New Jersey Office of the Attorney General
Division of Consumer Affairs
State Board of Medical Examiners
Physician Assistant Advisory Committee
140 East Front Street, 3rd Floor, P.O. Box 183
Trenton, New Jersey 08625
(609) 826-7100
BMEPA@dca.lps.state.nj.us

Physician Assistant Application for Licensure Checklist

Use this checklist as a guide to assure your application is complete.

Applicant's name:_____

I. Application

A. Answer each question completely.

B. Be sure to have the application notarized.

C. Attach one (1) passport photograph (2" x 2") to the application.

D. Provide a valid daytime telephone number (include area code).

E. Attach additional documents (if applicable). (For example, to explain gaps in curriculum vitae history, a statement of medical activity, or other.)

List here:

_____

_____

F. Provide the original or a notarized copy of your birth certificate, a notarized copy of your passport or citizenship documents.

G. Provide name-change documentation (a notarized copy of the marriage license/court orders (if applicable)).

II. Verification forms

a. Military Service Profile (PA-94-ll-A) ☐ Yes ☐ N/A

b. P.A. License(s)/Registration (PA-94-ll-B) ☐ Yes ☐ N/A

c. N.C.C.P.A. Verfication (PA-94-ll-C) ☐ Yes

d. Certification of Good Standing (PA-94-ll-D) ☐ Yes ☐ N/A

e. Verification of Graduation from a Physician Assistant Program (with one (1) passport photograph (2" x 2") (PA-94-ll-F) attached).

f. Employer(s) Verification of Hospital/Medical Employment, Privileges or Appointment (PA-94-ll-H)

Checklist

III. Transcripts: Verification of Education

A. Physician Assistant Program

IV. Curriculum Vitae

V. Application Fee

Personal check or money order payable to the Physician Assistant Advisory Committee, in the amount of $125.00. (This fee is not refundable.)

VI. Certification and Authorization Form for a Criminal History Background Check.

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Dear Applicant:

Enclosed please find a New Jersey application for licensure. Please be advised that pursuant to **N.J.S.A**. **45:9-27.13 "The Physician Assistant Licensing Act"** provides for licensure of applicants who have met the following criteria.

1. The applicant is at least 18 years of age.
2. The applicant is of good moral character.
3. The applicant has successfully completed an approved program, meaning the applicant is a graduate of a Physician Assistant Program that has been approved by the Committee on Allied Health Education and Accreditation, or its successor, and
4. The applicant has passed the national certifying examination administered by the National Commission on Certification of Physician Assistants, (the "N.C.C.P.A.") or its successor.

Currently, there are no provisions for the licensure of ***non-United States accredited medical graduates*** as Physician Assistants who have not met the requirements outlined above.

In order for your application to be processed, you must adhere to the following guidelines in conjunction with the checklist provided. Failure to answer each question completely will result in your application being returned to you for a response.

Very Important

Please read the application form in its entirety **before** completing. **Note: Under the Medical Conditions section of the application, there are instances when "not applicable" may apply.**

It will be your responsibility to contact the N.C.C.P.A. and have them send us your verification or certification.

I. Verification Forms A-H (These forms may be duplicated if necessary.)

The issuing authority, state or employer must return the applicable form directly to the Physician Assistant Advisory Committee at the address listed on the form. ***Forms submitted to the Physician Assistant Advisory Committee by an applicant will not be accepted.***

A. Military Service Profile (PA-94-II-A)

Forward a copy of this form to every branch of the U.S. military service in which you have served. The military branch(es) should be advised that profiles that are incomplete will not be accepted.

B. Certification of Physician Assistant License/Registration/Permit Issued (PA-94-II-B)

Forward a copy of this form to each state where you were licensed or are currently licensed as a physician assistant.

C. Certification of Good Standing (PA-94-II-D)

Forward a copy of this form to each state/country where you are currently, or have been in the past, licensed/certified as a health care professional other than a physician assistant. For example, as a physician, nurse, paramedic, X-ray technician, respiratory therapist, E.M.T., etc.

