

Instructions for Physician Assistant Application

Attached are the materials you will need to make application for licensure to practice as a physician assistant in the State of Missouri. It is suggested that you read this Instructions sheet before beginning the process.

Your Application Packet Consists of:

- These instructions;
- Verification of Licensure Form;
- Certificate of Professional Education;
- Application;
- Collaborative Practice Arrangement;
- Letter of Reference;
- Armed Forces of the United States Form.

Prior to completing the application, you should read the statutes and rules governing physician assistants in the State of Missouri. These are located on our website at <http://pr.mo.gov/healingarts-rules-statutes.asp>.

GENERAL INFORMATION

In addition to the materials you are required to submit, the Board makes independent inquiries into your background. You should allow a minimum of 30 days for the processing of your application once the Board has received all documents. When your application is received and processed, you will be notified via email of how to check the status of your application online. Additionally, the Board can request that you appear before them prior to issuing your license.

All physician assistant licenses expire on January 31. Please remember this date so you can allow time for your renewal to be processed. Information on renewing your license will be mailed to you on or before December 1 of each year to the last known address on file. Failure to receive the renewal application does not relieve any person of the duty to register and pay the fee required for renewal nor exempt them from the penalties for failure to renew. **You are required to notify the Board of any residential and business address change within 15 days.** If your license expires, you cannot practice in Missouri until your renewal is granted.

FEE

The fee for a license is \$28. Please make checks payable to the **Missouri Board of Healing Arts**. All checks must be drawn on a United States bank because our bank doesn't accept checks from International banks. No application will be processed until the fee is received. The Board cannot accept credit or debit cards for payment of the initial application fee.

ARMED FORCES OF THE UNITED STATES

If you have ever served on active duty in the Armed Forces of the United States and separated from such service under conditions other than dishonorable; or if you are the spouse of an active duty member of the Armed Forces of the United States, you may qualify for additional services. If applicable, please complete the form included in the application and return it with your application, along with verification of military status.

INFORMATION TO SUBMIT IF ANY OF THE PERSONAL HISTORY QUESTIONS ARE ANSWERED YES

- **Questions 2-10** - Include a separate statement/letter explaining the circumstances behind your "yes" answer. Documentation supporting your statement, if applicable (i.e. a settlement agreement from another state disciplining your license, documents showing probation in your postgraduate program, etc.) needs to be submitted directly from the state board, hospital, etc.
- **Question 11** - Include a separate statement/letter explaining the circumstances behind your "yes" answer and also submit a certified copy of the court records or have your attorney send the documents to the Board. The Board needs to receive a copy of the complaint/petition and judgment, settlement, or disposition.
- **Question 12** - Include a separate statement/letter explaining the circumstances behind your "yes" answer along with a copy of the charge (it may be called a petition, indictment, information, or complaint), and the judgment, sentence, or dismissal order, certified by the court or from your attorney.
- **Question 13** - Include a separate statement/letter explaining the circumstances behind your "yes" answer and documentation supporting that statement.
- **Question 14** - Please provide details and dates, including the names and addresses of the individuals and facilities which have treated you. Also please submit a letter from your current physician or treatment professional indicating your diagnosis, prognosis, and if your illness or condition affects your ability to practice.
- **Question 15** - Please contact the Board office for a Malpractice Claim Information form.

ACTIVITIES STATEMENT

- Please provide all professional and non-professional activities since high school graduation to the present date in CHRONOLOGICAL ORDER.
- All dates must be accounted for in the MM/YYYY format.
- Please include complete names and addresses for each activity listed.
- If unemployed or on vacation for at least a month, list your exact activities.

Note: if there are dates not accounted for, you will be contacted by the Board to account for those dates.

DOCUMENTS THAT NEED TO BE SUBMITTED

- **Name Change** - If you have had a name change for any reason, submit copies of the document evidencing the name change (Marriage Certificate, Divorce Decree, Adoption Order, Court Order). If the name change is due to naturalization, you must bring the document to the office as it is illegal to copy the Naturalization Certificate.
- **Photograph** - A recent photograph must be attached to the application in the space provided. Please glue or tape your photo - do not staple or paperclip.
- **Diploma** - A copy of your diploma (not larger than 8 ½" x 11").

