PAB
Physician Assistant Board

APPLICATION INSTRUCTIONS AND GENERAL INFORMATION

For the Application for Physician Assistant License

The Board wants to process your application as soon as possible. Please review the information on these Application Instructions and General Information pages carefully prior to completing the application forms and requesting all applicable supporting documents. Please allow the Board 30 days to perform an initial review before contacting the Board for an update on an application status.

All items listed that are applicable to you must be submitted in order for your qualifications for licensure to be assessed.

As an applicant, you are personally responsible for all information disclosed on your application, including any responses that may have been completed on your behalf by others. An application may be denied based upon falsification or misrepresentation of any item or response on the application or any attachment.

FORMS

- Forms PA1 through PA5, Application for Physician Assistant Licensure.
- Form PA6, Physician Assistant Training Program Certification, must be sent by you to your training program after you complete Part A. The training program must complete the form and mail it directly to the Physician Assistant Board. **Fax copies are not acceptable**.
- Form PA7, Verification of Licensure, must be submitted by you to every state in which you are/have been licensed or otherwise registered to practice as a physician assistant or other health care provider. Please make additional copies of this form as needed. Each licensing agency must then mail the completed form, with their agency seal, directly to the Board. **Fax copies are not acceptable.**

PHOTOGRAPH

One (1) recent 2” x 2” (approximate size) passport size photo of your head and shoulders only.

REQUEST FOR RELEASE OF PANCE SCORES FROM THE NCCPA

Contact the National Commission on Certification of Physician Assistants, 12000 Findley Road, Suite 200, Duluth, GA 30097, www.nccpa.net, telephone: (678) 417-8100, to authorize release of your Physician Assistant National Certifying Examination (PANCE) scores. Your PANCE scores must be sent by the NCCPA directly to the Board. **Fax copies are not acceptable.**

2005 Evergreen Street, Suite 1100, Sacramento, CA 95815 (916) 561-8780 FAX: (916) 263-2671 www.pac.ca.gov

FINGERPRINT PROCEDURES

Before the Board issues a license, clearances must be received from both the Department of Justice (DOJ) and Federal Bureau of Investigation (FBI) to verify that the applicant has no criminal history. Your physician assistant license will not be issued until the Board receives fingerprint clearance from both the DOJ and the FBI. Even though you may have been fingerprinted previously for another employer or regulatory body you will need to undergo the fingerprinting and criminal history check process again specifically for this application. California Penal Code section 11142 prohibits criminal history information from being released to any entity other than the requesting agency that you have authorized to receive it.

Two methods are available to complete the fingerprint requirement:

LIVE SCAN PROCESS—Applicants who either reside in California or are visiting California must use this process.

Live Scan Procedures:

1. Complete the Board's "Request for Live Scan Services" form in triplicate.
2. Take the completed form (in triplicate) to a Live Scan location. Visit www.ag.ca.gov/fingerprints to locate a Live Scan location. Hours of operation and fees vary, so please contact the Live Scan site directly for information.
3. Pay the processing and rolling fees to the Live Scan site.
4. Submit the second copy of the form with your physician assistant license application. The Board will be unable to process your application without the second copy of the "Request for Live Scan Services" form.

MANUAL FINGERPRINT CARD PROCESS

If you reside outside of California or are unable to obtain Live Scan services in California, you must use the manual fingerprint card process. Please contact the PAB by calling (916) 561-8780 or emailing pacommittee@mcb.ca.gov to obtain the 8" x 8" fingerprint cards (FD-258). You may also obtain the fingerprint cards from your local law enforcement agency.

Instructions:

1. Complete all areas marked in red on both cards.
2. Take the completed cards to a local law enforcement office and have your fingerprints rolled.
3. Submit both fingerprint cards with your physician assistant license application. DO NOT FOLD CARDS. The Board will be unable to process your application without two completed fingerprint cards. Please be sure to include the additional fee with your manual fingerprint cards.

ACTIVE DUTY MILITARY

Spouses or Partners Receive Expedited Review:
The Board is required to expedite the licensure process for an applicant whose spouse or partner is an active duty member of the U.S. Armed Forces and meets other criteria. (Business and Professions Code section 115.5.) If you would like to be considered for this expedited review and process, please answer or provide the following documentation:

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1. Are you married to, or in a domestic partnership or other legal union with, an active duty member of the Armed Forces of the United States who is assigned to a duty station in California under official active duty military orders?

