OFFICE OF PROFESSIONAL LICENSURE AND CERTIFICATION
STATE OF NEW HAMPSHIRE
DIVISION OF HEALTH PROFESSIONS
Board of Medicine
121 South Fruit Street, Suite 301
Concord, N.H. 03301-2412
Telephone 603-271-1203 · Fax 603-271-6702

PETER DANLES
Executive Director

JOSEPH G. SHOEMAKER
Division Director

TO THE APPLICANT:

This application must be completed in full for consideration of certification as a Physician Assistant in the state of New Hampshire. The following documentation is required:

1. Completion of the enclosed supervisory form with original signatures from the designating Registered Supervisory Physician/Alternate Registered Supervisory Physician.

*2. Certified proof of graduation from Physician Assistant Program as defined in Med 601.03.

*3. Certification of scores received directly from National Commission on Certification of Physician Assistants (NCCPA).

4. Two letters of reference from physicians who can attest to your performance as a Physician Assistant. These letters must be on proper letterhead, submitted as originals. References may be submitted by the applicant or by the physician providing the reference.

5. State Clearance (form attached) from every state in which you have ever held a license.

***2 and 3 above <u>may be</u> obtained through the Federation of State Medical Boards' Credentialing Verification Service (FCVS). <u>NOTE: FCVS IS NOT REQUIRED FOR LICENSURE IN NEW HAMPSHIRE.</u> FCVS provides primary source verification of your "core" medical credentials. The base fee for the FCVS profile is $145.00. The application for FCVS is available via the Federation's website at** www.fsmb.org **or you may contact FCVS at 1-800-ASK-FCVS.**

You will receive an acknowledgment letter once your application has been received. This letter will advise you of what information, if any, is outstanding at that time. If you do not receive an acknowledgment letter within 30 days, please contact the Board between 8:00 A.M. and 4:00 P.M. EST. With the acknowledgement letter, you will receive paperwork to complete a criminal background check. **<u>Pursuant to RSA 328-D:3-a, you are required to submit a notarized criminal history record release form, along with a fee, which authorizes the release of your criminal history record, if any, to the Board. This form will be provided to you with your acknowledgment letter once your application has been received by the Board.</u>

A copy of the PA Practice Act (RSA 328-D) and the Administrative Rules are enclosed for your information and file.

Any change in RSP/ARSP after licensure will require filing of a change in supervisor form, obtained through this office.

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APPLICATION FOR CERTIFICATION AS A PHYSICIAN ASSISTANT

FEE IS $115.00 -- Make check payable to: Treasurer, State of New Hampshire

PERSONAL INFORMATION

NAME:_____
(FIRST) (MIDDLE) (LAST) (MAIDEN)

HOME ADDRESS:_____
(STREET, CITY, STATE, ZIP CODE) (TELEPHONE #)

BIRTHDATE:_____PLACE OF BIRTH:_____SEX: M( ) F( )

The Board will deny licensure if you refuse to submit your social security number (SSN). Your professional license will not display your SSN. Your SSN will not be made available to the public. The Board is required to obtain your SSN for the purpose of child support enforcement and in compliance with RSA 161-B:11. This collection of your SSN is mandatory.

SOCIAL SECURITY NUMBER: _____-_____-_____

EMAIL ADDRESS:_____

VERIFICATION OF P.A. EDUCATION

NAME OF COLLEGE/PROGRAM:_____

_____
(ADDRESS OF COLLEGE/PROGRAM) (DATE OF GRADUATION)

**ENCLOSE A CERTIFIED COPY OF GRADUATION CERTIFICATE/DIPLOMA
OR HAVE LETTER COME DIRECTLY FROM SCHOOL VERIFYING GRADUATION **OR if you are using FCVS for verification, please start that process immediately.**

PLEASE MAKE ARRANGEMENTS TO HAVE NCCPA SCORES SENT DIRECTLY FROM NCCPA TO THIS OFFICE **OR if you are using FCVS for verification, please start that process immediately.**

EMPLOYMENT INFORMATION

PROPOSED EMPLOYER IN N.H.:_____

ADDRESS:_____

TELEPHONE NUMBER:_____

ANTICIPATED DATE OF EMPLOYMENT:_____

STATES OTHER LICENSES/CERTIFICATION

Please list all states where **you hold or have ever held** licensure/certification and the number. **Please send the enclosed Licensure Verification Form to each state for official verification.**

STATE	LICENSE/CERTIFICATION #

REFERENCES

Please have two letters of reference submitted from physicians who have served in an advisory capacity to the applicant. Letters must be on letterhead, submitted as originals. References may be submitted by the applicant or by the physician providing the reference.

