MONTANA BOARD OF MEDICAL EXAMINERS
PO Box 200513
(301 S PARK, 4TH FLOOR - Delivery)
Helena, Montana 59620-0513
(406) 444-5773 FAX (406) 841-2305
E-MAIL: dlibsdmed@mt.gov **WEBSITE:** www.medicalboard.mt.gov

APPLICATION FOR PHYSICIAN ASSISTANT LICENSE

IMPORTANT: A Physician Assistant may not practice medicine in Montana in any manner without the following (both are required):

1) an Active Montana license.
2) a signed Supervision Agreement on file with the Board.

LICENSING REQUIREMENTS:

- Must be a graduate of a physician assistant training program accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) or, if accreditation was granted before 2001, accredited by the American Medical Association's Committee on Allied Health Education and Accreditation or the Commission on Accreditation of Allied Health Education Programs.
- Must have successfully passed an examination administered by the National Commission on Certification of Physician Assistants.
- Must be of good moral character.

FEES: $500.00 License Application Fee
$ 25.00 Supervision Agreement Application Fee
Make payable to: Montana Board of Medical Examiners
(Fees are Non-refundable)

DOCUMENTS: The following documentation must be submitted to the Board office in order to complete your license application.

Original State Licensing Verifications (Form enclosed)
This form must be sent to all state boards or agencies in which you hold or ever held any license to practice in any profession. The completed verification, with original signature and seal, must be returned directly to the Montana State Board of Medical Examiners directly from that licensing agency.

NOTE: Any Documents not in English must be accompanied by certified translations.

NEW! The Board no longer requires P.A. applicants to submit a National Practitioner Data Bank (NPDB) self-query or a DEA Query. Instead, the Board will request a report from the NPDB about each applicant and obtain DEA information directly.
For more information about the NPDB and its reports, visit www.npdb.hrsa.gov.

APPLICATION PROCEDURES:

- When the application is complete, it will be processed and considered by Board staff for licensure.
  - If the application is considered non-routine there may be a delay in the processing of the application. The applicant may be notified to submit additional information or may be required to appear before the Board for a personal interview for consideration of the application during a regularly scheduled Board meeting.
  - **For an application requiring review by the full Board, all materials must be received by the Board office no later than 15 working days prior to the Board's next scheduled meeting. Applications completed after that deadline will not be put on the Board's agenda.** The Board meets six times per year (generally the third Friday of odd-numbered months) beginning in January. Please visit www.medicalboard.mt.gov for exact meeting dates.

- All verifications of licensure must be sent directly to the Board office from each state licensing board in which the applicant is currently licensed or has ever held a license. Please make copies of the attached verification request form as needed. Some states charge a fee for verifications. Contact each state board prior to sending the request to get specific information about requesting license verification.
- Keep the Board office informed at all times of any address changes or changes in license status, complaints or proposed disciplinary action. This is essential for timely processing of your application and subsequent licensure.

PROCESSING PROCEDURES:

- Once a completed routine application is received it may take up to 30 days to process.
- The applicant will be notified in writing of any deficient or missing items from the application file.
- The Board of Medical Examiners will verify your examination through NCCPA online services. You will be notified if there are any irregularities with the verification.
- The Board of Medical Examiners will request a report from the National Practitioner DataBank (NPDB.) You do not have to submit a "self-query" to the NPDB. You will be notified if the Board requires any additional information as a result of receiving the NPDB report.

SUPERVISION AGREEMENT:

A physician assistant has a dependent practice and must be under physician supervision. Under 37-20-101 and 37-20-403, MCA, the supervising physician is professionally and legally responsible for the all care and treatment of the physician assistant's patients.

In accordance with 37-20-401(5), MCA, a "supervision agreement" means a written agreement between a supervising physician and a physician assistant providing for the supervision of the physician assistant.
In accordance with Board rules, "supervision" is defined as accepting responsibility for, and overseeing all care and treatment of the physician assistant by telephone, radio or in person as frequently as necessary considering the location, nature of practice and experience of the physician assistant.

