



Jeremiah W. (Jay) Nixon
Governor
State of Missouri

Kathleen (Katie) Steele Danner, Division Director
DIVISION OF PROFESSIONAL REGISTRATION

Department of Insurance
Financial Institutions
and Professional Registration
John M. Huff, Director

STATE BOARD OF REGISTRATION FOR THE HEALING ARTS

3605 Missouri Boulevard
P.O. Box 4
Jefferson City, MO 65102-0004
573-751-0098
866-289-5753 TOLL FREE
573-751-3166 FAX
800-735-2966 TTY
website: <http://pr.mo.gov/healingarts.asp>

Connie Clarkston
Executive Director

Dear Physician Assistant:

Attached are the materials you will need to make application for licensure to practice as a Physician Assistant in the State of Missouri. Included in the packet are:

1. The application with specific instructions for completing it;
2. Documents and Fee Sheet;
3. Activity statement form;
4. Verification of Licensure form (if more than one is needed you may make additional copies);
5. Supervision Verification form;
6. Certificate of Professional Education.

It is suggested that you read the Physician Assistant statutes and rules before beginning the process. Besides containing applicant information, this statute governs your professional conduct as a Physician Assistant in the State of Missouri. The statutes and rules may be found on our website at the address listed above.

The Board will consider no application until the entire file is complete. Therefore, you should not make any firm commitment to actually begin working until you have received notification of licensure in writing from this office. Proof that a Physician Assistant has practiced in Missouri before becoming licensed is grounds for denial of licensure.

Please be advised no application will be processed without the fee. You will be notified in writing, one (1) time if your application is deficient in any way. In addition to the material you are required to submit, the Board makes independent inquiries into your professional background. Therefore, you should allow a minimum of **30 days** for the processing of your application once you have filed the completed application and the required documents in this office.

Please be reminded that it is unlawful to misrepresent any material fact, in any way, in connection with application for Missouri licensure. Proof that a Physician Assistant has misrepresented any material fact is grounds for denial of licensure.

If you have any questions during the process which are not answered in the enclosed material, you may contact the Board of Healing Arts Licensure Section for assistance by calling (573) 751-0098, or toll free (866) 289-5753 or via email at licensure@pr.mo.gov

Sincerely yours,

Licensure Section

INSTRUCTIONS FOR COMPLETING PHYSICIAN ASSISTANT LICENSURE APPLICATION

The Board wishes to stress that you should provide complete details and dates, complete names, addresses and zip codes as required on the application form. Answer all questions. If you fail to do so, the processing of your application may be delayed. Allow 30 days for processing your application. Please type or print your application in ink. The following information is provided to assist you in answering the questions.

Question #1 - Please print your complete name. If you have had a name change, include this name as well.

Question #2 - Indicate your current mailing address and email address.

Question #3 - Indicate your proposed Missouri business practice name, and address. If unknown, please indicate the reason why a Missouri license is needed.

Question #4 - Indicate month, day and year of birth. Indicate city and state of birth. Indicate Social Security number. State Law mandates the submission of Social Security numbers on professional applications. A citizen of any international country applying for licensure in Missouri who does not hold a United States Social Security number may submit his/her Visa or Passport Identification number in lieu of the Social Security number.

Question #5 - Indicate your home and business telephone numbers, including area code.

Question #6 - Indicate the complete name and address of your supervising physician.

Question #7 - List in chronological order the name and location of each institution attended, beginning with high school. Please indicate dates of attendance, graduation date and type of diploma or certificate awarded.

Question #8 - Indicate the name, city and state of your physician assistant program.

Question #9 - Indicate whether or not you have taken the National Commission on Certification of Physician Assistants (NCCPA) examination. List the number of times, location and date of the examination(s) taken.

Question #10 - Indicate whether or not you are certified by the NCCPA, your certification number and the certification issue date.

Question #11 - Indicate whether or not you have worked in any profession in any state. Indicate state, license number, dates held and profession.

