THE STATE
of
ALASKA
Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing

Alaska State Medical Board
PO Box 110806, Juneau, AK 99811
Phone: (907) 465-2550
Email: *MedicalBoard@Alaska.Gov*
Website: *ProfessionalLicense.Alaska.Gov/StateMedicalBoard*

Physician Assistant (PA) License Application Instructions

PHYSICIAN ASSISTANT – CERTIFIED

To practice as a Physician Assistant - Certified, or to use the title, a person must be licensed under regulation 12 AAC 40.400 and authorized to practice under 12 AAC 40.408 by the State Medical Board. An approved Collaborative Plan must be on file with the State Medical Board in order to be authorized to practice.

The following must be received by the division before your application for Physician Assistant Certified can be reviewed:

1. **APPLICATION**
   A completed application, signed and notarized (#08-4226, pages 1-8).

2. **FEES**
   Fees made payable to "State of Alaska" in accordance with 12 AAC 02.250.

Nonrefundable Application Fee:	$200.00
Permanent License Fee:	$250.00
Collaborative Plan Fee (to establish or change):	$125.00
Prescription Drug Monitoring Program (PDMP):	$ 0.00
Total Fees Due:	$575.00

3. **AUTHORIZATION FOR RELEASE OF RECORDS**
   A completed Authorization for Release of Records form (#08-4226a).

4. **NCCPA CERTIFICATE**
   A certified true copy of current certification by the National Commission on Certification of Physician Assistants.

5. **DEA REGISTRATION CERTIFICATE**
   A copy of your current DEA registration certificate.

6. **VERIFICATION OF LICENSURE**
   A Verification of Licensure form (#08-4226b) from all licensing jurisdictions where the applicant holds or has ever held a license as any health care professional (e.g., physician assistant, nurse, MICP, dentist, optometrist, etc.).

7. **VERIFICATION OF PHYSICIAN ASSISTANT PROGRAM EDUCATION**
   A completed Verification of Physician Assistant Program Education form (#08-4226c).

8. **COLLABORATIVE PLAN**
   An approved plan of collaboration with a physician licensed to practice in the State of Alaska (#08-4226d).

9. **CLEARANCE REPORT – DEA**
   A completed Clearance Report form (#08-4226h) from the Drug Enforcement Administration.

10. **CLEARANCE REPORT - FSMB**
    A completed Clearance Report form (#08-4226f) from the Federation of State Medical Boards.

A certified true copy of your current NCCPA certificate must be maintained in your license file at all times, as well as a current copy of your DEA registration. Without those documents, you are not in compliance with regulations and may not practice.

PHYSICIAN ASSISTANT – GRADUATE

The graduate permit is valid only until the board receives notice that the applicant either failed to take or failed to pass the NCCPA examination.

The following must be received by the division before your application for Physician Assistant Graduate can be reviewed:

1. **APPLICATION**
   A completed application, signed and notarized (#08-4226, pages 1-8).

2. **FEES**
   Fees made payable to "State of Alaska" in accordance with 12 AAC 02.250.

Nonrefundable Application Fee:	$100.00
Collaborative Plan Fee (to establish or change):	$125.00
Total Fees Due:	$225.00

3. **AUTHORIZATION FOR RELEASE OF RECORDS**
   A completed Authorization for Release of Records form (#08-4226a).

4. **VERIFICATION OF PHYSICIAN ASSISTANT PROGRAM EDUCATION**
   A completed Verification of Physician Assistant Program Education form (#08-4226c).

5. **NCCPA ACCEPTANCE**
   Proof of having been accepted to sit for the NCCPA examination.

6. **COLLABORATIVE PLAN**
   An approved Outline for Plan of Collaboration with a physician licensed to practice in the State of Alaska (#08-4226d).

It is the responsibility of the Physician Assistant - Graduate to notify the board immediately upon receiving examination results. The graduate permit is valid only until the board receives notice that the applicant either failed to take or failed to pass the NCCPA examination.

A Physician Assistant - Graduate must be provided with continuous on-site supervision by either a licensed Physician Assistant - Certified or by a physician licensed to practice in Alaska. A Physician Assistant - Graduate may not prescribe controlled substances.

All applications must be accompanied by the appropriate fees. Personal checks, cashier's checks, or money orders must be made payable to the State of Alaska. Incorrect fees will delay processing of your application.

APPLICATION STATUS UPDATES
Our licensing examiner will send you a written status update upon the initial screening of the application.

COMPLETION OF THE APPLICATION FORMS
Help us do a good job processing your application: type or print legibly all application documents. Please read the instructions and give careful thought before answering the questions in the application - remember - you are certifying that the information is truthful and correct. Make sure all notary seals are properly affixed on the application and all documentation has been properly certified as required. Provide all documents requested in the application; incomplete applications will delay processing.

Failure to answer all questions completely and accurately, or the omission or falsification of information may be cause for denial of your application or disciplinary action if you are issued a license or permit by the board.
WHEN IN DOUBT, DISCLOSE ALL INFORMATION OR CALL OUR OFFICE.

CONFIDENTIALITY
The contents of licensing files are generally considered public. If you believe the additional information you are attaching to explain a "yes" answer should be held confidential, so state in the attachment. A request for confidentiality may or may not be granted.

DEA CLEARANCE REPORT
You are required to request a clearance report from the Drug Enforcement Administration for your DEA registration. Use the form provided in this packet and send your request to:

Drug Enforcement Administration
300 5th Avenue, Suite 1300
Seattle, WA 98104

If you do not currently hold a DEA registration, you must obtain one before you may be granted prescribing authority. You may obtain an application for the DEA registration by contacting the Seattle office at (888)219-4261 or go to their website at *http://www.deadiversion.usdoj.gov/drugreg/index.html* for information and application forms. When you are applying for a DEA registration, include a copy of your temporary permit or license from Alaska along with your application.

DENIAL OF LICENSE

The denial of an application for licensure may be reported to any person, professional licensing board, federal, state, or local government agency, or other entity making a relevant inquiry or as may be required by law.

FAX DOCUMENTS

Fax copies of documents are NOT accepted for documentation or verification in our licensing process.

