Montana Department of LABOR & INDUSTRY

Montana Board of Medical Examiners
PO Box 200513
301 S Park, 4th Floor
Helena, MT 59620-0513
Phone: 406-444-5773
Email: dlibsdhelp@mt.gov Website: www.medicalboard.mt.gov

Licensing Requirements and Application Checklist
Physician Assistant

License Requirements for Physician Assistant

Below are the minimum requirements you must meet in order to be licensed in the state of Montana.

1. Graduation from an accredited PA training program – [MCA 37-20-402, ARM 24.156.1617]
2. Passage of an examination administered by the NCCPA (PANCE exam) – [MCA 37-20-402, ARM 24.156.1617]
3. Good moral character – [MCA 37-20-402]

Checklist of Required Documents to Submit for Application for Physician Assistant

The following documents and additional forms are required in addition to the basic application. Educational or exam verifications must be sent to the board directly from the source. The board will accept Uniform Applications for PAs submitted via the Federation of State Medical Boards. State PA license verifications may be sent via VeriDoc.

- ☐ Official license verification from states and jurisdictions in which the applicant holds or has ever held a professional license of any type. (Verifications submitted via VeriDoc will be accepted.)
- ☐ Description and/or documentation of education and work experience since completing physician assistant training.
- ☐ If you answered yes to discipline questions, include a detailed explanation on the event(s) and documentation from the source (licensing board, federal agencies/programs, or civil/criminal court proceedings such as initiating/charging documents, final disposition/judgement documents, etc.)

Application Fee(s) for Physician Assistant

The following fee(s) must be submitted with your application. Online applicants can pay using a credit card or e-check. If you submit a paper application you must submit a check. Do not mail cash.

- ☐ $375 application fee

You can apply for a license online at https://ebiz.mt.gov/POL/ or download a paper application from the website. Online application is recommended.

Include a valid e-mail address with your application. E-mail is the department's primary form of communication.

If you have any questions about the application process or the licensing requirements please contact the Department of Labor and Industry Professional Licensing Bureau using the contact information at the top of this checklist.

MONTANA BOARD OF MEDICAL EXAMINERS
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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: $375.00 License 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.

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 30 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 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.

SUPERVISION RELATIONSHIP EDUCATION:

A supervision physician or physician assistant who is new to supervision relationships in Montana will also be required to submit a certificate of completion for the board-approved online education for physicians and physician assistants in supervision relationships. One can access the education and assessment here: https://dlitraining.mt.gov/login/index.php You will find instructions for setting up/logging into the course on the board website, here.

Upon passage of the quiz please submit the certificate of completion in one of the following ways:

- email to dlibsdmed@mt.gov
- mail to Board of Medical Examiners, PO Box 200513, Helena, MT 59620-0513
- upload to your online application

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) 444-6880 or email the board at: dlibsdmed@mt.gov

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E-MAIL dlibsdmed@mt.gov
WEBSITE: www.medicalboard.mt.gov

Application for Licensure as a Physician Assistant

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

PERSONAL HISTORY QUESTIONS
IMPORTANT INSTRUCTIONS AND NOTICE

- Please read the following questions carefully. Giving an incomplete or false answer is unprofessional conduct and may result in denial of your application or revocation of your license. See, 37-1-105, MCA.
- You have a continuing duty to update the information you provide in your application and supplemental responses, including while your application is pending and after you are granted a license.
- Upon submittal of your application form, for every "yes" answer provided, you will receive a request for specific information or documents associated with the question. Your application is not complete until staff receive all information requested.

PERSONAL HISTORY QUESTIONS

14. Have you ever had any license, certificate, registration, or other privilege to serve as a volunteer or practice a profession denied, revoked, suspended, or restricted by a public or private local, state, federal, tribal, religious, or foreign authority? ◯ Yes ◯ No

15. Have you ever surrendered a credential like those listed in question 14, in connection with or to avoid action by a public or private local, state, federal, tribal, religious, or foreign authority? ◯ Yes ◯ No

16. Have you ever resigned to avoid discipline, been suspended, or been terminated from a volunteer or employment position? ◯ Yes ◯ No

17. Have you ever been required to participate in a behavioral modification or assistance program in lieu of suspension or termination from a volunteer or employment position? ◯ Yes ◯ No

18. Have you ever withdrawn an application for any professional license? ◯ Yes ◯ No

19. As of the date of this application, are you aware of any pending complaint, investigation, or disciplinary action related to any professional license you hold? ◯ Yes ◯ No

20. Are you under a current order that remains unsatisfied (e.g., fines unpaid, probation not concluded, conditions unmet?) ◯ Yes ◯ No

Note on Questions 21 and 22: Applicants who disclose medical, physiological, mental, or psychological conditions or chemical substance use in Question 21 or 22 may qualify for participation in the Montana Professional Assistance Program. Please visit the board website for more information about this program. "Chemical substances" include alcohol, drugs, or medications, whether taken legally or illegally.