Question #12 - Indicate whether or not you were employed as a physician assistant for three years prior to August 28, 1989. If yes,

and you are not a graduate of an accredited physician assistant program you must submit written documentation verifying employment. This verification should be submitted to the Board directly from the supervising physician(s) and include dates, locations and a description of the duties performed.

Question #13 - If your answer is "yes", provide complete details, dates, etc. on a separate notarized statement. This should include the States, Provinces or Country, dates and reasons.

Question #14 - If your answer is "yes", provide complete details on a separate notarized statement.

Question #15-17 - If your answer is "yes", provide complete details on a separate notarized statement. This should include States/Provinces, dates and reasons.

Question #18-22 - If your answer is "yes", provide complete details on a separate notarized statement. This should include the reason, dates, places, current disposition of the case(s), and all pertinent information. *It will also be necessary for you to provide a Certified Court copy, with court seal affixed regarding your "yes" response.

Question #23-26 - If your answer is "yes", provide full details and dates, including the names and addresses of individuals who treated you and any hospitals/institutions where you have been treated on a separate notarized statement. The Board also requires a letter from your treating professional indicating your diagnosis, prognosis and if your illness or condition affects your ability to practice.

Question #27 - If your answer is "yes", provide complete details on a separate notarized statement. This should include why you are required to register, conviction, date and state. The Board also requires a certified copy of the conviction and any court orders (i.e. probation, parole, etc.) requiring registration.

Question #28 - Applicant's Oath - You must sign this oath before a Notary Public. The Notary Public must complete his/her portion and sign, date and seal your signature. Also, place a recent photograph of yourself in the space provided.

Question #29 - In the space provided please list the name of one individual with whom we may discuss your file, other than yourself. Telephone calls and e-mails will be limited to you and the person listed on the application in an effort to expedite the processing of your file.

DOCUMENTS AND FEES YOU MUST FURNISH WITH YOUR APPLICATION FOR PHYSICIAN ASSISTANT PERMANENT LICENSE

1. **FEES** – Please submit the fee to this office in the form of a **Money Order or Cashier's Check** payable on or through a United States bank. All fees should be paid to the order of the Missouri Board of Registration for the Healing Arts. **All fees are non-refundable.**
Licensure Fee: \$25.00
2. **OFFICIAL TRANSLATIONS** – If any of your documents are in an international language, the Board requires you to furnish an **original**, official, word-for-word translation along with a **notarized true copy** of the translation.
AN OFFICIAL TRANSLATION IS:
 1. One which is done by a government official in the United States;
 2. One which is done by an official translation service in the United States;
 3. One which is done by a professor of a language department in a college or university located in the United States;
 4. One which is done by an Official of the American Embassy in a foreign country. This document must be translated by the American Embassy, not just certified as a true copy, and must have the Embassy seal placed on it.**THE TRANSLATOR MUST:**
 1. Certify that the document is a true translation to the best of his/her knowledge, that he/she is fluent in the language, and is qualified to translate;
 2. Sign the translation and have his/her signature certified by a Notary Public;
 3. Print his/her name and title under the signature;
 4. Translate on official letterhead.
3. **ACTIVITIES STATEMENT** – Each applicant is required to provide, on the form provided, a chronological listing of his/her activities since graduation of high school to the present date. All dates must be accounted for including all beginning and ending dates, months and years. In **chronological order**, list the position held, complete names, address and zip codes of employers and beginning and ending dates of employment.
4. **VERIFICATION OF LICENSURE** – If you currently hold or have previously held a permanent, temporary or institutional license, certification or registration, in any State/Province (including Canada), the enclosed Verification of Licensure form must be mailed to each agency in which you are now or have ever been licensed, certified or registered to practice in any profession. You may copy this form as needed. It is your responsibility to provide this form directly to the State Board(s).
5. **PHOTOGRAPH** – Attach a recent photograph in the space provided on the application. Copies of photographs and magazine clippings are not acceptable.
6. **NAME CHANGE** – If your name has changed since birth, you will be required to submit one of the following documents for verification:
 - Marriage - Furnish a copy no larger than 8½" x 11" of your marriage certificate.
 - Divorce - Furnish a copy no larger than 8½" x 11" of your divorce decree.
 - Court Order - Furnish a certified court copy of the name change document.
 - Naturalization - If you have had a name change by naturalization, you will be required to hand deliver your original Naturalization Certificate to the Board office for inspection, since it is unlawful to copy that particular document.
7. **VERIFICATION OF SUPERVISION** – This form must be completed by the physician who will be supervising you prior to practicing in the State of Missouri, and returned directly to the Missouri Board of Healing Arts by the supervising physician. If you have more than one supervising physician, each physician must complete a supervision form. Please indicate which is the primary supervising physician and which are your alternate supervising physicians. You may make additional copies of the form to provide to each of your supervising physicians.
8. **DEGREE** – Provide a copy, no larger than 8½" x 11", of the certificate received after the completion of an accredited Physician Assistant program. All applicants for physician assistant licensure who complete a physician assistant training program after January 1, 2008, shall have a master's degree from a physician assistant program.
9. **VERIFICATION OF EMPLOYMENT** – (Only applicable if you are not NCCPA certified) If you were employed as a Physician Assistant for three years prior to August 28, 1989, it will be necessary for the physician(s) who supervised you to provide this office with the dates, locations and description of duties while under his/her supervision. The statement should also include your performance during the employment period. This statement must be mailed directly to the Board's office by the physician.
10. **LETTER OF REFERENCE** – Request the Director of your Physician Assistant program to submit a letter of reference directly to the Board office. The Certificate of Professional Education form **CANNOT** be accepted in lieu of this requirement.
11. **SOCIAL SECURITY CARD** – Furnish a copy of your Social Security card. Do not fax. A citizen of an international country applying for licensure in Missouri, who does not hold a United States Social Security number, shall submit his/her Visa or Passport in lieu of the Social Security card.