If "yes," please provide evidence of your legal union and your spouse or partner's military duty. For example, attach a copy of the marriage certificate or certified declaration/registration of domestic partnership filed with the Secretary of State AND military orders establishing duty station in California. For other forms of "legal union" not recognized by California, you may submit other documentary evidence of legal union issued by the State that recognizes your legal union for consideration by the Board in meeting this requirement.

NATIONAL PRACTITIONER DATA BANK REPORT

If you are or you have ever been licensed or otherwise registered in any manner in any state or country in any healthcare occupation you must provide the Board with an original National Practitioner Data Bank Self-Query report. To request a report contact the NPDB at http://www.npdb-hipdb.hrsa.gov. Please forward, by mail, the sealed Self-Query Report from the National Practitioner Data Bank to the Board for review. **The Board can't accept the PDF version of the NPDB report.**

FEES

Application ($25) and Initial License ($200). The initial licensing fee will be refunded if licensure not granted. Make check or money order payable to the "Physician Assistant Board."

- With Live Scan fingerprinting: $225 ($25 application fee+ $200 initial license fee)
- With Manual Fingerprint cards: $274 ($25 application fee+ $200 initial license fee + $49 manual fingerprint processing fee)

MENTAL ILLNESS, DISEASE, OR DISORDER

"Mental illness, disease or disorder" includes mental or psychological conditions or disorders, such as, but not limited to, schizophrenia, paranoia, bipolar illness (manic depression), sociopathy or any other psychotic disorder.

"Currently" does not mean on the day of or even in the weeks or months preceding, the completion of the application. Rather, it means recently enough so that you believe that the mental condition may have an ongoing impact on your functions as a Physician Assistant.

Please submit complete official medical, psychiatric and treatment records related to the specific medical or psychiatric issue, evidence of ongoing rehabilitation treatment, and a personal written statement identifying and describing the mental illness, disease, disorder, or other condition. Completion of an authorization and release of medical or psychiatric records form may be required by the Board to finalize the application process.

PROOF OF DISMISSAL

If you have obtained a dismissal of your conviction(s) pursuant to Penal Code sections 1203.4, 1203.4a, or 1203.41, please submit a certified copy of the court order dismissing the conviction(s) with your application.

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GENERAL INFORMATION

APPLICATION PROCESSING TIMES

Your application is considered complete once all required forms, documentation, FBI and DOJ criminal record clearance, and appropriate fees have been received and validated. You will be notified of the status of your application, including any file deficiencies, generally within 30 days from the date your application is received. We recognize that some items may be in transit; however, in an effort to ensure that your application can be reviewed in a timely manner, we ask for your patience in not calling for the status of your application until after this 30-day period.

RELEASE OF APPLICATION STATUS

A pending application is not a public record; therefore you must sign and submit a release of information to the Board before we will release information to anyone other than you.

ADDRESS OF RECORD

It is your responsibility to provide, in writing, notice of any address or name changes to the Board. All correspondence will be sent to your address of record. If the address of record is a post office box, the law requires that you also provide a street address which will not be disclosed to the public. **Once licensed, your address of record is a public record and will be available on the Board's website. The Board is required to provide the address of record to anyone who may request it.**

Address changes must be submitted to the Board by either submitting an address change on-line, via fax, or by mailing in a written change of address. You may obtain an address change request by accessing the Board's website and clicking on the tab "Forms/Publications". You can also find the link on the home page under "Quick Hits".

CANCELED PHYSICIAN ASSISTANT LICENSE

Business and Professions Code Section 3526 states, "A person who fails to renew his or her license or approval within five years after its expiration may not renew it, and it may not be reissued, reinstated, or restored thereafter, but that person may apply for and obtain a new license or approval if he or she:

1. Has not committed any acts or crimes constituting grounds for denial of licensure under Division 1.5 (commencing with Section 475).
2. Takes and passes the examination, if any, which would be required of him or her if application for licensure was being made for the first time, or otherwise establishes to the satisfaction of the Board that, with due regard for the public interest, he or she is qualified to practice as a physician assistant.
3. Pays all of the fees that would be required as if application for licensure was being made for the first time."

If your California physician assistant license has expired for more than five years and has been canceled you must submit a new application. Please contact the Board for further information.

