

REINSTATEMENT APPLICATION—PHYSICIAN ASSISTANT

APPLICANT INSTRUCTIONS

Mandatory Practice Act. Colorado has a mandatory practice act, which means that you may not practice as a Physician Assistant in this state without a Colorado license. Submission of this application does not guarantee licensure. Therefore, do not make life or career decisions based on the probability that you may receive a license. Plan ahead for the time it will take for us to receive all required documents and complete our evaluation.

Basic Requirements. Requirements for licensure are outlined in the Medical Practice Act, specifically 12-36-107 and 12-36-111; the Board's rules, specifically Rule 400 and Rule 410; and the Board's policies, specifically Policy 20-9 and Policy 20-13. The Medical Practice Act and complete rules and policies are available online at www.dora.state.co.us/medical.

In compliance with the Michael Skolnik Medical Transparency Act of 2010, licensees are required to complete an online Healthcare Professions Profile on our website at www.dora.state.co.us/hppp.

About the Application. This application is to be completed by you and returned to the Office of Licensing. All questions on the application are mandatory, and all supporting documents must be submitted with the application. You may copy as many forms as needed; however, each form submitted must be completed in original ink or typed. Keep a copy of the completed application for your records.

Application Expiration. Your application will be kept on file for one (1) year from date of receipt in the Division. Your file and all supporting documentation will be purged if you do not submit required documents and complete your application process in one year. You will need to resubmit a new application packet and fee after that time.

Social Security Number is Required. Effective January 1, 2009, a Social Security Number is required for all licensees. The Division will consider an application to be incomplete when the applicant fails to submit his/her Social Security Number. Exceptions are made for foreign nationals not physically present in the United States and for non-immigrants in the United States on student visas who do not have a Social Security Number. These applicants must submit a signed Social Security Number Affidavit in lieu of a Social Security Number. The affidavit is available on our website at www.dora.state.co.us/registrations/SSNAffidavit.pdf, or you may call (303) 894-7800 to request that one be mailed to you.

Disclosure of Addresses. Consistent with Colorado law, all addresses and phone numbers on record with the Division are public record and must be provided to the public when requested. It is your responsibility to keep your address and contact information up-to-date in our database. All letters, renewal notices, and licenses are mailed to the last known address of record. **If your address is not current, it is possible you will not receive important documents.** You can change your address online by using Registrations Online Services at www.doradls.state.co.us.

License Expiration Grace Period for Applicants. All applicants who are issued a license within 120 days of the upcoming renewal expiration date will be issued a license with the subsequent expiration date. For example, licenses issued between October 1, 2011 and January 31, 2012 will reflect a license expiration date of January 31, 2014. Licenses issued prior to October 1, 2011 will reflect an expiration date of January 31, 2012 and must renew in the upcoming renewal period.

- All Physician Assistant licenses expire on January 31 of even-numbered years and must be renewed to continue practicing.

APPLICANT CHECKLIST

To apply to reinstate your lapsed Physician Assistant license into INACTIVE status:

- Submit a completed Reinstatement Application.** Return the completed application and all supporting documentation to the Office of Licensing.
- Enclose the non-refundable application processing fee.** See page 1 of the application form for current fees. Fees may be paid by a check or money order drawn in U.S. dollars on a U.S. bank and made payable to *State of Colorado*. All fees are non-refundable and subject to change every July 1.
- Provide documentation of any name change.** If your name has changed since you obtained a previously-issued license, or if your name is different on any of your supporting documentation, you must provide a copy of the legal document verifying the name change (i.e., marriage license, divorce decree, or court order).
- Complete and return the attached Affidavit of Eligibility.** Pursuant to C.R.S. 24-34-107, all applicants for licensure are required to complete and sign an Affidavit of Eligibility, and may also be required to provide a copy of a secure and verifiable document.

