NOTE TO APPLICANTS:

This document is NOT a paper version of the licensure application. Some applicants have technical difficulties that prevent them from completing all sections of the online application. This document is intended to provide hard copies of any forms these applicants are unable to complete during the online application process.

Physician Assistant On-Line Application Forms Check List

Item Needed	Instructions	Completed
PA Reference Forms	Three recent (no older than six months) references required. Each must be completed in full with an original signature and date. At least one reference form must be from a physician with whom you have worked or trained regarding your competence to practice as a PA. Two reference forms must be completed by peers (coworker, professor, preceptor, physician) and must be someone with whom you have worked or trained. References must be able to evaluate your academic competence, clinical skills and character as a physician assistant. References cannot be from relatives or fellow students. **Please send the reference forms to the references.**	
Verification of Physician Assistant Education	Dean or other medical school official (program director) must complete the certification form and sign/date. PA school seal must be affixed. The original form must be returned to the NCMB. **Please send the form to the PA school.**	
License Verification Form	Complete top portion of form and send to each state licensing agency where you have held or currently hold a PA license. **Please send the form to the state licensing agency.**	
State of Connecticut	Applicable only if you have been or are currently licensed in the state of Connecticut. **Please send the form to the State of Connecticut.**	
Applicant's Oath	Complete, have notarized and **send the original form to the NCMB.**	
Authority for Release of Information	Complete, sign/date and **send the original form to the NCMB.** We cannot send for your background check report without this form.	
Federation of State Medical Boards	Complete form and **fax or mail the form to the Federation of State Medical Boards (FSMB).** Address is listed on form.	
Fingerprint Cards (2)	Complete two fingerprint cards and **return the two completed fingerprint cards to the NCMB along with the Authority for Release of Information Form.**	
NCCPA Authorization for Release of Information	Complete form and **send to NCCPA**. NCCPA's address is on the bottom of the form. Request that NCCPA send the certification **exam results** verification letter to the NCMB (Section 3).	
CME Summary Log	Send the NCCPA CME Summary Log (with your name typed directly on the summary page by NCCPA) to the NCMB or use the hand written form including your CME for the past two years. This requirement is non-applicable for PAs who graduated within the past two years. If you are currently certified by NCCPA, you will be deemed in compliance with the requirement of PA Rule 21 NCAC 32S.0216 and will not be required to submit your CME.	
Name Change Documentation	Provide copies to the NCMB of your marriage, divorce, adoption, legal name change certificates, if applicable.	
Immigration	Please see immigration status requirements inside the application.	

Please have the completed, original forms sent to the NCMB. Copies and faxes are not accepted. Some of these requirement instructions do not apply for Reactivation, Reinstatement and FCVS applications. Please check the requirements listed separately for each application on the web site, www.ncmedboard.org. Thank you.

NCCPA

Request and Authorization for Release of Information

Please type or print information to send to third party. Scores are automatically sent to PA. Duplicate as needed.

Section 1: Identification

Name:_____

Address: _____

City: _____ State:_____ Zip:_____

Daytime Telephone: (_____) _____-_____ PA Identification #_____

Section 2: Exam Information

Indicate which exam and examination period you're requesting information. One request per form.

- ☐ PANCE (Physician Assistant National Certifying Exam)
- ☐ PANRE (Physician Assistant National Recertifying Exam)
- ☐ Pathway II
- ☐ Surgery Exam

Year:_____

Section 3: Information Request

Indicate the nature of this request and the person or agency to whom it should be sent.

- ☐ Eligibility letter, verifying that you are eligible for and registered to take the above exam
- ☒ Exam results

(Complete only if different from above.)

Name:_____

Agency: _____

Address: _____

City: _____ State:_____ Zip:_____

Want us to send the information via fax? If so, please provide the fax number here: (_____) _____-_____

Section 4: Signature and Authorization

Each state licensing authority sets its own rules and regulations. NCCPA strives to stay up-to-date on individual state regulations. We will send the required information, which may consist of current scores and/or score history, to the agency listed above in accordance with the information on state requirements on file with NCCPA.

I acknowledge that I have read and understand the above statement and authorize NCCPA to release all information required by the agency listed above.

_____ _____

(signature) (date)

Fax completed form to 678.417.8135 or mail to: NCCPA, 12000 Findley Road, Ste. 100, Johns Creek, GA 30097-1409.

PHYSICIAN ASSISTANT REFERENCE FORM

North Carolina Medical Board
P.O. Box 20007, Raleigh, NC 27619
or
1203 Front Street, Raleigh, NC 27609

TO APPLICANT: The North Carolina Medical Board requests completion of **three** reference forms. These forms must be sent from the reference sources **directly** to the NCMB in sealed envelopes **with the source's signature affixed across the seal**.