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APPLICATION DENIAL

The Physician Assistant Board has the authority to deny licensure based upon an applicant's act of dishonesty or unprofessional conduct, conviction of a crime substantially related, discipline by another state, country or agency of the federal government, or inability to practice safely.

If your application for licensure is denied, you will have a right to a hearing under Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code upon written request. Unless written request for a hearing is made within a 60-day period, the right to a hearing is deemed waived.

Once a license denial is final, you may reapply one year from the date of the denial.
You will be notified in writing the reason(s) for denial and provided information about the appeal process.

ABANDONMENT OF LICENSURE APPLICATION

Notwithstanding any other provision of law, the abandonment date for an application that has been returned to the applicant as incomplete shall be 12 months from the date of returning the application per California Business and Professions Code section 142.

PRACTICING AS A PA

You may not begin practicing as a PA in California until:

1. You have been granted a license by the Board; and,
2. Have a supervising physician with whom you have established in writing:
    - Delegation of Services Agreement that includes guidelines for adequate supervision of the PA. A sample copy of this document is available on the Board's website: www.pac.ca.gov.

LICENSE RENEWALS

Once your license is issued, it will be valid until the last day of your second birth month after licensure. Therefore, your initial license may be valid for as few as thirteen months or as many as twenty-four months. For this reason, the initial licensing fee is $200. Thereafter, your license will expire biennially on the last day of your birth month. The expiration is based on your birth month, not your birth date. A courtesy renewal notice is sent to your address of record approximately ten weeks prior to the expiration date. You may verify your current address of record and expiration date online, or call (916) 561-8780. Processing time for license renewals is six to eight weeks. Renew your license online at: www.breeze.ca.gov or www.pac.ca.gov.

If you wait until close to your birth month to apply for licensure, then your license may be valid for a full 24-month period. Should you choose to be licensed as soon as possible, your license may be valid for as few as 13 months depending upon when you reach the second birth month after licensure.

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CONTINUNG MEDICAL EDUCATION

Licensees are required to complete continuing medical education as a condition of license renewal. The requirement may be met by completing 50 hours of category 1 continuing medical education every two years or by obtaining and maintaining certification by the National Commission on Certification of Physician Assistants.

RESOURCE

The Board's website address is: www.pac.ca.gov. You may obtain physician assistant applications, forms, general information, relevant laws and regulations, and other resources on the Board's website. You may also link to other agencies and organizations. You are encouraged to visit the site on a regular basis for information that will be useful to you.

The Board's website also includes an online subscription service which sends out notices of changes in laws and regulations, enforcement actions taken against licensees, and information related to physician assistant practice. You are encouraged to take advantage of this service. Visit the Board's website and click on "Join the Board E-mail Subscriber List" under "Quick Hits" located on the home page.

PHYSICIAN ASSISTANT LAWS AND REGULATIONS

It is your responsibility to know and to keep current on the laws and regulations pertaining to the practice as a physician assistant as they are subject to change. You may obtain a copy of the physician assistant laws and regulations at the Board's website: www.pac.ca.gov.

NOTICE OF COLLECTION OF PERSONAL INFORMATION

All items in this application are mandatory; none are voluntary. **Failure to provide any of the requested information will delay the processing of your application and may result in the application being rejected as incomplete.** The information provided will be used to determine your qualifications for licensure per Section 3519 of the California Business and Professions Code and Title 16, California Code of Regulations section 1399.506, which authorizes the collection of this information. The information on your application may be transferred to other medical licensing authorities, the Federation of State Medical Boards, other governmental or law enforcement agencies to perform their statutory or constitutional duties, or otherwise transferred or disclosed as provided in California Civil Code Section 1798.24. You have the right to review your application and your files except information that is exempt from disclosure as provided in Civil Code section 1798.40, or as otherwise provided by the California Information Practices Act. Certain information provided may be disclosed to a member of the public, upon request, under the California Public Records Act or pursuant to court order. The Executive Officer is responsible for maintaining the information in this form and may be contacted at 2005 Evergreen Street, Suite 1100, Sacramento, CA 95815, telephone number (916) 561-8780 regarding questions about this notice or access to records.

PAB
Physician Assistant Board

APPLICATION FOR LICENSURE
PHYSICIAN ASSISTANT

Please **READ** all instructions and general information prior to completing this application. **ALL** questions on this application must be answered, and all supporting documents must be submitted with this application as per instructions. When space provided is insufficient, attach additional sheets of paper. Please type or print neatly.