—OR—

To apply to reinstate your lapsed Physician Assistant license into ACTIVE status:

- Submit a completed Reinstatement Application.** Return the completed application and all supporting documentation to the Office of Licensing.
- Enclose the non-refundable application processing fee.** See page 1 of the application form for current fees. Fees may be paid by a check or money order drawn in U.S. dollars on a U.S. bank and made payable to *State of Colorado*. All fees are non-refundable and subject to change every July 1.
- Provide documentation of any name change.** If your name has changed since you obtained a previously-issued license, or if your name is different on any of your supporting documentation, you must provide a copy of the legal document verifying the name change (i.e., marriage license, divorce decree, or court order).
- Complete and return the attached Affidavit of Eligibility.** Pursuant to C.R.S. 24-34-107, all applicants for licensure are required to complete and sign an Affidavit of Eligibility, and may also be required to provide a copy of a secure and verifiable document.
- Demonstrate continued competency.** Refer to the Board's [Continued Competency Rule 410](#). (If your license has been lapsed for more than four (4) years, you may be subject to additional requirements.)
- Submit a completed Report of Practice History** (attached).
- Complete and submit a signed Primary Physician Supervisor Registration Form** (attached).
 - You must have a primary supervising physician in order to hold an active Physician Assistant license in Colorado. If your license is approved prior to the registration of your primary supervising physician, you will have 180 days from the approval date in which to do so. Failure to register a primary supervising physician within that 180 days will result in your license being placed in an inactive status. You would then need to reactivate your license prior to practicing.
 - Your supervising physician must be licensed in Colorado. This also applies to practice at military facilities.
- Complete and submit the Request for Disciplinary Action Report** (attached) directly to the Federation of State Medical Boards (FSMB). Do not send the request form to the Office of Licensing. When the FSMB receives the request form from you, they will provide the Disciplinary Action Report directly to the Colorado Board.
- Complete a Healthcare Professions Profile.** In compliance with the Michael Skolnik Medical Transparency Act of 2010, you are required to complete an online profile on our website at www.dora.state.co.us/hppp. You cannot start your profile until the Division of Registrations receives your application and enters it into our database. Allow 10 days from the date your application was mailed before accessing the website. If you have questions or technical issues regarding your online profile, contact the Healthcare Professions Profiling Program at hppp@dora.state.co.us or (303) 894-5942.

Return your completed application packet and all supporting documentation to:

Division of Registrations
Office of Licensing—Medical
1560 Broadway, Suite 1350
Denver, CO 80202



IMPORTANT NOTICE

TO: All Applicants

FROM: Rosemary McCool, Director, Division of Registrations

SUBJECT: Licensure and Criminal History

Thank you for your interest in becoming a licensed* professional within the Division of Registrations. Before you submit your application, please be aware of a few facts regarding criminal conduct, convictions, and disciplinary actions in other states.

The mission of the Division of Registrations is “public protection through effective licensure and enforcement.” One way the Division safeguards consumers is by issuing licenses to fully qualified, competent, and ethical applicants.

During the licensing process – and depending on the specific application – the Division will ask whether you have ever been disciplined in any state, arrested, charged, convicted, or pled guilty to a crime. An arrest, subsequent criminal conviction, or disciplinary action is not an automatic disqualification from licensure. Instead, the appropriate board or program will look at the facts surrounding the criminal conduct and disciplinary action to determine whether you are fit for licensure. You should know that licensure is a privilege, not a right. One thing you must do to obtain the privilege is to be completely honest on your application.

Be sure to list all relevant complaints, disciplinary actions, arrests, charges, or convictions in response to the licensure questions. Failure to fully disclose could constitute grounds alone for denial of your application or revocation of your license. More important, avoid some of the common excuses we have heard from people who failed to disclose, such as:

- My attorney told me I didn’t have to disclose the criminal conduct or disciplinary actions.
- I didn’t think the prior conduct had anything to do with the profession.
- I didn’t think the disciplinary action, arrest, charges, or conviction was still on my record.
- I didn’t think it was subject to disclosure because I received a deferred sentence/judgment.