In addition, the forms must meet the following criteria:

a) Recent (no older than six months).
b) Original signature and date required.
c) One reference form must be completed by a physician. Two reference forms must be completed by peers (coworker, professor, preceptor, physician) and must be someone with whom the applicant has worked or trained. References must be able to evaluate the applicant's academic competence, clinical skills and character as a physician assistant.
d) References cannot be from relatives or fellow students.

Please be sure to indicate your name below for identification purposes.

Name of Applicant: _____
(Please Print Clearly)

** **On the application form, the applicant has agreed to release, discharge and exonerate any person furnishing information from any and all liability of every nature and kind arising out of this furnishing or inspection of such documents, records, other information or the investigation made by the North Carolina Board.** **

REFERENCE SOURCE: Please complete this form, sign, date and **return directly to the NCMB** in a sealed envelope with your signature affixed across the seal. Your response is confidential, pursuant to North Carolina law. **Please print or type all information.**

Important: The processing time for licensure directly depends on timely receipt of critical forms such as this.

From: _____

_____
Address City State Zip

_____
Phone Number Email Address

1. How long have you known the applicant? _____

2. In what capacity are you acquainted with him/her? _____

_____

NOTE: If you answer "YES" to any of the following questions please give an explanation.

3. Have you ever received reports of poor medical practice by this physician assistant or have you discussed concerns you had about his/her practice with medical staff officers at a hospital? Yes No

4. Have you ever received reports of poor relationships between this physician assistant and other members of hospital medical staff? Yes No

5.	Do you know of any derogatory information about this physician assistant with respect to his/her ability to practice medicine?	Yes	No
6.	Do you know if this physician assistant has or has this physician assistant had in the past, any mental or physical illnesses or personal problems that interfere with his/her medical practice?	Yes	No
7.	Do you know if this physician assistant has ever abused alcohol or drugs or shown signs of chemical dependency?	Yes	No
8.	Do you know of any lawsuits having to do with this physician assistant's medical practice that this physician assistant has either lost or settled out of court?	Yes	No
9.	Do you know of any restrictions, limitations or other actions of any nature taken against this physician assistant by a hospital or other health related entity?	Yes	No

NOTE: If you answer "NO" to questions 10, 11, or 12, please give an explanation.

10.	Does this physician assistant accept medical staff and hospital policies and function willingly according to these policies?	Yes	No
11.	Does this physician assistant enjoy professional respect among his or her colleagues and in the community where this physician assistant practices?	Yes	No
12.	Do you recommend this physician assistant for unrestricted medical licensure in North Carolina?	Yes	No

*****Additional comments are encouraged and assist the Board in evaluating the applicant.*****

COMMENTS: _____

_____

_____

_____

_____

_____

_____

_____ _____

Signature **Title**

_____ _____

Name of Institution **Date**

Name:_____
(Printed)

CHRONOLOGY OF ACTIVITIES

List in chronological order EVERYTHING you have done since high school. This would include places of employment, hospitals, teaching institutions, private practice, corporations, military assignments, government agencies and Locum Tenens assignments. The Board requires you to account for any and all time. They will not allow any time gaps. You will need to label any unemployed time as "vacation" or "moving" (whatever is appropriate). A CV will NOT replace completing this section of the application.

If you have never worked as a physician assistant, please indicate that in the space above the signature line.

You must complete the top section of the enclosed page titled "Licensure Biography: and forward to each state in which you have held a license or certification in a health related field.

	Place of Institution or Employment	Geographical Location	Type of Employment
From _____ To _____ At			
From _____ To _____ At			
From _____ To _____ At			
From _____ To _____ At			
From _____ To _____ At			
From _____ To _____ At			
From _____ To _____ At			
From _____ To _____ At			
From _____ To _____ At			
From _____ To _____ At			
From _____ To _____ At			
From _____ To _____ At			
From _____ To _____ At			
From _____ To _____ At			
From _____ To _____ At			
From _____ To _____ At			
From _____ To _____ At			
From _____ To _____ At			

Please check if applicable:

☐ **I have never held a license or approval as a physician assistant in any state.**

_____ _____

Signature of PA applicant **Date**

LICENSURE BIOGRAPHY

Applicant: Complete the top portion of this form and forward one copy to each licensing agency in all the state(s) and countries where you **have held OR currently hold** a PA license. The completed form must be directly mailed to the NCMB by the licensing agency. Most states require a fee for processing. The fee is the applicant's responsibility.