- **Verification of Licensure** – If you have ever held a permanent, temporary or institutional license, permit or certificate in any state, territory or country to practice as a physician assistant, dentist, nurse, or any other profession in which a license, permit or certificate was issued, the licensing agency must submit a verification of each to our office. The verification must be submitted directly from the licensing agency to our office. Some licensing agencies use a secure online verification portal however it is your responsibility to contact the licensing agency and advise them you are applying for a Missouri license. The Board accepts verifications from VeriDoc.
- **Collaborative Practice Arrangement** – If you do not have a collaborating physician at the time of application, no form is required to be submitted. **** This form must be completed and submitted by the physician who will be your PRIMARY COLLABORATING PHYSICIAN prior to you practicing in the State of Missouri. ****
- **Letter of Reference** – Request the director of your Physician Assistant Program to complete and submit the Letter of Reference provided.

TEMPORARY LICENSE APPLICANTS – ADDITIONAL DOCUMENTS THAT NEED TO BE SUBMITTED

- **Temporary License Fee** - Please submit an additional \$25 fee for a temporary license.
- **NCCPA Verification of Eligibility to Sit for Examination** – Request the NCCPA to submit a letter directly to the Missouri Board stating the date you are scheduled to take the certification examination. **This must be received directly from the NCCPA.**
- **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. The diploma is required for permanent licensure.

HOW TO CHECK THE STATUS OF YOUR APPLICATION

When your application is received and processed, you will be notified via email of how to check the status of your application online.

NOTICE

All persons receiving a license from, or renewing a license with the Division of Professional Registration, are required to have paid all Missouri state income taxes, and also are required to have filed all necessary Missouri state income tax returns for the preceding three years. If you have failed to pay your Missouri taxes or have failed to file your Missouri tax returns, your license will be subject to immediate suspension within 90 days of being notified by the Missouri Department of Revenue of any delinquency or failure to file.

ADDITIONAL INFORMATION

- Missouri law (section 324.024, RSMo) requires submission of your Social Security number. If you are a citizen of a foreign country and do not have a Social Security number, you are required to submit your visa or passport number in lieu of the Social Security number. This same law requires a Social Security number in order to renew your Missouri license.
- 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.

If you have questions after reading these instructions, you may call the Board office at 573-751-0098 or toll free at 866-289-5753 or email at licensure@pr.mo.gov.



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

STATE BOARD OF REGISTRATION FOR THE HEALING ARTS
 P.O. BOX 4
 JEFFERSON CITY, MO 65102
 FOR OVERNIGHT DELIVERIES
 3605 MISSOURI BLVD.
 JEFFERSON CITY, MO 65109
 TELEPHONE (573) 751-0098
 TOLL FREE (866) 289-5753
 FAX (573) 751-3166

INSTRUCTIONS

Complete each section by providing complete details in black ink or by typed responses. Failure to answer all questions could result in delayed processing of your application. If additional responses are necessary, submit in a separate statement.

A. MISSOURI TAX COMPLIANCE

- Check this box if in all of the last three 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.

Pursuant to Section 324.010 RSMo, all persons applying for and renewing a license with the Division of Professional Registration are required to have paid all Missouri state taxes and are also required to have filed Missouri state income tax returns for the last three years. If such licensee is delinquent on any Missouri state taxes or has failed to file Missouri state income tax returns in the last three years, your license will be subject to suspension within 90 days after being notified by the Missouri Department of Revenue of such delinquency or failure to file.

False statements are subject to criminal penalties and/or license discipline. For tax questions, please contact the Department of Revenue at (573) 751-7200 or email at income@dor.mo.gov.

B. IDENTIFYING INFORMATION

Print your full name, mailing address, and personal information.