NOTE: For further information regarding Physician Assistant Montana Regulations and to read the FAQ's about Physician Assistants, please visit our website at: www.medicalboard.mt.gov

For information with regard to the processing of this application and other concerns please contact the Department at (406) 444-5773 or email the board at:
dlibsdmed@mt.gov

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Application for Licensure as a Physician Assistant

Allow 30 days from the date the Board has a complete routine application file for licensure.

1. FULL NAME: ____
   Last First Middle

2. OTHER NAME(S) KNOWN BY: ______________________________________

3. BUSINESS NAME: ____

4. BUSINESS ADDRESS: ____
   Street or PO Box # City and State Zip

5. HOME ADDRESS: ____
   Street or PO Box # City and State Zip

   PREFERRED MAILING ADDRESS: Business Home

   E-MAIL ADDRESS: ______________________________

6. TELEPHONE: (____) __________ (____) __________ (____) __________
   Business Home Fax

7. SOCIAL SECURITY NUMBER: ______________ FOREIGN ID NUMBER: __________

8. DATE OF BIRTH: ____________

9. GENDER: FEMALE MALE

10. Have you ever previously applied for a license to practice in Montana? If yes, give date, and results. Yes No

11. Have you ever been denied licensure or the opportunity to take this profession's licensing examination in any state or country? If yes, attach a detailed explanation. Yes No

12. Have you ever withdrawn an application for medical licensure? If yes, please give the state and reasons for withdrawal. Yes No

13. List all professional licenses you hold or **ever** have held. Verification must be sent directly to Montana from each state/province/territory.

State	License #	Issue Date	Expiration Date	License Method			Requested State Verification	
				Exam	Endorse	Other	Yes	No
				Exam	Endorse	Other	Yes	No
				Exam	Endorse	Other	Yes	No
				Exam	Endorse	Other	Yes	No
				Exam	Endorse	Other	Yes	No
				Exam	Endorse	Other	Yes	No

14. Have you ever had an application for a professional or occupational license refused or denied? If yes, please attach a detailed explanation and provide supporting documentation from the source. Yes No

15. Have you ever withdrawn an application for licensure prior to the licensing agency's decision regarding your application? If yes, please attach a detailed explanation and provide supporting documentation from the source. Yes No

16. Have you ever been denied the privilege of taking an examination required for any professional or occupational license? If yes, please attach a detailed explanation and provide supporting documentation from the source. Yes No

17. Have you ever withdrawn or been suspended, placed on probation, expelled or requested to resign from any postsecondary educational program? If yes, please attach a detailed explanation and provide supporting documentation from the source. Yes No

18. Have you ever requested temporary or permanent leave of absence, been placed on probation, restricted, suspended, revoked, allowed to resign, or otherwise acted against by any professional or occupational education program (i.e., residency, internship, apprenticeship, etc)? If yes, please attach a detailed explanation and provide supporting documentation from the source. Yes No

19. Has a licensing agency initiated or completed disciplinary action against any professional or occupational license you have held? If yes, please provide agency documents including the complaint, initiating documents, orders, final orders, stipulations and consent and/or settlement agreements directly from the source. Yes No

20. Have you ever voluntarily surrendered, cancelled, forfeited, failed to renew a professional or occupational license in anticipation of or during an investigation or disciplinary proceedings or action? If yes, please attach a detailed explanation and provide supporting documentation from the source. Yes No

21. Is there a complaint or investigation currently pending against you with a professional or occupational licensing agency? If yes, please attach a detailed explanation and provide supporting documentation from the source. Yes No

Please answer the following questions. If you answer yes, give specific details (names of organizations, dates, reasons, and outcome) on a Supplemental Sheet.