Remember, there is no excuse not to disclose disciplinary actions and criminal conduct. Even after licensure, you are still required to notify your professional licensing board or program about subsequent convictions and disciplinary actions in other states.

The Division conducts audits of its licensing database against several criminal and national disciplinary databases. This allows the Division to verify the truthfulness of your application and track subsequent criminal and disciplinary conduct after initial licensure. Keep in mind, you will not necessarily be revoked or denied a license if you have been disciplined, arrested, charged or convicted, but you will most likely be denied or revoked if you fail to disclose it.

**The word "license" is used as a general term. While most of the professions and occupations are licensed, others may be registered, certified, or listed. For precise terminology and requirements related to a profession or occupation, please consult the [website](#) of the appropriate board or program.*



Colorado Department of Regulatory Agencies
 Division of Registrations
 1560 Broadway, Suite 1350
 Denver, CO 80202

Licensee/Applicant Full Legal Name

| Last | First | Middle | Suffix |
|------|-------|--------|--------|
| | | | |

Colorado Professional or Occupational License/Certification/Registration Number: _____
 (if already licensed)

Professional or Occupational License/Certification/Registration type applying for: _____

AFFIDAVIT OF ELIGIBILITY

Pursuant to H.B. 06S-1009, C.R.S. 24-34-107, ALL applicants for original licensure* or licensees renewing or reinstating a current Colorado license after January 1, 2007 are required to complete and sign this Affidavit of Eligibility.

**The word "licensure" is used as a general term. While most of the professions and occupations are licensed, others may be certified, registered, or listed. For precise terminology and requirements related to a profession or occupation, please consult the website of the appropriate board or program.*

Section A: LAWFUL PRESENCE in the United States

1. I am a U.S. citizen. Check one of the acceptable secure and verifiable documents in Section B that applies and fully complete the information requested. Complete documentation must be provided upon request.
2. I am not a U.S. citizen, but I am lawfully present in the U.S. and authorized by the Department of Homeland Security to be employed in the U.S. Check one of the acceptable secure and verifiable documents in Section B that applies and fully complete the information requested. Complete documentation must be provided upon request.
3. I am not physically present in the U.S. under 8 U.S.C. sec. 1621 (c)(2)(c) or employed in the U.S. pursuant to 8 U.S.C. sec. 1621 (c)(2)(a). Check one option, a or b below, then skip to Section C. (Do not complete Section B.)
 - a. I am a U.S. citizen, not physically present or employed in the United States.
 - b. I am a Foreign National, not physically present or employed in the United States.

Section B: SECURE AND VERIFIABLE DOCUMENTS
 Select ONE document in this section if you checked 1 or 2 in Section A.

| Government Issued Identification | Name of state agency or federal agency that issued the document | Full name as shown on driver's license or state/federal issued ID | License/ID Number | Expiration Date (mm/dd/yyyy) |
|---|---|---|-------------------|------------------------------|
| <input type="checkbox"/> Driver's license or permit | | | | |
| <input type="checkbox"/> Government issued ID card | | | | |
| <input type="checkbox"/> Valid U.S. military ID/common access card | | | | |
| <input type="checkbox"/> Colorado Department of Corrections inmate ID | | | | |
| <input type="checkbox"/> Tribal ID card | | | | |
| <input type="checkbox"/> U.S. passport | | | | |
| <input type="checkbox"/> Certificate of Naturalization | | | | |

