate practicing direct patient care as a physician assistant in Pennsylvania?

- Less than 3 years 3 to less than 6 years 6 to less than 11 years 11 to less than 16 years 16+ years

30. If you plan to leave direct patient care in Pennsylvania in less than 6 years, indicate your **primary** reason below (check one).

- | | | |
|--|---|---|
| <input type="checkbox"/> Change careers | <input type="checkbox"/> Financial reasons – salary/income/benefits | <input type="checkbox"/> Retirement |
| <input type="checkbox"/> Complete further training | <input type="checkbox"/> Physical demands | <input type="checkbox"/> Relocation |
| <input type="checkbox"/> Dissatisfaction with career | <input type="checkbox"/> Practice demands | <input type="checkbox"/> Stress/burnout |
| <input type="checkbox"/> End of fellowship/training | <input type="checkbox"/> Practice restrictions | <input type="checkbox"/> Unknown future |
| <input type="checkbox"/> Family reasons | | <input type="checkbox"/> Other: _____ |

Thank you!

If you are interested in learning more about emergency disaster response effort volunteer opportunities in Pennsylvania, please access www.serv.pa.gov for more information.

Pennsylvania County Codes						
01=Adams	11=Cambria	21=Cumberland	31=Huntingdon	41=Lycoming	51=Philadelphia	61=Venango
02=Allegheny	12=Cameron	22=Dauphin	32=Indiana	42=McKean	52=Pike	62=Warren
03=Armstrong	13=Carbon	23=Delaware	33=Jefferson	43=Mercer	53=Potter	63=Washington
04=Beaver	14=Centre	24=Elk	34=Juniata	44=Mifflin	54=Schuylkill	64=Wayne
05=Bedford	15=Chester	25=Erie	35=Lackawanna	45=Monroe	55=Snyder	65=Westmoreland
06=Berks	16=Clarion	26=Fayette	36=Lancaster	46=Montgomery	56=Somerset	66=Wyoming
07=Blair	17=Clearfield	27=Forest	37=Lawrence	47=Montour	57=Sullivan	67=York
08=Bradford	18=Clinton	28=Franklin	38=Lebanon	48=Northampton	58=Susquehanna	
09=Bucks	19=Columbia	29=Fulton	39=Lehigh	49=Northumberland	59=Tioga	00=Not in PA
10=Butler	20=Crawford	30=Greene	40=Luzerne	50=Perry	60=Union	