D. Verification of Graduation from a Physician Assistant Program (PA-94-II-F)

Please attach a passport-size **photograph (2" x 2")** taken within the past ***six (6) months***. Please forward this form to your Physician Assistant Program to verify your graduation. This form must be mailed directly to the Physician Assistant Advisory Committee.

E. Verification of Medical Employment Form (PA-94-II-H)

Forward a copy of this form to every medical facility or hospital/medical employer for whom you have worked in a medical capacity within the past ***five (5) year period*** that immediately precedes the submission of your application for licensure in New Jersey.

Please ensure that your employer understands that this form must be completed in its entirety, and then sent to the Committee along with a letterhead and/or business card. Incomplete verification forms will not be accepted. Please Note: This form must be mailed by the employer and must not be submitted by the applicant.

II. Verification of Education

All applicants must request official transcripts from the Physician Assistant Program attended to. The transcripts must be mailed or emailed, directly from the schools. ***Transcripts submitted to the Physician Assistant Advisory Committee by the applicant will not be accepted.***

III. Curriculum Vitae/Resume

Note: List all activities chronologically, including formal education, professional experiences/employment and activities. Also, include a rationale for any gaps in your employment or education. Be sure to provide addresses and phone numbers for all employers.

IV. Fees

Please forward a **check or money order in the amount of $125.00** with your application. If approved for licensure, you will be notified to forward the licensure fee of **$220.00 for a permanent license.**

V. Certification and Authorization Form for a Criminal History Background Check

Complete this form in its entirety and mail it to the address on top of page one of the checklist. **Please do not send any fees** when returning the Certification and Authorization Form. Upon receipt of the Certification and Authorization Form, a Sagem Morpho letter will be sent to each applicant with instructions regarding how to proceed to have the fingerprint process completed.

If you answered **"Yes"** to question **six (6),** please submit a written explanation to the Physician Assistant Advisory Committee. Also, contact the court involved and have the court forward a copy of the Indictment, the Judgment of Conviction and the Transcript of Sentencing to the address on top of page one of the checklist.

If you have any questions or need assistance, contact the Physician Assistant Advisory Committee at **(609) 826-7100**

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Attach a clear, full-face passport-style photograph (2″x 2″) of your head and shoulders, taken within the past six months.

A photo is required with each application.

Do not use staples to attach the photo.

New Jersey Office of the Attorney General
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Physician Assistant Advisory Committee
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Physician Assistant Application for Licensure

Date : _____

A nonrefundable application filing fee of $125.00, in the form of a check or money order made out to the State of New Jersey, must be submitted with this application. (Applicants should understand that if the application filing fee is paid with a personal check, and the check is returned by the bank due to insufficient funds, the next step in the licensure or certification process will be delayed until the fee is paid.)

The Division is precluded by law from disclosing to the public the place of residence of licensees or applicants, without their consent. However, you are required to provide an address that may be released to the public in our directories or in response to other requests (by putting a check in the appropriate box). If you provide your place of residence as your public address of record, we will assume that you have consented to have that address be disclosed. If you do not consent to the disclosure of your place of residence, you should provide an address of record other than your place of residence that may be released to the public. One of your addresses must include a street, city, state and ZIP code.

Information that you provide on this application may be subject to public disclosure as required by the Open Public Records Act (OPRA).

Please print clearly. You must answer all of the questions on this application.

Personal Information

Date of birth: _____
Month Day Year

Place of birth: _____
City State Country

1. Name ☐ Mr. ☐ Mrs. ☐ Ms. _____ (_____)
Last name First name Middle initial Maiden name

2. Address

☐ Home: _____
Street or P.O. Box City State ZIP code County

_____ _____
Telephone number (include area code) E-mail address

☐ Business: _____
Name of company Telephone number (include area code)

_____
Street City State ZIP code County

☐ Mailing: _____
Street or P.O. Box City State ZIP code County

3. Social Security Number

You **must** provide your Social Security number to the Board or Committee. Failure to do so will result in denial/nonrenewal of licensure or certification.

