REQUIREMENTS AND INSTRUCTIONS - PHYSICIAN ASSISTANT

Access this form via website at: **cca.hawaii.gov/pvl**

APPLICANTS ARE SUBJECT TO REQUIREMENTS IN EFFECT AT THE TIME OF FILING.

APPLICATION FOR LICENSURE

Complete the on-line fillable form or print legibly in black ink. Sign the application.

SOCIAL SECURITY NUMBER

Your Social Security Number is used to verify your identity for licensing purposes and for compliance with the below laws. For a license to be issued, you must **provide your Social Security Number or your application will be deemed deficient and will not be processed further.**
The following laws require that you furnish your Social Security Number to our agency:

FEDERAL LAWS:
42 U.S.C.A. §666(a)(13) requires the Social Security Number of any applicant for a professional license or occupational license be recorded on the application for license; and
If you are a licensed health care practitioner, **45 C.F.R., Part 61, Subpart B, §61.7** requires the Social Security Number as part of the mandatory reporting we must do to the Healthcare Integrity and Protection Data Bank (HIPDB), of any final adverse licensing action against a licensed health care practitioner.
HAWAII REVISED STATUTES ("HRS"):
§576D-13(j), HRS requires the Social Security Number of any applicant for a professional license or occupational license be recorded on the application for license; and
§436B-10(4), HRS which states that an applicant for license shall provide the applicant's Social Security Number if the licensing authority is authorized by federal law to require the disclosure (and by the federal cites shown above, we are authorized to require the Social Security Number).

FEES

Attach appropriate fee payable to: ***COMMERCE & CONSUMER AFFAIRS.*** (check must be in U.S. dollars and be from a U.S. financial institution.)

If you wish to be licensed during this period, pay:

February 1, even-numbered year through January 31, odd-numbered year $182
(*Application fee - $20*, License fee - $32, Compliance Resolution Fund - $110, 1/2 renewal for second year of two-year license period - $20)*

If you wish to be licensed during this period, pay:

February 1, odd-numbered year through January 31, even-numbered year $107**
(*Application fee - $20*, License fee - $32, Compliance Resolution Fund - $55)*

**The application fee is not refundable.*
***Subject to renewal January 31, even-numbered year regardless of issue date.*

NOTE: *One of the numerous legal requirements that you must meet in order for your new license to be issued is the payment of fees as set forth in this application. You may be sent a license certificate before the payment you sent us for your required fees is honored by your bank. If your payment is dishonored, you will have failed to pay the required licensing fee and your license will not be valid, and you **may not** do business under that license. Also, a $25.00 service charge shall be assessed for payments that are dishonored for any reason.*

If for any reason you are denied the license you are applying for, you may be entitled to a hearing as provided by Title 16, Chapter 201, Hawaii Administrative Rules, and/or Chapter 91, Hawaii Revised Statutes. Your written request for a hearing must be directed to the agency that denied your application, and must be made within 60 days of notification that your application for a license has been denied.

RELEASE OF INFORMATION

If an agency or individual is assisting you with the licensure process, we will not be able to release any information to them unless you provide us with authorization. If you wish to do so, please complete the portion on **Release of Information to Third Party**, sign and date it.

(CONTINUED ON PAGE 2)

FEDERATION REPORT

ARRANGE to have the Federation Discipline Report sent **directly** to the Hawaii Medical Board (HMB). Email the "Federation Discipline Report" form (MD-04) to the Federation of State Medical Boards (Federation - **boardinquiry@fsmb.org**) and request that they send the form **directly** to the HMB.

EDUCATION

ATTACH a copy of your certificate from the institution where you completed a training program for physician assistant.

VERIFICATION OF NCCPA CERTIFICATION

ARRANGE to have the National Commission on Certification of Physician Assistants (NCCPA) send a verification of current certification to the HMB.

NCCPA may be contacted at:

NCCPA
1200 Findley Rd., Suite 200
Duluth, GA 30097

Phone: (678) 417-8100
Fax: (678) 417-8135
www.nccpa.net

VERIFICATION OF LICENSE

On the application, list **all** the licenses you hold or held.