Application and licensing fees. Select one option only. ☐ Live Scan $225.00 ☐ Fingerprint cards $274.00

PART I: TO BE COMPLETED BY APPLICANT

PAB Use Only

Personal Information

1. Name — Last / First / Middle

2. Other Names/Aliases (Including Birth Name)

3. SSN/ITIN

5. Gender ☐ Male ☐ Female

4a. Address of Record/ Mailing Address
Will be released by the Board to the public and posted on the PAB's website if a license issues. This address will also be used for service of all official correspondence, notices, and orders from the Board.
Number and Street (include apartment number, if applicable)
City / State / Zip Code / Country

4b. Confidential Address
If you provided a P.O. Box in 4a, you must also provide a street address. This address will not be posted on the Board's website.
Number and Street (include apartment number, if applicable)
City / State / Zip Code / Country

6. E-mail Address Optional—For office use only.

7. Date of Birth (month/day/year)

8. Telephone Numbers
Home / Cell

EDUCATION

9. Physician Assistant Program Attended

Name of PA Training Program	Graduation Date	Address	Telephone Number

School Code _____

MANDATORY DISCLOSURE OF SOCIAL SECURITY NUMBERS:
Disclosure of your Social Security Number (SSN) or Individual Taxpayer Identificaiton Number (ITIN) is mandatory. Sections 30 and 31 of the Business and Professions Code authorize collection of your SSN or ITIN.Your SSN or ITIN will be used exclusively for tax enforcement purposes, for purposes of compliance with any judgement or order for family support in accordance with Section 17520 of the Family Code, or for verification of license or examination status by a licensing or examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your SSN or ITIN, your application for initial licensure will not be processed AND you may be reported to the Franchise Tax Board, which may assess a $100 penalty against you.

STATE TAX OBLIGATION NOTICE:
Effective July 1, 2012, the State Board of Equalization and the Franchise Tax Board may share taxpayer information with the Board. You are obligated to pay your state tax obligation and your license may be suspended or denied if the state tax obligation is not paid.

PA1

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MILITARY EXPERIENCE/LICENSE HISTORY

10. Are you serving in, or have your previously served in, the United States military? ☐ Yes ☐ No

11. Are you married to, or in a domestic partnership or other legal union, with an active duty member of the Armed Forces of the United States who is assigned to a duty station in California under official active duty military orders? ☐ Yes ☐ No

If "Yes", please see instructions for further documentation required to expedite licensure.

12. Have you ever applied for a California physician assistant license? ☐ Yes ☐ No

13. Are you, or have you ever been, licensed or otherwise registered in any manner in any state, country, or with any federal agency in any healthcare occupation? ☐ Yes ☐ No

If "Yes", please complete Form PA6 and the National Practitioner Data Bank Report, see instructions. Please list type of license, state, license number, issue date, expiration and current status. Use a separate sheet of paper if necessary.

Type of License	State or Country	License Number	Date of Licensure From:	Date of Licensure To:	Current Status of License (active, inactive, suspended, revoked, probation, other, explain)

14. Have you ever taken the Physician Assistant National Certifying Examination (PANCE) as administered by the National Commission on Certificaiton of Physician Assistants (NCCPA)? ☐ Yes ☐ No

Please see instructions for authorization and release requirements for PANCE scores. Your PANCE scores must be sent by the NCCPA directly to the Board.

Written Exam

DISCIPLINARY HISTORY

QUESTIONS 15 - 18: If you answer "YES" to any of the questions in this section, please provide ALL official documentation regarding the matter, in addition to a written narrative description. If applicable, an applicant should also provide official hearing/court documents and original letters of explanation from training program directors or other appropriate authorities.

15. Have you ever had a healthcare license or certificate, or narcotics (controlled substance) permit denied or disciplined by this State, any other state, agency of the federal government, or another country, or have you ever surrendered such a license, certificate or permit? ☐ Yes ☐ No

PA2

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DISCIPLINARY HISTORY (continued)

16. Have you ever had charges filed against a healthcare license that you currently hold or held in the past, including charges that are still pending or charges that were dropped? ☐ Yes ☐ No

If "Yes" to either #15 or #16, give details (locations, dates, rulings). Use a separate sheet of paper if necessary.