*Social Security Number: _____ -_____ - _____

*Pursuant to N.J.S.A. 54:50-24 et seq. of the New Jersey taxation law, N.J.S.A. 2A:17-56.44e of the New Jersey Child Support Enforcement Law, Section 1128E(b)(2)A of the Social Security Act and 45 C.F.R. 60.7,60.8 and 60.9, the Board or Committee is required to obtain your Social Security number. Pursuant to these authorities, the Board or Committee is also obligated to provide your Social Security number to:

a. the Director of Taxation to assist in the administration and enforcement of any tax law, including for the purpose of reviewing compliance with State tax law and updating and correcting tax records;

b. the Probation Division or any other agency responsible for child support enforcement, upon request; and

c. the National Practitioner Data Bank and the H.I.P. Data Bank, when reporting adverse actions relating to health care professionals.

4. Citizenship / Immigration Status

Federal law limits the issuance or renewal of professional or occupational licenses or certificates to U.S. citizens or qualified aliens. To comply with this federal law, check the appropriate box below which indicates your citizenship/immigration status. If you are not a U.S. citizen, attach a copy of your alien registration card (front and back) or other documentation issued by the office of U.S. Citizenship and Immigration Services (USCIS).

☐ U.S. citizen
☐ Alien lawfully admitted for permanent residence in U.S.
☐ Other immigration status

Questions about your immigration status and whether or not it is a qualifying status under federal law should be directed to the USCIS at: 1-800-375-5283.

5. Child Support **(You must answer a, b, c and d.)**

Please certify, under penalty of perjury, the following:

a.	Do you currently have a child-support obligation?	☐ Yes	☐ No
	(1) If "Yes," are you in arrears in payment of said obligation?	☐ Yes	☐ No
	(2) If "Yes," does the arrearage match or exceed the total amount payable for the past six months?	☐ Yes	☐ No
b.	Have you failed to provide any court-ordered health insurance coverage during the past six months?	☐ Yes	☐ No
c.	Have you failed to respond to a subpoena relating to either a paternity or child-support proceeding?	☐ Yes	☐ No
d.	Are you the subject of a child-support-related arrest warrant?	☐ Yes	☐ No

In accordance with N.J.S.A. 2A:17-56.44d, an answer of "Yes" to any of the questions a(1) through d will result in a denial of licensure or certification. Furthermore, any false certification of the above may subject you to a penalty, including, but not limited to, immediate revocation or suspension of licensure or certification.

_____ _____ _____

Applicant's name (please print) Applicant's signature Date

6. Illegal Use of Controlled Dangerous Substances

The question below pertains to the illegal use of controlled dangerous substances. Please read the definitions carefully. Your responses will be treated confidentially and retained separately. Please be aware that you have the right to elect not to answer this question if you have reasonable cause to believe that answering may expose you to the possibility of criminal prosecution. In that event, you may assert the Fifth Amendment privilege against self-incrimination. Any claim of Fifth Amendment privilege must be made in good faith. If you choose to assert the Fifth Amendment, you must do so in writing. You must fully respond to all other questions on the application. Your application for licensure or certification will be processed if you claim the Fifth Amendment privilege against self-incrimination. You should be aware, however, that you may later be directed by the Attorney General to answer a question that you have refused to answer on the basis on the Fifth Amendment, provided that the Attorney General first grants you immunity afforded by statutory law, (N.J.S.A. 45:1-20).

"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or within the previous 365 days, whichever is longer.

"Illegal use of controlled dangerous substance" means the use of a controlled dangerous substance obtained illegally (e.g. heroin or cocaine) as well as the use of controlled dangerous substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

a. Are you currently engaged in the illegal use of controlled dangerous substances? (As stated above, "currently" is defined as "recently enough… [to] have an ongoing impact…" or "within the previous 365 days," whichever is longer.)

☐ Yes ☐ No

If you answered "Yes," are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances?