22.	Have you ever been the subject of any sanction or action, denial,suspension, revocation, restriction or termination regarding hospital, facility or staff privileges; health maintenance organization participation, third party provider or Medicare/Medicaid participation; or any other privileges? If yes, please attach a detailed explanation and provide supporting documentation from the source.	Yes	No
23.	Have you ever been censured, expelled, denied membership or asked to resign from a professional organization related to your profession or occupation? If yes, please attach a detailed explanation and provide documentation from the source.	Yes	No
24.	Have you ever been the subject of any sanction or action, denial, suspension, revocation, restriction or termination regarding your ability to prescribe, dispense or administer drugs including controlled substances? If yes, please attach a detailed explanation and provide documentation from the source.	Yes	No
25.	Do you have any initiated or completed action against you by any state, federal, tribal, or foreign licensing jurisdiction? (For example: Drug Enforcement Agency; Alcohol, Tobacco and Firearms; Homeland Security; Indian Health Service, etc) If yes, please attach a detailed explanation and provide documentation from the source.	Yes	No
26.	Have any civil legal proceedings been filed against you by a (patient/client), (former patient/client) or employer/employee? If yes, attach a detailed explanation and documentation from the source including initiating document(s) and documentation of final disposition.	Yes	No
27.	Do you have any criminal charges pending or have you ever pled guilty, forfeited bond, or been convicted of a crime (whether or not sentence was suspended or deferred), or have you pled no contest or had prosecution deferred whether or not an appeal is pending? If yes, attach a detailed explanation and documentation from the source. You must report but may omit documentation for: (1) misdemeanor traffic violations resulting in fines of less than $100; and (2) charges or convictions prior to your 18th birthday unless you were tried as an adult.	Yes	No
28.	Have you ever been diagnosed with chemical dependency or another addiction, or have you participated in a chemical dependency or other addiction treatment program? If yes, please attach a detailed explanation and provide documentation regarding evaluations, diagnosis, treatment recommendations and monitoring from the source.	Yes	No
29.	Have you ever been diagnosed with a physical condition or mental health disorder involving potential health risk to the public? If yes, please provide a detailed explanation.	Yes	No
30.	Have you ever been court-martialled or discharged other than honorably from any branch of the armed service? If yes, attach a detailed explanation and documentation for the source.	Yes	No

31. **PROFESSIONAL EDUCATION**:

Name of University or College	City and State/Province/Territory	Dates Attended	Degree Earned

Name of Physician Assistant School or Program	City and State/Province/Territory	Dates Attended	Degree Earned or Completion Date

Residency Program (if applicable)	City and State/Province/Territory	Dates Attended	Diploma Received
			Yes No
			Yes No

32. PRACTICE HISTORY: List **all** activities after physician assistant school (other than those already set forth above) in chronological order, up to and including the present. Specify nature of activity; for example, private practice, hospital practice, vacation, school, private employment, etc. (Indicate specific month and year for each activity).

Name & Location of Practice	Activity/Position	Inclusive Dates	Reason for Leaving

AFFIDAVIT

I authorize the release of information concerning my education, training, record, character, license history and competence to practice, by anyone who might possess such information, to the Montana Department of Labor and Industry, Healthcare Licensing Bureau.

I hereby declare under penalty of perjury the information included in my application to be true and complete to the best of my knowledge. In signing this application, I am aware that a false statement or evasive answer to any question may lead to denial of my application or subsequent revocation of licensure on ethical grounds. I have read and will abide by the current licensure statutes and rules of the State of Montana governing the profession. I will abide by the current laws and rules that govern my practice.

Legal Signature of Applicant ______________________ Dated ______________

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Helena, Montana 59602-0513

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AUTHORIZATION FOR RELEASE OF INFORMATION AND RELEASE FROM LIABILITY

(FOR APPLICANTS FOR PHYSICIAN ASSISTANT)

I, ______________________________, am an applicant for licensure as a physician assistant.

I authorize the Montana State Board of Medical Examiners (Board) to release information, verbally and in writing, to ______________________________ that includes, but is not limited to, application status, the particulars of missing application information or fees, disciplinary action, and any and all other information provided to the Board as part of my application.

I further expressly release the Board, the Department of Labor and Industry, and the State of Montana from liability for further unauthorized dissemination of this information by the above-named individual or entity.

A photocopy or electronic version of this signed release shall be considered as valid as the original. This authorization shall remain in force for as long as my application is pending, after a license is issued to me, and until revoked by me, in writing and received the Board.

____

Signature (Applicant/Licensee) Date

VERIFICATION OF LICENSURE

THIS IS NOT AN ENDORSEMENT CERTIFICATION

PLEASE COMPLETE THIS SECTION OF THE FORM AND MAIL TO EACH STATE BOARD IN WHICH YOU ARE NOW OR HAVE EVER BEEN LICENSED TO PRACTICE AS A PHYSICIAN. YOU MAY COPY THIS FORM AS MANY TIMES AS NEEDED. SOME BOARDS REQUIRE A FEE FOR THIS SERVICE.