Section B: SECURE AND VERIFIABLE DOCUMENTS (continued)

| Government Issued Identification | Name of state agency or federal agency that issued the document | Full name as shown on driver's license or state/federal issued ID | License/ID Number | Expiration Date (mm/dd/yyyy) | |
|---|--|--|---|-------------------------------------|--------------------------------|
| <input type="checkbox"/> Certificate of (U.S.) Citizenship | | | | | |
| <input type="checkbox"/> Valid Temporary Resident card | | | | | |
| <input type="checkbox"/> Valid I-94 issued by Canadian government | | | | | |
| <input type="checkbox"/> Valid I-94 with refugee/asylum stamp | | | | | |
| <input type="checkbox"/> Valid I-766 (Employment Authorization Card) | | | Issuing federal agency: | | |
| Name on card | Alien Number (A#) | Card Number | Valid from (mm/dd/yyyy) | Expires (mm/dd/yyyy) | |
| | | | | | |
| <input type="checkbox"/> Valid I-551 (Resident Alien or Permanent Resident Card) | | | Issuing federal agency: | | |
| Name on card | Alien Number (A#) | Country of birth | Card expires (mm/dd/yyyy) | Resident since (mm/dd/yyyy) | |
| | | | | | |
| <input type="checkbox"/> Valid foreign passport with an unexpired visa with proper classification for work authorization, and an unexpired I-94 | | | | | |
| Issuing foreign country | Passport Number | Visa Number | Visa Class (ex.: J-1, P-1, H-1B, etc.) | Date of entry (mm/dd/yyyy) | Until date (mm/dd/yyyy) |
| | | | | | |
| <input type="checkbox"/> Valid foreign passport bearing an unexpired "Processed for I-551" stamp or with an attached unexpired "Temporary I-551" visa | | | | | |
| Issuing foreign country: | | | Passport Number: | | |

Section C: ATTESTATION

- I understand that this sworn statement is required by law because I have applied for or hold a professional or commercial license regulated by 8 U.S.C. sec. 1621. I understand that state law requires me to provide proof that I am lawfully present in the United States when asked as well as submission of a secure and verifiable document. I may also be required to provide proof of lawful presence.
- I understand that in accordance with sections 18-8-503 and 18-8-501(2)(a)(I), C.R.S., false statements made herein are punishable by law. I state under penalty of perjury in the second degree, as defined in 18-8-503, C.R.S. that the above statements are true and correct.
- I am the person identified above and the information contained herein is true and correct to the best of my knowledge. I understand that under Colorado law, providing false information is grounds for denial, suspension or revocation of a license, certificate, registration or permit.
- I understand that the above information must be disclosed to the Department of Regulatory Agencies upon request and is subject to verification.

Print Full Legal Name

Signature (Full Name)

Date

The content of this application must not be changed. If the content is changed, the applicant may be referred to the Colorado State Attorney General's Office for violation of Colorado law.

Fees may be paid by a check or money order drawn in U.S. dollars on a U.S. bank and made payable to *State of Colorado*.

Colorado Physician Assistant License Number: _____ Date License Lapsed: _____

Select a license status:

- Reinstatement with full **ACTIVE** status. Required fee: **\$260**
 ➤ Complete the entire application. Supporting documents ARE required.
- Reinstatement with **INACTIVE** status. Required fee: **\$242**
 ➤ Complete the entire application. Supporting documents are NOT required.

PART 1—APPLICANT INFORMATION

| | | | | |
|---|--|---|--|----------------|
| Name: Last: | | First: | Middle: | Suffix: |
| Previous Name(s): | | | | |
| Social Security Number: | | Date of Birth (mm/dd/yyyy): | Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female | |
| Place of Birth (city and state, or foreign country): | | | | |
| Mailing Address: | | PO Box, Street: | | |
| This is a <input type="checkbox"/> Home <input type="checkbox"/> Business | | City, State, Zip: | | |
| Daytime Telephone Number: () | | E-mail Address: | | |
| | | Preferred method for communication: <input type="checkbox"/> Mail <input type="checkbox"/> E-mail | | |

PART 2—LICENSE INFORMATION

Are you currently certified by the National Commission on Certification of Physician Assistants (NCCPA)? YES NO
 ➤ If YES, request that NCCPA send verification of current certification directly to the Office of Licensing.