LICENSE APPLICATION PROCESSING STAFF

Please visit our website to find the contact information for your Licensing Examiner:
ProfessionalLicense.Alaska.Gov/StateMedicalBoard or call (907)465-2550.

LICENSING PROCESS

Submit your complete application to the board with fees and pertinent documents. The licensing examiner assembles the documents for your file and advises the applicant of the application status. Upon the completion of the application file when all documents have been received from other organizations, the file is forwarded to the board's administrator who reviews the entire file. At the discretion of the administrator, a permit may be issued.

Applications will be processed in the order in which they are received in the board's office. Please ensure that you apply well in advance of your need for the permit or license. Board staff will not expedite one application before another.

LICENSE RENEWAL

All medical board licenses in Alaska are on a two-year cycle, with all licenses expiring December 31 of even-numbered years. Notification for license renewal is mailed out to license holders of record at least 30 days prior to expiration, usually in late October. You are required by law to keep your current address on file with the division (12 AAC 02.900).

Failure to receive a renewal notice is not considered an excuse for non-renewal. A physician assistant not intending to practice medicine in Alaska may renew their license in an inactive status. If you practice in the state occasionally, you must renew your license in active status. An inactive status license prohibits you from practicing; however, if you wish to reactivate your inactive license, contact the licensing examiner for instructions. It is illegal to practice medicine in Alaska with an inactive or lapsed license or permit.

If a physician assistant does not have a current collaborative plan in place, they may still renew their license as active but not authorized to practice. At a later date, when the physician assistant enters into a new collaborative plan, the active license remains in place.

OPIOID EDUCATION

Attestation of opioid education related to pain management, opioid use and addiction is required to qualify for a new license in the State of Alaska, unless you do not hold a valid DEA registration. You must document compliance with the opioid education requirement on your application.

PAYMENT OF CHILD SUPPORT

If the Alaska Child Support Enforcement Division has determined that you are in arrears on child support, you may be issued a nonrenewable temporary license valid for 150 days. Contact Child Support Services at (907)269-6900 to resolve payment issues.

PERFORMANCE ASSESSMENTS

Regulation 12 AAC 40.430 specifies the nature and frequency of performance assessments to be conducted by collaborating physicians with their physician assistants. Please review that regulation and its requirements. Copies of the statute and regulations may be obtained from the Division of Corporations, Business, and Professional Licensing or from our website.

PERSONAL INTERVIEWS

Applicants for medical licensure in Alaska may be required to have a personal interview either with an individual board member or with the full board. Should an interview be required, you will be notified and an interview scheduled. An interview may be required if, during the processing of your application, a question arises for which the board determines it requires additional information from you.

PLANS OF COLLABORATION

Collaborative plans must be on file with the board no later than 14 days following the effective date (beginning date of employment) of the plan. Both the physician assistant and the collaborating physician must retain copies of their active collaborative plans for their records. There must be at least one alternate collaborating physician on each plan. Plans must also be maintained at the practice location and available for public scrutiny.

PRACTICE REGULATIONS

It is the responsibility of the Physician Assistant - Certified to learn the governing regulations under which they must practice. Copies of the statute and regulations may be obtained from the Division of Corporations, Business, and Professional Licensing.

PRACTICING IN ALASKA

For information on physician assistant practice opportunities, you may wish to contact:

Alaska Academy of Physician Assistants
4450 Cordova Street – Suite 110
Anchorage AK 99503
Office Phone (800)478-8684 or 907/646-0588
Fax Phone (907)562-8641
Email: *info@akapa.org*

PRESCRIPTION DRUG MONITORING PROGRAM (PDMP)

A licensee may not prescribe or dispense a controlled substance until registration with the PMDP is complete. All actively licensed practitioners with a DEA registration number valid in any state or practice location must register with the Alaska Prescription Drug Monitoring Program (PDMP) within 30 days of initial licensure and use the PDMP to review a patient's prescription history each time before prescribing, administering, or dispensing a federally scheduled II or III controlled substance. For more information, please visit *PDMP.Alaska.Gov*

PROCESSING TIME

In general, average processing time for a temporary physician assistant permit is six to eight weeks. Full licensure can take twelve to fourteen weeks or longer. PLEASE PLAN ACCORDINGLY. Application processing time depends to a large extent on the response time from other organizations. Time required also depends upon our workload and the volume of applications being processed. Because the length of processing time for your application may vary considerably, we urge you to be patient until our processing is complete and the permit is issued.

If there are any "yes" responses or if adverse information is received, it will typically take longer to gather and evaluate additional data. If the application is referred to the Investigations Unit for investigation of a particular issue, processing time is extended by the time required to complete an investigation. Since investigations must be prioritized, it may take longer to complete the file.

SOCIAL SECURITY REQUIREMENT

Alaska Statute 08.01.060(b) requires an applicant for an occupational license to provide a United States social security number. Applicants who are foreign citizens and are unable to obtain a social security number must contact the division office for instructions. Social security numbers are required by federal law to be held confidential; we do not release these numbers to the public.

STALE DOCUMENTS

If during the license application process certain documents become older than twelve months from the date the document was received in our office, that document is considered to be stale and must be resubmitted. Affected documents include the application document, verifications of licensure from other licensing jurisdictions, the DEA clearance report and the FSMB Board Action Data Bank report.

TELEPHONE QUERIES

We have a very small staff and work hard to process applications as quickly as possible. Unnecessary telephone calls to our offices delay processing. If the licensing examiner must spend time answering numerous telephone queries, application processing time is affected. Because of the huge volume of telephone calls regarding the status of applications and because of privacy issues, we must restrict our telephone responses to the applicant only. We will not discuss your application with others.

TEMPORARY PERMIT

Upon receipt of your application and fees, and the minimally required documents,* your file is forwarded to the board's executive administrator. Following her review, she may authorize the issuance of a six-month temporary permit. Since the board only meets four times each year, the temporary permit is a courtesy license to expedite your ability to practice until the next board meeting when your full file will be considered.

During the six-month period of your temporary permit, the licensee is responsible for ensuring any remaining outstanding documents needed to complete the application are submitted to the division. The board must review and approve each complete application to convert the temporary license to a full license.

