Checklist for a Physician Assistant Reactivation Applicaiton

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

APPLICATION FEE	
☐ Reactivation Application Fee	$370
LICENSE APPLICATION	
☐ Completed Application	Provide a complete application, pages 1 - 5. 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.
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.
REACTIVATION REQUIREMENTS	
☐ Narrative and Supporting Documents	Include all information that will allow the Board to determine your ability to return to the performance of healthcare tasks, i.e., a detailed listing of all continuing medical education taken during your inactivation or medical activities and reports from your current treating physician if there could be a question regarding your mental or physical ability to safely perform healthcare task.
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
REACTIVATION APPLICATION

1740 W. Adams St. Ste. 4000
Phoenix, AZ 85007-2664
www.azpa.gov

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

☐ REACTIVATION APPLICATION $370

BEFORE COMPLETING THIS REACTIVATION REQUEST FORM: Please review your physician 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.

NOTE: Effective February 14, 2012, the Arizona Regulatory Board of Physician Assistants no longer issues **wallet cards**. The ARBoPA website profile is the most reliable way to verify current license status. The profile can be accessed at **www.azpa.gov**.

1. **First Name:** _____ **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.

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

☐ Same as Practice Address ☐ Same as Home Address

5. CITIZENSHIP ATTESTATION

PROOF OF CITIZENSHIP: All applicants must provide evidence that the applicant is lawfully present in the United States.

A.R.S. § 41-1080 and A.A.C. R4-17-203(B)(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.

However, if you provided documentation to the Board of your U.S. Citizenship or nationalization at the time of your last renewal or at the time of your initial application to the Board, no further documentation are required.

Alternatively, if you have become a U.S. citizen or U.S. national since the time of your most recent application with the Board or are not currently a U.S. citizen or national, you must submit proof of your current status to the Board before your license will be renewed.

Documentation can be submitted to the Board via email at Licensingreport@azmd.gov. Please see the Evidence list included with this application for a list of acceptable documents. Additionally, a copy of your birth certificate or passport must be submitted in accordance with R4-17-203(B)(1) if you have not previously established your citizenship or nationalization with the Board.

- ☐ I am a U.S. Citizen or U.S. National.
- ☐ I have become a U.S. Citizen or U.S. National since the time of my last renewal.
- ☐ I am not a U.S. Citizen or U.S. National.

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

7. REACTIVATION REQUIREMENTS

A.R.S. § 32-2528(D): The board may convert an inactive license to a regular license on payment of the annual renewal fee and presentation of evidence to the board that the holder possesses the medical knowledge and the physical and mental ability to safely engage in the performance of health care tasks. The board may require any combination of physical examination, psychiatric or psychological evaluation, oral competency examination or a board qualified written examination or interview it believes necessary to assist it in determining the ability of a physician assistant who holds an inactive license to return to regular licensure.

All reactivation applications must go before the full Board for review and consideration. Please provide a narrative explaining why you believe you currently possess the medical knowledge to safely perform delegated health care tasks. Also, include all information that will allow the Board to determine your ability to perform delegated health care tasks, i.e., a detailed listing of all continuing medical education taken during your inactivation or medical activities and reports from your current treating physician if there could be a question regarding your mental or physical ability to safely practice. Finally, include information detailing your intentions as they pertain to performing health care tasks.

NARRATIVE:

First Name: **Last Name:**

8. Questionnaire

1. 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. 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. Have you voluntarily surrendered a health care license and if so, provide an explanation.	☐ Yes	☐ No
4. H ave 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. 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. 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. 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. Have you been court-martialed or discharged other than honorably from any branch of military service? If so, provide an explanation.	☐ Yes	☐ No
10. 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. 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

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

9. Confidential Questions

1. Have you received treatment within the last five years 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 judgement 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 practice medicine. 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 Medical Board 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.

Moral Turpitude includes but is not limited to: Armed Robbery, Assault with a Deadly Weapon, Attempted Insurance Fraud, Embezzlement, Fabricating and Presenting False Public Claims, False Reporting to Law Enforcement Agency, Falsification of Records of the Court, Forgery, Fraud, Hit & Run, Illegal Sale and Trafficking in Controlled Substances, Indecent Exposure, Kidnapping, Larceny, Mann Act (Federal Commercialization of Women Statute), Misleading Sale of Securities in Connection with transfer of Real Property, Perjury, Possession of Heroin for Sale/Unlawful Sale or Dispensing Narcotic Drugs, Rape, Shoplifting, Theft and Soliciting Prostitution.

12. Attestation

I attest that all of the information contained in the reactivation request form and accompanying evidence or other credentials submitted are true. This includes any corrections made to the enclosed physician assistant profile.

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

License Number: _____

Signature of Applicant: _____ Date: _____

PAYMENT CARD AUTHORIZATION
PHYSICIAN ASSISTANT REACTIVATION APPLICATION

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

License Number: _____

☐ **Reactivation Application Fee $370**

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:** _____

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 will not be processed and will be destroyed.

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:** _____