Licensing Board/Agency: The North Carolina Board requires information regarding my license/certification. This is my request for you to respond to the questions below and also gives you authority to release any information, favorable or otherwise, to the North Carolina Medical Board.

I am applying for a North Carolina license as a physician assistant. I was granted license number

_____ on _____ by the State of _____ .

_____ Printed or Typed Name	_____ Signature
_____ Social Security Number	_____ Address
_____ Date of Birth	_____ Area Code/Phone #

PLEASE COMPLETE AND MAIL THIS FORM DIRECTLY TO THE NORTH CAROLINA MEDICAL BOARD, P.O. Box 20007, RALEIGH, NC 27619.

This is to certify that the records of the _____ Professional Licensing Board/Agency indicate that _____ physician assistant was issued license number _____ on to practice _____ in the State of _____.

Respond to the following questions:

1.	Is this license current?	YES	NO
2.	Is this license in good standing?	YES	NO
3.	Have any charges ever been filed against this professional?	YES	NO
4.	Do you know of any information that may discredit this professional?	YES	NO
5.	Do your files indicate any derogatory information?	YES	NO
6.	Have you received any complaints against this professional?	YES	NO
7.	Has this professional been investigated by your Agency/Board?	YES	NO

If **YES** answered to any questions 3-7, attach an explanation and certified copies of all relevant documents.

_____ / _____
Authorized Signature **Date**

(Board Seal)

Revised 02/10

North Carolina Medical Board
Physician Assistant Applicant's Oath

THIS ENTIRE FORM MUST BE COMPLETED IN THE PRESENCE OF A NOTARY PUBLIC

_____

Applicant's Printed Name

THE FOLLOWING SENTENCE IS TO BE COPIED BY THE APPLICANT IN THE APPLICANT'S USUAL HANDWRITING.

I hereby certify under oath that I am the person named in this application and that all statements I have made or may make are true and complete.

_____

_____

_____

_____

I further certify and acknowledge the following (initial each statement):

_____ I am the person named in the various forms and credentials furnished with respect to my application and that all documents, forms or copies furnished with respect to my application are true in every aspect.

_____ If I fail to answer questions truthfully and completely, the NC Medical Board (NCMB) may deny my application or take other disciplinary action and that all license denials are reported to the National Practitioners Data Bank and other state medical boards.

_____ If I am in doubt about whether to report any information requested, I should fully disclose the information and provide an explanation of the circumstances.

_____ If someone else completed the application for me, I am responsible to make sure the answers are truthful and complete.

I waive confidentiality, authorize and request every person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me to furnish to the NCMB any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, my examination grades, or any other pertinent data and to permit the NCMB or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application that can subsequently be provided to professional licensing boards, hospitals and other entities when I apply for licensure, staff membership, employment or other privileges.

I hereby release, discharge and exonerate the NCMB, its agents or representatives and any person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the NCMB.

I will immediately notify the NCMB in writing of any changes to the answers to any questions contained in this application if such a change occurs at any time prior to a decision by the NCMB regarding my application.

NOTE: NOTARY SEAL MUST BE PARTIALLY OVER THE APPLICANT'S PHOTO *AND* SIGNATURE

_____
Applicant's Printed Name

_____
Applicant's Social Security Number

_____
Applicant's Date of Birth

Applicant Photograph

Securely tape or glue in this square a current, front-view, 2" X 2" passport-type color photograph of yourself on photo quality paper.

_____
Applicant's Signature

_____
Date of Signature

NOTARY PUBLIC

State of _____, County of _____

SUBSCRIBED AND SWORN TO before me this _____ day of _____, 20 ____

My commission expires: _____

_____
Notary Public

I certify that on the date set forth above the individual named above did appear personally before me and that I: (a) did identify this applicant by comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) did witness this applicant complete this form including the handwritten statement above.

VERIFICATION OF PHYSICIAN ASSISTANT EDUCATION

Please return the completed form to: **NORTH CAROLINA MEDICAL BOARD**
P.O. Box 20007
Raleigh, NC 27619

Name of Physician Assistant: _____

Name of Institution: _____

Institution Address: _____

_____

City: _____ State: _____ Zip: _____

Country: _____

If name of institution was different when this individual attended, please note the prior name below:

_____

Enrollment and Participation:

Our records indicate _____ attended our Physician Assistant Program
(Physician Assistant's name)

From _____ to _____.

This individual was awarded the Physician Assistant degree on _____.
month/year

This individual did not receive the Physician Assistant degree and left the institution on _____.
month/year

The Physician Assistant Program Director or other school official must complete the certification and sign. Original signature is required – signature stamps will not be accepted.