*List of minimally required documents needed to issue a temporary permit include: a) Complete license application form & licensing fee; b) NCCPA Certification / Notification of SPEX Exam Eligibility (PA Graduates); c) Release of Information form.

WEBSITE ADDRESS

The Division of Corporations, Business and Professional Licensing maintains a website where you may check to see if your license or permit has been issued. The address is *ProfessionalLicense.Alaska.Gov*

The medical board's website is *ProfessionalLicense.Alaska.Gov/StateMedicalBoard*

WITHDRAWAL OF APPLICATIONS

The board permits the withdrawal of an application that it has not yet considered at a board meeting. Should you wish to withdraw your application, please submit a request for withdrawal in writing stating the reason for the withdrawal. Such requests must be received before the first time the board reviews and considers the application. All withdrawals are reported to the Federation of State Medical Boards stating the reason for the withdrawal.

PROFESSIONAL FITNESS QUESTIONS

A “yes” response in the application does not mean your application will be denied. If you have responded “yes” to any question in the application, additional time will be required for the gathering and assessment of pertinent information. You can expedite this process by providing with your application complete explanations and documentation for any “yes” responses.

HOW CAN YOU HELP?

1. First and foremost: apply far enough in advance to allow for application processing.
2. If you are concerned about your application being received in our office, mail it Certified - Return Receipt.
3. Ensure the application is complete when you submit it and provide any necessary explanations with the application. Print legibly or type your application.
4. Provide complete explanations for any “yes” responses. It saves time if we don’t have to contact you and request such information.
5. Provide a brief description for any malpractice claims describing the allegation, the nature of the case, your level of involvement, and the resolution of the case.

WHEN IN DOUBT, DISCLOSE AND EXPLAIN.

THE STATE of ALASKA

Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing

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FOR DIVISION USE ONLY

Alaska State Medical Board
PO Box 110806, Juneau, AK 99811
Phone: (907) 465-2550
Email: *MedicalBoard@Alaska.Gov*
Website: *ProfessionalLicense.Alaska.Gov/StateMedicalBoard*

Physician Assistant License Application

PART I Payment of Fees

Required Fees: (PA – Certified)	☐ Nonrefundable Application Fee	**$200.00**
	☐ License Fee	**$250.00**
	☐ Collaborative Plan Fee	**$125.00**
Required Fees: (PA – Graduate)	☐ Nonrefundable Application Fee	**$100.00**
	☐ Collaborative Plan Fee	**$125.00**
PDMP Fees:	☐ I have an active DEA registration number valid in any state or practice location.	**$ 0.00**
	☐ I do not have an active DEA registration number valid in any state or practice location.	**$ 0.00**

PART II Personal Information

Full Legal Name:

Provide all other names used (maiden, nicknames, aliases). If any documentation will be received in a prior name, you must provide a certified true copy of the documentation showing proof of legal name change(s).

☐ Not Applicable
☐ Other Names Used: ____

	Street	City	State	Zip
Residence Address:				
Practice Address:				

Which address do you want to use for your mailing address and for the public record? ☐ Residence Address ☐ Practice Address

Contact Phone:		**Date of Birth:**	
Place of Birth:		**Gender:**	

PART II Personal Information (continued)

EMAIL AGREEMENT: By choosing to receive correspondence on any matter affecting my license or other business with the Alaska Division of Corporations, Business and Professional Licensing, I agree to maintain an accurate email address through the MY LICENSE web page. I understand that failure to check my email account or to keep the email address in good standing may result in an inability to receive crucial information, potentially resulting in my inability to obtain or maintain licensure.

Email Address:		**Select One:**	☐ Send my Correspondence Electronically ☐ Send my Correspondence by Mail

Note: If both boxes are selected above, you will receive correspondence electronically.

SOCIAL SECURITY NUMBER: AS 08.01.060 requires you to provide your United States Social Security Number. It is considered confidential information and will not be publicly disclosed; it may be used to verify inter-state licensure.	

PART III Alaska License or Permit

Complete the following if you have previously held a license or permit in Alaska.

Previous License or Permit Type:			
Previous AK License or Permit Number:		**Date Issued:**	

PART IV Physician Assistant Education Information

Identify the physician assistant program you completed. If you attended more than one program, list all.

Name of Institution	Location (City, State)	Degree/Certificate Awarded	Date Awarded

PART V Additional Education

Other than as a physician assistant, have you attended or completed any other education for any of the professions in the healing arts? ☐ Yes ☐ No

Name of Institution	Location (City, State)	Degree/Certificate Awarded	Date Awarded

PART VI Opioid Education

☐ I have received education in pain management, opioid use, and addiction. Upon renewal of my Alaska license, I will provide a Certificate of Completion that confirms at least two hours of credit covering all three areas of the required subject matter: pain management, opioid use, addiction.

☐ I request a waiver of the requirement for two hours of education in pain management, opioid use, and addiction until I apply for a DEA registration number.

PART VII Military Service

Have you ever been in the armed forces?	☐ Yes ☐ No		
Branch of Service:		**Date of Commission:**	
Location(s) Where You Served:			
Type of Discharge:		**Date of Discharge:**	

PART VIII DEA Registration and PDMP Acknowledgment

1. **Providers with a DEA registration number valid to use in any state or practice location must register with the PDMP. Do you have a DEA Registration number?**

☐ **a.** **NO**, I do not have an active DEA registration number valid to use in any state or practice location. I understand if I obtain a DEA registration number, I must register with the Alaska PDMP within 30 days as required by the board. I will comply with mandatory use and refer to all applicable authorizing statutes and regulations. (Skip to Part IX)

☐ **b.** **YES,** I have an active DEA registration number valid to use in any state or practice location. I understand I must register with the Alaska PDMP within 30 days of receiving this license, as required by the board, and will comply with mandatory use as required by AS 17.30.200 and 12 AAC 40.967.

☐ I acknowledge I must review a patient's prescription history prior to prescribing, administering, or dispensing a federally scheduled II or III controlled substance. I understand that I must also review the patient's history once every 30 days for up to 90 days, and at least once every three months if treatment continues for more than 90 days.