DOCUMENTS AND FEES YOU MUST FURNISH WITH YOUR APPLICATION FOR PHYSICIAN ASSISTANT TEMPORARY LICENSE

1. **FEES** – Please submit the fee to this office in the form of a **Money Order or Cashier's Check** payable on or through a United States bank. All fees should be paid to the order of the Missouri Board of Registration for the Healing Arts. **All fees are non-refundable.**

Fee for Temporary Licensure: \$25.00

2. **OFFICIAL TRANSLATIONS** – If any of your documents are in an international language, the Board requires you to furnish an **original**, official, word-for-word translation along with a **notarized true copy** of the translation.

AN OFFICIAL TRANSLATION IS:

1. One which is done by a government official in the United States;
2. One which is done by an official translation service in the United States;
3. One which is done by a professor of a language department in a college or university located in the United States;
4. One which is done by an Official of the American Embassy in a foreign country. This document must be translated by the American Embassy, not just certified as a true copy, and must have the Embassy seal placed on it.

THE TRANSLATOR MUST:

1. Certify that the document is a true translation to the best of his/her knowledge, that he/she is fluent in the language, and is qualified to translate;
2. Sign the translation and have his/her signature certified by a Notary Public;
3. Print his/her name and title under the signature;
4. Translate on official letterhead.

3. **ACTIVITIES STATEMENT** – Each applicant is required to provide, on the form provided, a chronological listing of his/her activities since graduation of high school to the present date. All dates must be accounted for including all beginning and ending dates, months and years. In **chronological order**, list the position held, complete names, address and zip codes of employers and beginning and ending dates of employment.

4. **VERIFICATION OF LICENSURE** – If you currently hold or have previously held a permanent, temporary or institutional license, certification or registration, in any State/Province (including Canada), the enclosed Verification of Licensure form must be mailed to each agency in which you are now or have ever been licensed, certified or registered to practice in any profession. You may copy this form as needed. It is your responsibility to provide this form directly to the State Board(s).

5. **PHOTOGRAPH** – Attach a recent photograph in the space provided on the application. Copies of photographs and magazine clippings are not acceptable.