ARRANGE to have verification of licensure sent **directly** to the HMB. To do this, contact all the jurisdictions that you are/were licensed in and request that they send a verification of licensure **directly** to the HMB.

VERIFICATION OF SUPERVISING PHYSICIAN

ATTACH a completed verification form signed by you **and** your supervising physician who must be currently licensed in Hawaii. This form may be duplicated as needed.

FILING DEADLINE

Submit all required items (application, fees and supporting documents) at least 20 business days prior to employment starting date.

MAILING ADDRESS

Mail to:
Hawaii Medical Board
DCCA, PVL Licensing Branch
P.O. Box 3469
Honolulu, HI 96801

OR

Deliver to:
DCCA, PVL Licensing Branch
335 Merchant Street, Room 301
Honolulu, HI 96813
Phone: (808) 586-3000

COMPLETE APPLICATION

We are unable to take action on an application unless it is complete. Therefore, please ensure that we have received all the documents necessary. In the event the response to any of the questions numbered 5 and 6 is "YES", please file a typewritten or legible handwritten detailed explanation as directed on the application.

To do this, you may call (808) 586-3000 to inquire about the status of your application.

TEMPORARY LICENSE

A temporary license to practice as a physician assistant may be granted to an applicant who has graduated from an approved training program within 12 months of the date of application and has never taken a national certifying examination approved by the Board. The applicant shall file a complete application with the Board and pay all the required fees. If the applicant fails to apply for, or to take the first examination scheduled following the issuance of the temporary license, fails to pass the examination, or fails to receive licensure, all privileges shall automatically cease. Contact the Board's office at (808) 586-3000 for more information on this type of license.

INACTIVE STATUS

If an applicant is not under the supervision of a licensed physician, the license will be placed on an inactive status.

REACTIVATION STATUS

To reactivate your license, complete the "Reactivation" application and submit completed form and reactivation fee of $12 and completed Verification - Supervising Physician (AMD-03). Fillable forms are located on the Board's website at: **cca.hawaii.gov/pvl**. Click on "**Medical and Osteopathy"**.

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LAWS AND RULES

The pertinent laws and rules are posted on our website free of charge at: **cca.hawaii.gov/pvl**. Click on **Medical and Osteopathy**.

You may also obtain copies by sending a written request to: Licensing Branch, PVL, P.O. Box 3469, Honolulu, HI 96801.

1. Chapter 453, Hawaii Revised Statutes
2. Chapter 85, Hawaii Administrative Rules
3. Chapter 436B, Hawaii Revised Statutes

ABANDONMENT OF APPLICATION

Pursuant to HRS §436B-9 your application shall be considered abandoned and shall be destroyed if you fail to provide evidence of continued efforts to complete the licensing process for two consecutive years. The failure to provide evidence of continued efforts includes, but is not limited to: (1) failure to submit any required information and documents requested by the licensing authority within two consecutive years from the last date the documents and information were requested, or (2) failure to complete any additional requirements for licensure that remain after approval of your application, such as attempting to complete an exam requirement, within two consecutive years from the date your application was approved, or (3) failure to provide the licensing authority with any written communication during two consecutive years indicating that you are attempting to complete the licensing process. If an application is deemed abandoned, the applicant shall be required to reapply for licensure and comply with the licensing requirements in effect at the time of the reapplication.

LICENSE DENIAL

If for any reason you are denied the license you are applying for, you may be entitled to a hearing as provided by Title 16, Chapter 201, Hawaii Administrative Rules, and/or Chapter 91, Hawaii Revised Statutes.

Your written request for a hearing must be directed to the agency that denied your application (BME), and must be within 60 days of notification that your application for a license has been denied.

BIENNIAL RENEWAL

To maintain licensure by the Board, a renewal fee is due by January 31 of each even-numbered year. Your certificate from NCCPA must also be **current** to maintain licensure.

About 2 months before the license expiration date, a renewal application is mailed to all licensees at their address of record. If you do not receive a renewal application approximately one month prior to the license expiration date, contact the Licensing Branch (808-586-3000) for assistance. To ensure that you receive a renewal application, keep the Board informed of your address. Licenses that are not renewed by the deadline are forfeited and the holders of a forfeited license are considered unlicensed and may not practice. After two years license forfeiture, reapplication is required.