☐ Yes ☐ No

_____ _____

Applicant's signature Date

7. Have you ever been summoned; arrested; taken into custody; indicted; tried; charged with; admitted into pre-trial intervention (P.T.I.); or pled guilty to any violation of law, ordinance, felony, misdemeanor or disorderly persons offense, in New Jersey, any other state, the District of Columbia or in any other jurisdiction? (Parking or speeding violations need not be disclosed, but motor vehicle violations such as driving while impaired or intoxicated must be.) ☐ Yes ☐ No

8. Have you ever been convicted of any crime or offense under any circumstances? This includes, but is not limited to, a plea of guilty, non vult, nolo contendere, no contest, or a finding of guilt by a judge or jury. ☐ Yes ☐ No

   If "Yes," provide a copy of the judgment of conviction and the release from parole or probation. Please provide a complete explanation. (Attach additional sheets of paper to this application.)

9. Have you ever served in the Armed Forces of the United States? ☐ Yes ☐ No

   If "Yes," submit a copy of your military discharge documents and see the instructions on the Committee's Military Service Profile form (PA9411-A).

10. Have you previously applied for a license or certificate as a physician assistant in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No
    If "Yes," when and where? _____

11. Do you currently hold, or have you ever held, a professional license or certificate of **any** kind in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

    If "Yes," for each license or certificate held, provide the date(s) held and the number(s). If the license or certificate was issued under a different name, please provide that name. _____
    Last name First name Middle initial

Type of license or certificate	Number	State or jurisdiction that issued the license or certificate	Date issued/expired

(If you hold a certificate issued by the National Commission on Certification of Physician Assistants (N.C.C.P.A.), you must contact the Commission to request that documentation confirming your acquisition of the certificate be forwarded directly to the Committee.)

12. Have you ever been disciplined or denied a license or certificate as a physician assistant or any other professional license in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

13. Have you ever had a professional license or certificate of any type suspended, revoked or surrendered in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

14. Has any action (including the assessment of fines or other penalties) ever been taken against your professional practice by any agency or certification board in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

15. Have you ever been named as a defendant in any litigation related to practice as a physician assistant or any other professional practice in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

16. Are you aware of any investigation pending against a professional license or certificate issued to you by any professional board in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

17. Are there any criminal charges now pending against you in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

18. Have you ever been sanctioned by, or is any action pending before, any employer, association, society, or other professional group related to practice as a physician assistant or any other professional practice in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

    If the answer to any of the above questions, numbers 12 through 18, is "Yes," provide a complete explanation of the circumstances leading to the action, and any supporting documentation, on separate sheets of paper.

Education

1. What is the name and address of the Physician Assistant Program(s), that you attended?

Name of college or university			Dates attended (from/to)
Street address	City	State	ZIP code
Name of college or university			Dates attended (from/to)
Street address	City	State	ZIP code
Name of college or university			Dates attended (from/to)
Street address	City	State	ZIP code

A curriculum vitae is required. Label all gaps in chronological order and provide a rationale for each gap.

AFFIDAVIT

This affidavit is to be executed by the applicant before a notary public:

State of: _____

County of: _____ } *ss.*

I, _____ , in making this application to the Physician Assistant Advisory Committee for licensure or certification under the provisions of Title 45 of the General Statutes of New Jersey and the Rules of the Physician Assistant Advisory Committee, swear (or affirm) that I am the applicant and that all information provided in connection with this application is true to the best of my knowledge and belief. I understand that any omissions, inaccuracies or failure to make full disclosures may be deemed sufficient to deny licensure or certification or to withhold renewal of or suspend or revoke a license or certificate issued by the Committee.

I further swear (or affirm) that I have read N.J.S.A. 45:9-27.10 et seq., together with the Rules and Regulations of the Physician Assistant Advisory Committee, N.J.A.C. 13:35-2B.1 et seq., and fully understand that in receiving licensure or certification from the Committee, I bind myself to be governed by them.

Furthermore, I voluntarily consent to a thorough investigation of my present and past employment and other activities for the purpose of verifying my qualifications for licensure or certification. I further authorize all institutions, employers, agencies and all governmental agencies and instrumentalities (local, state, federal or foreign) to release any information, files or records requested by the Committee.