	YES	NO
1. Have you ever, for any reason, been refused a license or certification by any other licensing or certifying body and if so, the circumstances of the incident?	____	____
2. Have you ever been or have reason to believe that you are, or will soon be, the subject of any kind of disciplinary investigation or action by any hospital, healthcare organization or licensing or certifying body and if so, the nature of the allegations and the subsequent disposition of the action?	____	____
3. Have you ever been convicted of a felony or misdemeanor, and, if so, the name of the court, the details of the offense, the date of conviction and the sentence imposed?	____	____
4. Have you ever been treated for drug or alcohol abuse, or been hospitalized for any mental illness within the year preceding the filing of the application, or have you ever had such treatment or hospitalization for a condition which affected your ability to perform the functions of a physician assistant?	____	____

AFFIDAVIT OF APPLICANT

State of _____

County of _____

_____ of _____
(Applicant) (Address)

being duly sworn says that (s)he is the person referred to in the above application for certification (and photograph below) as a Physician Assistant in the state of New Hampshire; that (s)he is a graduate of an approved program for Physician Assistants; and that all statements herein or attached hereto are each and all true in every respect. Further, (s)he has never been an inmate in an institution for the treatment of insanity, drug addiction or inebriety.

_____
(SIGNATURE OF APPLICANT)

(PHOTO)

Sworn to before me this _____ day of _____, 19___.

(SEAL) _____
(NOTARY PUBLIC)
MY COMMISSION EXPIRES:_____

****

For Board Use Only:

APPLICATION RECEIVED:_____FEE:_____CHECK#_____

CERTIFICATION #:_____ISSUED:_____

Licensure Verification Form

New Hampshire Board of Medicine

RELEASE OF INFORMATION FROM OTHER LICENSING AUTHORITIES

I am applying for a license to practice as a physician assistant in the State of New Hampshire. The NH Board of Medicine requires that the following form be completed by each jurisdiction in which I am now or was previously licensed. This constitutes your authority to release any and all information in your files, favorable or otherwise, directly to the NH Board of Medicine. Kindly mail your response to:

BOARD OF MEDICINE
121 SOUTH FRUIT STREET, SUITE 301
CONCORD, NEW HAMPSHIRE 03301-2412
Tel: (603) 271-1203

Biographic Information:

_____, P.A.
Last Name First Name Middle Name

_____
Mailing Address City State Zip Code

_____ _____
Social Security Number: Date of Birth:

_____ _____
License Number (if known) Signature

The following should be completed by the licensing authority and returned directly to the NH Board at the address above.

1. Name of Licensing Authority: _____
2. Full Name of Licensee: _____
3. License Number: _____
4. Is License Current? Yes No Expiration Date:_____
5. Is License Restricted? Yes No
6. Previous Disciplinary Action? Yes No
7. Pending Investigations? Yes No

If the answer is yes to questions 5, 6 or 7, please attach supporting information.

Please affix official Board seal here

_____
Signature/Title

_____
Date

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In accordance with RSA 328-D and regulations issued thereunder, I certify that _____, P.A. assists me professionally and that I assume responsibility for supervision of his/her professional activities.

_____	_____
RSP Signature	ARSP Signature
_____	_____
(Print or type name)	(Print or type name)
_____	_____
(Professional Address)	(Professional Address)
_____	_____
_____	_____
(NH License Number)	(NH License Number)
_____	_____
(Effective Date of Supervision)	(Effective Date of Supervision)