Print Form

This material can be made available for individuals with special needs. Please call the Licensing Branch Manager at (808) 586-3000 to submit your request.

Application for Licensure - PHYSICIAN ASSISTANT

Access this form via website at: **cca.hawaii.gov/pvl**

Legal Name (First, Middle)	(Last)
Other names used	
Residence Address (include apt. no., city, state & zip code)	
Mailing Address (only if different from above)	
PERSONAL E-Mail Address	Birthdate:
Social Security No. / Phone No. (days)	OPTIONAL — Sex: ◯ M ◯ F

FOR BOARD USE ONLY

Approved: ☐ Initials/Date:

CHECKOUT:

☐ *Lic. Ver.* _____

☐ *$107 or $182* ☐ *Supervisor Verification*

☐ *PA cert* ☐ *Fed. Disc. Report*

☐ *Current NCCPA certification*

Date issued: | Cert. No. AMD - / MD -

Check answers and provide details as directed for any "YES" response to the questions below:

1) Are you at least 18 years of age? ☐ YES ☐ NO

2) Are you a U.S. citizen, a U.S. national, or an alien authorized to work in the United States? ☐ YES ☐ NO

3) Have you graduated from a physician assistants training program approved and accredited by the Committee on Allied Health Education and Accreditations of the American Medical Association (AMA)? ☐ YES ☐ NO

4) Have you passed the National Certifying Exam developed by the NCCPA? ☐ YES ☐ NO

- Provide date certification was requested to be sent to HMB: _____

5) Has any license you hold or ever held ever been suspended, revoked or otherwise subject to disciplinary action? ☐ YES ☐ NO

6) Is any disciplinary action presently pending against you? ☐ YES ☐ NO

(If response is "YES" to question 5 or 6, give jurisdiction, dates and nature on a separate sheet and have licensing authority send documents including final orders, findings of fact and conclusion of law and any other relevant information.)

7) In the past 5 years, have you been addicted to, dependent on, or a habitual user of alcohol or a narcotic, barbiturate, amphetamine, hallucinogen, or other drug having similar effects? ☐ YES ☐ NO

(If response is "YES", attach a detailed explanation on a separate sheet.)

8) Have you ever been convicted of a crime in any jurisdiction that has not been annulled or expunged? ☐ YES ☐ NO

(Explain "YES" response on a separate sheet with detailed information and attach certified court documentation on the date, place, violation of each conviction and fulfillment of conditions for each sentence.)

EDUCATION

Name of Program/College	Location	Major and Degree Earned	Dates (mo/yr) Entry	Dates (mo/yr) Graduated
Physician Assistant Program & Name of College				
Other College/University				

(SIGNATURE REQUIRED ON PAGE 2)

Appl	323	$20	CRF	324	$55/$110
Lic	312	$32	1/2 Renewal	300	$20
			Service Charge	BCF	$25

Physician Assistant Name: _____ Date: _____

LICENSES	Name of Jurisdiction (Attach additional sheets if necessary)	Date Issued	Expiration Date	License Number	Date Verification Requested

EXPERIENCE	Name and Address of Employer	Duties	Name of Supervisor	Dates (mo/yr)	
				From	To

Affidavit of Applicant:

I hereby certify that the statements, answers, and representations made in this application and in the documents attached are true and correct. I understand that any misrepresentation is grounds for denial, refusal or subsequent revocation of license and is a misdemeanor *(Section 710-1017, and Sections 436B-19, and 453-8 Hawaii Revised Statutes)*. I further certify that I have read and will abide by the provisions of Chapter 453, 436B, and Chapter 85.

_____ _____

Signature of Applicant Date

Release of Information to Third Party:

To assist me in the licensing process, I authorize DCCA's staff to release any and all information regarding my application (including, but not limited to application status) to the following third party:

Print Name of Individual who is assisting you: _____

Name of Organization: _____

Phone Number: _____

_____ _____

Signature of Applicant Date

Print Form

This material can be made available for individuals with special needs. Please call the Licensing Branch Manager at (808) 586-3000 to submit your request.