



COMMONWEALTH OF MASSACHUSETTS  
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES  
DEPARTMENT OF PUBLIC HEALTH  
BUREAU OF HEALTH PROFESSIONS LICENSURE  
**BOARD OF REGISTRATION OF PHYSICIAN ASSISTANTS**  
239 CAUSEWAY STREET, SUITE 500  
BOSTON, MA 02114  
800-414-0168  
617-973-0806  
[www.mass.gov/dph/boards/pa](http://www.mass.gov/dph/boards/pa)

**TEMPORARY PRACTICE CERTIFICATE APPLICATION  
INSTRUCTIONS AND CHECKLIST**

**Please read these instructions carefully. All supporting materials must be submitted at the same time. Applications will not be reviewed by the Board until all documentation has been received.**

**General Information About the Application Process:**

**The Board of Registration of Physician Assistant (“Board”) highly recommends that you refrain from accepting a PA position in Massachusetts until you are licensed.**

Once an application is received by the Board, it takes a **minimum of 3 - 5 weeks** to review the completed application and determine if any additional information is required. Once complete, applications are processed for the issuance of a license in the order received. Every effort is made to process license applications in a timely manner; however, the Board is unable to expedite the processing of applications.

To facilitate the processing of your application, please ensure that you provide all the information requested. **DO NOT LEAVE BLANKS.** If you are unable to provide the requested information, attach a separate sheet with an explanation. Missing information will delay the processing of your application.

As an applicant, it is your responsibility to ensure that ALL supporting documentation for licensure is sent directly to the Board and to check with the Board on the status of your application.

All requested information must be provided; failure to provide requested information may result in a delay in processing an application. **Incomplete applications will be returned to applicant.**

**Complete applications must include the following documents:**

- Completed application form, signed and dated by the applicant and notarized.
- 2x2 passport style color photo; white or off-white background; copies and printer generated photos are not acceptable.
- Signed and notarized Criminal Offender Record Information (CORI) Acknowledgement Form obtained from the Board’s website.
- Check or money order payable to the Commonwealth of Massachusetts for \$150.00; cash or foreign currency is not accepted.
- Official transcripts in signed, sealed envelopes from physician assistant programs/degrees with proof of a bachelor’s degree or higher. When requesting official transcripts, please inform each school’s

registrar that the **transcript must be complete and indicate the degree and date conferred in mm/dd/yyyy format.**

NCCPA documentation that you are registered for, and have been determined to be eligible to take, the next available administration of the physician assistant certification examination administered by NCCPA.

**NOTE:** The documentation must be sent directly from NCCPA; email verifications are not acceptable.

Verification of licensure status, in signed, sealed envelopes, from any state or jurisdiction in which you now or have ever held any professional license or board certification. Verifications must be sent directly to the Board by the state or other jurisdiction.

If you hold, or have ever held, any professional license or certification, you must request a National Practitioner Data Bank-Healthcare Integrity and Protection Data Bank Self-Query and submit the **Original** report in a signed and sealed envelope with this application. To request a Self-Query, please contact the National Practitioner Data Bank at 1-800-767-6732 or <http://www.npdb.hrsa.gov/>. Keep a copy for your records.

**NOTE A:** If you do **NOT** hold and have never held any professional licenses in any other state, you do not need to submit a National Practitioner Data Bank self-query.

Submission of completed application and fee acknowledges that the applicant understands and agrees to all provisions herein. Applications are void if requirements for physician assistant licensure are not met within one (1) year from the date of Board receipt of this application. All fees are non-refundable and non-transferable.

Application must be submitted on single-sided paper.

Retain a copy of the completed application and related documentation for your records. **The Board is not able to provide copies of the application.** Employers may require that you provide them with a copy.

All submissions and documentation for agenda items must be received by the Board at the close of business on the Monday of the week preceding the scheduled Board meeting. Materials received after the deadline will be reviewed prior to being placed on the agenda for the next scheduled meeting.

\*A Supervising Physician form with a MA Board of Registration in Medicine Physician Profile and Work Setting Information form must be on file with the Board within thirty (30) days of beginning employment. Physician Profiles are available online at [www.massmedboard.org](http://www.massmedboard.org). Your license may be issued without these forms.

**NOTE A:** If there has been no change in supervising physician[s] and/or work setting[s] since a Temporary Practice Certificate was issued, new forms do not need to be resubmitted.

**NOTE B:** Multiple supervising physicians and work settings require submission of separate forms for each supervising physician and each work setting.