STATE BOARD: ______________________________

I am applying for a license to practice medicine in the State of Montana. The Medical Board requires this form to be completed by each state wherein I hold or ever have held a professional/occupational license. This is your authority to release any information in your files, favorable or otherwise, **DIRECTLY** to the **BOARD OF MEDICAL EXAMINERS, P. O. BOX 200513, 301 SOUTH PARK AVENUE, HELENA, MT 59620-0513**. Your early response is appreciated.

______________________________ Name: ______________________________
(Signature) (Please print)

Address: ______________________________

____

My License Number is: ______________

DO NOT DETACH -- THIS SECTION TO BE COMPLETED BY AN OFFICIAL OF THE STATE BOARD AND

RETURNED DIRECTLY TO THE MONTANA STATE BOARD OF MEDICAL EXAMINERS

State of: ______________________________

Full Name of Licensee: ______________________________

License No. ______________ Issue Date: ______________________________

License is current? YES NO If NO, explain ______________________________

Has license been suspended, revoked, placed on probation or otherwise disciplined? YES NO

If YES, explain and attach documentation

____

Has licensee ever been requested to appear before your Board? YES NO

If YES, explain ______________________________

Derogatory information, if any ______________________________

Comments, if any ______________________________

BOARD SEAL

Signed: ______________________________
Title: ______________________________
State Board: ______________ Date: ______________

GENERAL INFORMATION FOR SUPERVISION AGREEMENTS

In order to practice as a Physician Assistant (PA) in Montana the PA must have on file with Board in accordance to MCA: 37-20-301, a supervision agreement. The following outlines general information for a supervision agreement for new applicants to the State of Montana, a new supervising physician and PA practice relationship or a change in supervising physician.

A. **Application Fee:** $25.00 for new Supervision Agreement with Physician Assistant License application;

B. **Supervising Physician** is defined as a medical doctor or doctor of osteopathy licensed by the Board who agrees to a supervision agreement and duties and delegation agreement.

C. **Qualification of Supervising Physician:**
  a. possess a current, active Montana license
  b. exercises supervision over the physician assistant in accordance with the rules adopted by the Board
  c. retains professional and legal responsibility for the care and treatment of patients by the physician assistant

D. **Qualifications for Physician Assistant** must have a current active Montana PA license.

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PLEASE TYPE OR PRINT IN INK.

(Please allow 10 days for processing from the date that the Board has a completed application. Non-routine applications requiring interviews may take longer depending on the applicant and supervising physician's schedule.)

Application for Supervision Agreement:

PHYSICIAN ASSISTANT INFORMATION:

1. FULL NAME: ______________________________
   Last First Middle
2. BUSINESS NAME: ______________________________
3. BUSINESS ADDRESS: ______________________________
   Street or PO Box # City and State Zip
4. HOME ADDRESS: ______________________________
   Street or PO Box # City and State Zip

   PREFERRED MAILING ADDRESS: Business Home E-MAIL ADDRESS: ______________
5. TELEPHONE (____) ______________ (____)______________ (____)______________
   Business Home Fax
6. SOCIAL SECURITY NUMBER: ______________ LICENSE NUMBER: ______________
7. DEA REG. # ______________ START DATE: ______________

SUPERVISING PHYSICIAN INFORMATION:

1. FULL NAME: ______________________________
   Last First Middle
2. BUSINESS NAME: ______________________________
3. BUSINESS ADDRESS: ______________________________
   Street or PO Box # City and State Zip
4. HOME ADDRESS: ______________________________
   Street or PO Box # City and State Zip

   PREFERRED MAILING ADDRESS: Business Home E-MAIL ADDRESS: ______________
5. TELEPHONE: (____) ______________ (____)______________ (____) ______________
   Business Home Fax
6. SOCIAL SECURITY NUMBER: ______________ LICENSE NUMBER: ______________
7. DEA REG. # ______________ START DATE: ______________

Requirements for use of a Physician Assistant:

A physician, office, firm, state institution or professional service corporation may not employee or make use of the services of a physician assistant in the practice of medicine unless the physician assistant is supervised by a physician licensed in the State of Montana, possesses a current active Montana PA license and has completed and submitted this Supervision Agreement application form with fee to the Board.