6. **NAME CHANGE** – If your name has changed since birth, you will be required to submit one of the following documents for verification:

- Marriage - Furnish a copy no larger than 8½" x 11" of your marriage certificate.
- Divorce - Furnish a copy no larger than 8½" x 11" of your divorce decree.
- Court Order - Furnish a certified court copy of the name change document.
- Naturalization - If you have had a name change by naturalization, you will be required to hand deliver your original Naturalization Certificate to the Board office for inspection, since it is unlawful to copy that particular document.

7. **NCCPA VERIFICATION OF ELIGIBILITY TO SIT FOR EXAM** – Request the NCCPA to submit a letter directly to the Missouri Board stating the date you are scheduled to take the certification examination. **The above information must be received directly from the NCCPA.**

8. **VERIFICATION OF SUPERVISION** – This form must be completed by the physician who will be supervising you prior to practicing in the State of Missouri, and returned directly to the Missouri Board of Healing Arts by the supervising physician. If you have more than one supervising physician, each physician must complete a supervision form. Please indicate which is the primary supervising physician and which are your alternate supervising physicians. You may make additional copies of the form to provide to each of your supervising physicians.

9. **DEGREE** – Provide a copy, no larger than 8½" x 11", of the certificate received after the completion of an accredited Physician Assistant program or complete the enclosed Certificate of Professional Education. All applicants for physician assistant licensure who complete a physician assistant training program after January 1, 2008, shall have a master's degree from a physician assistant program.

10. **CERTIFICATION OF PROFESSIONAL EDUCATION** – This form may be submitted in lieu of the professional diploma **ONCE ALL DEGREE REQUIREMENTS ARE COMPLETED** for the purpose of obtaining a temporary license. However, a copy of the diploma must be received by the Board before your permanent license can be issued.

11. **LETTER OF REFERENCE** – Request the Director of your Physician Assistant program to submit a letter of reference directly to the Board office.

12. **SOCIAL SECURITY CARD** – Furnish a copy of your Social Security card. Do not fax. A citizen of an international country applying for licensure in Missouri, who does not hold a United States Social Security number, shall submit his/her Visa or Passport in lieu of the Social Security card.

The temporary license is valid from the date issued until three weeks after the examination results are released by the NCCPA. After that time, the temporary license is null and void.



STATE OF MISSOURI
 DIVISION OF PROFESSIONAL REGISTRATION
 STATE BOARD OF REGISTRATION FOR THE HEALING ARTS
APPLICATION FOR PHYSICIAN ASSISTANT LICENSURE

BOARD OF REGISTRATION FOR THE HEALING ARTS
 3605 MISSOURI BLVD.
 P.O. BOX 4
 JEFFERSON CITY, MO 65102
 TELEPHONE 573-751-0171
 TOLL FREE 866-289-5755

Pursuant to Section 324.010 RSMo:

CHECK THIS BOX ONLY IF IN ALL OF THE LAST THREE (3) YEARS: YOU WERE NOT A MISSOURI RESIDENT, YOU DID NOT HAVE ANY MISSOURI INCOME, AND YOU ARE NOT SUBJECT TO ANY TYPE OF MISSOURI INCOME TAX.

False statements are subject to criminal penalties and/or license discipline.

If you have any questions regarding taxes contact the Department of Revenue at 573-751-7200 or e-mail income@dor.mo.gov.

1. APPLICANT NAME (LAST, FIRST, MIDDLE, SUFFIX, MAIDEN)

2. CURRENT MAILING ADDRESS (STREET, CITY, STATE, ZIP)	EMAIL ADDRESS
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3. PROPOSED MISSOURI PRACTICE ADDRESS (INSTITUTION/GROUP, STREET, CITY, STATE, ZIP) IF UNKNOWN, PLEASE EXPLAIN.

4. DATE OF BIRTH	PLACE OF BIRTH	SOCIAL SECURITY NUMBER
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5. HOME TELEPHONE NUMBER	BUSINESS TELEPHONE NUMBER
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6. SUPERVISING PHYSICIAN NAME AND ADDRESS

7. EDUCATION

STATE IN CHRONOLOGICAL ORDER, BEGINNING WITH HIGH SCHOOL, THE NAME AND LOCATION OF EACH INSTITUTION ATTENDED, AMOUNT OF TIME ATTENDED AND YEAR OF GRADUATION IF APPLICABLE.