LAST NAME	FIRST NAME	MIDDLE NAME	MAIDEN NAME	SUFFIX
OTHER NAMES USED		CONTACT PHONE NUMBER	EMAIL ADDRESS	
STREET ADDRESS		CITY	STATE	ZIP CODE
DATE OF BIRTH	PLACE OF BIRTH	SSN	GENDER	

C. PRACTICE INFORMATION

ANTICIPATED MISSOURI PRACTICE ADDRESS

NAME OF BUSINESS	ADDRESS	CITY	STATE	ZIP
COLLABORATING PHYSICIAN NAME		COLLABORATING PHYSICIAN LICENSE NUMBER		
COLLABORATING PHYSICIAN STREET ADDRESS		CITY	STATE	ZIP

D. NAMES OF INDIVIDUALS WITH WHOM THE BOARD IS AUTHORIZED TO DISCUSS YOUR FILE

CONTACT #1 NAME	CONTACT #1 EMAIL	CONTACT #1 TELEPHONE NUMBER
CONTACT #2 NAME	CONTACT #2 EMAIL	CONTACT #2 TELEPHONE NUMBER

ISSUANCE OF A MISSOURI LICENSE IS REQUIRED PRIOR TO PRACTICING IN THE STATE OF MISSOURI.

Approximate date that a Missouri license is needed: _____ The Board will process your application as quickly as possible but be advised that your application, fee and supporting documentation needs to be received and approved prior to issuing a Missouri license. Sometimes applications require additional review by Board members and this can delay the decision on whether or not a Missouri license is issued.

J. PERSONAL HISTORY

Answer the following questions with the appropriate checkmark. **If any are answered yes, see the Instruction Sheet for specific information and documentation needed for review.**

1. Were you employed as a physician assistant for three (3) years prior to August 28, 1989? Yes No
2. Have you been denied a license, registration or certificate to practice as a physician assistant or any other profession or been denied the privilege of taking an examination administered by a U.S. state, Canadian provincial or international licensing agency? Yes No
3. Have you made application for licensure, registration or certification in another state, province or country and subsequently withdrawn said application? Yes No
4. Has any license or right to practice held by you been disciplined, including but not limited to restriction, revocation, suspension, probation, censure, or reprimand, whether voluntarily agreed to or not, by any U.S. state, territory, federal agency, Canadian province or foreign country? Yes No
5. Have you had any disciplinary or corrective action taken against you, or had your right to practice restricted, by any professional medical or osteopathic association or society, or by any licensed hospital or medical staff of a hospital? Yes No
6. Have you ever been restricted, suspended, terminated, requested to voluntarily resign, placed on probation, counseled, received a warning or been subject to any remedial or disciplinary action? Yes No
7. Have you surrendered a license issued to you by any U.S. state or any Canadian provincial licensing agency for any reason, other than failure to renew, retirement or relocating to another state? Yes No
8. Have any charges or complaints been filed against you with the federal government, any federal agency or any U.S. state or Canadian provincial licensing or disciplinary agency? Yes No
9. Have you been denied or surrendered a controlled substance license, registration, certificate or authority issued by the Drug Enforcement Administration (DEA) or any state bureau of narcotics or other agency concerned with controlled substances, or had such license, registration, certificate or authority restricted or disciplined, including, but not limited to, revocation, suspension, probation, censure, or reprimand, whether voluntarily agreed to or not? Yes No
10. Has any disciplinary action been taken against you, or has your authority to practice been restricted, by any federal or state agency including, but not limited to, Medicare or Medicaid? Yes No
11. Have you 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? Yes No
12. Have you been arrested, charged, indicted, found guilty, or entered a plea of guilty, an Alford plea, no contest plea or plea of nolo contendere, in a criminal prosecution in any state, federal, or municipal court whether or not sentence was imposed, including suspended imposition of sentence or suspended execution of sentence, except for minor traffic violations? Alcohol-related traffic violations must be reported. Yes No
13. Have you been required by federal law or the law of any state to register as a sex offender? Yes No
14. Do you currently have any condition or impairment which in any way affects your ability to practice in a professional, competent and safe manner, including but not limited to: (1) a mental, emotional, nervous or sexual disorder, (2) an alcohol or substance abuse disorder or (3) a physical disease or condition? Yes No
15. Have you 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? Yes No

15a. If your answer is yes, please indicate how many claims in which you have been named. _____

L. APPLICANT'S OATH

During the period of time in which the Board is processing my application and determining whether to issue me a license, I will inform the Board of any change in information included in my application for licensure, including but not limited to address updates, malpractice suits, discipline imposed by another state, administrative agency, hospital or other entity, arrests, and criminal charges. I understand that failure to disclose this information could result in discipline pursuant to section 334.100.2(11) and/or (15).