Since the date your license lapsed, have you been practicing as a physician assistant:

(a) in the state of Colorado? YES NO

(b) in another jurisdiction? YES NO

* **Social Security Number Disclosure.** Section 24-34-107(1) of the Colorado Revised Statutes requires that every application by an individual for a license issued pursuant to the authority set forth in title 12, C.R.S., by the Department of Regulatory Agencies, shall require the applicant's social security number. Disclosure of your social security number is mandatory for purposes of establishing, modifying, or enforcing child support under § 14-14-113 and § 26-13-126, C.R.S.; locating an individual who is under an obligation to pay child support as required by § 26-13-107(3)(a)(I)(A), C.R.S.; and reporting to the National Practitioner Data Bank pursuant to 45 CFR §§ 60.1 et seq., and the Health Integrity and Protection Data Bank as required by 45 CFR §§ 61.1 et seq. Failure to provide your social security number for these mandatory purposes will result in the denial of your licensure application. Disclosure of your social security number is voluntary for disclosure to other state regulatory agencies, testing and examination vendors, law enforcement agencies, and other private federations and associations involved in professional regulation. Your social security number will not be released for any other purpose not provided for by law.

PART 2—LICENSE INFORMATION (Continued)

Are you now or have you ever been licensed to practice as a physician assistant in any state, territory, or district? YES NO

➤ If YES, request verification of each active license be sent to the Office of Licensing and provide information below (if needed, attach an additional sheet using the same format).

| State | License Number | Year license Issued | Disciplinary action against license? | Is this license current/active? |
|-------|----------------|---------------------|--|--|
| | | | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| | | | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| | | | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |

PART 3—SCREENING QUESTIONS

1. Have you ever been notified by any state, territory, district, or country, U.S. government agency, or state medical/osteopathic licensing board of any complaint, investigation, or inquiry which is currently pending? YES NO
 ➤ If YES, give details below AND request official complaint and/or investigative report be sent directly to the Board from the licensing body, as well as personally submit a narrative regarding the complaint.

| State | Date | Charge | Disposition |
|-------|------|--------|-------------|
| | | | |
| | | | |

2. Has any healing arts license which you now hold or have ever held been admonished, reprimanded, censured and/or disciplined in any way by any licensing agency in another state or country, by any peer review committee or body, by any healthcare facility or committee thereof, by any professional or medical society or association or committee thereof, or by any governmental agency, law enforcement agency or court of law? (Disciplinary actions include, but are not limited to, any allegations currently pending.) Washington licensees must disclose any Stipulation to Informal Disposition in response to this question. YES NO
 ➤ If YES, give details below AND request all official disciplinary documents including initial complaint, stipulations, orders or reprimands be sent directly to the Board, as well as a narrative regarding the action taken.

| Agency | Date | Charge | Disposition |
|--------|------|--------|-------------|
| | | | |
| | | | |

3. Have you ever entered into any agreement with any state, territory, district, country, U.S. government agency, and state medical/osteopathic board regarding your physician assistant license? YES NO
 ➤ If YES, give details below AND request all official disciplinary documents including initial complaint, stipulations, orders or reprimands be sent directly to the Board. Also submit your narrative regarding the action taken.

| Agency | Date | Reason |
|--------|------|--------|
| | | |
| | | |

4. Have you ever been denied a license/certificate, permission to practice as a physician assistant or any other healing art, or permission to take an examination in any state, country, or U.S. federal jurisdiction? YES NO
 ➤ If YES, give details below AND request all official disciplinary documents including initial complaint, stipulations, orders, agreements or reprimands be sent directly to the Board. Also submit your narrative regarding the action taken.

| Agency | Date | Reason for Denial |
|--------|------|-------------------|
| | | |
| | | |

PART 3—SCREENING QUESTIONS (Continued)

5. Have you ever voluntarily surrendered a license/certificate to practice in the healing arts in any other state? This does not include allowing your license to lapse solely due to non-payment of the renewal fee. YES NO
 > **If YES**, summarize below AND request all official disciplinary documents including initial complaint, stipulations, orders, agreements or reprimands be sent directly to the Board. Also submit your narrative regarding the action taken.