INSTITUTION	DATES ATTENDED	DIPLOMA/YEAR

8. GRADUATE OF PHYSICIAN ASSISTANT PROGRAM

PHYSICIAN ASSISTANT PROGRAM LOCATION (CITY, STATE)

9. HAVE YOU TAKEN THE NATIONAL COMMISSION ON CERTIFICATION OF PHYSICIAN ASSISTANTS EXAMINATION? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE INDICATE:			
NUMBER OF TIMES TAKEN	LOCATIONS	DATE	
10. ARE YOU CERTIFIED BY THE NATIONAL COMMISSION ON CERTIFICATION OF PHYSICIAN ASSISTANTS? <input type="checkbox"/> YES <input type="checkbox"/> NO			
CERTIFICATION NUMBER		ISSUE DATE	
11. ARE YOU LICENSED IN ANY PROFESSION IN ANY STATE? IF SO, PLEASE INDICATE BELOW. <input type="checkbox"/> YES <input type="checkbox"/> NO			
STATE	LICENSE NUMBER	DATES HELD	PROFESSION
Please answer the following questions with the appropriate checkmark. If any are answered yes, see separate instructions.			YES
12. Were you employed as a physician assistant for three (3) years prior to August 28, 1989?			<input type="checkbox"/>
13. Have you ever been denied a license, certificate or registration to practice as a Physician Assistant or been denied the privilege of taking an examination administered by a U.S. state and/or Canadian provincial licensing agency?			<input type="checkbox"/>
14. Have you ever been reprimanded, censured, disciplined, had admissions monitored, had privileges limited, had privileges suspended, been put on probation, or ever been requested to withdraw from any licensed hospital, nursing home, clinic, or other hospital care facility within an organized medical staff, in which you have trained, been a staff member, been a partner, or held hospital privileges?			<input type="checkbox"/>
15. Has any U.S. state and/or Canadian provincial licensing or disciplinary agency limited, probated, restricted, stipulated, suspended, or revoked a license, registration or certificate you have held?			<input type="checkbox"/>
16. Have you ever voluntarily surrendered a license, registration or certificate issued to you by a U.S. state and/or Canadian provincial licensing agency for reasons other than failure to renew?			<input type="checkbox"/>
17. Have you ever been notified of any charges or complaints filed against you with any U.S. state and/or Canadian provincial licensing or disciplinary agency?			<input type="checkbox"/>
18. Have you ever been arrested, fined, charged with or convicted of a crime, indicted, imprisoned or placed on probation, pled guilty or had sentence imposed?			<input type="checkbox"/>
19. Have you ever forfeited collateral for breach or violation of any law, police regulation or ordinance whatsoever, been summoned into court as a defendant, or has any lawsuit (other than malpractice) been filed against you?			<input type="checkbox"/>
20. Have you ever been a defendant in a legal action involving professional liability (malpractice) or had a professional liability claim paid in your behalf or paid such a claim yourself?			<input type="checkbox"/>
21. Have you ever been denied participation in any State Medicaid or Federal Medicare Programs?			<input type="checkbox"/>
22. Have you ever been terminated, sanctioned, penalized, or had to repay monies as a result of termination or sanction to any State Medicaid or Federal Medicare Programs?			<input type="checkbox"/>
23. Are you currently addicted to or dependent upon narcotics, intoxicating liquors, or other substances?			<input type="checkbox"/>
24. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism, or other sexual behavior disorder?			<input type="checkbox"/>
25. Have you in the last ten years or since the age of 18 been treated for or hospitalized for bipolar disorder, schizophrenia, paranoia or any other psychotic disorder?			<input type="checkbox"/>
26. Are you currently experiencing any medical condition or disorder that limits or impairs your judgment or that otherwise affects your ability to practice as a physician assistant in a safe and competent manner?			<input type="checkbox"/>
27. Are you now or have you ever been required by federal law or the law of any state to register as a sex offender?			<input type="checkbox"/>

ALL APPLICANTS MUST PLACE AN ORIGINAL RECENT PHOTOGRAPH IN THE SPACE PROVIDED.