If I have a change in DEA registration number or status, I also understand I must promptly submit the DEA Registration Status Change Form (#08-4763).

If you're unsure of the DEA issue date, indicate January 1st of the estimated year.

DEA Registration Number:		Issue Date:		Expiration Date:	

2. **Providers who directly dispense a federally scheduled II - IV controlled substance are required to report daily. Do you plan to directly dispense?** Directly dispense means you deliver the substance directly to the user. Writing a prescription for a patient to fill at a pharmacy is NOT direct dispensing.

Reporting does not apply to you if you directly dispense an outpatient supply of 24-hours or less in practice locations exempt under AS 17.30.200(t). Exempted facilities include health care facilities (defined in AS 18.07.111 or AS 18.20.499), correctional facilities, inpatient pharmacies, and emergency departments.

Per AS 11.71.900(8) "dispense" means to deliver a controlled substance to an ultimate user or research subject by or under the lawful order of a practitioner, including the prescribing, administering, packaging, labeling, or compounding necessary to prepare the substance for that delivery; "dispenser" means a practitioner who dispenses.

☐ **a.** **YES**, I plan to directly dispense and acknowledge I must report daily per AS 17.30.200 and 12 AAC 52.865.

☐ **b.** **NO**, I do not plan to directly dispense and acknowledge that if I begin directly dispensing, I must report daily. (If you are not directly dispensing, the reporting criteria do not apply to you.)

PART IX Professional License(s)

Please list all states, territories, provinces, or foreign countries in which you currently are or have ever been licensed as any health care professional. Include instructional and training permits.

State or Jurisdiction	License Number	Issue Date	License Status (Active, Lapsed)

PART X Work History

Please provide a chronological listing of all medical and non-medical activities beginning with your graduation from high school or college, if appropriate, to the present date with no more than a 60-day gap in time. If necessary, make additional copies of this page, or continue to list your work history on a separate sheet labeled with your name and signed by you.

Please explain any gap in time of more than sixty (60) days duration.

Start Date	End Date	Facility / Location	Activity

PART XI Medical Malpractice History

Have you ever had any claims of malpractice filed against you?	☐ Yes ☐ No
If "yes," you must provide an explanation and support document for each case. Use the Medical Malpractice History Explanation Form (#08-4869) appended to this application.	

PART XII Professional Fitness Questions – Disciplinary History

The following questions must be answered. "Yes" answers may not automatically result in license denial.

For each "yes" response to any question, you must provide an explanation and documentation. Use the letter of explanation form (#08-4752) appended to this application; include full details, dates, locations, type of action, organizations or parties involved, and specific circumstances. A separate letter of explanation form must be provided for each "yes" answer documented below. Documentation includes copies of court orders, charging documents, board, or license actions, etc.

The contents of licensing files are generally considered public records. If you believe that the additional information you are attaching to explain a "yes" answer should be considered confidential, state that in the attachment. A request for confidentiality may or may not be granted.

For the purposes of this application, the word "discipline" is used. There are many forms of disciplinary actions that may be imposed by organizations, schools, programs, licensing authorities, and other agencies. Such disciplinary actions may include but not be limited to: Suspension, Surrender, Revocation, Probation, Academic Probation, Reprimand, Censure, Restricted License, Limited License, Conditioned License, or Letters of Counseling, Concern, Advice, Warning, Caution, Admonishment, Reprimand, etc. You must include non-reported disciplinary actions. Failure to disclose past history may be grounds for disciplinary sanctions.

When in doubt, disclose and explain.

	Question	Answer
1.	Have you ever been convicted of a crime (felony or misdemeanor) in any jurisdiction of the United States, including military, or any international jurisdiction?	☐ Yes ☐ No
	Is any such action pending?	☐ Yes ☐ No
2.	Have you ever been charged with a crime (felony or misdemeanor) in any jurisdiction of the United States, including military, or any international jurisdiction that did not result in acquittal or dismissal?	☐ Yes ☐ No
	Is any such action pending?	☐ Yes ☐ No
3.	Relating to the practice of medicine, has there ever been a finding of, or have you ever been found guilty of, professional misconduct, unprofessional conduct, incompetence, or negligence, by any jurisdiction of the United States, including military, or any international jurisdiction?	☐ Yes ☐ No
	Is any such action pending?	☐ Yes ☐ No
4.	Relating to the practice of medicine, have you ever had charges filed against you alleging professional misconduct, unprofessional conduct, incompetence, or negligence, in any jurisdiction of the United States, including military, or any international jurisdiction?	☐ Yes ☐ No
	Is any such action pending?	☐ Yes ☐ No
5.	Has any hospital or other health care facility disciplined, restricted, or terminated your professional training, employment, or privileges, or investigated a complaint or accusation regarding your practice (except for late medical records)?	☐ Yes ☐ No
	Is any such action pending?	☐ Yes ☐ No
6.	Have you ever voluntarily or involuntarily resigned or withdrawn from professional training, from employment, or your privileges from any hospital or other health care facility to avoid the imposition of disciplinary sanction, restriction, or termination?	☐ Yes ☐ No
	Is any such action pending?	☐ Yes ☐ No

PART XII Professional Fitness Questions – Disciplinary History (continued)

7. Have you ever been disciplined by a medical school or post-graduate training program, including academic probation? (Please read definition of "discipline" on page 5.) ☐ **Yes** ☐ **No**

Is any such action pending? ☐ **Yes** ☐ **No**

8. Have you ever had a license to practice medicine disciplined by any authority including a state medical board or a military authority (except for late medical records)? (Please read definition of "discipline" on page 5.) ☐ **Yes** ☐ **No**

Is any such action pending? ☐ **Yes** ☐ **No**

9. Have you ever been under investigation or inquiry by any medical licensing jurisdiction or authority? ☐ **Yes** ☐ **No**

Is any such action pending? ☐ **Yes** ☐ **No**

10. Have you ever had a medical license application denied by any medical licensing jurisdiction or authority? ☐ **Yes** ☐ **No**

Is any such action pending? ☐ **Yes** ☐ **No**

11. Have you ever voluntarily or involuntarily withdrawn an application for a license to practice medicine in any United States jurisdiction or any international jurisdiction? ☐ **Yes** ☐ **No**