**IMPORTANT INFORMATION:**

Pursuant to 263 CMR 3.03 (4), Board regulations state that a physician assistant applicant/registrant must notify the Board in writing of any of the following events within thirty (30) days of their occurrence: change of address of applicant/registrant; change of identity of the applicant/ registrant's employer or employment status of the applicant/registrant; any change in the identity or address of the registered physician supervising the practice of the applicant/registrant; or, the permanent departure of the applicant/registrant from the Commonwealth of Massachusetts.

Your address is a PUBLIC RECORD that is available to anyone who requests it. If you are using your home address, you may wish to consider changing this to an office address. Address changes may be done on online at the board's website [www.mass.gov/dph/boards/pa](http://www.mass.gov/dph/boards/pa) or you may obtain a form online to submit to the Board's office.

Answers to many questions may be found on the Board's website. Statutes and regulations governing physician assistant licensure and practice may be found on the website; they are also available for purchase from the State House Bookstore, Massachusetts State House, Room 116, Boston, MA 02108, 617-727-2834.

For further information, please contact the Board office at 1-800-414-0168 or 1-617-973-0806.



**EDUCATION**

7. I certify under the pains and penalty of perjury, that I have taken or I will register for and take the next available administration of the NCCPA certifying examination

Scheduled date of NCCPA Certification Exam: \_\_\_/\_\_\_/\_\_\_  
(mm/dd/yyyy)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Applicant must arrange for official written documentation of certification to be sent directly to the Board by NCCPA. Request form included with application forms.**

8. PA Program Name/Location: \_\_\_\_\_

\_\_\_\_\_

Degree awarded: \_\_\_\_\_ Date of Graduation: \_\_\_/\_\_\_/\_\_\_  
(mm/dd/yyyy)

**Submit official transcript in a signed, sealed envelope. Transcripts may be mailed directly to the Board.**

**VERIFICATION OF OTHER LICENSES/BOARD CERTIFICATIONS**

9. LIST BELOW ALL OTHER PROFESSIONAL LICENSES AND BOARD CERTIFICATIONS EVER HELD; INCLUDE ALL STATES AND JURISDICTIONS

I DO NOT CURRENTLY HOLD AND HAVE NEVER HELD ANY PROFESSIONAL LICENSE OR CERTIFICATION IN ANY STATE OR JURISDICTION.

<u>Issuing State/Jurisdiction</u>	<u>Profession</u>	<u>License/Certification Number</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Applicants must arrange for official documentation of current license status from each state or jurisdiction to be mailed directly to the Board in a signed, sealed envelope.**

## QUESTIONS

**IF YOU ANSWER "YES" TO ANY OF THE FOLLOWING QUESTIONS PLEASE ATTACH A SEPARATE SHEET EXPLAINING THE CIRCUMSTANCES.**

10. Have you ever been denied a license, or ever withdrawn or attempted to withdraw an application, for any professional license in the United States or any country or foreign jurisdiction?

Yes  No

11 Has any licensing or certification board, government authority, hospital or health care facility or professional association located in the United States or any country or foreign jurisdiction taken any disciplinary action against you?

Yes  No

12 Are you the subject of any pending disciplinary action by any licensing or certification board, government authority, hospital or health care facility or professional association located in the United States or any country or foreign jurisdiction?

Yes  No

13 Have you ever voluntarily surrendered or resigned any professional license or board certification in the United States or any country or foreign jurisdiction?

Yes  No

14 Have you ever been arrested, charged, arraigned, indicted, prosecuted, convicted or been the subject of any criminal investigation or any court proceeding in relation to any criminal violation? Do not report minor violations for which a fine of \$250 or less was imposed.

Yes  No

15. Have you ever been court martialled or other than honorably discharged from the armed services (military) of the United States or of any country or foreign jurisdiction?

Yes  No

## RELEASE

I hereby authorize all hospitals, institutions, credentialing agencies, organizations, personal physicians, employers (past and present), business and professional associates (past and present), and all government agencies and entities (local, state, federal, or foreign) to release to the Board of Registration of Physician Assistants any information, files or records requested by the Board in connection with the processing of my application. I further authorize the Board of Registration of Physician Assistants to release information contained in this application in association with its processing.

## AFFIDAVIT OF APPLICANT

To the best of my knowledge and belief, I have filed all state tax returns and paid all state taxes required by state law and do not owe child support.

I understand that the Board is certified by the Massachusetts Criminal History Systems Board for access to Criminal Offender Record Information (CORI), including conviction and pending criminal case data. As an applicant for a temporary practice certificate to practice as a Physician Assistant, I understand that a CORI check may be conducted by the Board for conviction and pending criminal case information only and that the CORI results will not necessarily disqualify me.