_____
Signature of applicant

Sworn and subscribed to before me this _____

day of _____ , _____
Month Year

_____
Name of Notary Public (please print)

_____
Signature of Notary Public

Affix Seal Here

Official Use Only
☐ Dual License
License Type 1
_____
Applicant's Number
_____
License Type 2
_____
Applicant's Number
_____

New Jersey Office of the Attorney General
Division of Consumer Affairs
State Board of Medical Examiners
Physician Assistant Advisory Committee
P.O. Box 183
Trenton, New Jersey 08625
(609) 826-7100

Official Use Only
☐ Resubmit
_____
Board or Committee
_____

Certification and Authorization Form For a Criminal History Background Check

Directions: Answer all of the questions on this form.

1. Name ☐ Mr. ☐ Mrs. ☐ Ms. _____ (_____)
   Last First Middle Maiden Name

2. Address _____
   Street or P.O. Box City State ZIP code

3. Date of birth __ __ /__ __ /__ __ Sex: ☐ Male ☐ Female
   Month Day Year

4. Social Security number _____/_____ / _____

5. Have you completed the fingerprinting process for any **Board or Committee of the New Jersey Division of Consumer Affairs** since November 2003? ☐ Yes ☐ No
   If "No," you will receive a separate mailing from the Board or Committee regarding the criminal history background process. Please send no payment now.
   If "Yes," please provide the following information and follow the instructions outlined below:

   _____ _____
   Board or committee requiring the fingerprinting Month and year you were fingerprinted

   If you were fingerprinted after November 2003 as part of the criminal history background process for licensure or certification by any other any other **Board or Committee of the New Jersey Division of Consumer Affairs** (a background check conducted for the Department of Education, another state agency or another state does not apply) you will not be required to be fingerprinted a second time. However, the Division must perform a criminal history background check each time you apply for licensure or certification. **The fee for this service is $18.75.** Payment should be made in the form of a check or money order payable to the State of New Jersey and should accompany your application packet.

6. Have you ever been arrested and/or convicted of a crime or offense? (Minor traffic offenses such as a parking or speeding violations need not be listed.) ☐ Yes ☐ No

   Every such conviction on record must be disclosed. A true copy of every police report, judgment of conviction, sentencing order and termination of probation order, if applicable, **must** be submitted with this form. Any documents (including employer or supervisor letters of reference, if applicable) which present clear and convincing evidence of rehabilitation **must** be submitted with this form. **Failure to follow these instructions may result in the denial of an initial application.**

   Note: Copies of judgments, sentencing and termination of probation orders may be obtained from the clerk of the county where those orders, disposing of the conviction, were issued and filed.

   Your continuing responsibility to disclose convictions of crimes or offenses: You **must** notify the Board or Committee within five (5) business days if you are convicted of any crimes or offenses after this form has been completed.

Continuation on the reverse side ➡

CERTIFICATION

I, _____, in making this application to the Board or Committee for certification or licensure, certify that I am the applicant and that all of the information provided in connection with this application is true to the best of my knowledge and belief. I understand that any omissions, inaccuracies or failure to make full disclosures may be deemed sufficient to deny certification or licensure or to withhold renewal of or suspend or revoke a certificate or license issued by the Board or Committee.

I voluntarily consent to a thorough investigation of my present and past employment and other activities for the purpose of verifying my qualifications for certification or licensure. I further authorize all institutions, employers, agencies and all governmental agencies and instrumentalities (local, state, federal or foreign) to release any information, files or records requested by the Board or Committee.

I certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

_____ _____

Signature of applicant Date

New Jersey Office of the Attorney General
Division of Consumer Affairs
State Board of Medical Examiners
Physician Assistant Advisory Committee
140 East Front Street, 3rd Floor, P.O. Box 183
Trenton, New Jersey 08625
(609) 826-7100

Military Service Profile

Applicant's name:_____

Applicant's rank :_____

Branch of service:_____

You are hereby authorized to release any information in your files, favorable or otherwise, directly to the **New Jersey Physician Assistant Advisory Committee, 140 East Front Street, P.O. Box 183, Trenton, New Jersey 08625**. Your early attention is appreciated.

