APA-1
6/93

TRANSMITTAL SHEET FOR NOTICE OF INTENDED ACTION

Control 540 Department or Agency Alabama State Board of Medical Examiners
Rule No. 540-X-7, Appendix D
Rule Title: Application for Licensure of a Physician Assistant
_______ New ___X___ Amend ________ Repeal _______ Adopt by Reference

Would the absence of the proposed rule significantly harm or endanger the public health, welfare, or safety?	YES
Is there a reasonable relationship between the state's police power and the protection of the public health, safety, or welfare?	YES
Is there another, less restrictive method of regulation available that could adequately protect the public?	NO
Does the proposed rule have the effect of directly or indirectly increasing the costs of any goods or services involved and, if so, to what degree?	NO
Is the increase in cost, if any, more harmful tot he public than the harm that might result from the absence of the proposed rule?	NO
Are all facets of the rulemaking process designed solely for the purpose of, and so they have, as their primary effect, the protection of the public?	YES

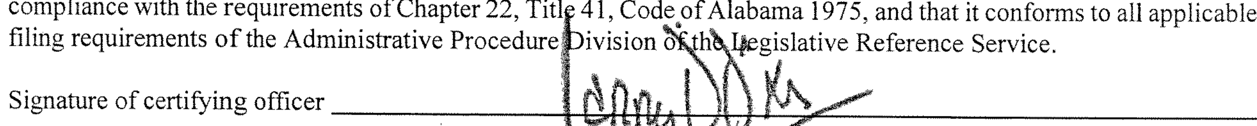
****

Does the proposed rule have an economic impact? NO

If the proposed rule has an economic impact, the proposed rule is required to be accompanied by a fiscal note prepared in accordance with subsection (f) of Section 41-22-23, Code of Alabama 1975.

****

Certification of Authorized Official
I certify that the attached proposed rule has been proposed in full compliance with the requirements of Chapter 22, Title 41, Code of Alabama 1975, and that it conforms to all applicable filing requirements of the Administrative Procedure Division of the Legislative Reference Service.



Signature of certifying officer ______________________

Date: December 16, 2011

APA-2
6/93

ALABAMA STATE BOARD
OF MEDICAL EXAMINERS

NOTICE OF INTENDED ACTION

AGENCY NAME: Alabama State Board of Medical Examiners

RULE NO. & TITLE: 540-X-7, Assistants to Physicians, Appendix D, Application for Licensure of Physician Assistant

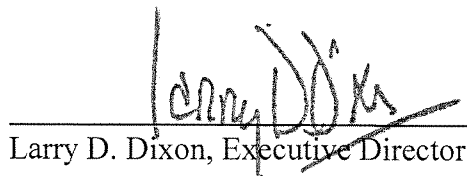
INTENDED ACTION: To amend the rule

SUBSTANCE OF PROPOSED ACTION: To add a statement concerning the statutory authority for requesting, requirement for requesting, uses of and consequences of not supplying an applicant's social security number.

TIME, PLACE, MANNER OF PRESENTING VIEWS: All interested persons may submit data, views, or arguments concerning the proposed new rule(s) and regulation(s) in writing to: Patricia E. Shaner, General Counsel, Alabama State Board of Medical Examiners, Post Office Box 946, Montgomery, Alabama 36101-0946, by mail or in person between the hours of 8:30 a.m. and 4:30 p.m., Monday through Friday, until and including Friday, February 3, 2012. Persons wishing to obtain copies of the text of this rule and submit data, views, or comments or arguments orally should contact Patricia E. Shaner, by telephone (334-242-4116) during said period in order to set up an appointment for a hearing respecting such oral data, views, or arguments.

FINAL DATE FOR COMMENT AND COMPLETION OF NOTICE: February 3, 2012

CONTACT PERSON AT AGENCY: Patricia E. Shaner



Larry D. Dixon, Executive Director

ALABAMA BOARD OF MEDICAL EXAMINERS

P.O. Box 946 / Montgomery, AL 36101-0946 / (334) 242-4116

APPLICATION FOR LICENSURE OF PHYSICIAN ASSISTANT

I. Physician Assistant's Name in Full____

Home Address ____________________________City____________State_____Zip_______

Place of Birth____________________________ Date of Birth____________ Sex ______

Social Security #* ____/____/______ Home telephone number (______) ________________

*Pursuant to Ala. Code § 30-3-194, it is mandatory that we request and that you provide your social security number (SSN) on this application. The uses of your SSN are limited to the purpose of administering the state child support program and intra-agency for identification purposes. If your SSN is not provided, your application is not complete, and no license will be issued.