State	Date	Charge	Disposition

17. Have you ever withdrawn from, or been suspended, dismissed or expelled from a physician assistant training program or have you ever taken a leave of absence from such a program? *If "Yes", please attach a written explanation.* ☐ Yes ☐ No

18. Have you ever been charged with, or been found to have committed unprofessional conduct, professional incompetence, gross negligence or repeated negligent acts or malpractice by any licensing board, other agency, or hospital or has any disciplinary action ever been filed or taken regarding any healthcare license which you now hold or have ever held, or is any such action pending? Include any disciplinary actions by the U.S. Military, U.S. Public Health Service or other U.S. governmental agency. *If YES, provide details:* ☐ Yes ☐ No

State	Date	Charge	Disposition

19. Have you ever been denied a license, permission to practice medicine or any other healthcare occupation, or denied permission to take an examination in any state, country, or U.S. federal jurisdiction, or is any such action pending? *If YES, provide details:* ☐ Yes ☐ No

State	Date of Denial	Reason for Denial

PA3

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DISCIPLINARY HISTORY (continued)

20. Have you ever been diagnosed or treated for a medically recognized mental illness, disease or disorder that would currently interfere with your ability to practice medicine? (See instructions for further details.) ☐ Yes ☐ No

21. Do you have a current physical or mental impairment related to drugs or alcohol? ☐ Yes ☐ No

22. Have you been adjudicated by a court to be mentally incompetent or are you currently under a conservatorship? ☐ Yes ☐ No

If you answered "Yes" to question 22, please submit copies of official court documents regarding the legal proceedings.

For any of the boxes checked YES above, please submit complete official medical, psychiatric and treatment records related to the specific medical or psychiatric issue, evidence of ongoing rehabilitation treatment, and a personal written statement identifying and describing the mental illness, disease, disorder, or other condition. Completion of an authorization and release of medical or psychiatric records form may be required by the Board to finalize the application process.

For each conviction disclosed, you must provide CERTIFIED copies of arresting agency reports and CERTIFIED copies of court documents, including a plea form and court docket and a detailed written narrative description of the incident that led to the conviction. All documents will need to be provided directly by the issuing agency to the Board. If documents were purged by arresting agency and/or court, a letter of explanation from these agencies is required. YOU ARE REQUIRED TO INCLUDE ANY CONVICTION THAT HAS BEEN SET ASIDE AND DISMISSED OR EXPUNGED, OR WHERE A STAY OF EXECUTION HAS BEEN ISSUED.

23a. Have you ever been convicted of or pled nolo contendere to any violation (including misdemeanor or felony) of any local, state, or federal law of any state, territory, country, or U.S. federal jurisdiction? This includes every citation, infraction, misdemeanor and/or felony, including traffic violations. Convictions that were adjudicated in the juvenile court or convictions under California Health and Safety Code sections 11357(b), (c), (d) and (e) or sections 11360(b) which are two years or older should **NOT** be reported. Convictions that were later dismissed pursuant to sections 1203.4, 1203.4a, or 1203.41 of the California Penal Code or equivalent non-California law **MUST** be disclosed. ☐ Yes ☐ No

23b. Is any appeal related to the above pending? ☐ Yes ☐ No

23c. Have you had any conviction dismissed/expunged? ☐ Yes ☐ No

23d. Was a stay of execution of the court's judgment in your case issued? ☐ Yes ☐ No

Violation and Location	Date	Penalty or Disposition

PA4

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PHOTOGRAPH

TOP OF PHOTO

INSTRUCTIONS

Photographs must be of head and shoulders only.

Attach a 2" x 2" (approximate size) photograph in this space.

Scanned, altered, or Polaroid photos are not acceptable.

BOTTOM OF PHOTO

NOTICE OF COLLECTION OF PERSONAL INFORMATION

All items in this application are mandatory; none are voluntary. ***Failure to provide any of the requested information will delay the processing of your application and may result in the application being rejected as incomplete.*** The information provided will be used to determine your qualifications for licensure per Section 3519 of the California Business and Professions Code and Title 16, California Code of Regulations section 1399.506, which authorizes the collection of this information. The information on your application may be transferred to other medical licensing authorities, the Federation of State Medical Boards, other governmental or law enforcement agencies to perform their statutory or constitutional duties, or otherwise transferred or disclosed as provided in California Civil Code Section 1798.24. You have the right to review your application and your files except information that is exempt from disclosure as provided in Civil Code section 1798.40, or as otherwise provided by the California Information Practices Act. Certain information provided may be disclosed to a member of the public, upon request, under the California Public Records Act or pursuant to court order. The Executive Officer is responsible for maintaining the information in this form and may be contacted at 2005 Evergreen Street, Suite 1100, Sacramento, CA 95815, telephone number (916) 561-8780 regarding questions about this notice or access to records.