_____ _____
Applicant's signature Date

1. What position and rank does this individual hold or did he/she hold when discharged?

   _____

   _____

2. What were this individual's dates of service?_____

3. What type of discharge did this individual receive?_____

   a. What was the date of discharge?_____

4. Was the individual on probation, suspended or in any way sanctioned/disciplined while in the military? ☐ Yes ☐ No

5. Was this individual granted a leave of absence while in the military? ☐ Yes ☐ No

6. Were any restrictions placed on this individual's activities which were not placed on all other personnel holding similar positions? ☐ Yes ☐ No

7. Would this individual be recommended for re-enlistment? ☐ Yes ☐ No

   If "No," please explain._____

   _____

8. Would this individual be recommended for promotion? ☐ Yes ☐ No

   If "No," please explain._____

   _____

9. Did quality assessment review of this individual ever result in a negative finding? ☐ Yes ☐ No

If "Yes," please explain._____

_____

10. Was this individual in the Medical Corps? ☐ Yes ☐ No

If "Yes," please answer questions A-H:

A. Was this individual denied clinical privileges while in the military? ☐ Yes ☐ No

B. Were any restrictions placed on this individual's clinical privileges? ☐ Yes ☐ No

C. Were any formal patient or staff complaints filed against this individual? ☐ Yes ☐ No

D. Were any incident reports filed involving the professional conduct or behavior of this individual? ☐ Yes ☐ No

E. Was this individual ever subject to nonroutine monitoring while in the military service? ☐ Yes ☐ No

F. Was this individual removed from a call schedule for cause? ☐ Yes ☐ No

G. Was this individual subject to nonroutine quality assessment review? ☐ Yes ☐ No

H. Would you recommend this individual for privileges at a hospital? ☐ Yes ☐ No

Please supply any additional comments or information that the Committee should consider prior to determining this applicant's eligibility for licensure.

_____

_____

Please print the name of the individual supplying the information: _____

Signature of the individual supplying the information: _____

Address and full telephone number where the individual supplying the information may be contacted:

_____

_____

_____

Date form was completed: _____

Please return directly to:

State Board of Medical Examiners
Physician Assistant Advisory Committee
140 East Front Street - 3rd floor
P. O. Box 183
Trenton, NJ 08625

Please Affix Official Seal Here

New Jersey Office of the Attorney General
Division of Consumer Affairs
State Board of Medical Examiners
Physician Assistant Advisory Committee
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Trenton, New Jersey 08625
(609) 826-7100

Certification of Physician Assistant License/Registration/Permit Issued

Please complete the top portion only and forward one form to each state where you hold or have held a license to practice as a Physician Assistant. Extra copies may be photocopied if needed.

This section is to be completed by the applicant:

I,_____, am applying for a New Jersey Physician Assistant License.

The New Jersey Physician Assistant Advisory Committee requests that I submit evidence that my License/Registration

in the State of _____is in good standing.

I was granted License/Registration Number_____on _____.
Date

You are hereby authorized to release any information in your files, favorable or otherwise, directly to the **New Jersey Physician Assistant Advisory Committee, 140 East Front Street, P.O. Box 183, Trenton, New Jersey 08625**. Your early attention is appreciated.

_____ _____
Applicant's signature Date

This section is to be completed by an Official of the Issuing Authority:

Please complete and return this form to: **Dept. of Law & Public Safety, Division of Consumer Affairs, Physician Assistant Advisory Committee, P.O. Box 183, Trenton, New Jersey 08625**.

Name:_____

License/registration number :_____ Date issued: _____ Expiration date: _____

Is license/registration current? ☐ Yes ☐ No

If "No," please explain: _____

_____

Is license/registration in good standing? ☐ Yes ☐ No

If "No," please explain:_____

_____

Additional information or other remarks:_____

_____ _____ _____
Date Print name Signature

_____ _____
State Board Title

(Seal of attesting Issuing Authority must be impressed over signature.)