Scope of Practice:

A physician assistant may diagnosis, examine and treat human conditions, ailments, diseases, injuries or infirmities either physical or mental by any means, method, device or instrumentalities authorized by the supervising physician. The above named supervising physician and physician assistant shall execute a duties and delegation agreement constituting a contract that defines the physician assistants professional relationship with the supervising physician and the limitations on the physician assistant's practice under the supervision of the supervising physician. The duties and delegation agreement must be kept current by amendment or substitution to reflect changes in the duties of each party occurring over time. ***(All physician assistants must have a duties and delegation agreement on file prior to commencing practice.)***

Supervision:

A physician assistant is considered the agent of the supervising physician with regard to all duties delegated to the physician assistant. The supervising physician is professionally and legally responsible for the care and treatment of a patient by a physician assistant. The onsite or direct supervision of a physician assistant by the supervising physician is not required if the supervising physician has provided a means of communication between the supervising physician and the physician assistant or has identified a "back-up" supervising physician in the event of the primary supervising physician's absence.

"Back-up" supervision for periods of absence:

When the supervising physician is unavailable by means of communication the following will apply:

The supervising physician will provide for a "back- up" supervising physician(s) to supervise the above listed PA when the supervising physician is unavailable. A list of the "back-up" supervising physician(s) must be on file with the duties and delegation agreement, kept current and available upon request by the Board. ***(Important Note: Having a "back-up" supervising physician doesn't relieve the supervising physician listed in this agreement of the professional and legal responsibilities for the care and treatment of patients by the PA listed above.)*** OR

The physician assistant will cease to practice when the supervising physician is unavailable.

Chart Review:

The Board of Medical Examiners has recently amended its rule regarding Physician review of PA charts as follows. (NOTE: this is an unofficial version of the rule. The official version can be found only at the Montana Secretary of State's website: http:mtrules.org. The updated version of this rule may not be immediately available at that website.)

24.156.1623 CHART REVIEW
(1) Chart review for a physician assistant having less than one year of full-time practice experience from the date of initial licensure must be 20 percent for the first six months of practice, and then may be reduced to 10 percent for the next six months, on a monthly basis, for each supervision agreement.

(2) After twelve months, further chart review shall occur. The amount of chart review shall be at the discretion of the physician assistant and the supervising physician to determine in a duties and delegation agreement.

AFFIDAVITS AND SIGNATURES

I hereby declare under penalty of perjury the information included in my supervision agreement application to be true and complete to the best of my knowledge. In signing this application, I am aware that a false statement or evasive answer to any question or request for information may lead to a denial of my application or grounds for subsequent disciplinary action imposed on my licensure. I further affirm that I have read and accepted the licensing statutes and pursuant to my profession, including supervision agreement and duties and delegation agreement, and hereby certify that I will abide by all statues and rules of the Board of Medical Examiners that pertain to my licensure. I acknowledge and understand that I may not practice medicine independently pursuant to 37-20-104(2) and 37-20-301, MCA.

Physician Assistant:

____

(Print Name) (Signature) (Date)

PRIMARY SUPERVISING PHYSICIAN AFFIRMATION

I affirm that I have read and understand the current Board of Medical Examiners statutes and rules, including those pertaining to physician assistant, supervision agreements and duties and delegation and my responsibilities as supervising physician. I acknowledge and agree pursuant to 37-20-101, 37-20-301, 37-20-403, MCA to exercise appropriate supervision over the above named PA in accordance with all statues and rules of the Board of Medical Examiners. I acknowledge and agree that I will retain professional and legal responsibility for the care and treatment of patients by the above named PA. I understand that duties and responsibilities may be delegated, or restrictions imposed, at my discretion, including additional limitations on prescribing and dispensing of drugs above those granted by the Board, pursuant to 37-20-404, MCA, and will be reflected in the duties and delegation agreement.

Supervising Physician:

____

(Printed name) (Signature) (Date)