

Michigan Department of Community Health
Task Force on Physician's Assistants

P.O. Box 30670
Lansing, Michigan 48909
(517) 335-0918
www.michigan.gov/healthlicense

PHYSICIAN'S ASSISTANTS LICENSURE INSTRUCTIONS

Authority: P.A. 368 of 1978, as amended
This form is for information only.

NOTE: It is your responsibility to have all required documentation sent to the Task Force on Physician's Assistants. Questions regarding your application can be directed to the Task Force on Physician's Assistants at (517) 335-0918 three weeks after the date you sent the application. Please allow 6-8 weeks processing time.

GENERAL INSTRUCTIONS FOR LICENSURE BY EXAMINATION

An applicant for licensure as a physician's assistant must be a graduate of a program for the training of physician's assistants approved by the task force.

1. Please mark the appropriate type of licensure for which you are applying. Read all instructions carefully and answer all questions on the application. Failure to correctly complete the application in its entirety may delay the processing of your application.
2. Your check or money order drawn on a U.S. Financial Institution and made payable to the **STATE OF MICHIGAN** must accompany the application. Applications received without a fee will be returned to you and will not be considered by the Task Force until the proper fee has been received. An application accompanied by the appropriate fee is valid for two years. If an applicant fails to complete the requirements for licensure within two years from the date of filing the application, the application is no longer valid.
3. **Effective October 1, 2008**, all applicants for a health profession license or registration in Michigan are required to submit fingerprints and undergo a criminal background check. Please see the attached instructions. The Michigan Board is not able to accept fingerprints that have been obtained for any other purpose. Your license or registration will not be issued until this process is complete.
4. Authorize your Physician's Assistant Educational Program to forward a final, official transcript directly to this office. The transcript must show the degree/certificate earned and date the degree was conferred.
5. If you are also applying for a temporary license, you must have your school send us either a) a final, official transcript of your PA degree or b) an official letter of good standing from your Dean or Program Director that includes the date you completed your PA program. A temporary license is valid for not more than 18 months, is non-renewable, and will be revoked upon notification that the applicant has failed the examination.
6. You must submit an Information Release Form to NCCPA to have your PANCE Examination scores sent directly to the Board office. Download this form from www.nccpa.net by clicking on Resources and then Applications, Forms, and Site Map. You may submit the completed form by fax to (678) 417-8135 or by mail to NCCPA, 12000 Findley Rd, Ste 200, Duluth GA 30097.
7. Verification of licensure from any state where you hold or have ever held a permanent physicians assistant license. A form is enclosed for this purpose and may be copied as needed. As most states charge a fee for this service, you should contact each state board to determine if a fee is required prior to sending them the form for completion. The Verification of Licensure form must be sent to the Michigan Board directly from the state(s) where you are or have been licensed.

8. For information regarding the NCCPA Examination, please contact:

The National Commission on Certification of Physician's Assistants, Inc.
12000 Findley Road
Suite 200
Duluth, GA 30097
(678) 417-8100
www.nccpa.net

GENERAL INSTRUCTIONS FOR LICENSURE BY ENDORSEMENT (must be currently licensed in another state that has substantially equivalent license requirements as those in Michigan.)

