Checklist for a PA Renewal Application

Please do not submit this form with your application. Keep it for your records.

APPLICATION FEE	
☐ License Renewal Fee	$370 (if postmarked by due date)
☐ Late Fee	$470 (if postmarked 31 days after due date)
LICENSE APPLICATION	
☐ Completed Application	Provide a complete application, pages 1 - 4. You must complete all questions. If you fail to complete a question, your application will be considered deficient and the processing of your application will be delayed. If your application is not complete, the Board will send you a deficiency notice with a list of the deficient items.
GOVERNMENT ISSUED PHOTO ID	
☐ Government Issued Photo ID	A copy of a government issued photo ID is required if the Board does not currently have a legible copy on file.
CONTINUING MEDICAL EDUCATION	
☐ CME Audit form	If selected for CME Audit, please complete and submit the CME audit form and provide proof of having completed the required Category 1 Continuing Medical Education approved by the American Academy of Physician Assistants, the American Medical Association, the American Osteopathic Association, or other accrediting organization acceptable to the board, and the three (3) hours of opioid prescribing CME (as part of your total hours).
QUESTIONNAIRE AFFIRMATIVE RESPONSES	
☐ Narrative and Supporting Documents	If you have answered "Yes" to a question on the questionnaire page, you must submit an explanation and photocopies of any corresponding documents. Failure to properly answer these questions can result in Board disciplinary action, including revocation or denial of license.
Information requested to be sent directly to the Board can be sent to the following:	
DO NOT EMAIL APPLICATION(S) Email: licensingreport@azmd.gov	Arizona Regulatory Board of Physician Assistants 1740 W. Adams St. Ste. 4000 Phoenix, AZ 85007-2664

ARIZONA REGULATORY BOARD OF PHYSICIAN ASSISTANTS
BIENNIAL LICENSE RENEWAL APPLICATION

1740 W. Adams St. Ste. 4000 Phoenix, AZ 85007-2664
www.azmd.gov; Email: licensingreport@azmd.gov

To be completed and signed by the applicant. All questions MUST be answered, even if only to indicate "None" or "N/A".

☐ **License Fee $370 (if postmarked by due date)**

☐ **License Fee $470 (if postmarked 31 days after due date)**

BEFORE COMPLETING THIS RENEWAL FORM: Please review your physician assistant profile, located at www.azpa.gov. If any of the information is incorrect, please print a copy, line out the erroneous information, write in the correct information and submit it with your renewal. You are subject to discipline if you provide erroneous information. Please note that name changes must be made under separate cover.

1. **First Name:** _____ **Middle Initial:** _____ **Last Name:** _____

License Number: _____

ADDRESS INFORMATION

Practice Address: This is the practice/principal place of your business. The address and phone number provided will appear in the Medical Directory and on the Board's website. **Every physician assistant must have an address available to the public**. If only one address is provided, even if it is your home address, it will be available to the public upon request. If you want your home address to be listed as your practice address on the Board's website, include the address in the practice address field.

2. **Practice/Training Name:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____ ***Practice address not required for licensure**

Home Address: You are **required** to provide a home address, telephone number and email address. Your home address and telephone number will not be released to the public *unless* you fail to provide an office address. Your email address will not be released to the public.

3. **Home Address:** _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Mobile:** _____

Primary Email Address: _____

Mailing Address: If no address is provided, all Board correspondence will be sent to your practice address.
Please note: You are required to notify the Board in writing within 30 days of any change in address or phone number.

4. **Mailing Address:** _____ **City:** _____ **State:** _____ **Zip:** _____

☐ Same as Practice Address ☐ Same as Home Address

In addition to your primary e-mail address provided on page one of this application, please indicate if you would like to designate/authorize an individual, beside yourself, to receive status updates on your application.

Please note: If a substantive review/investigation is required during the application process, the applicant will be required to provide additional authorization, in writing, for the third party to receive status updates concerning the substantive review.