| Agency | Date | Reason |
|--------|------|--------|
| | | |
| | | |

6. Have either your medical staff membership or clinical privileges at any hospital or healthcare facility or your DEA registration been voluntarily or involuntarily reduced, limited, placed on probation, not renewed or relinquished or have either been denied, revoked or suspended? You must answer YES if any of these actions are currently pending. You must answer YES if you have withdrawn or failed to proceed with an application for these items. YES NO
 > **If YES**, summarize below AND request hospital or DEA to submit a report directly to the Board regarding the action. Also submit your narrative regarding the action taken.

| Name of Facility | Date | Reason for Action |
|------------------|------|-------------------|
| | | |
| | | |

7. Have you ever been charged, indicted, convicted, received a deferred prosecution, received a deferred judgment and sentence, entered a plea of guilty, entered a plea of *nolo contendere*, or been placed on adult diversion for any violation of any law? Note: It is unnecessary to report traffic offenses that do not involve alcohol or drugs. YES NO
 > **If YES**, summarize below AND submit your narrative regarding the incident as well as court and police records and information regarding final disposition of the case.

| Date | Court Address and Zip | Violation | Penalty or Disposition |
|------|-----------------------|-----------|------------------------|
| | | | |
| | | | |

8. Do you now abuse or excessively use, or have you in the last five years abused or excessively used, any habit forming drug, including alcohol, or any controlled substance that has a) resulted in any accusation or discipline for misconduct, unreliability, neglect of work, or failure to meet professional responsibilities; or b) affected your ability to practice as a physician assistant safely and competently? YES NO

9. In the last five years, have you been diagnosed with or treated for a condition that significantly disturbs your cognition, behavior, or motor function, and that may impair your ability to practice as a physician assistant safely and competently, such as bipolar disorder, severe major depression, schizophrenia or other major psychotic disorder, a neurological illness, or sleep disorder? YES NO

You may answer NO to Question 8 or 9 if the behavior or condition is already known to the Colorado Physician Health Program (CPHP). "Known to CPHP" means that you have informed CPHP of your behavior or condition and you are complying with all of CPHP's requirements for evaluation, treatment, and/or monitoring.

If you answer YES to Question 8 or 9, submit detailed information to the Board that will allow the Board to assess your ability to practice safely, competently, and without impairment to your professional judgment, skill, or knowledge. In addition to that information, you are required to provide copies of any related records, reports, evaluations, police reports, probation reports, and court records directly to the Board.

Please be advised that an affirmative response to Question 8 or 9 may result in a request from the Board for evaluation by the Colorado Physician Health Program (CPHP). The CPHP evaluation process could potentially delay consideration of an application. Therefore, the Board is providing advance notice of this possibility so that applicants may contact CPHP to schedule an evaluation at the beginning of the application process. By doing so, the application for licensure should not be unduly delayed. An applicant is not required to contact CPHP in advance of Board consideration of the application. The applicant may choose to wait for a specific decision by the Board that a CPHP evaluation is necessary. This information is being provided to put applicants on notice with respect to this potential requirement and afford the applicant the opportunity to expedite the process if he or she so desires. (Colorado Physicians Health Program – CPHP, 899 Logan Street, #410, Denver, CO 80203; 303-860-0122.)

10. Within the last five years, has any final judgment, settlement or arbitration award for medical malpractice been paid on your behalf or has any claim been filed which is still pending? YES NO

| Date | Name and Address of Insurance Company | Reason for Action |
|------|---------------------------------------|-------------------|
| | | |
| | | |

ATTESTATION

I hereby make application to reinstate my license as a physician assistant in the state of Colorado. In so doing, I authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), business and professional associations (past and present), and all government agencies (local, state, federal and foreign) to release to the Colorado Medical Board or its successors any information, files or records requested by the Board relative to my qualifications as a physician assistant and my eligibility for licensure.