1. Please mark the appropriate type of licensure for which you are applying. Read all instructions carefully and answer all questions on the application. Failure to correctly complete the application in its entirety may delay the processing of your application.
2. Your check or money order drawn on a U.S. Financial Institution and made payable to the **STATE OF MICHIGAN** must accompany the application. Applications received without a fee will be returned to you and will not be considered by the Task Force until the proper fee has been received. An application accompanied by the appropriate fee is valid for two years. If an applicant fails to complete the requirements for licensure within two years from the date of filing the application, the application is no longer valid.
3. **Effective October 1, 2008**, all applicants for a health profession license or registration in Michigan are required to submit fingerprints and undergo a criminal background check. Please see the attached instructions. The Michigan Board is not able to accept fingerprints that have been obtained for any other purpose. Your license or registration will not be issued until this process is complete.
4. Applicants who were first licensed in another state after July 7, 1986, must authorize your Physician's Assistant educational program to forward a final, official transcript directly to this office. The transcript must show the degree/certificate earned and date the degree was conferred.
5. You must submit an Information Release Form to NCCPA to have your PANCE Examination scores sent directly to the Board office. Download this form from www.nccpa.net by clicking on Resources and then Applications, Forms, and Site Map. You may submit the completed form by fax to (678) 417-8135 or by mail to NCCPA, 12000 Findley Rd, Ste 200, Duluth GA 30097.
6. Verification of licensure from any state where you hold or have ever held a permanent physicians assistant license. A form is enclosed for this purpose and may be copied as needed. As most states charge a fee for this service, you should contact each state board to determine if a fee is required prior to sending them the form for completion. The Verification of Licensure form must be sent to the Michigan Board directly from the state(s) where you are or have been licensed.

GENERAL INFORMATION

1. NAME AND/OR ADDRESS CHANGES: If your name and/or address changes please notify the Michigan Task Force on Physician's Assistants in writing. To change a name or address, you can download the [Data Change/Duplicate License Request Form](#) from our website www.michigan.gov/healthlicense and fax it to (517) 373-2179 or mail the form to Bureau of Health Professions, PO Box 30670, Lansing, MI 48909. Telephone calls are NOT accepted for these changes.
2. REFUND POLICY: If you wish to withdraw your application, you may be eligible for a partial refund. You must notify the Michigan Task Force on Physician's Assistants in writing to request a refund.
3. **NOTE:** If you have ever been licensed in another state and you have a current disciplinary sanction on that license, (even if the license is inactive), you are **not** eligible for licensure in Michigan according to the Public Health Code, PA 368, as amended, Section 222.16174 (3). Sanctions include probation, limitation, suspension, revocation, or fine. Upon resolution of the sanction and verification that the license is active with no disciplinary action in effect, you can proceed with the filing of an application for a Michigan license or registration.
4. ORIGINAL LICENSES ARE VALID FOR ONE YEAR OR LESS, SUBSEQUENT RENEWALS ARE VALID FOR A TWO-YEAR PERIOD.



STATE OF MICHIGAN

JENNIFER M. GRANHOLM
GOVERNOR

DEPARTMENT OF COMMUNITY HEALTH
LANSING

JANET OLSZEWSKI
DIRECTOR

CRIMINAL BACKGROUND CHECK FINGERPRINT REQUEST FORM INSTRUCTIONS- (Michigan locations only)

Procedure to search criminal history records when fingerprints are required by law:

1. Complete the attached Livescan Fingerprint Request Form and schedule a fingerprinting appointment with Integrated Biometric Technology (IBT). A fee of \$65.25 is required for the fingerprinting process. The fee may be paid while registering on-line or at the fingerprinting appointment with either a business check or money order. Please note: The Agency ID Number needed for scheduling is 71734k.
2. To schedule a fingerprinting appointment on-line (Michigan locations only):

Register with the approved fingerprinting vendor, IBT, at www.ibtfingerprint.com.

Use the "click here to schedule by location" link to locate Michigan Livescan locations near you.

Select Michigan as the State for which you are being fingerprinted, then complete the registration process and finalize your appointment.

3. To schedule a fingerprinting appointment by telephone (Michigan locations only):
Call IBT toll-free at 1-866-226-2952 (8 am - 5 pm EST) and a representative will schedule the fingerprinting appointment and assist you in identifying a convenient location.
4. Please have the following with you upon arriving at your fingerprinting appointment:

The attached completed Livescan Fingerprint Request Form.

A driver's license or other state or federal issued picture identification (government ID, passport, military ID).