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Score Release Form

National Commission on Certification of Physician Assistants
Certification Verification Request

Section I Instructions to Applicant

For the Committee to obtain verification of your N.C.C.P.A. credentials, complete the following information, sign, date and send this form to the N.C.C.P.A., 12000 Findley Road, Suite #200 Duluth, GA. 30097.

Section II Personal Information and Signature

Print your name as it appears on your Certificate and your address.

_____
Last name First name Middle initial Former name

_____
Address Apt. number

_____
City State ZIP code

☐ Registered to take exam on: Date: _____

☐ Completed exam on: Date: _____

Certificate number: _____ Expiration date:_____

I hereby give my permission to the N.C.C.P.A. to verify my credentials to the New Jersey Physician Assistant Advisory Committee pursuant to N.J.S.A. 45:9-27.13 et seq.

_____ _____
Signature Date

New Jersey Office of the Attorney General
Division of Consumer Affairs
State Board of Medical Examiners
Physician Assistant Advisory Committee
140 East Front Street, 3rd Floor, P.O. Box 183
Trenton, New Jersey 08625
(609) 826-7100

Certification of Good Standing Non-Physician Assistant License/Registration/Permit Issued/Certification

Please complete the top portion only and forward one form to each state where you hold or have held a state issued license, permit or certificate as a health care provider other than a physician assistant. Extra copies may be photocopied if needed.

This section is to be completed by the applicant:

I,_____ am applying for a New Jersey Physician Assistant License.

The New Jersey Physician Assistant Advisory Committee requests that I submit evidence that my License/Registration

in the State of _____is in good standing.

I was granted License/Registration Number_____on _____ .
Date

You are hereby authorized to release any information in your files, favorable or otherwise, directly to the **New Jersey Physician Assistant Advisory Committee, 140 East Front Street, P.O. Box 183, Trenton, New Jersey 08625**. Your early attention is appreciated.

_____ _____
Applicant's signature Date

This section is to be completed by an Official of the Issuing Authority:

Please complete and return this form to: **Dept. of Law & Public Safety, Division of Consumer Affairs, Physician Assistant Advisory Committee, P.O. Box 183, Trenton, New Jersey 08625**.

Name:_____

License/registration number :_____ Date issued: _____ Expiration date: _____

Is license/registration current? ☐ Yes ☐ No

If "No," please explain: _____

_____

Is license/registration in good standing? ☐ Yes ☐ No

If "No," please explain:_____

_____

Additional information or other remarks:_____

_____ _____ _____
Date Print name Signature

_____ _____
State Board Title

PA-94-ll-D

(Seal of attesting Issuing Authority must be impressed over signature.)

New Jersey Office of the Attorney General
Division of Consumer Affairs
State Board of Medical Examiners
Physician Assistant Advisory Committee
140 East Front Street, 3rd Floor, P.O. Box 183
Trenton, New Jersey 08625
(609) 826-7100

Verification of Graduation from a Physician Assistant Program

Part 1 - Directions for applicant:
Complete the top of this page and send this form to the director of your Physician Assistant Program for completion of Part 2.

Attach Photo Here

Name:_____
Last First

Address:_____
Street City State ZIP code

You are hereby authorized to release any information in your files, favorable or otherwise, directly to the **New Jersey Physician Assistant Advisory Committee, 140 East Front Street, P.O. Box 183, Trenton, New Jersey 08625**. Your early attention is appreciated.

_____ _____
Applicant's signature Date

Part 2 - Directions for Program Director:
Complete the bottom portion of this page and return it directly to the Physician Assistant Advisory Committee.