In accordance with Colorado Revised Statutes 18-8-503 and 18-8-501(2)(a)(I), false statements made herein are punishable by law. I state under penalty of perjury, as defined in C.R.S. 18-8-503, that the information contained in this application is true and correct to the best of my knowledge. I understand that under the Colorado Medical Practice Act, providing false information is grounds for denial, suspension or revocation of a medical license.

I further state that I have read all the disclosures contained in the application packet including the one related to social security numbers.

Applicant Signature

Date

Colorado Division of Registrations
Office of Licensing—Medical
 1560 Broadway, Suite 1350
 Denver, CO 80202
 Phone: (303) 894-7800 / FAX: (303) 894-7693
www.dora.state.co.us/registrations

REPORT OF PRACTICE HISTORY
 (See instructions on following page)

| | Dates of Practice | | Facility Name | Address (Street & Number, City, State, ZIP) | Physician Supervisor Name | Nature of Practice |
|----|-------------------|---------------|---------------|--|---------------------------|--------------------|
| | From mm/yyyy | To mm/yyyy | | | | |
| 1 | | | | | | |
| 2 | | | | | | |
| 3 | | | | | | |
| 4 | | | | | | |
| 5 | | | | | | |
| 6 | | | | | | |
| 7 | | | | | | |
| 8 | | | | | | |
| 9 | | | | | | |
| 10 | | | | | | |

Supplying false information in an application for a license is punishable by law.

I state under penalty of perjury in the second degree, as defined in Colorado Revised Statutes 18-8-503, that the information contained in this application is true and correct to the best of my knowledge. I understand that under the Medical Practice Act, providing false information is grounds for denial, suspension or revocation of a medical license.

Applicant Signature

Applicant Last Name (print)

Date

Instructions for Completing Report of Practice History

1. List all of your experience as a physician assistant in chronological order for the last two (2) years, including:
 - Clinic practice;
 - Private practice;
 - Any other medical practice or position;
 - Any hospital that you held privileges at during the last two (2) years, including temporary privileges and consulting privileges;
 - Any locum tenens positions; and
 - Breaks in the practice history of one month or greater.

2. If you have held a license to practice in another jurisdiction or previously been employed as a physician assistant, request letters of reference from physician supervisors familiar with your current practice – within the last two (2) years – be provided directly to the Board.
 - Each letter should be addressed to “Office of Licensing—Medical.”
 - Each letter must be an original on letterhead with dates of employment listed as month/year.

Note: If you have not practiced medicine for more than two years immediately preceding the filing of this application, refer to Board Rule 410 regarding Continued Competency.

PRIMARY PHYSICIAN SUPERVISOR REGISTRATION FORM

Colorado Medical Board
1560 Broadway, Suite 1350, Denver, CO 80202; (303) 894-7800 / FAX (303) 894-7692

This form is to be completed and forwarded to the Colorado Medical Board upon the formation of a supervisory relationship between a primary physician supervisor and a physician assistant in conformance with Board Rule 400, Licensure of and Practice by Physician Assistants. Secondary supervisors are not required to register with the board.

CHECK ONE:

- New registration of a primary physician supervisor (check if you are a first-time PA to Colorado).
- Change of primary physician supervisor, replacing Dr. _____.
- Additional primary physician supervisor (check if you are working for more than one employer).

SECTION 1—To be completed by Physician Assistant

| | | | |
|---|--------|---------|---------|
| Physician Assistant Name: Last: | First: | Middle: | Suffix: |
| Colorado License Number: | | | |
| Practice Address: PO Box, Street: City, State, Zip: | | | |

By my signature, I certify that I have reviewed Board Rule 400 regarding Licensure of and Practice by Physician Assistants. I understand that I must comply with this rule as well as and all rules and statutes of the Colorado Medical Board when practicing as a physician assistant in Colorado.

I understand that this primary physician supervisor/physician assistant relationship remains in effect until rescinded in writing to the Board by either party. If rescinded, I further understand I may not practice as a physician assistant until a new primary physician supervisor has been properly registered with the Board.