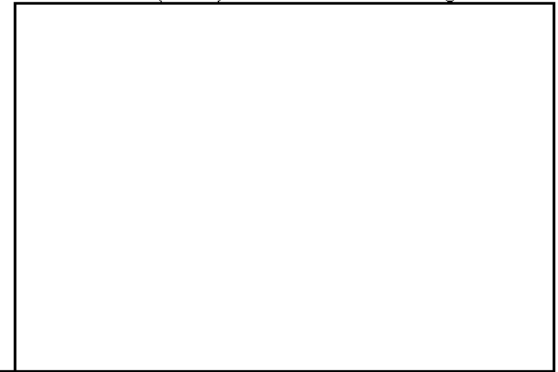
A business check or money order for \$65.25 made payable in U.S. Funds to: Integrated Biometric Technology, unless you have made payment on-line.
5. A technician will scan your fingerprints and submit the data electronically to the Michigan State Police.
6. You will receive a signed receipt at the end of your fingerprinting session, which will include a TCN identification number that can be kept as proof of completing the fingerprinting process.
7. If no criminal history information is found, the Bureau of Health Professions will be notified.
8. If criminal history information is found, the Michigan State Police will send the record directly to the Bureau of Health Professions for review.
9. IBT is under contract with the Michigan State Police (MSP) to provide fingerprint services. For questions, call MSP at (517) 322-1956.

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P.O. Box 30670
 Lansing, MI 48909
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 www.michigan.gov/healthlicense

**APPLICATION FOR LICENSURE AS A
 PHYSICIAN'S ASSISTANT**

Authority: Public Act 368 of 1978, as amended
 If this form is not completed, a license will not be issued.



| Board Use Only |
|-------------------|
| License Number |
| Date of Licensure |

Type or Print Only

| | | |
|--|---------------|--------------------------|
| <p>I AM APPLYING FOR THE FOLLOWING:</p> <p><input type="checkbox"/> Physician's Assistant License by Examination Fee: \$90.00 71-5601-01</p> <p><input type="checkbox"/> Physician's Assistant License by Endorsement Fee: \$90.00 71-5601-09 (Must Currently be Licensed in Another State)</p> <p><input type="checkbox"/> Physician's Assistant License by Examination and Temporary License Fee: \$125.00 71-5601-0401</p> <p>Your check or money order drawn on a U.S. financial institution and made payable to the STATE OF MICHIGAN must accompany this application. DO NOT SEND CASH. Fees are deposited upon receipt and can only be refunded under refund rules promulgated by the Department.</p> | | |
| First Name | Middle Name | Last Name |
| U.S. Social Security Number | Date of Birth | Daytime Telephone Number |
| Street Address | | |
| City | State | ZIP Code |
| All Previous Names and/or Birth Name Used (if applicable) | | E-Mail Address: |
| Have you ever held a health professional license in Michigan? <input type="checkbox"/> No <input type="checkbox"/> If Yes, Please provide Michigan Permanent I.D. Number # and Expiration Date: _____ | | |

Check the appropriate answer to each of the following questions. NOTE: Attach a detailed explanation for any Yes answer you check.

| | |
|---|--|
| 1. Have you ever been convicted of a felony? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Have you ever been convicted of a misdemeanor punishable by imprisonment for a maximum term of 2 years? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Have you ever been convicted of a misdemeanor involving the illegal delivery, possession, or use of alcohol or a controlled substance (including motor vehicle violations)? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Have you been treated for substance abuse in the past 2 years? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Have you had 3 or more malpractice settlements, awards, or judgments in any consecutive 5 year period? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Have you had one or more malpractice settlements, awards, or judgments totaling \$200,000 or more in any consecutive 5 year period? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Have you ever had a federal or state health professional license revoked, suspended, or otherwise disciplined; been denied a license; or currently have disciplinary action pending against you? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

Name

8. Have you ever been censured, or requested to withdraw from a health care facility's staff or had your health care facility staff privileges involuntarily modified? Yes No

9. Do you hold or have you ever held a physician's assistant license in any state? If so, list each state, the license number, the date issued, and how the license was obtained (either endorsement or examination). Yes No
DO NOT LIST TEMPORARY LICENSES. You must have each state board verify licensure directly to this board office. (Attach additional sheets if necessary.)

