MINNESOTA
BOARD OF MEDICAL PRACTICE

335 Randolph Avenue, Suite 140
St. Paul, MN 55102
612.617.2130 (phone) | 612.617.2166 (fax)
medical.board@state.mn.us | mn.gov/boards/medical-practice

PHYSICIAN ASSISTANT
Application Instructions and Requirements

Please thoroughly review these materials before submitting your application. Any processing fees incurred are your responsibility. The Board reserves the right to reject any outdated applications submitted; therefore, it is recommended that you complete the application in a timely manner. Incomplete applicant files will be destroyed after six months of inactivity.

Methods of Licensure

All applicants must submit a completed application and appropriate fees online at MN Health Board or by paper to the Medical Board.

Licensure Requirements

- Non-refundable $267.00 fee paid online by credit/debit card or submit paper application with check, money order, or cashier's check payable to the **Minnesota Board of Medical Practice.** Cash will not be accepted. Any cash received will be returned, and processing of your application may be delayed.
- The name on the application and your NCCPA certificate must be the same. If there has been a name change, submit a copy of the documentation, e.g., marriage certificate.
- Affidavit of Applicant Form A recent, full-face, 2" X 2" color photograph must be affixed as indicated on the form and notarized as a true likeness. Please ensure to fill in and sign all required areas of the form.
- Copy of driver's license or other government issued photo ID.
- Collaborative Practice Verification For Physician Assistant Form is required **ONLY** with the paper application.
    - Applicants applying online will affirm that they have or have not completed 2,080 hours of collaborative practice. The hours must be completed with a licensed physician and must be in an employment setting rather than educational as a student.
    - If you select "No" indicating that you have not completed the 2,080 hours, you can still qualify for licensure and should submit the Affidavit of Collaborative Practice Form once the hours are completed.
- Criminal Background Check: applicant will receive emailed instructions once the application is processed. **Use ORI number for Board of Medical Practice: MN920158Z on CBC forms.**
- Any other information requested by the Board.

The following requirements must be sent directly to the Minnesota Board from the facility/person completing the form:

- **Direct Verification of Active/Expired Licensure/Registration/Certification:** The Verification of Licensure/Registration/Certification Form or the state generated verification of licensure letter can be sent from the state to the Medical Board by email or mail. Verification letters can also be requested through VeriDoc Inc. to the Medical Board. Go to http://www.veridoc.org to have a verification letter sent from another participating state board to the Medical Board. If the state does not do verifications, please forward the email response from state stating they do not do verifications or email the link to the state website showing the verbiage the state does not do verifications and attach the pdf verification from the state website. The Board must

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receive a separate verification form completed by each state board where you have ever held a healthcare professional license/registration/certification.

- **Verification of Physician Assistant Education:** Certification of Physician Assistant Education Form is for certification of physician assistant education and must be completed and emailed or mailed by the facility directly to the Medical Board.
- **Verification of NCCPA certification:** NCCPA offers a credential verification service on their website at www.nccpa.net which can be emailed or mailed to the Medical Board.

Application Fees

Please be aware that all fees are non-refundable. Fees submitted will not be refunded if it is determined that you are not eligible for licensure.

Applicants are required to submit written notification to the Board within 30 days of any name or address change. The law takes precedence over any conflicts between these instructions and the law.

APPLICATION FOR PHYSICIAN ASSISTANT LICENSE

MINNESOTA BOARD OF MEDICAL PRACTICE
335 Randolph Avenue, Suite 140
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612-617-2130 or mn.gov/boards/medical-practice

Hearing Impaired-Minnesota Relay Service
Metro Area 651-297-5353
Outside Metro Area 1-800-627-3529

FOR BOARD USE ONLY

APPLICATION #: _____

CHECK/RECEIPT #: _____

AMT PAID: _____

LICENSE #: _____

Date of Application:

MONTH	DAY	YEAR

ACCOUNT CODE	AMOUNT
635020 app	
635048 reg	
635064 cbc	

Instructions to Applicant

1. Enter all dates as Month/Day/Year.
2. Please type or print and answer all questions completely and accurately. Failure to answer all questions completely and accurately, and/or omission or falsification of material facts may be cause for denial of your application, or disciplinary action if you are subsequently licensed by the Board.
3. Have attached forms completed and submitted to our office, where applicable.
4. Read the attached statutes regarding physician assistant licensure.
6. See the attached Licensure Instructions for information regarding fees to be submitted with your application.
7. The name you enter must exactly match the name on your physician assistant certificate or documentation of formal name change must be submitted.
8. The application fee is not refundable.