Name: | Phone# | E-Mail:

5. Questionnaire

1. Since your last renewal, have you had an application for a certificate, registration, or license refused or denied by any licensing authority? If so, provide an explanation. ☐ Yes ☐ No
2. Since your last renewal, have you had the privilege of taking an examination for a professional license refused or denied by any entity? If so, provide an explanation. ☐ Yes ☐ No
3. Since your last renewal, have you voluntarily surrendered a health care license and if so, provide an explanation. ☐ Yes ☐ No
4. Since your last renewal, have you had a health professional license suspended or revoked, or have you ever surrendered a health professional license or had any other disciplinary action taken against your health professional license? If so, provide an explanation. ☐ Yes ☐ No
5. Are you currently under investigation by any health profession regulatory authority, health care association, licensed health care institution, or are there any pending complaints or disciplinary actions against you? If so, provide an explanation. ☐ Yes ☐ No
6. Since your last renewal, have you had any action taken against your privileges, including termination, resignation, or withdrawal by a health care institution or health profession regulatory authority? If so, provide an explanation. ☐ Yes ☐ No
7. Since your last renewal, have you had a federal or state regulatory authority take any action against your authority to prescribe, dispense, or administer controlled substances including revocation, suspension, denial, or whether you ever surrendered such authority in lieu of any of these actions? If so, provide an explanation ☐ Yes ☐ No
8. Since your last renewal, have you been charged with, convicted of, pled guilty to, or entered into a plea of no contest to a felony or misdemeanor involving moral turpitude or been pardoned or had a record expunged or vacated? If so, provide an explanation. ☐ Yes ☐ No
9. Since your last renewal, have you been court-martialed or discharged other than honorably from any branch of military service? If so, provide an explanation. ☐ Yes ☐ No
10. Since your last renewal, have you been involuntarily terminated from a health professional position, with any city, county, state, or federal government? If so, provide an explanation. ☐ Yes ☐ No
11. Since your last renewal, have you been convicted of insurance fraud or received a sanction, including limitation, suspension, or removal from practice, imposed by any state or the federal government? If so, provide an explanation. ☐ Yes ☐ No

NOTE: In the event that the response to any of the questions is "Yes", you must file an explanation and submit photocopies of any corresponding documents. Failure to properly answer these questions can result in Board disciplinary action, including revocation or denial of license.

First Name: | **Last Name:**

6. Confidential Questions

1. Since your last renewal, have you received treatment for use of alcohol or a controlled substance, prescription-only drug, or dangerous drug or narcotic or a physical, mental, emotional, or nervous disorder or condition that currently affects your ability to exercise the judgment and skills of a medical professional? If so, provide the following: ☐ Yes ☐ No

A.) A detailed description of the use, disorder, or condition; and

B.) An explanation of whether the use, disorder, or condition is reduced or ameliorated because you receive ongoing treatment and if so, the name and contact information for all current treatment providers and for all monitoring or support programs in which you are currently participating.

C.) A copy of any public or confidential agreement or order relating to the use, disorder, or condition, issued by a licensing agency or health care institution within the last five years, if applicable.

The purpose of the confidential question is to allow the Board to determine the applicant's current fitness to perform health care tasks. The mere fact of treatment, monitoring or participation in a support group is not, in itself, a basis of which admission is denied; the Board routinely licenses individuals who demonstrate personal responsibility and maturity in dealing with fitness issues. The Board encourages those applicants who may benefit from assistance to seek it. The Board may limit or deny licensure to applicants whose ability to function is impaired in a manner relevant to the practice of medicine at the time the licensing decision is made or to applicants who demonstrate a lack of candor by their responses. This is consistent with the public purpose that underlies the licensing responsibilities assigned to the Arizona Regulatory Board of Physician Assistants and to the applicants seeking licensure.

NOTE: In the event that the response to any of the questions is "Yes", you must file an explanation and submit photocopies of any corresponding documents. Failure to properly answer these questions can result in Board disciplinary action, including revocation or denial of license.