28. APPLICANT OATH

State/Province of _____ County/Parish of _____

I, _____, hereby certify under oath that I am the person named in this application for a license to practice as a Physician Assistant in the State of Missouri; that all statements I have made are true; that I am the original and lawful possessor of and person named in the various documents and credentials furnished to the Board in connection with this application, and the photograph on this page is an identifiable photograph of myself.

I acknowledge and state that I have read Chapter 334, RSMo, which contains the Statutes, Rules and Regulations governing Physician Assistants, that can be located on the Board's website; I have answered all questions truthfully and in compliance with the instructions provided; and I understand that the application fee submitted with this application is non-refundable and cannot be transferred to another application.

I further state that by filing this application for a license to practice as a Physician Assistant in the State of Missouri, I hereby authorize and consent to have an investigation made as to my moral character, professional reputation and fitness as a Physician Assistant, when in the opinion of the Missouri Board such an investigation is deemed necessary. I agree to give any further information which may be required in reference to my past record. I understand that I will not receive a copy of the report unless determined otherwise by court order.

I authorize and request every person, hospital, clinic, community, governmental agency (local, state, federal or international), court, association, institution or other organization having control of any documents, records, and other information pertaining to me to furnish to the Missouri State Board of Healing Arts any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Missouri State Board of Healing Arts or any of its agents or representatives to inspect and make copies of such documents, records, and other information, in connection with this application, subsequent licensure or practice hereunder.

I understand that I cannot practice in the State of Missouri as a Physician Assistant until the Missouri Board of Healing Arts has issued a license to practice to me.

MUST BE SIGNED IN PRESENCE OF NOTARY

APPLICANT SIGNATURE



NOTARIZATION AND NOTARY INFORMATION

STATE	COUNTY
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The applicant identified him/herself with a government issued photographic identification and bearing true likeness to the above photograph subscribed and swore to the truthfulness of this application before me, this _____ day of _____, _____.	USE A RUBBER STAMP IN CLEAR AREA BELOW
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NOTARY PUBLIC SIGNATURE	COMMISSION EXPIRES	NOTARY PUBLIC EMBOSSEER SEAL
NOTARY PUBLIC PRINTED NAME		

29. APPLICATION INFORMATION RELEASE AUTHORIZATION

I hereby authorize the State Board of Registration for the Healing Arts, its Directors or designee to release and/or discuss information contained in my application for licensure in the State of Missouri to the following individual. Please provide one name of an individual with whom we may discuss your file, other than yourself. (If name is not listed we will not speak to that individual regarding your file.)

NAME: _____



STATE OF MISSOURI
 DIVISION OF PROFESSIONAL REGISTRATION
 STATE BOARD OF REGISTRATION FOR THE HEALING ARTS
**PHYSICIAN ASSISTANT VERIFICATION OF LICENSURE
 CERTIFICATION OR REGISTRATION**

BOARD OF REGISTRATION FOR THE HEALING ARTS
 3605 MISSOURI BLVD.
 P.O. BOX 4
 JEFFERSON CITY, MO 65102
 TELEPHONE 573-751-0171
 TOLL FREE 866-289-5755

I _____, hereby authorize and request the state board of _____
 having control of any documents, records and other information pertaining to me to furnish to the Missouri State Board of Healing Arts,
 information including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other
 pertinent information.

SIGNATURE OF APPLICANT	LICENSE NUMBER	ISSUE DATE
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NAME IN FULL (PLEASE PRINT)	DATE OF BIRTH	SOCIAL SECURITY NUMBER
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OTHER NAMES USED IN OBTAINING LICENSURE

CURRENT ADDRESS (STREET, CITY, STATE, AND ZIP CODE)

THE FOLLOWING SECTION MUST BE COMPLETED BY AN OFFICIAL OF THE STATE BOARD AND RETURNED DIRECTLY TO THE MISSOURI BOARD OF HEALING ARTS.