Your Current Name and Address: **Minn. Stat. 13.41, Subd. 2 requires designated contact information to be PUBLIC and it will be placed on license and Board website. You may change this information online, upon licensure, by following instruction letter issued at that time.**

Full Legal Name: Last	First	Middle
Street Address:		
City:	State or Province:	Zip Code: / Country:
Home Phone: / Other Phone:	Gender ❑ Male ❑ Female	Other Names:
Social Security or Alien Registration Number:	Email Address: (Required)	

Record of Birth

Birthdate (Mo/Day/Year) / /	City of Birth:	State of Birth:	Country of Birth:

NCCPA Certification

Date of Certification (Mo/Day/Year) / /	Certificate Number:	Expiration Date (Mo/Day/Year) / /
Primary Specialty:	Secondary Specialty:	

Preliminary Education

Name of High School:	City:	State or Province:	Zip Code:	From Date:	To Date:
Name of College:	Cite:	State or Province:	Zip Code:	From Date:	To Date:
Type of Degree:	Name of Issuing School:	City:	State or Province:	Date Degree Received:	

Physician Assistant Education and Training

Institution	City	State	Zip Code	From Date Month/Day/Year	To Date Month/Day/Year	Degree/ Certificate

Other Education and Training

Institution	City	State	Zip Code	From Date Month/Day/Year	To Date Month/Day/Year	Degree/ Certificate

STATES/PROVINCES/COUNTRIES IN WHICH YOU ARE OR HAVE BEEN LICENSED OR REGISTERED
List all health professional licenses

State/Province/Country	Health Profession	License/Registration Number	Date Issued Month/Day/Year	Exam

Drivers License

State: License Number:

DEA Certificate(s)

State: Certificate Number: Expiration Date:

State: Certificate Number: Expiration Date:

Attestation questions: Please answer all questions by selecting Yes or No and provide an explanation when requested. If responses to questions change during the time your application is pending, you must make the board aware of the new information. If additional space is necessary, please attach a separate sheet.

Yes No 1. Do you currently have any condition that is not being appropriately treated which is likely to impair or adversely affect your ability to practice as a physician assistant with reasonable skill and safety in a competent, ethical, and professional manner? If yes, please describe.

_____

_____

Yes No 2. Does your use of alcohol or chemical substance(s), including prescription medications, in any way impair or limit your ability to practice as a physician assistant with reasonable skill and safety? If yes, please describe.

_____

_____

Yes No 3. Are you engaged in the use of illegal controlled substances (e.g. heroin, cocaine) or illegal use of legal controlled substances (i.e. not obtained pursuant to a valid prescription of a licensed health care provider)? If yes, please describe.

_____

_____

Yes No 4. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism, or other sexual behavior disorders? If yes, please describe.

_____

_____

Yes No 5. Have you ever been the subject of an investigation by any federal, state, or local agency having jurisdiction over controlled substances? If yes, please describe.

_____

_____

Yes No 6. Have you ever been denied a license, or the privilege of taking an examination before any physician assistant examining board, or has a conditioned license been issued to you by any state board or licensing authority? If yes, please describe.

_____

_____

Yes No 7. Has your license to practice as a physician assistant in any state or country been voluntarily or involuntarily (i.e. by state board order or any other form of disciplinary action) revoked, suspended, restricted, or conditioned by a state board or other licensing authority? If yes, please describe.

_____

_____

Yes No 8. Have you ever been notified of an investigation by a state board, physician assistant society, or health facility of any complaints against you relative to the practice as a physician assistant, or have you been reprimanded or censured by any physician assistant society or licensing board? If yes, please describe.

_____

_____

Yes No 9. In the five-year period of active practice preceding the date of filing your application, have you been a defendant in any malpractice lawsuits, had any malpractice settlements, or have any pending? If yes, give a detailed clinical explanation of each case and provide documentation of the outcome (insurance papers or court documents).

Yes No 10. Have you ever been denied, restricted, or revoked staff affiliations with a hospital, nursing home, clinic, or other healthcare facility? If yes, please describe.

_____

_____

Yes No 11. Have there ever been any criminal charges filed against you, whether the charges were misdemeanor, gross misdemeanor, or felony? This includes any offenses which have been expunged or otherwise removed from your record by executive pardon. If yes, submit a personal statement regarding the date of conduct, state and local jurisdiction in which the charges were filed, date of closure, what role you played, and the outcome. If the charge involved the use of alcohol or other chemicals, include in your personal statement whether a chemical dependency evaluation was done (and if so, submit results) and a description of your current drinking or other substance use habits.

Yes No 12. Have you ever voluntarily or involuntarily surrendered your DEA certificate or the right to prescribe controlled substances? If yes, please describe.

_____

_____

RIGHTS OF SUBJECTS OF DATA

This information is requested by the Minnesota Board of Medical Practice. The purpose and intended use of this information is to enable the Board to determine whether you meet statutory and rule requirements for licensure. The information is classified as private while your application is pending or if your application is denied, and as public if your license is granted. You are required to submit this information. Your application will not be processed without it and the form will be returned to you for completion. This information may be used as the basis for further investigation by the Board into your qualifications. Under some circumstances, the information could become available to other agencies or persons authorized by law to have access. Attach a separate page for detailed explanations, when appropriate. Failure to answer all questions completely and accurately, and/or omission or falsification of material facts may be cause for denial of your application, or disciplinary action if you are subsequently licensed by the Board.