Is any such action pending? ☐ **Yes** ☐ **No**

12. Have you voluntarily or involuntarily surrendered or suspended your license to practice medicine in any United States jurisdiction or any international jurisdiction? ☐ **Yes** ☐ **No**

Is any such action pending? ☐ **Yes** ☐ **No**

13. Have you ever voluntarily or involuntarily agreed to any limitations, restrictions, or conditions to your license to practice medicine? ☐ **Yes** ☐ **No**

Is any such action pending? ☐ **Yes** ☐ **No**

14. Has your employment by a clinic, hospital, or other health care organization ever been terminated involuntarily as a result of an actual or potential investigation or as grounds for disciplinary proceedings? ☐ **Yes** ☐ **No**

Is any such action pending? ☐ **Yes** ☐ **No**

"Yes" Answers

If you answered "yes" to any of the above questions, you must submit signed and dated documentation explaining the specific circumstance(s) of the incident(s).

PART XIII Professional Fitness Questions – Personal History

The following questions must be answered. "Yes" answers may not automatically result in license denial. **For each "yes" response to any question, you must provide an explanation and documentation.** Use the letter of explanation form (#08-4752) appended to this application; include full details, dates, locations, type of action, organizations or parties involved, and specific circumstances. A separate letter of explanation form must be provided for each "yes" answer documented below. Documentation includes copies of court orders, charging documents, board, or license actions, etc.

You must also have your treating physician submit a letter directly to the Board; the letter must include the following information:

- Summary of your diagnoses (including explanation, dates of onset and significant events, and frequency of contact with you)
- Medication history
- Impact on your ability to practice safely and competently

When in doubt about your response, disclose and provide the required explanation and documents. Applications submitted without the required attachments will be considered incomplete and will not be processed. The contents of licensing files are generally considered public records. If you believe that the additional information you are attaching to explain a "yes" answer should be considered confidential, state that in the attachment. A request for confidentiality may or may not be granted.

For the purposes of the questions in this section:
"Medical Condition" includes physiological, mental, or psychological conditions or disorders such as, but not limited to, orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

"Controlled Substances" means any substance as defined in either Alaska Statute 11.71.900 or the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C.A. Section 801 et seq. (Public Law 91-513) and any subsequent amendment(s).

"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application; rather, "currently" means recently enough so that the event, condition, behavior, impairment, limitation, etc., may have an ongoing impact on the applicant's ability to practice medicine in a competent manner.

"Illegal Drug Use" means the use of an illegally obtained controlled substance or dangerous drug; the term "illegal drug use" also means the use of a legally obtained controlled substance or dangerous drug which is not taken in accordance with the directions of the licensed physician who prescribed the controlled substance or dangerous drug.

1. In the past two years, have you been diagnosed as having, or been hospitalized for, a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? ☐ **Yes** ☐ **No**

2. Do you currently have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? ☐ **Yes** ☐ **No**

3. In the past two years, have you been the subject of any civil investigation or court process relating to your ability to practice in a safe and competent manner? ☐ **Yes** ☐ **No**

4. Are you currently engaged in the illegal use of drugs, or the use of illegal drugs? ☐ **Yes** ☐ **No**

5. In the past two years, have you used or are you currently using any chemical substance(s), legal or illegal, that in any way impaired or limited, or is currently impairing or limiting, your ability to practice medicine in a safe and competent manner? ☐ **Yes** ☐ **No**

6. Are you currently taking a controlled substance that limits your ability to practice medicine in a fully competent and professional manner with safety to patients? ☐ **Yes** ☐ **No**

7. Have you had or do you now have any disease or condition that interferes with your ability to perform the essential functions of your profession, including any disease or condition generally regarded as chronic by the medical community, i.e., (1) mental or emotional disease or condition; (2) alcohol or other substance abuse; (3) physical disease or condition, that presently interferes with your ability to practice your profession? ☐ **Yes** ☐ **No**

"Yes" Answers

If you answered "yes" to any of the above questions, in addition to your personal statement, you must submit a statement from your health care provider indicating your ability to safely practice medicine. Applications submitted without the appropriate attachments will be considered incomplete and will not be processed.

THE STATE *of* ALASKA

Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing

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FOR DIVISION USE ONLY

Alaska State Medical Board
PO Box 110806, Juneau, AK 99811
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Email: *MedicalBoard@Alaska.Gov*
Website: *ProfessionalLicense.Alaska.Gov/StateMedicalBoard*

Notary Signature Page

PART XIV Notarized Signature

I certify that the information in this application is true and correct to the best of my knowledge. I understand that if information is provided in the Criminal History Report from the State of Alaska, or FBI, that I did not report, the issuance of my license may be delayed or denied. I further certify that all credentials and supporting documents supplied by me are true and correct and that the photograph below is a true likeness of me taken within the past 60 days.

I agree to inform the Alaska State Medical Board within 30 days of any change in my credentialing or privilege status in any place of employment, any disciplinary actions or restrictions, or investigation of a complaint or accusation regarding my practice (except for late medical records).

I understand that any falsification or misrepresentation of any item or response in this application, or any attachment hereto, or falsification or misrepresentation of documents to support this application, is sufficient grounds for denying, revoking, or otherwise disciplining a license or permit to practice in the state of Alaska.

I further understand that it is a Class A misdemeanor under Alaska Statute 11.56.210 to falsify an application and commit the crime of unsworn falsification.

A person who makes a false statement on this application may be subject to civil and criminal penalties, including prosecution for perjury (AS 11.56.200 & AS 11.56.230).