CERTIFICATION

I hereby certify, under penalty of perjury under the laws of the State of California, that I have read the questions in the foregoing application and that all information, statements, attachments and representations provided by me in this application are true and correct. By submitting this application and signing below, I am granting permission to the Board or its assignees and agents to verify the information provided and to perform any investigation pertaining to the information I have provided as the Board deems necessary.

My signature on this application, or copy thereof, authorizes the National Practitioner Data Bank and the Federal Drug Enforcement Agency to release any and all information required by the Physician Assistant Board of California.

NOTICE: FALSIFICATION OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT HERETO IS GROUNDS FOR DENYING OR REVOKING A LICENSE.

SIGNATURE OF APPLICANT: _____ **DATE:** _____

PA5

PAB
Physician Assistant Board

PHYSICIAN ASSISTANT TRAINING PROGRAM CERTIFICATION

Print or Type ***(Read instructions before completing)***

(A): TO BE COMPLETED BY APPLICANT

1. Name	Last	First	Middle
2. Mailing Address	Number and Street (include apartment number, if applicable)		
	City	State	Zip Code

3. Telephone Numbers

Home	Cell

(B): TO BE COMPLETED BY PROGRAM

This certifies that _____ of _____, matriculated
NAME ADDRESS

in _____ and has attended this institution
NAME OF PA PROGRAM

from _____, _____, to _____, _____, successfully completing

the training for licensure as a Physician Assistant as set forth in the Physician Assistant regulations.

For a "Yes" response to ANY of the following questions, the training program should provide a brief written explanation on a separate attachment.

1. Did this individual ever take a leave of absence from their medical education?	☐ Yes ☐ No
2. Was this individual ever placed on probation?	☐ Yes ☐ No
3. Was this individual disciplined or under investigation?	☐ Yes ☐ No
4. Were there incident reports regarding this individual ever filed by instructors?	☐ Yes ☐ No
5. Were any limitations or special requirements imposed on this individual because of questions of academic or disciplinary problems, or for any other reason?	☐ Yes ☐ No

CERTIFICATION

OFFICIAL SEAL

Signed and the school seal affixed this

_____ day of _____, _____

By _____

Title _____

After completion by the approved Program, this form must be mailed by the Program to the Board at the address below.

FAXES ARE NOT ACCEPTABLE.

PA6

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PAB
Physician Assistant Board

VERIFICATION OF LICENSURE PHYSICIAN ASSISTANT OR OTHER HEALTHCARE PROFESSIONAL

Instructions to the Applicant: Please complete Part I below and forward a copy of this form to **ALL** states, territories, licensing or registration jurisdictions where you have **EVER** been licensed or registered, including any other health care professions. Copy this form as needed. Please type or print legibly.

PART I: TO BE COMPLETED BY APPLICANT

1. Name	Last	First	Middle
2. Other Names Used (Including Birth Name)		**3. Date of Birth**	MM/DD/YY
4. Mailing Address	Number and Street (include apartment number, if applicable)		
	City	State	Zip Code
5. Applicant Signature		**5. Date of Signature**	

I hereby authorize your agency to release information concerning my licensure/registration/certification status. Please return this completed form to the Board at the address listed below. All questions must be answered.

PART II: TO BE COMPLETED BY STATE BOARD OR OTHER LICENSING JURISDICTION

Instructions to the Licensing Agency: Please complete Part II below for the applicant identified above and mail this document directly to the Physician Assistant Board. **Faxes are not acceptable.**

License Type	State	License Number	Issue Date	Expiration Date

If YES to any of the following questions, please provide any information and documentation which may be released, including charges and final disposition.