21. Do you have any medical, physiological, mental, or psychological condition which in any way currently (within the last 6 months) impairs or limits your ability to practice your profession or occupation with reasonable skill and safety? ◯ Yes ◯ No

22. Do you currently (within the last 6 months) use one or more chemical substances in any way which impairs or limits your ability to practice your profession or occupation with reasonable skill and safety? ◯ Yes ◯ No

The following information is provided for Question **23** below:
A criminal conviction may not automatically bar you from receiving a license. For more information about how a criminal conviction may impact your application, consult the board or program website.

23. Have you ever been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or sentence deferred or suspended as an adult or "juvenile convicted as an adult" in any state, federal, tribal, or foreign jurisdiction? ◯ Yes ◯ No

24. Are you now subject to criminal prosecution or pending criminal charges? ◯ Yes ◯ No

25. Have you ever been disciplined, censured, expelled, denied membership or asked to resign from a professional society or organization? ◯ Yes ◯ No

26. Have you ever had a civil judgment entered against you in a lawsuit for incompetence, negligence, or malpractice in practicing any profession? ◯ Yes ◯ No

27. Have you ever been disqualified from working with children, elderly persons, mentally ill persons, or other vulnerable persons? ◯ Yes ◯ No

28. Have you ever been placed on probation, restricted, reprimanded, suspended, revoked, resigned in lieu of action against you, or had other action taken against you by any hospital, clinic, health care facility, group medical practice, health maintenance organization, or third-party insurance provider, including Medicare and Medicaid? ◯ Yes ◯ No

29. Are you currently on an exclusion list by the Office of Inspector General (OIG) for the U.S. Department of Health and Human Services prohibiting you from working in a facility receiving federal funding? ◯ Yes ◯ No

30. Has your authority to prescribe, dispense, or administer drugs, including controlled substances, ever been denied, restricted, suspended, or revoked? ◯ Yes ◯ No

31. Have you ever voluntarily surrendered or had your U.S. Drug Enforcement Administration registration placed on probation, restricted, suspended, or revoked? ◯ Yes ◯ No

32. **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

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PHYSICIAN ASSISTANT PRACTICE HISTORY & SPECIALTY INFO

Practice History: List **ALL** activities after PA education (other than those already set forth above) in chronological order, up to and including the present, indicating **Month and Year** for each activity. **Account for all periods of time longer than 1 month**. Specify nature of activity; for example, private practice, hospital practice, vacation, school, private employment, etc. For any non-working time, you must state exactly what your activities were, such as "vacation" or "seeking employment" as well as your permanent address during that time. If you are listing a medical practice, indicate the nature of the practice and the percentage of working time spent in clinical and administrative duties. If you worked for a physician staffing group or did locum tenens, you must list all facilities where you worked and include complete dates and addresses. **DO NOT SUBSTITUTE ANY OTHER RESUME FORMAT FOR THIS SECTION.** Use additional paper if necessary.

Start (MM/ YYYY)	End (MM/ YYYY)	Type of Activity/ Position	Name and Address of Practice	Position/ Department	Percentage of Time Spent (total = 100%)		Reason For Leaving
					Clinical	Administrative	

Have you ever been certified by a Specialty Board?

Certifying Agency	Specialty	Date Awarded/ Re-Certified

Have you ever been denied specialty certification or failed to pass a specialty certification examination or portion thereof? No

If so, by whom? _____

Reason for denial?_____ Number of times failed:_____

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

(406) 444-6880 FAX (406) 841-2305

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 or dlibsdmed@mt.gov**. 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 _____

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. 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.

B. 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

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

D. Supervision Relationship Education:

A supervision physician or physician assistant who is new to supervision relationships in Montana will also be required to submit a certificate of completion for the board-approved online education for physicians and physician assistants in supervision relationships. One can access the education and assessment here: https://dlitraining.mt.gov/login/index.php You will find instructions for setting up/logging into the course on the board website, here.

Upon passage of the quiz please submit the certificate of completion in one of the following ways:

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- mail to Board of Medical Examiners, PO Box 200513, Helena, MT 59620-0513
- upload to your online application

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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: _____

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)