Current Passport-Type Photo / Notary Seal				
	Applicant Printed Name:			
	Applicant Signature:			
	Notary Public for State of:		**Subscribed and Sworn to Before me on this Day:**	
	Notary Signature:		**My Commission Expires:**	

THE STATE
of
ALASKA
Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing

Alaska State Medical Board
PO Box 110806, Juneau, AK 99811
Phone: (907) 465-2550
Email: *MedicalBoard@Alaska.Gov*
Website: *ProfessionalLicense.Alaska.Gov/StateMedicalBoard*

Authorization for Release of Records

I hereby authorize the Alaska Division of Corporations, Business, and Professional Licensing and its investigators to examine my medical and dental records, employment and education records including all training which pertains to my medical practice, and any records pertaining to litigation, judgments, suits, and/or settlements, and any law enforcement records pertaining to me and discuss them with persons having possession of them. I also expressly permit and authorize the release of any and all such records pertaining to me to the Alaska Division of Corporations, Business, and Professional Licensing and its investigators. This release also applies to all records that pertain to credentialing records at facilities at which I have applied for or held privileges to practice medicine.

I authorize the division to discuss my records with persons or organizations that are considered appropriate by the division in connection with an official investigation, and to provide copies of my records to those persons or organizations deemed appropriate by the division.

This release also applies to any documents or records which contain information pertaining to psychiatric, psychological, drug, or alcohol evaluation, counseling, diagnosis or treatment received by me and which were prepared or made in conjunction with, or under the authority or guidance of any local, state, or federal law which relates to psychiatric, drug or alcohol evaluation, diagnosis or treatment, including all information previously identified, collected, or stored under the authority of any state or federal law, including 42 CFR Part 2.

I request that upon presentation of this release, or a Certified True Copy thereof, that you provide copies of those records to the division and/or its investigators, and/or representatives of the Office of the Attorney General of the State of Alaska.

This authorization expires one (1) year from the date of my signature below.

Name:	First / Middle / Last		
Full Address:	P.O. Box or Street / City / State / Zip		
Phone:		**Date of Birth:**	
Email:			
Signature:		**Date Signed:**	

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Verification of Licensure

→ Applicant:

Please complete the identifying information below and forward a copy of this form to all states, territories, or jurisdictions where you currently are or have ever been licensed. *Make additional copies of this form, as needed.*

Applicant Name:		**Date of Birth:**	
Maiden or Other Names Used:			
Mailing Address:	P.O. Box or Street / City / State / Zip		
Physician Assistant Program Attended:		**Year of Graduation:**	
Applicant Signature:		**Date Signed:**	

→ Licensing Agency or State Board:

Please complete this bottom part for the applicant identified above and return the form directly to the Alaska State Medical Board at the letterhead address.

License Number:		**State or Jurisdiction:**	
Name of Training Program:		**License Status:**	
Original Issue Date:		**Expiration Date:**	

1.	Has this applicant ever been the subject of an investigation by a licensing or disciplinary authority in your state or jurisdiction, or is any such investigation or action pending?	☐ Yes	☐ No
2.	Have formal disciplinary proceedings been initiated against this applicant or the applicant's license by a licensing or disciplinary authority in your state or jurisdiction?	☐ Yes	☐ No
3.	Has this applicant's license ever been suspended, revoked, disciplined, restricted, warned, placed on probation, or in any other manner limited by a licensing or disciplinary authority in your state, or is any such investigation or action pending?	☐ Yes	☐ No
4.	Is any such investigation or action pending?	☐ Yes	☐ No
5.	Are you aware of any derogatory information regarding this applicant?	☐ Yes	☐ No

"Yes" Answers

If you answered "yes" to any question above, please attach a detailed explanation or documentation signed and dated by the person whose signature appears below.

Board Seal	**Signature:**		**Date Signed:**	
	Printed Name:		**Title:**	
	Email:		**Phone:**	

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Verification of Physician Assistant Program Education

Applicant: Please complete the identifying information below and forward a copy of this form to the program or school which awarded your physician assistant diploma.

Applicant Name:		**Date of Birth:**	
Maiden or Other Names Used:			
Mailing Address:	P.O. Box or Street / City / State / Zip		
Full Program or School Name:		**Program Location:**	
Applicant Signature:		**Date Signed:**	

Program or School Staff: Please complete this bottom part for the applicant identified above and return the form directly to the Alaska State Medical Board at the letterhead address. All information requested below must be provided; if any space is left blank, the document will be returned to you for completion.

Exact Date on Diploma or Certificate:	

1. The physician assistant program included at least two hours of education in pain management and opioid use and addiction. ☐ Yes ☐ No

2. During this physician assistant's education, was he/she ever investigated by the program/school or disciplined by the program/school for any reason? Disciplinary actions include but are not limited to being placed on probation, issued a letter of reprimand, censured, suspended, restricted, or otherwise disciplined. ☐ Yes ☐ No

"Yes" Answers

If you answered "yes" to question 2, please attach a detailed explanation or documentation signed and dated by the person whose signature appears below.

Board Seal	**Signature:**		**Date Signed:**	
	Printed Name:		**Title:**	
	Email:		**Phone:**	

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Physician Assistant Collaborative Plan

Important Instructions:

1. **Complete all parts of the plan** – print legibly or type. **Incomplete plans will not be accepted.**
2. Include the $125 Collaborative Plan fee with this form.
3. Attach a detailed curriculum vitae for the PA, if applicable, for remote site practice (see remote site information below).

IT IS YOUR RESPONSIBILITY TO ENSURE THAT THIS DOCUMENT IS FILED IN A TIMELY MANNER AND THAT IT IS COMPLETE WHEN FILED.

**** * INCOMPLETE PLANS WILL BE RETURNED AND WILL NOT BE PROCESSED *****

Physician Assistant Name:		**Collaborating Physician Name:**	

This section is only for Physician Assistants in a remote site practice.

REMOTE SITE: Location of physician assistant's practice is more than 30 miles by road from physician's primary office.

Option 1: Physician Assistants with less than two years of full-time clinical experience:

☐ Must work 160 hours in direct patient care under the direct and immediate supervision of the primary collaborating physician or an alternate.

☐ The first 40 hours must be completed before going to the remote site practice; the remaining 120 hours must be completed within 90 days of going to the remote site practice.

I hereby certify the hours of supervision will commence as soon as this plan is approved and prior to practicing at the remote site. The completed Verification of Hours of Supervision form (#08-4226g) will be sent to the State Medical Board immediately upon completion of the required hours.

_______________ **(Physician: Initial this statement if applicable.)**

- OR -

Option 2: Physician Assistants with more than two years of full-time clinical experience:

☐ Must attach a detailed curriculum vitae which describes the education, skills, and experience sufficient to meet the needs and demands of the remote site practice.