Signature of Physician Assistant

Date

SECTION 2—To be completed by the Primary Physician Supervisor

| | | | |
|---|--------|---------|---------|
| Primary Supervising Physician Name: Last: | First: | Middle: | Suffix: |
| Colorado License Number: | | | |
| Practice Address: PO Box, Street: City, State, Zip: | | | |

By my signature, I certify that I have reviewed Board Rule 400 regarding Licensure of and Practice by Physician Assistants. I understand that I must comply with this rule as well as all rules and statutes of the Colorado Medical Board when practicing as a physician and serving as a Primary Physician Supervisor in Colorado.

I understand that this primary physician supervisor/physician assistant relationship remains in effect until rescinded in writing to the Board by either party.

I understand that I may not be the "primary physician supervisor," as described in the rules, for more than four physician assistants, unless I have requested and been granted a specific waiver of this provision of the rule. I understand that I may be a secondary physician supervisor for physician assistants other than those for whom I am the primary physician supervisor. However, I may supervise **only four physician assistants at one moment in time.**

Signature of Primary Physician Supervisor

Date

Colorado Division of Registrations
Office of Licensing—Medical
 1560 Broadway, Suite 1350
 Denver, CO 80202
 Phone: (303) 894-7800 / FAX: (303) 894-7693
www.dora.state.co.us/registrations

**REQUEST FOR
 FEDERATION OF STATE MEDICAL BOARDS (FSMB)—DISCIPLINARY ACTION REPORT**

PHYSICIAN ASSISTANT: To complete your application we must have a report from the Federation's National Databank of disciplinary actions taken by state licensing boards and/or other credentialing agencies. Note: an unfavorable report does not automatically disqualify you from licensure in Colorado.

Do not send this request form to the Colorado Office of Licensing.
When the FSMB receives the request form from you, they will provide the Disciplinary Action Report directly to the Colorado Board.

Complete this form and mail directly to:

Federation of State Medical Boards of the United States, Inc.
 400 Fuller Wisser Road, Suite 300
 Euless, TX 76039-3856

Phone: 817-868-4000
 Fax: 817-868-4099

No fee is required.

| | | | |
|--|------------------------------------|----------------------------|---------|
| Physician Assistant Name: Last: | First: | Middle: | Suffix: |
| Social Security Number: | Date of Birth (mm/dd/yyyy): | | |
| Address: PO Box, Street: City, State, Zip: | | | |
| Physician Assistant School: | | Date of Graduation: | |

I hereby authorize and request that the Federation of State Medical Boards of the United States, Inc. provide a disciplinary history to the following:

Colorado Division of Registrations
 Office of Licensing—Medical
 1560 Broadway, Suite 1350
 Denver, CO 80202

 Signature

 Date

**COLORADO MEDICAL BOARD
CLAIMS INFORMATION FORM**

Applicant: Complete this form for each liability or malpractice claim identified in the application Screening Question regarding malpractice.

Name of Physician Assistant Business Telephone Number

Address City, State, Zip

1. On a separate sheet of paper, type your full name and provide a clinical narrative regarding each malpractice case(s) / allegations. Include name of patient, age, sex, date of occurrence, and location (include address). Do not omit the answers to these questions or make reference to attached documents for answers. This section must be completed with your own description, which includes all of the facts requested above. Simply stating that the charges were dismissed is inadequate, more detail must be provided.

2. Indicate your position in case, i.e., intern, resident, primary doctor, etc. _____

3. Case was filed against: Individual doctor Group Hospital

List names of other doctors and/or hospitals also named in the suit: _____

4. Plaintiff's Attorney and Telephone: _____

5. Is the claim pending? YES NO

6. Was there a judgment or settlement? YES NO

7. What was the amount and date of the judgment or settlement? _____

8. What amount was attributable to you, your insurance company, or your employer? _____

I certify that the information I have provided is correct to the best of my knowledge.

Signature

Date