I hereby certify under oath that I am the person named in this application for a license to practice in the State of Missouri; that all statements I have made herein are true and that I have personally read, reviewed and answered each of these questions; that all documents submitted with this application or as part of the application process that are original, or duplicated copies of the originals, have not been altered in any fashion whatsoever; 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. I acknowledge and state that I have read Chapter 334 (statutes and rules), RSMo, which contains the Statutes, Rules and Regulations governing the 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 hereby authorize the Missouri State Board of Healing Arts, its Director or designee, to release and/or discuss information contained in my application for licensure in the State of Missouri to the individuals indicated on the application.

I further state that by filing this application for a license to practice in the State of Missouri, I hereby authorize and consent to have an investigation made as to my moral character, professional reputation and fitness for practice, 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 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.

I further certify that I understand that I cannot practice my profession in the state of Missouri unless and until a license has been granted by the Missouri Board of Healing Arts.

APPLICANT'S NAME (PLEASE PRINT)

APPLICANT'S SIGNATURE



MUST BE SIGNED IN PRESENCE OF NOTARY

M. NOTARIZATION

STATE

COUNTY

The applicant identified him/herself with a government issued photographic identification and bearing true likeness to the attached photograph subscribed and swore to the truthfulness of this application before me, this _____ day of _____, _____.

NOTARY PUBLIC RUBBER STAMP

NOTARY PUBLIC SIGNATURE

COMMISSION EXPIRES

NOTARY PUBLIC EMBOSSEER SEAL

NOTARY PUBLIC PRINTED NAME

PLEASE GLUE OR TAPE YOUR PHOTO TO THE APPLICATION.

DO NOT STAPLE OR PAPER CLIP PHOTO.

PHOTO



STATE OF MISSOURI
 DIVISION OF PROFESSIONAL REGISTRATION
 STATE BOARD OF REGISTRATION FOR THE HEALING ARTS
LETTER OF REFERENCE – PHYSICIAN ASSISTANT

STATE BOARD OF REGISTRATION FOR THE HEALING ARTS
 P.O. BOX 4
 JEFFERSON CITY, MO 65102
 FOR OVERNIGHT DELIVERIES
 3605 MISSOURI BLVD.
 JEFFERSON CITY, MO 65109
 TELEPHONE (573) 751-0098
 TOLL FREE (866) 289-5753
 FAX (573) 751-3166

APPLICANT LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX
---------------------	------------	-------------	--------

The physician assistant named above has applied for licensure in the State of Missouri. Pursuant to the Board's Rule 20 CSR 2150-7.100(1) and/or 20 CSR 2150-7.300(7), applicants shall furnish satisfactory evidence as to their good moral character including a letter of reference from the director of their physician assistant program.

PROGRAM DIRECTOR NAME	EMAIL ADDRESS	PHONE NUMBER
-----------------------	---------------	--------------

NAME OF PHYSICIAN ASSISTANT PROGRAM	ADDRESS	CITY, STATE, ZIP CODE
-------------------------------------	---------	-----------------------

- I certify that the above-named Physician Assistant met the standards of personal and professional ethics, and proved to be of good moral character. I support without reservation the above-named Physician Assistant for licensure in the State of Missouri.
- I do not recommend the above-named Physician Assistant for licensure in the State of Missouri.

PROGRAM DIRECTOR SIGNATURE	DATE
----------------------------	------



STATE OF MISSOURI
DIVISION OF PROFESSIONAL REGISTRATION
STATE BOARD OF REGISTRATION FOR THE HEALING ARTS

PHYSICIAN ASSISTANT COLLABORATIVE PRACTICE ARRANGEMENT

PHYSICIAN NAME	PHYSICIAN LICENSE NUMBER	PHYSICIAN ASSISTANT NAME
----------------	--------------------------	--------------------------

I certify I have entered into a collaborative practice arrangement with the above-named physician assistant, as provided in sections 334.735 through 334.749, RSMo, and the board's rules governing collaborative practice arrangements. I have delegated authority to the physician assistant consistent with the physician assistant's skill, training, and competence and my own skill, training, education and competence.