Certification: By my signature, I _____, certify that the above information is an accurate account of the above named individual's office records maintained in this and is true and correct to my knowledge.

Affix Institutional Seal Here

Signature of certifying official: _____
(Original signature is required)

Title: _____

Email address: _____

Date of signature: _____

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the Physician Assistant's medical education. Please check the appropriate response and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation (attach additional pages as necessary).

1. Does this individual's official records reflect (an) interruption(s) or extension(s) in his/her medical education? Yes ( ) No ( )

If YES, select the reasons(s) for, indicate the dates of the interruption(s) or extensions(s) and check whether the interruption/extension was approved or unapproved.

	From Mo/Yr	To Mo/Yr	Approved	Unapproved
Personal/Family			( )	( )
Academic remediation			( )	( )
Health			( )	( )
Financial			( )	( )
Participation in joint degree program			( )	( )
Participation in non-research special study (e.g., fellowship, international experience)			( )	( )
Participation in non-degree research			( )	( )
Other			( )	( )

Please specify_____

2. Does this Physician Assistant's official record reflect he/she was ever placed on academic or disciplinary probation during his/her medical education? Yes ( ) No ( )

	From Mo/Yr	To Mo/Yr
Academic Probation		
Probation for unprofessional conduct/behavior		
Probation for other reason		

Please specify reason: _____

3. Does this Physician Assistant's official records reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the PA school or parent university? Yes ( ) No ( )

If YES, provide detailed documentation/information about the circumstances and outcome(s):

_____

_____

4. Does this Physician Assistant's official records reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the PA school or parent university? Yes ( ) No ( )

If YES, provide detailed documentation/information about the circumstances and outcome(s):

_____

_____

5. Does this Physician Assistant's official records reflect that there were any limitations or special requirements imposed on the Physician Assistant because of questions of academic incompetence, disciplinary problems, or any other reason? Yes ( ) No ( )

If YES, provide detailed documentation/information about the circumstances and outcome(s):

_____

_____

State of Connecticut

Department of Public Health and Addiction Services
Bureau of Health System Regulation
Division of Medical Quality Assurance

Consent for Release of Confidential Disciplinary Records

This is to certify that I hereby give my consent and authorizes the Department of Public Health and Addiction Services, Division of Medical Quality Assurance, to confirm the existence of any pending petitions and to release any records of disciplinary action maintained by that Division (with the exception of any documents identified below) to:

NC Medical Board
PO Box 20007
Raleigh, NC 27619-0007

I understand that these records are confidential pursuant to the provisions of Connecticut General Statute §20-13e and may not be disclosed without my permission. This information will only be disclosed when this release is executed by me. I also understand that if I am a participant in a rehabilitation program sponsored by a County Medical Association or by the Connecticut State Medical Society that I have the right to contact the Association or Society prior to signing this release.

Documents the Department is Not Authorized to Release:

_____	_____
Signature	Date
_____	_____
Name (Printed or Typed)	Conn. Medical License Number
_____	_____
Date of Birth	Expiration Date

For office use only	Initials-Date
Petition under investigation (see attached)	_____
Confidential action (see attached)	_____
No confidential action	_____

DBB:

0241Q

APPLICANT: MAIL OR FAX THIS FORM TO:

FEDERATION OF STATE MEDICAL BOARDS OF THE UNITED STATES, INC.
400 Fuller Wiser Road, Suite 300
Euless, TX 76039
Telephone: (817) 868-4000 – FAX: (817) 868-4099

(Not to the North Carolina Medical Board)

BOARD ACTION DATA BANK INQUIRY FORM

The **NORTH CAROLINA MEDICAL BOARD** requests a Board Action Search concerning the following individual:

Physician Assistant's Name: _____
Last First Middle

Date of Birth: _____
(YY/MM/DD)

Physician Assistant Program: _____
(Include Complete Name and Branch Location)

Year of Graduation: _____

Attention FSMB: **Please mail the result to the following address:**

North Carolina Medical Board
PO Box 20007
Raleigh, NC 27619
ATTN: Licensing Section

AUTHORITY FOR RELEASE OF INFORMATION
State and Federal Record Check

I authorize the North Carolina Department of Justice through the State Bureau of Investigation, Division of Support Services to perform a fingerprint search of the State's criminal history record file and a fingerprint search of the Federal Bureau of Investigation's files for a national criminal history record check in connection with my application for a medical license with the North Carolina Medical Board pursuant to N.C.G.S. 90-11(HB 1638).