7. Citizenship Attestation

Proof of Citizenship: Effective January 1, 2008, based on Federal and State laws, all applicants must provide evidence that the applicant is lawfully present in the United States, pursuant to A.R.S. § 41-1080 and A.A.C. R4-16-201(C)(1) require documentation of citizenship or alien status for licensure. If the documentation does not demonstrate that the applicant is a United States citizen, national, or a person described in specific categories, the applicant will not be eligible for licensure in Arizona.

☐ **I am a U.S. Citizen or U.S. National.**	If this box is checked, please submit documentation as stated on the Statement of Citizenship form (also review the application checklist).
☐ **I am NOT a U.S. Citizen or U.S. National.**	If this box is checked, please submit documentation as stated on the Statement of Citizenship form (also review the application checklist).

First Name: _____ **Last Name:** _____

8. Attestation

I hereby certify, under penalty of perjury by my signature below that all information on this form is currently accurate, I am a U.S. Citizen or a qualified/registered alien; and,

☐ **I have completed the required Category I continuing medical education (CME) hours, as set forth in A.R.S. § 32-2523(A), and A.R.S. § 32-3248.02; or,**

☐ **I have filed a timely request for extension of time to complete the required Category 1 CME hours as set forth in A.R.S. § 32-2523(A), and A.A.C. R4-17-205.**

First Name: _____ **Last Name:** _____

License Number: _____

Signature of Applicant: _____ Date: _____

PAYMENT CARD AUTHORIZATION
PA BIENNIAL LICENSE RENEWAL

First Name: _____ **Last Name:** _____

License Number: _____

☐ **License Fee $370 (if postmarked by due date)**

☐ **License Fee $470 (if postmarked 31 days after due date)**

Type of Card: ☐ **Visa** ☐ **Mastercard** ☐ **Amex**

Card Number: _____ **Expiration Date:** _____

(No dashes between numbers)

Name as Shown on Payment Card: _____

Billing Address of Cardholder: _____ **City:** _____ **State:** _____ **Zip:** _____
(Required)

Office Phone: _____

Mailing Address of Cardholder: _____ **City:** _____ **State:** _____ **Zip:** _____
(If different from billing address)

Cardholder Signature: _____ **Date:** _____

(Required)

The Arizona Regulatory Board of Physician Assistants will only accept credit card payment via mail (USPS, FedEx, UPS, or any other mail carrier). Any credit card information received via any other method <u>will not be processed and will be destroyed</u>.

Please complete and return this form *with your license application and all necessary documents.* Return the application and payment form (credit card form, check or money order) to the address listed below.

Mail to: **Arizona Regulatory Board of Physician Assistants**
1740 W. Adams St. Ste. 4000
Phoenix, AZ 85007-2664

For receipt, please include an e-mail address for submission: **Email Address:** _____

ARIZONA MEDICAL BOARD
CONTINUED MEDICAL EDUCATION (CME) AUDIT FORM

If your license number was selected for CME audit, as indicated on your renewal notice letter, please complete this form and submit it with your renewal application.

First Name: **Initial:** **Last Name:**

License Number:

In order to maintain a medical license in the State of Arizona, per Arizona Administrative Code (A.A.C.) R4-16-101, licensees are required to complete at *least* forty (40) hours of CME in the *two calendar years preceding this registration*.

Please refer to A.A.C. R4-16-102 to identify statutorily approved CME activities. Statutes and rules are available on our web site www.azmd.gov.
PLEASE attach this form to your proof of CME. (Use two pages if necessary)

Renewal is considered **incomplete** until all continued medical education documentation has been reviewed by the Board. (*Examples of Proof*: copy of the certificate received; front page of the journal article read; title page and first page of text for a book)

Date(s)	Type of CME Activity (Journals, Books, Articles, Certificates, etc.)	Earned Credit Hours

My signature below, attests that the above is a true and correct representation of the CME completed during the two years preceding this registration and that proof of CME is attached .

Signature: **Date:**

THIS FORM MUST BE RETURNED WITH YOUR RENEWAL APPLICATION