PHYSICIAN SIGNATURE	DATE	TELEPHONE NUMBER
---------------------	------	------------------

I _____, Physician Assistant, certify that I have reviewed this document with the above-named collaborating 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 (OR PENDING)	DATE
-------------------------------	-----------------------------	------

PHYSICIAN ASSISTANT CHANGE OF COLLABORATIVE PRACTICE ARRANGEMENT

If this is a change in collaborating physicians, please indicate your previous collaborating physician's name and license number.

PHYSICIAN NAME	PHYSICIAN LICENSE NUMBER
PHYSICIAN NAME	PHYSICIAN LICENSE NUMBER
PHYSICIAN NAME	PHYSICIAN LICENSE NUMBER



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

STATE BOARD OF REGISTRATION FOR THE HEALING ARTS
 P.O. BOX 4
 JEFFERSON CITY, MO 65102
 FOR OVERNIGHT DELIVERIES
 3605 MISSOURI BLVD.
 JEFFERSON CITY, MO 65109
 TELEPHONE (573) 751-0098
 TOLL FREE (866) 289-5753
 FAX (573) 751-3166

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
NAME IN FULL (PLEASE PRINT)	DATE OF BIRTH	SOCIAL SECURITY NUMBER

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	PROFESSION	FULL NAME OF LICENSEE
LICENSURE STATUS	LICENSE NUMBER	ISSUE DATE

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

STATE BOARD OF REGISTRATION FOR THE HEALING ARTS
 P.O. BOX 4
 JEFFERSON CITY, MO 65102
 FOR OVERNIGHT DELIVERIES
 3605 MISSOURI BLVD.
 JEFFERSON CITY, MO 65109
 TELEPHONE (573) 751-0098
 TOLL FREE (866) 289-5753
 FAX (573) 751-3166

CERTIFICATE OF PROFESSIONAL EDUCATION – PHYSICIAN ASSISTANT

ONLY COMPLETE THIS FORM IF YOU ARE APPLYING FOR A TEMPORARY LICENSE AND DO NOT HAVE A COPY OF YOUR DIPLOMA

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 the Accreditation Review Commission on Education for the Physician Assistant. It is further certified that the applicant will receive/has received the diploma evidencing satisfactory completion of this program dated the _____ day of _____, which is the final diploma offered by this school as qualification
(MONTH AND YEAR)

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*



STATE OF MISSOURI
DIVISION OF PROFESSIONAL REGISTRATION
STATE BOARD OF REGISTRATION FOR THE HEALING ARTS
3605 MISSOURI BLVD., P.O. BOX 4
JEFFERSON CITY, MO 65102
TELEPHONE: (573) 751-0098
TOLL FREE: (866) 289-5753
FAX: (573) 751-3166
EMAIL: Licensure@pr.mo.gov

ARMED FORCES OF THE UNITED STATES

- (1) Are you currently an active duty member of the Armed Forces of the United States or a veteran from such service who received an honorable discharge? ___ Yes ___ No
- (2) If answering question (1) in the affirmative, would you like to receive information and assistance regarding veterans benefits and services? ___ Yes ___ No
- (3) If answering question (2) in the affirmative, may the agency share your contact information with the Missouri Veterans Commission in order to provide you with information regarding available veterans benefits and services? ___ Yes ___ No
- (4) Are you the spouse of an active duty member or an honorably discharged veteran of the Armed Forces of the United States? ___ Yes ___ No

General information may also be found on the Missouri Veterans Commission's website.

If you answered questions (1) or (2) in the affirmative, please see the information below regarding the agency's veteran services and return this form with verification of military status.

- Upon proof and approval, you may qualify for:
 - Expedited Application Processing pursuant to section(s) 324.006 and 324.007, RSMo.
 - Military Education, Training and Service Toward Licensure Qualification pursuant to section 324.007, RSMo.
 - Licensure Reciprocity pursuant to section 324.009, RSMo.
 - Fee Waiver Request pursuant to section 324.015, RSMo.

Veterans taking professional state licensing or certification examinations required by the Department of Commerce & Insurance (DCI) can be reimbursed for the cost of the exam. Visit the Missouri Department of Elementary and Secondary Education's [Veterans Education website](#) to learn more about how the GI Bill can pay the cost of a license or certification test.

Name (Please Print)

Email Address

Address

City, State

Zip Code

Examples of acceptable documents can be found <https://help.id.me/hc/en-us/articles/202211570-Documents-to-verify-military-status>