Upon my careful review, as primary collaborating physician, it is my opinion that the previous experience of the physician assistant documented in the attached curriculum vitae has adequately prepared and qualified this individual to work at the remote site practice location identified in this plan.

Primary Collaborating Physician Signature:	

IMPORTANT REGULATIONS (See Booklet for Complete Regulations Language)

PERFORMANCE AND ASSESSMENT OF PRACTICE, 12 AAC 40.430: It is understood by the physician and the physician assistant that a periodic method of assessment is or will be established which will include the physician's evaluation of physician assistant's work performance which means evaluation of medical care and clinic management. Please refer to the full regulation for the frequency of assessments required. It is further understood that documentation of such periodic assessments may be audited by the State of Alaska at any time.

COMMUNICATIONS WITH SENSORY-IMPAIRED PATIENTS, 12 AAC 40.980(A)(4): A method is or will be devised whereby a physician assistant's level of education and professional training are communicated to patients who may be blind, deaf, or otherwise impaired.

IDENTIFICATION OF PHYSICIAN ASSISTANT, 12 AAC 40.460: It is understood that the physician assistant will wear on his/her clothing a nameplate identifying them as a "Physician Assistant-Certified" and shall display a sign at the place of employment which posts current state licensure and that documents of the Physician Assistant's education and plan of collaboration are available for inspection.

PRESCRIPTIVE AUTHORITY, 12 AAC 40.450:

Prescribing Schedules II, III, IV, and V [12 AAC 40.450(c)] The physician assistant named in this plan may, with a valid DEA registration, write a prescription for a schedule II, III, IV, or V controlled substance medication with primary collaboration physician's approval.

Prescribing Authority May Not Exceed Physician's Authority, 12 AAC 40.450(d): The PA's prescriptive authority may not exceed that of the collaborating physician's prescriptive authority.

Obtaining Controlled Substance Supplies, 12 AAC 40.450(e): The physician assistant named in this plan may use the physician assistant's own DEA registration number to request, receive, order, or procure controlled substance supplies from a pharmaceutical distributor, warehouse, or other entity only with primary collaboration physician's approval.

Prescribe, Order, Administer, or Dispense Non-Controlled Medications, 12 AAC 40.450(f): The physician assistant named in this plan may prescribe, order, administer, or dispense a medication that is not a controlled substance only with primary collaboration physician's approval.

Physician Assistant

Full Name:		**License Number:**	
Address:	P.O. Box or Street / City / State / Zip		
Work Phone:		**Home Phone:**	
Email Address:			

Primary Collaborative Physician

Full Name:		**License Number:**	
Address:	P.O. Box or Street / City / State / Zip		
Work Phone:		**Home Phone:**	
Email Address:			

Alternate Physician #1

Full Name:		**License Number:**	
Address:	P.O. Box or Street / City / State / Zip		
Alternate #1 Signature:		**Work Phone:**	

(Attach addendum form #08-4226e with additional alternates if needed.)

Practice Information

Specific Location:	
Remote Site:	☐ Yes ☐ No

Effective Date of Plan

Beginning Date of Employment:	

PLAN MUST BE FILED WITH THE BOARD NO LATER THAN 14 DAYS FROM THIS DATE.

Prescriptive Authority

☐	12 AAC 40.450 (c) Prescribe, order, administer, and dispense schedule II, III, IV, and V drugs.
☐	12 AAC 40.450 (d) PA's prescriptive authority does not exceed physician's prescriptive authority. The physician must check the appropriate boxes in this section in order to grant those specific prescriptive authorities.
☐	12 AAC 40.450 (e) May procure controlled substance supplies.
☐	12 AAC 40.450 (f) Prescribe, order, dispense, administer non-controlled drugs.
☐	I do not wish to have any prescriptive authority under this plan.

Requirements of Law

The physician assistant will work only within the agreed scope of practice with the primary physician. All parties to this plan agree to comply with the provisions of all statutes and regulations relating to the physician assistant's practice of medicine in Alaska.

Signatures

Physician Assistant Printed Name:			
Physician Assistant Signature:		**Date Signed:**	
Primary Collaborating Physician Printed Name:			
Primary Collaborating Physician Signature:		**Date Signed:**	

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Addendum to Collaborative Plan

Physician Assistant Name:		**Primary Physician Name:**	

If you have more than one alternate collaborating physician for a collaborative plan, use this form to add additional alternate collaborating physicians and attach to the plan between the PA-C and the physician shown above.

Alternate Collaborating Physician's Statement

I hereby certify that I am familiar with the statutes and regulations of the State of Alaska governing the activities and responsibilities of a collaborating physician and that I will fulfill those responsibilities in this collaborative agreement in the absence of the primary collaborating physician. In entering into this agreement as alternate collaborating physician, I accept professional or employer liability to patients of the physician assistant for whom malpractice is adjudged. I have retained a copy of this agreement for my records. I will also maintain and make available for audit by the State of Alaska any performance assessment records which are generated as a result of this collaborative agreement in my capacity as alternate collaborating physician.

1. ☐ Add ☐ Delete ☐ No Change			
Signature:		**Date:**	
Printed Name:		**AK License Number:**	
Address:		**Phone:**	

2. ☐ Add ☐ Delete ☐ No Change			
Signature:		**Date:**	
Printed Name:		**AK License Number:**	
Address:		**Phone:**	

3. ☐ Add ☐ Delete ☐ No Change			
Signature:		**Date:**	
Printed Name:		**AK License Number:**	
Address:		**Phone:**	

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Website: *ProfessionalLicense.Alaska.Gov/StateMedicalBoard*

Physician Board Action Data Bank Inquiry

⟶ **Applicant**: Please complete the information below. Type or print legibly. **MAIL THIS REQUEST FORM TO:**

Federation of State Medical Boards
400 Fuller Wiser Rd., Suite 300
Euless, TX 76039-3855

Full Legal Name:			
Date of Birth:		**Social Security Number:**	
Mailing Address:	P.O. Box or Street	City	State Zip
Physician Assistant Program Name:		**Location:**	
Year of Graduation:		**If International Graduate, ECFMG No.:**	

⟶ **Applicant: Do Not Write Below This Line - Do Not Detach**

Instructions to the Data Bank Staff: Please search the data bank for any record of this practitioner. Please forward your report to the medical board at the letterhead address.