(Print or Type)

Last Name	First	Middle	Maiden
_____	_____	_____	_____

Social Security Number	Date of Birth	Sex	Race
_____	_____	____	____

I understand that the North Carolina State Bureau of Investigation, Division of Support Services, and its officials and employees shall not be held legally accountable in any way for providing this information to the North Carolina Medical Board, and I hereby release said agency and persons from any and all liability which may be incurred as a result of furnishing such information. I further understand that the North Carolina Medical Board cannot provide a **hard copy** of the results of this criminal history record check to me.

Applicant's Signature

_____

Date

_____

ORI # BOME00000 – NORTH CAROLINA MEDICAL BOARD

01-132-10
North Carolina Medical Board
November 2002

Instruction Sheet for Completing the Fingerprint Card

1. The complete name of the subject is to be listed as indicated: Last name, First name, and Middle name. Please ensure the name is legible if written.

2. Signature of the subject being fingerprinted is written here.

3. List any and all alias names or nicknames, maiden name or any other married names.

4. List the date of birth numerically – month, day, and year.

   Example: May 11, 1948, should be shown as 05111948; October 15, 1930, should be shown as 10151930

5. Current residence of subject fingerprinted is written here.

6. Sex is to be listed M for male, and F for female, or U for Unknown.

7. Race is to be listed by placing an individual into one (1) of the following categories by writing the appropriate letter in the space provided:

   W - White
   B - Black
   I - American Indian or Alaskan Native
   A - Asian or Pacific Islander
   U - Unknown if unsure or unable to determine

8. Indicate the subject's height in feet and inches using all numerics.

   Example: 6'01" = 601, 6'11" = 611, 6' = 600

9. Indicate the subject's weight in pounds using all numerics.

   Example: 186 or 098, etc.

10. List the subject's eye color by placing one (1) of the following eye color codes in the space provided:

BLK – Black	GRY – Gray	MAR – Maroon
BLU – Blue	GRN – Green	PNK – Pink
BRO – Brown	HAZ – Hazel	XXX – Unknown

11. Color of hair should be indicated by writing one (1) of the following color codes in the space provided:

    BAL – Bald (When subject has lost most of his hair or is hairless)
    BLK – Black
    BLN – Blond or Strawberry
    BRO – Brown
    GRY – Gray or partially
    RED – Red or Auburn
    SDY – Sandy

12. Indicate, if possible, the city and state where the subject was born. The state should be indicated by the two-digit abbreviation.

13. Indicate the date of the fingerprinting here.

14. Signature of Official taking fingerprints is written here.

15. Write the Social Security number in this space. The Social Security number is a very important identifier.

Due to the volume of fingerprints that get rejected, please read the following in order to obtain the best possible set of prints.

SBI FINGERPRINT REJECTION POLICY

The quality of ten-print fingerprint image submissions accepted by the North Carolina State Bureau of Investigation has deteriorated in the last few years. Poor quality fingerprint images result in decreased reliability for both ten-print and latent searches. Low quality fingerprint data are frequently the result of poor rolling practices as opposed to poor image scanning of the rolled prints. For records to be maintained in both the State and Federal level, fingerprints must be rolled from the tip to below the first joint, and nail to nail. Ridge characteristic must be distinct and fingerprint impressions must be in sequential order. We request that all law enforcement agencies and non-criminal justice agencies submit fingerprints that are of good quality.

The following is the SBI/Identification Section Fingerprint Rejection Policy implemented February 2, 2004:

1. Every criminal and applicant fingerprint card must have all ten fingerprint images of good quality. The ten fingerprint images of the plain impressions/slaps must be completely discernable thereby allowing comparison between the plain impressions and rolled impressions.

   NOTE: If a fingerprint in the plain impressions has been cut off (either too low or too high) the FBI cannot compare the rolled images to the plain images, and they will reject the card.

2. The exception to this is amputated, bandaged or deformed fingers. If one of these three notations is in a rolled impression block, there should be **NO** fingerprint in the plain impression/slaps.

3. Fingerprint cards submitted with the following will be rejected:

   - Hands out of sequence, or
   - Fingerprints out of sequence, or
   - Hand printed twice, or
   - Fingerprints printed twice, or
   - Fingerprints missing with no reason given

The definition of a good quality fingerprint is an image that provides sufficient data to accurately identify and locate principal fingerprint features. These features include minutia, cores and delta, and ridges. The image should cover sufficient area to allow examiners to identify fingerprint patterns and to compare the prints with those in the database.

Photocopy of a Sample Fingerprint Card

Each numbered block on this SAMPLE must be completed on the actual fingerprint cards. Follow the *Instruction Sheet for Completing the Fingerprint Cards* to ensure you are completing each block on the actual fingerprint cards with the correct information and in the proper format.

(The actual card must be white with blue writing)