I understand that I am responsible for reading and understanding the laws and regulations governing practice with a temporary practice certificate in Massachusetts and I hereby agree to comply with such laws and regulations.

I understand that this application for a temporary practice certificate shall be deemed no longer valid if requirements for a temporary practice certificate are not met within one (1) year from the date of Board receipt. I also understand that fees are non-refundable and non-transferable.

I certify, under the pains and penalties of perjury, that the information I have provided pursuant to this application for licensure is truthful and accurate. I understand that any failure to provide truthful and accurate information in connection with this application for a temporary practice certificate may be grounds for the Board of Registration of Physician Assistants to deny issuance of a temporary practice certificate and to suspend or revoke a temporary practice certificate issued to me, all in accordance with Massachusetts law.

APPLICANT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PRINT NAME \_\_\_\_\_

**Attach a recent  
passport  
photo  
(2x2)**

NOTARY NAME: \_\_\_\_\_

COMMISSION EXPIRES: \_\_\_\_\_

[Seal]

**INCLUDE A NON-REFUNDABLE FEE OF \$150.00 (CHECK OR MONEY ORDER ) PAYABLE TO THE COMMONWEALTH OF MASSACHUSETTS**



***If you answer YES to any of the questions below, please submit a separate sheet with a detailed explanation.***

I. Have you [the supervising physician] been disciplined [as defined by the Board of Registration in Medicine regulations] by any government authority, hospital or health care facility or professional medical association [international, national or local] within the past ten years from the date of this application?

Yes  No

II. Within the last ten years from the date of this application, have you ever had staff privileges, employment or appointment in a hospital or health care institution denied, suspended or revoked?

Yes  No

III. Within the last ten years from the date of this application, have you ever resigned from a medical staff in lieu of disciplinary action or has any quality assurance committee suggested any form of corrective action concerning your practice?

Yes  No

**I understand that, notwithstanding any other provisions of law, a physician assistant may perform medical services when such services are rendered under my supervision. Such supervision shall be in conformance with Board regulations at 263 CMR 5.04 and 5.05.**

\_\_\_\_\_  
Signature of Supervising Physician

\_\_\_\_\_  
Date

A MA BOARD OF REGISTRATION IN MEDICINE PHYSICIAN PROFILE MUST BE ATTACHED. PROFILES ARE AVAILABLE ON LINE AT [WWW.MASSMEDBOARD.ORG](http://WWW.MASSMEDBOARD.ORG). SEND THE PROFILE AND THE COMPLETED FORM TO THE MA BOARD OF PHYSICIAN ASSISTANTS AT THE ADDRESS ABOVE.



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**WORK SETTING INFORMATION  
FOR  
TEMPORARY PRACTICE CERTIFICATE AND  
LICENSE APPLICATIONS**

Complete a separate copy of this form for each work setting in which you are employed as a physician assistant. If you are not employed at the time of application, return this completed form to the Board of Registration of Physician Assistants, 239 Causeway Street, Suite 500, Boston, MA 02114 within thirty (30) days of commencing employment.

APPLICANT NAME:

\_\_\_\_\_  
(Last) (First) (Middle) (License/Temp. Practice #)

NAME OF FACILITY OR OFFICE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

EFFECTIVE DATE: \_\_\_\_\_

TYPE FACILITY: Office ( ) Clinic ( ) HMO ( ) Hospital ( ) Other: \_\_\_\_\_

TYPE EMPLOYMENT: Full time ( ) Part time ( )

**LIST NAMES OF MASSACHUSETTS'S HEALTH CARE FACILITIES (INCLUDING GROUP PRACTICES) AT WHICH YOU WILL PRACTICE OR BE AFFILIATED WITH IN THIS WORK SETTING:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**CHECK ALL AREAS OF PRACTICE THAT APPLY TO THIS SETTING:**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Primary Care       | <input type="checkbox"/> Administration      | <input type="checkbox"/> Emergency Medicine  |
| <input type="checkbox"/> General Surgery    | <input type="checkbox"/> Internal Medicine   | <input type="checkbox"/> Occupational Health |
| <input type="checkbox"/> Geriatric Medicine | <input type="checkbox"/> Education           | <input type="checkbox"/> Clinical Research   |
| <input type="checkbox"/> Obstetrics/Gyn.    | <input type="checkbox"/> Pediatrics/Adolesc. | <input type="checkbox"/> Orthopedics         |
| <input type="checkbox"/> Oncology           | <input type="checkbox"/> Dermatology         | <input type="checkbox"/> Cardiology          |

Medical Specialty \_\_\_\_\_

Surgical Specialty \_\_\_\_\_

Other \_\_\_\_\_