II. If you answer yes to any of the following questions attach detailed explanation or document requested

		YES	NO
1.	Have you ever been convicted of a felony?	____	____
2.	Have you ever been convicted of a crime or offense (felony or misdemeanor) related to the practice of medicine?	____	____
3.	Have you ever been convicted of any violation of a state or federal law relating to controlled substances?	____	____
4.	Have you ever been denied a state or federal controlled substance certificate?	____	____
5.	Have you ever been denied prescription privileges for non-controlled or legend drugs by any state or federal authority?	____	____
6.	Has your certification or license to practice as a physician assistant in any state been suspended, revoked, restricted, curtailed, or voluntarily surrendered while under investigation in any state?	____	____
7.	Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited, placed under conditions restricting your practice, or voluntarily surrendered while under investigation?	____	____
8.	Have you ever been denied a certification or license to practice as a physician assistant in any state or has your application for certification or for a license to practice as a physician assistant been withdrawn under threat of denial?	____	____
9.	Have you ever had a judgment rendered against you or action settled relating to the performance of your professional service?	____	____
10.	Have you successfully completed the Physician Assistant National Certifying Examination?	____	____

If YES, ATTACH VERIFYING DOCUMENTATION from the National Commission on Certification of Physician Assistants (NCCPA).

If NO, have you ever taken the examination? YES____ NO____

Are you registered to take the next PANCE offered? YES ____ NO____
If YES ATTACH VERIFYING DOCUMENTATION **from the NCCPA.**

		YES	NO
11.	Are you currently registered, certified to or working for any other primary supervising physician either in Alabama or another state? ie Are you presently working as a physician assistant? If so, answer yes. **If YES, attach a list with name and principal practice location of each primary supervising physician to whom you are certified. In addition, state your designated working hours per week for each physician listed.**	____	____
12.	Have you ever been certified as a physician assistant by the Alabama Board of Medical Examiners in the past?	____	____

If YES, please list names of physicians in the spaces provided.

		YES	NO
13.	Within the past two years, have you been diagnosed with or have you been treated for bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder?	____	____
14.	Do you currently have any mental or physical condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or mental, emotional, or nervous disorder or condition) which in any way currently affects, or if untreated could affect, your ability to practice in a competent and professional manner?	____	____

15. Within the past five years, have you ever raised the issue of consumption of drugs or alcohol or the issue of a mental, emotional, nervous, or behavioral disorder or condition as a defense, mitigation, or explanation for your actions in the course of any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed

termination by an educational institution, employer, government agency, professional organization or licensing authority? _____ _____

16. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism? _____ _____

17. Are you currently engaged in the illegal use of controlled dangerous substances?[1] _____ _____

If your answer to the preceding question is yes, are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances?

YES _____ NO_____

18. Have you been, within the past five years, convicted of driving under the influence (DUI) or have you been charged with DUI and been convicted of a lesser offense such as reckless driving? _____ _____

19. Has your medical training or medical practice been interrupted or suspended for a period longer than 60 days for any reason other than a vacation? _____ _____

[1] The term "**currently**" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the condition referred to may have an ongoing impact on one's functioning as an assistant to a physician within the past two years.

IF ANY OF THE ANSWERS QUESTIONS ARE IN THE AFFIRMATIVE, PLEASE EXPLAIN IN DETAIL ON AN ATTACHED SHEET AND PROVIDE THE COMPLETE ADDRESS OF ANY PSYCHIATRIST / PSYCHOLOGIST, STATE BOARD, HOSPITAL, IF APPROPRIATE.

III. APPLICANT'S EDUCATION (since graduating from high school): ATTACH A COPY of your diploma(s) reflecting graduation from a Physician Assistant program.

	Date	Name of School	Address
1.	From________ to ________		
2	From________ to ________		
3.	From________ to ________		

IV. APPLICANT'S ACTIVITIES since graduation from high school: (cover all time periods - attach additional sheets if needed)

	Date	Place of employment or activity	Address
1.	From________ to ________		
2	From________ to ________		
3.	From________ to ________		
4.	From________ to ________		
5.	From________ to ________		

V. CERTIFICATION or LICENSURE:

List all states where you have been certified / registered / licensed or have applied for certification / registration / licensure as a Physician Assistant. It is a requirement that each state complete one of the verification forms and return it directly to this agency where it will be attached to your application for licensure. It is your responsibility to make the written request to each state. Make copies of the form is needed.

____________ ____________ ____________ ____________ ____________

____________ ____________ ____________ ____________ ____________

VI. AFFIDAVIT and RELEASE:

I, ______________________________Certify after being duly sworn, that all of the information supplied in the foregoing application is true and correct to the best of my knowledge, that the photograph submitted herein is a true likeness of the assistant and was taken within sixty days prior to the date of this application. I acknowledge that any false or untrue statement or representation made in this application may result in the revocation of any certification / licensure granted.

I further authorize the release of this application and any information submitted with it or information collected by the Alabama Board of Medical Examiners in connection with this application, including derogatory information, to any person or organization having a legitimate need for the information and release of the Alabama Board of Medical Examiners from all liability for the release of this information.

I further authorize the release of information, including derogatory information, which may be in the possession of other individuals or organizations to the Alabama Board of Medical Examiners and release this person or any organization from any liability for the release of information.

Date:__________________________ Physician Assistant's Signature____

County of __________________________ State of __________________________

SWORN to and subscribed before me this _____ Day of __________________________, 20 .

(SEAL) Notary Public Signature ____

My Commission Expires: ______________________

ATTACH PHOTOGRAPH HERE