1. (a) Did the individual noted above attend your program? ☐ Yes ☐ No

   (b) Is the individual whose photograph is attached, the individual who attended this Physician Assistant Program? ☐ Yes ☐ No

2. What were the applicant's dates of enrollment in the program? From_____ to _____.

3. Did this individual complete all of the requirements of the Physician Assistant Program? ☐ Yes ☐ No

   If "No," please explain: _____

4. What was the date of graduation? _____

5. Did this individual take a leave of absence during his/her attendance at this Physician Assistant Program? ☐ Yes ☐ No

   If "Yes," please explain: _____

6. Was this individual on probation during his/her attendance at this Physician Assistant Program? ☐ Yes ☐ No

   If "Yes," please explain: _____

7. Was this individual ever disciplined or under investigation during his/her attendance at this Physician Assistant Program? ☐ Yes ☐ No

8. Were any negative reports filed by instructors regarding this individual? ☐ Yes ☐ No

9. Were any special requirements imposed on this individual that were not required of all other students at his/her level of education? ☐ Yes ☐ No

10. Please supply any additional comments or information that the Committee should consider prior to determining this applicant's eligibility for licensure.

I hereby certify that the person whose name is on this form successfully completed the Physician Assistant Program and that his/her scholastic standing and practical performance were satisfactory during the course of study completed.

Name of institution:_____

Address of institution:_____

_____

Name of the Director of the Program (please print): _____

Signature of the Director of the Program: _____ Date: _____

Please return directly to:

State Board of Medical Examiners
Physician Assistant Advisory Committee
140 East Front Street, 3rd Floor
P. O. Box 183
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Affix School Seal

New Jersey Office of the Attorney General
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Verification of Hospital/Medical Employment, Privileges or Appointment

Applicant's name:_____

Name of Hospital/Facility:_____

Hospital/Facility address:_____

Hospital/Facility's telephone number (include area code): _____

You are hereby authorized to release any information in your files, favorable or otherwise, directly to the **New Jersey Physician Assistant Advisory Committee, 140 East Front Street, P.O. Box 183, Trenton, New Jersey 08625**. Your early attention is appreciated.

_____ _____
Applicant's signature Date

1. What position did this health practitioner hold at your facility? _____

2. What were this health practitioner's dates of employment at your facility?

   From: _____ to: _____.

3. Was this health practitioner placed on probation, suspended or in any way sanctioned/disciplined while at your facility? ☐ Yes ☐ No

4. Was this health practitioner granted a leave of absence while employed at your facility? ☐ Yes ☐ No

5. Were any restrictions placed on this health practitioner's activities that were not placed on all other employees holding similar positions? ☐ Yes ☐ No

6. Were any restrictions placed on this health practitioner's privileges? ☐ Yes ☐ No

7. Were any formal patient or staff complaints filed against this health practitioner? ☐ Yes ☐ No

8. Were any incident reports filed involving the professional conduct or behavior of this health practitioner? ☐ Yes ☐ No

9. Was this health practitioner ever subject to nonroutine monitoring while at your facility? ☐ Yes ☐ No

10. Was this health practitioner involuntarily removed from a call schedule for cause? ☐ Yes ☐ No

11. Was this health practitioner subject to nonroutine quality assessment review? ☐ Yes ☐ No

12. Was this health practitioner the subject of a negative review by a quality assurance or departmental committee? ☐ Yes ☐ No

13. Was this health practitioner the subject of an investigation by your facility or any

committee or department of your facility? ☐ Yes ☐ No

14. Were any malpractice actions filed naming this health practitioner as a defendant that involved his/her period of employment at your facility? ☐ Yes ☐ No

If you answered "Yes" to any of the above questions 1-14, please explain: _____

_____

_____

15. Did this health practitioner leave your facility in good standing? ☐ Yes ☐ No

16. Would you consider rehiring this health practitioner for a position at your facility? ☐ Yes ☐ No

17. Would you recommend this health practitioner for privileges at your facility? ☐ Yes ☐ No

If you answered "No," to questions 15, 16 or 17, please explain: _____

_____

_____

18. Please supply any additional comments or information that the Committee should consider prior to determining this applicant's eligibility for licensure.

_____

_____

Please print the name and title of the Certifying Official:_____

Signature of the Certifying Official: _____

Date the form was completed: _____

Please attach a letterhead or some form of identification such as a business card for the individual supplying this information.

Please return directly to:

State Board of Medical Examiners
Physician Assistant Advisory Committee
140 East Front Street, 3rd Floor
P. O. Box 183
Trenton, NJ 08625

Seal of Hospital
(If applicable)