1. Have any complaints been filed against the license? ☐ Yes ☐ No ☐ Unable to answer
2. Is there any pending investigation regarding the license? ☐ Yes ☐ No ☐ Unable to answer
3. Has any disciplinary activity been taken regarding this license? ☐ Yes ☐ No ☐ Unable to answer

CERTIFICATION

OFFICIAL SEAL

Verified by _____
Signature

Print Name _____

Title _____

Date _____

Telephone Number _____

PA7

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REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

ORI: A0433 (Code assigned by DOJ) Type of Application: License

Job Title or Type of License, Certification or Permit: Physician Assistant

Agency Address Set Contributing Agency:

Physician Assistant Board — Agency authorized to receive criminal history information

06339 — Mail Code (five digit code assigned by DOJ)

2005 Evergreen Street, Suite 1100 — Street No. Street or P.O. Box

Licensing Staff — Contact Name (Mandatory for all school submissions)

Sacramento CA 95815 — City State Zip Code

(916) 561-8781 — Contact Telephone No.

Name of Applicant: (please print) Last First MI

Alias: Last First

Driver's License No.

Date of Birth: Sex: ☐ Male ☐ Female

Misc. No. **BIL-** N/A — Agency Billing Number (if applicable)

Height: Weight:

Misc. No:

Eye Color: Hair Color:

Home Address: Street or P.O. Box

Place of Birth:

City, State and Zip Code

SOC:

Your Number: OCA No. (Agency Identifying No.)

Level of Service ☒ DOJ ☒ FBI

If resubmission, list Original ATI No.

Employer: (Additional response for agencies specified by statute)

This Section is not applicable

Employer Name

Street No. Street or P.O. Box

Mail Code (five digit code assigned by DOJ)

City State Zip Code

( ) Agency Telephone No. (optional)

Live Scan Transaction Completed By: Name of Operator

Date:

Transmitting Agency

ATI No.

Amount Collected/Billed

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

ORI: A0433 (Code assigned by DOJ) Type of Application: License

Job Title or Type of License, Certification or Permit: Physician Assistant

Agency Address Set Contributing Agency:

Physician Assistant Board — Agency authorized to receive criminal history information

06339 — Mail Code (five digit code assigned by DOJ)

2005 Evergreen Street, Suite 1100 — Street No. Street or P.O. Box

Licensing Staff — Contact Name (Mandatory for all school submissions)

Sacramento CA 95815 — City State Zip Code

(916) 561-8781 — Contact Telephone No.

Name of Applicant: (please print) Last First MI

Alias: Last First

Driver's License No.

Date of Birth: Sex: ☐ Male ☐ Female

Misc. No. **BIL-** N/A — Agency Billing Number (if applicable)

Height: Weight:

Misc. No:

Eye Color: Hair Color:

Home Address: Street or P.O. Box

Place of Birth:

City, State and Zip Code

SOC:

Your Number: OCA No. (Agency Identifying No.)

Level of Service ☒ DOJ ☒ FBI

If resubmission, list Original ATI No.

Employer: (Additional response for agencies specified by statute)

This Section is not applicable

Employer Name

Street No. Street or P.O. Box

Mail Code (five digit code assigned by DOJ)

City State Zip Code

( ) Agency Telephone No. (optional)

Live Scan Transaction Completed By: Name of Operator

Date:

Transmitting Agency

ATI No.

Amount Collected/Billed

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

ORI: A0433 (Code assigned by DOJ) Type of Application: License

Job Title or Type of License, Certification or Permit: Physician Assistant

Agency Address Set Contributing Agency:

Physician Assistant Board — Agency authorized to receive criminal history information

06339 — Mail Code (five digit code assigned by DOJ)

2005 Evergreen Street, Suite 1100 — Street No. Street or P.O. Box

Licensing Staff — Contact Name (Mandatory for all school submissions)

Sacramento CA 95815 — City State Zip Code

(916) 561-8781 — Contact Telephone No.

Name of Applicant: (please print) Last First MI

Alias: Last First

Driver's License No.

Date of Birth: Sex: ☐ Male ☐ Female

Misc. No. **BIL-** N/A — Agency Billing Number (if applicable)

Height: Weight:

Misc. No:

Eye Color: Hair Color:

Home Address: Street or P.O. Box

Place of Birth:

City, State and Zip Code

SOC:

Your Number: OCA No. (Agency Identifying No.)

Level of Service ☒ DOJ ☒ FBI

If resubmission, list Original ATI No.

Employer: (Additional response for agencies specified by statute)

This Section is not applicable

Employer Name

Street No. Street or P.O. Box

Mail Code (five digit code assigned by DOJ)

City State Zip Code

( ) Agency Telephone No. (optional)

Live Scan Transaction Completed By: Name of Operator

Date:

Transmitting Agency

ATI No.

Amount Collected/Billed