Applicant Name_____ Last 4 digits of SSN _____ Date_____

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AFFIDAVIT OF APPLICANT:

State of: _____ County of: _____

I, _____, swear that I am the person described and identified in this application and that I have not engaged in any acts prohibited by Minnesota statutes and rules.

I hereby authorize all educational institutions, hospitals, medical institutions or organizations, clinics, my references, personal physicians, employers (past and present), business and professional associates (past and present), all Governmental agencies and instrumentalities (local, state, federal or foreign) to release to this licensing Board any information, files, or records including (but not limited to) transcripts, medical records, personnel files, and any information, favorable or otherwise, the Board may require for its evaluation of my professional, ethical, and physical qualifications for licensure in Minnesota.

I hereby release, discharge, and exonerate the Board, its agents, and representatives, and any person furnishing information to the Board from any and all liability of every nature and kind arising out of the furnishing of oral information or of documents, records, or other information to the Board.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension or revocation of my license to practice in Minnesota. I understand that I am required to update my application with pertinent information to cover the time period between date of application and date approved by the Board.

Sworn to before me this _____ day of _____ , _____ . _____
Signature of Applicant

Signature of Notary Public _____

My Commission Expires: _____

Certification of Identification
(Certification of Notary Public is required.)

I certify that on the date set forth below, the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document. Sworn to before me by the applicant

on this _____ day of _____ , _____.

Signature of Notary Public _____

Expiration Date _____ / _____ / _____

Paste a recent photo, front-view passport-type photo in this square

_____ Notary Seal _____

_____
Signature of Applicant

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ADDENDUM TO APPLICATION

1. BUSINESS ADDRESS

Effective August 1, 2012, Minn. Stat. §214.073 requires licensees to provide their primary business address at the time of initial application and all subsequent renewals. Your primary business address is public and you are required to submit it for application purposes. Your license will not be issued without it unless you check the box below certifying that you are not currently in the workforce related to your practice.

Facility name _____

Street Address_____

City _____ State_____ Zip_____

☐ I certify that I am not currently in workforce related to my practice, and I don't have a business address related to my practice.

2. MILITARY STATUS

Are you or your spouse returning from active military duty (discharged less than 6 months ago) or still in active military duty?

☐ No ☐ Yes. If discharged, please provide discharge date: _____

3. CRIMINAL CONVICTIONS

Effective July 1, 2013, Minn. Stat. §214.072 requires the Board to collect and post on its website the names and business address of each regulated individual who has be conviction of a felony or gross misdemeanor occurring on or after July 1, 2013 in any state or jurisdiction. This information shall be posted for new licensees issued a license on or after July 1, 2013 and for current licensees upon license renewal occurring on or after July 1, 2013. This information is public and you are required to submit it for application purposes. You must notify the Board if a previously reported conviction has been expunged and provide written documentation of expungement.

If you have more than one item to report please attach additional sheets.

Conviction Date (mm/dd/yyyy): _____

Conviction Type (Check one): ☐ Felony ☐ Gross misdemeanor

Crime Description: _____

City: _____ State: _____ County: _____ Country: _____

Sentence:_____

_____

☐ I certify that I have had no convictions on or after July, 1, 2013

Applicant Name_____ Last 4 digits of SSN_____ Date_____

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PHYSICIAN ASSISTANT
Verification of Physician Assistant Education

This form is for certification of physician assistant education and must be completed and **emailed or mailed by the facility directly to the Minnesota Board of Medical Practice**. Any processing fees are the applicant's responsibility. The applicant's signature authorizes release of information, favorable or otherwise, directly to the Board.

Print Name: ____ SS#:____________________

Signature:____ Date:______________

Date of Degree(mo/day/yr)____________________ Degree Received________________ * * * *
* *

The School completes the following information:

It is hereby certified that:____
(Name of Applicant)

Matriculated in:____
(Name of School)

Program located at: ____
(City/State of School)

And received a diploma conferring:_________________________ On:_______________
(Degree) (Mo/Day/Year

Program accredited by: (check one)
___ Commission on Allied Health Education and Accreditation (CAHEA), Commission on Accreditation of Allied Health Education Programs (CAAHEP), or a successor agency
___ Accreditation Review Committee on Education for the Physician Assistant (ARC-PA)
___ Other (explain)______________________

Any disciplinary action? Yes*______ No______
***Please** attach letter of explanation.
Any derogatory information on file? Yes*______ No______

President, Secretary Dean, Registrar

School Seal**

Print Name: ____________________________

Signature: ____________________________

Title: ____________________________

Date: ____________________________

Phone: ____________________ Fax________________

**If there is no seal, attach letter of explanation on letterhead.

4/22

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PHYSICIAN ASSISTANT
Verification of Licensure/Registration/Certification

This form is for verification of all physician assistant and other healthcare professional licenses or registrations from every board issuing any type of license including training and temporary permit even if license is not current. **Each Board completing the form must email or mail directly to the Minnesota Board of Medical Practice.** Any fees are the applicant's responsibility. The applicant's signature authorizes release of information, favorable or otherwise, directly to the Board.