STATE OF	FULL NAME OF LICENSEE
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LICENSURE STATUS	LICENSE NUMBER	ISSUE DATE
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LICENSURE METHOD

NATIONAL EXAM STATE BOARD EXAM RECIPROCITY WITH _____

OTHER (SPECIFY): _____

- HAS THE APPLICANT EVER BEEN NOTIFIED OR REQUESTED TO APPEAR BEFORE ANY LICENSING OR DISCIPLINARY AUTHORITY IN YOUR STATE? IF YES, ATTACH DETAILS.
 YES NO
- HAS THE APPLICANT EVER BEEN THE SUBJECT OF COMPLAINTS OR CHARGES RECEIVED BY A DISCIPLINARY AUTHORITY IN YOUR STATE? IF YES, ATTACH DETAILS.
 YES NO
- HAS THE APPLICANT EVER BEEN WARNED, CENSURED OR DISCIPLINED IN ANY MANNER BY A LICENSING OR DISCIPLINARY AUTHORITY IN YOUR STATE? IF YES, ATTACH DETAILS.
 YES NO
- HAS ANY APPLICATION FOR INITIAL LICENSURE OR REINSTATEMENT EVER BEEN DENIED? IF YES, ATTACH DETAILS.
 YES NO

COMMENTS, IF ANY

BOARD SEAL	SIGNATURE AND TITLE	DATE
	STATE BOARD	



STATE OF MISSOURI
 DIVISION OF PROFESSIONAL REGISTRATION
 STATE BOARD OF REGISTRATION FOR THE HEALING ARTS
PHYSICIAN ASSISTANT VERIFICATION OF SUPERVISION

BOARD OF REGISTRATION FOR THE HEALING ARTS
 3605 MISSOURI BLVD.
 P.O. BOX 4
 JEFFERSON CITY, MO 65102
 TELEPHONE 573-751-0171
 TOLL FREE 866-289-5755
 FAX 573-751-3166

PHYSICIAN NAME	PHYSICIAN LICENSE NUMBER	PHYSICIAN ASSISTANT NAME
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In accordance with Chapter 334 RSMo, I certify that I will be supervising the above named physician assistant, as set forth in Sections 334.735 through 334.748, RSMo and Rule 20 CSR 2150-7.135.

PHYSICIAN SIGNATURE	DATE	TELEPHONE NUMBER
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I _____, Physician Assistant, certify that I have reviewed this document with the above stated supervising physician and have also reviewed the Statutes, Rules and Regulations that govern the practice of physician assistants in the State of Missouri.

PHYSICIAN ASSISTANT SIGNATURE	LICENSE NUMBER	DATE
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PHYSICIAN ASSISTANT CHANGE OF SUPERVISION

If this is a change in supervisors, please indicate your previous supervisor's name and license number.

PHYSICIAN NAME	PHYSICIAN LICENSE NUMBER
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PHYSICIAN NAME	PHYSICIAN LICENSE NUMBER
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PHYSICIAN NAME	PHYSICIAN LICENSE NUMBER
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CERTIFICATE OF PROFESSIONAL EDUCATION – PHYSICIAN ASSISTANT

It is hereby certified that _____
(NAME OF STUDENT)

attended _____
(NAME OF SCHOOL)

at _____ from
(ADDRESS OF SCHOOL)

the _____ day of _____ to the _____ day of _____,
(MONTH AND YEAR) (MONTH AND YEAR)

during which time he/she pursued, passed and successfully completed all the requirements of the physician assistant program according to the standards of the American Medical Association’s Committee on Allied Health Education and Accreditation or its successor. It is further certified that the applicant will receive the diploma evidencing satisfactory completion of this program dated the _____ day of _____, which is the final diploma
(MONTH AND YEAR)

offered by this school as qualification for practice as a Physician Assistant.

SIGNATURE OF PRESIDENT, REGISTRAR, DEAN OR DIRECTOR OF PROGRAM

DATE

SCHOOL SEAL (IF THE SCHOOL HAS NO SEAL THE STATEMENT MUST BE NOTARIZED)

*The Certificate of Professional Education form **will not** be accepted in lieu of the Letter of Reference*