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Physician Assistant – Certified
Verification of Hours of Supervision

In accordance with 12 AAC 40.410 (e and f), physician assistants must complete 160 hours of direct and immediate supervised work before practicing at a remote location. Please complete this form and return to the address above.
You must hold a valid permit before working.

Physician Assistant

Full Name:				Contact Phone:	
Address:	P.O. Box or Street	City	State	Zip	

Collaborating Physician

Full Name:				Contact Phone:	
Address:	P.O. Box or Street	City	State	Zip	

Documented Hours of Supervised Work

Date	No. of Hours	Date	No. of Hours	Date	No. of Hours	Date	No. of Hours

Total Hours Submitted: ________________

Physician Assistant Signature:		Date Signed:	
Collaborating Physician Signature:		Date Signed:	

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Website: *ProfessionalLicense.Alaska.Gov/StateMedicalBoard*

DEA Clearance Report

→ **Applicant:** Please complete this top section, then mail to the Drug Enforcement Administration (DEA):
DEA Diversion, Registration
1630 East Tudor Road
Anchorage, AK 99507

Full Legal Name:			
Other Names Used:			
Date of Birth:		**DEA Registration Number:**	
Mailing Address:	P.O. Box or Street	City	State Zip
Address of DEA Registration:	P.O. Box or Street	City	State Zip
Applicant Signature:		**Date Signed:**	

→ **DEA Use Only:** Please search your records and advise if there is any derogatory information on file against this applicant. Please return this form directly to the Alaska State Medical Board at the letterhead address.

Has this applicant ever surrendered (for cause) or had a federal controlled substance registration revoked, suspended, restricted or denied? ☐ Yes ☐ No

Comments: ____

____

____

____

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Phone: (907) 465-2550
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Website: *ProfessionalLicense.Alaska.Gov/StateMedicalBoard*

Medical Malpractice History Explanation

Use this form to list and explain your history of malpractice claims filed against you. Include all settlements, judgements, award and claims, even if no money was paid.

Provide documents to corroborate your explanation, including a copy of the order for settlement, dismissal, or removal from the case.

Please do not send all of the motions or filings for a case.

Letters from attorneys or insurance carriers may be submitted to corroborate explanations but may not be substituted for this required explanation.

Location of Incident:		**Date of Occurrence:**	
Date of Case Closure:		**Amount of Settlement:**	
If there was a monetary settlement, upon what basis was it awarded ? (e.g., Attorney/Insurance Company recommended)			
Nature of Allegation and Description of the Case:			
Practitioner Explanation and Response to Allegation:			
What was the overall final injury to the patient? (e.g., disability or death)			

Full Name:			
Signature:		**Date Signed:**	

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Letter of Explanation for a Professional Fitness “Yes” Answer

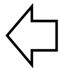
Use this form only to explain and document any professional fitness “yes” answers. A "yes" answer is not necessarily disqualifying but concealing one may be.

Each “yes” answer requires a separate explanation and associated documentation. Submit all relevant documentation with this form, even if you have previously provided it.

- **Explanations** include full details, dates, locations, type of action, organizations or parties involved, and specific circumstances. If the space provided is insufficient, make additional copies as needed.
- **Documentation** includes copies of court orders, charging documents, board or license actions, decisions against your professional certification, satisfaction of consent agreements (fines paid, community service completed, off probation, etc.), and fitness to practice letters (statement from your provider that you are safe to practice if you check “yes” to any of the questions regarding mental or physical health, or drug or alcohol abuse or addiction).
- **Disciplinary actions** may include, but not be limited to, suspension, surrender, revocation, probation, academic probation, reprimand, censure, restricted license, limited license, conditioned license, or letters of counseling, concern, advice, warning, caution, admonishment, or reprimand.

If you have multiple “yes” answers or multiple incidents for any professional fitness question, you must use a separate copy of this form and provide a full explanation and documentation for each incident.

The contents of licensing files are public records. If you believe that the additional information you are attaching to explain a “yes” answer should be considered confidential, state that in the attachment. A request for confidentiality may or may not be granted according to state law.

☐  **Write the professional fitness question number you are answering “yes” to in the box.**

Location of Incident:		**Date of Incident:**	
Explanation of Incident: When in doubt, disclose and explain. *Make copies as necessary.*			

Did you attach all applicable documents associated with this incident?

☐ Court Orders ☐ Consent Agreements ☐ Disciplinary Actions ☐ Charging Documents

☐ Court Records ☐ Fitness to Practice ☐ All Other Documentation Related to This Incident

☐ I have additional incidents for this “yes” answer, or “yes” answers to other Professional Fitness questions and have attached a separate copy of this form for each incident.

Full Name:		**Program:**	
Signature:		**Date Signed:**	

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Phone: (907) 465-2550

Credit Card Payment Form

All major credit cards are accepted. For security purposes, do not email credit card information. Include this credit card payment form with your application.

Name of Applicant or Licensee: ______________________________

Profession Type (e.g., Acupuncture): ______________________________

License Number *(if applicable)*: ______________________________

I wish to make payment by credit card for the following *(check all that apply)*: **AMOUNT**

- ☐ Application Fee: ______________________________ ____________
- ☐ License or Renewal Fee: ______________________________ ____________
- ☐ Other *(fine, exam, etc.)*: ______________________________ ____________

1. ______________________________ ____________
2. ______________________________ ____________

TOTAL: ____________

Name *(as shown on credit card)*: ______________________________

Mailing Address: ______________________________

Phone Number: ______________________________ Email *(optional)*: ______________________________

Signature of Credit Card Holder: ______________________________

- -

CREDIT CARD INFO: Your payment cannot be processed unless all fields are completed!

1. Credit Card Number: - **2.** Expiration Date: - **3.** Security Code: -	All 3 fields **MUST** be completed! This section will be destroyed after the payment is processed.