Print Your Name:_____SS#: _____

Signature: _____ Date: _____

* *

The State Board completes the following information:

It is hereby certified that: _____
(Name of Applicant)

Date of birth: _____
(Month / Day / Year)

Was issued license/registration number: _____

By: _____ On:_____
(State) (Month / Day / Year)

Expiration date is: _____
(Month / Day / Year)

Issued on the basis of: _____

Disciplinary action ever initiated, pending, or invoked? Yes*_____ No _____

Ever voluntarily relinquished license? Yes*_____ No _____

State

Print name: _____

_____

Seal**

Signature: _____

_____

*If yes, please attach letter of explanation.
**If there is no seal, attach letter of explanation on letterhead.

4/22

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COLLABORATIVE PRACTICE VERIFICATION FOR PHYSICIAN ASSISTANTS

Minnesota Statutes, section 147A.02(c) states the following:

A physician assistant who qualifies for licensure must practice for at least 2,080 hours, within the context of a collaborative agreement, **within a hospital or integrated clinical setting** where physician assistants and physicians work together to provide patient care. The physician assistant shall submit written evidence to the board with the application, or upon completion of the required collaborative practice experience. For purposes of this paragraph, a collaborative agreement is a mutually agreed upon plan for the overall working relationship and collaborative arrangement between a physician assistant, and one or more **physicians licensed under chapter 147**, that designates the scope of services that can be provided to manage the care of patients. The physician assistant and one of the collaborative physicians must have experience in providing care to patients with the same or similar medical conditions. The collaborating physician is not required to be physically present so long as the collaborating physician and physician assistant are or can be easily in contact with each other by radio, telephone, or other telecommunication device.

• Type or print clearly • Provide all information • Do not use initials or abbreviations

APPLICANT/LICENSEE INFORMATION			
LAST NAME	FIRST NAME	MIDDLE NAME	
STREET ADDRESS			
CITY	STATE/PROVINCE	ZIP/POSTAL CODE	COUNTRY
BIRTH DATE (mm/dd/yyyy)			

I have reviewed Minnesota Statute § 147A.02(c) above and affirm that **(one box must be checked)**:

☐ I ***have not*** completed 2,080 hours of collaborative practice as outlined in this section of Minnesota Statutes. (with a Minnesota licensed physician, outside of an education program)

☐ I ***have*** completed 2,080 hours of collaborative practice as outlined in this section of Minnesota Statutes. (with a Minnesota licensed physician, outside of an education program)

I understand that if I have not completed 2,080 hours of collaborative practice, that I am to submit this form at the time of application and resubmit upon completion of 2,080 hours. The information asked is to provide confirmation of completed 2,080 hours of practice within the context of a collaborative agreement, as outlined in this section of Minnesota Statutes.

The undersigned does hereby affirm that the above statement is true and correct.

_____ _____

Print Name | Date of Completion (mm/dd/yyyy)

_____ _____

Legal Signature | Date (mm/dd/yyyy)

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ADDITIONAL REQUIREMENTS

You may be required to apply for a Drug Enforcement Administration (DEA) registration and register an account with the Minnesota Prescription Monitoring Program (PMP).

To obtain an application for a DEA number/registration:
Access the DEA website at https://www.deadiversion.usdoj.gov/ or call the DEA Regional Field Office at 612-344-4136.

Once you have obtained a DEA number/registration, you may also be required to register and maintain a user account with the Minnesota Prescription Monitoring Program, pursuant to Minnesota Statute § 151.126, Subd. 6(c):

By July 1, 2017, every prescriber licensed by a health-related licensing board listed in section 214.01, subdivision 2, practicing within this state who is authorized to prescribe controlled substances for humans and who holds a current registration issued by the federal Drug Enforcement Administration, and every pharmacist licensed by the board and practicing within the state, shall register and maintain a user account with the prescription monitoring program. Data submitted by a prescriber, pharmacist, or their delegate during the registration application process, other than their name, license number, and license type, is classified as private pursuant to section 13.02, subdivision 12.

To register an account with the PMP, follow this link:
http://pmp.pharmacy.state.mn.us/pmp-user-registration-and-resources.html or contact the PMP at 651-201-2836 or minnesota.pmp@state.mn.us