| State | License/Registration Number | Date of Issue | How Obtained (Endorsement or examination) |
|-------|-----------------------------|---------------|--|
| | | | |
| | | | |
| | | | |
| | | | |

10. Have you passed the NCCPA PANCE examination? Yes No

**Provide a complete chronological record of your PA education.
Attach additional sheets if necessary.**

| Name and address of Institution | Dates of Attendance | | Degree |
|---------------------------------|---------------------|----|--------|
| | From | To | |
| | | | |
| | | | |
| | | | |
| | | | |

CERTIFICATION

I understand that it is the policy of this agency to secure a criminal conviction history as part of the pre-licensure screening process. I authorize this agency to use the information provided in this application to obtain a criminal conviction history file search from the Central Records Division of the Michigan Department of State Police or other law enforcement or judicial record-keeping organization.

I further consent to the release of information to this agency regarding any disciplinary investigations conducted by a similar licensure, registration, or specialty certification board of this or any other state, of the United States military, of the federal government, or of another country.

The statements in this application are true and correct. I have not withheld information that might affect the decision to be made on this application. In signing this application, I am aware that a false statement or dishonest answer may be grounds for denial of my application or revocation of my license and that such misrepresentation is punishable by law.

| | |
|------------------------|------|
| Signature of Applicant | Date |
|------------------------|------|

Michigan Department of Community Health
Bureau of Health Professions
P.O. Box 30670
Lansing, MI 48909
www.michigan.gov/healthlicense

VERIFICATION OF LICENSURE OR REGISTRATION IN ANOTHER STATE

Authority: Public Act 368 of 1978, as amended.

PART I: To be completed by the applicant and forwarded to the appropriate State Licensing Board for completion.

| | | | |
|--|---|---|--|
| Check the profession for which you are requesting verification. | | | |
| <input type="checkbox"/> Audiology | <input type="checkbox"/> Medicine | <input type="checkbox"/> Osteopathy | <input type="checkbox"/> Psychology |
| <input type="checkbox"/> Chiropractic | <input type="checkbox"/> Nursing | <input type="checkbox"/> Pharmacy | <input type="checkbox"/> Respiratory Therapy |
| <input type="checkbox"/> Counseling | <input type="checkbox"/> Nursing Home Adm. | <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Sanitarians |
| <input type="checkbox"/> Dentistry | <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Physician's Assistants | <input type="checkbox"/> Social Work |
| <input type="checkbox"/> Marriage & Family Therapy | <input type="checkbox"/> Optometry | <input type="checkbox"/> Podiatry | <input type="checkbox"/> Veterinary |
| First Name | Middle Name | Last Name | |
| Previous Names Used | Date of Birth | U. S. Social Security Number | |
| State Board | License Number | Date of Issue | |

The applicant listed above has applied for licensure in Michigan and has indicated licensure in your State. Please complete Part II of this form and return it to the appropriate Michigan Board at the address shown above.

PART II: To be completed by the State Licensing Board.

| | | |
|---|---|-----------------|
| Type of License: | Original Issue Date | Expiration Date |
| Basis for Issuance of License: | | |
| <input type="checkbox"/> Examination - Please indicate type of exam (National, Regional, State, etc.) _____ | | |
| <input type="checkbox"/> Endorsement - Please indicate name of state _____ | | |
| License Status | Has the applicant incurred any formal or informal actions in your State? | |
| <input type="checkbox"/> Current <input type="checkbox"/> Lapsed <input type="checkbox"/> Inactive | <input type="checkbox"/> No <input type="checkbox"/> Yes - If Yes, Please attach certified copies of any actions. | |
| Are formal or informal actions pending? | Has the applicant's license ever been limited, denied, surrendered, reprimanded, suspended or revoked? | |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> Yes | |

CERTIFICATION

I hereby verify, to the best of my knowledge, the information above is true to the records of this Board.

Signature

Date

Type or Print Name

(S E A L)

Title

Full Name of Licensing Board