



WYOMING BOARD OF MEDICINE
 PHYSICIAN ASSISTANT
 APPLICATION TO PRACTICE IN THE STATE OF WYOMING

***PLEASE NOTE: INCLUSION OF REQUIRED DOCUMENTATION AND APPROPRIATE FEES WILL EXPEDITE PROCESSING OF YOUR LICENSE**

SECTION 1. IDENTIFYING INFORMATION

Fee MUST be paid with cashiers or certified check or money order

A. Full Name:

_____ Last
 _____ First
 _____ Middle
 _____ Maiden _____ Mother's Maiden Name

Indicate Previous Names: _____
If name has changed, please attach written explanation of circumstances.

B. Mailing Address:

_____ Street Address or Post Office Box
 _____ City
 _____ State _____ Zip _____ (Area Code) Phone Number
 E-Mail: _____

C. Social Security Number:

D. Birth Date:

E. Birthplace

F. Gender

G. DEA Controlled Substance & UPIN

H. Height _____ Weight _____ Eye Color: _____

Female
 Male

Certification Number: _____

Hair Color _____

Identifying Marks _____

SECTION 2. PRACTICE IN WYOMING

A. Intended Wyoming Location _____

City

B. Do you plan to leave practice in your present location and practice primarily in Wyoming: _____

C. Are you applying for a temporary license? _____

If so, when do you intend to begin practicing in Wyoming? _____

SECTION 3. NCCPA CERTIFICATION

A. Are you certified by the National Commission on Certification of Physician Assistants?: _____ YES _____ NO

B. If yes, Date Certified: _____ Date of Expiration: _____

C. Certificate Number: _____

C. If no, have you previously failed the examination? _____ YES _____ NO If yes, list the date(s) _____

D. Please list the precise stage of the examination process you are in OR an estimated date on which you plan to take the examination? _____

SECTION 4. EDUCATION

College	Area of Study	Date & Type of Degree
Graduate Study <u>Other than Medicine</u>	Area of Study	Date & Type of Degree

SECTION 5. PHYSICIAN ASSISTANT EDUCATION

List name and location of institutions attended and dates:

Name and Location (<i>City and State</i>)	Dates of Attendance	
	Entrance – mm/dd/yy	Leaving – mm/dd/yy

P.A. Diploma

From: _____
Name of School, Location
Date Awarded

SECTION 6. EMPLOYMENT ACTIVITIES

List employment activities and two references from each facility since graduation from medical school to present. Vacation and unemployed periods must be included. If necessary, list on a separate sheet.

Employer/Activity	Location	Dates (mm/dd/yy)	
		From:	To:

Reference: _____
(Name)
(Address)

Reference: _____
(Name)
(Address)

Employer/Activity	Location	Dates (mm/yy)	
		From:	To:

Reference: _____
(Name)
(Address)

Reference: _____
(Name)
(Address)

Employer/Activity	Location	Dates (mm/yy)	
		From:	To:

Reference: _____
(Name)
(Address)

Reference: _____
(Name)
(Address)

SECTION 7. STAFF PRIVILEGES:

Please list the names and address of all facilities in which you hold practice privileges of any kind

SECTION 8. LICENSURE IN OTHER STATES AND/OR COUNTRIES:

Indicate states and or/countries in which you are or have been licensed. You must include all jurisdictions in which you have ever been licensed.

State	License No.	Date Issued	Obtained by (Exam/Reciprocity)	Valid	
				Y	N
				Y	N
				Y	N
				Y	N
				Y	N

IT IS NECESSARY TO SUBMIT THE ATTACHED VERIFICATION OF LICENSURE FORM TO EACH STATE/COUNTRY LISTED ABOVE AND REQUEST THAT JURISDICTION RETURN IT DIRECTLY TO THE WYOMING BOARD OF MEDICINE

SECTION 9. PERSONAL AND PROFESSIONAL INFORMATION

IF YOU ANSWER "YES" TO ANY OF THE FOLLOWING QUESTIONS YOU MUST ATTACH A DETAILED EXPLANATION OF THE EVENT(S) REFERRED TO IN YOUR AFFIRMATIVE RESPONSE AND PROVIDE COMPLETE AND LEGIBLE DOCUMENTATION REGARDING SUCH EVENT(S). YOUR APPLICATION WILL NOT BE PROCESSED FURTHER UNLESS AND UNTIL THE BOARD RECEIVES SUCH EXPLANATION AND DOCUMENTATION AND, IF APPROPRIATE, INVESTIGATES SUCH MATTERS.

I. DEFINITIONS: The following definitions apply to this section:

- A. "Ability to practice medicine" includes all of the following:
 1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasonable medical judgments and to learn and keep abreast of medical developments.
 2. The ability to communicate those judgments and medical information to patients and other health care providers with or without the use of aids and devices such as voice amplifiers; and
 3. The physical capability to perform medical tasks such as physical examination and surgical procedures with or without the use of aids or devices such as corrective lenses or hearing aids.
- B. "Chemical Substances" includes alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes in accordance with the prescriber's direction, as well as those used illegally.
- C. "Medical Condition" includes mental or psychological conditions or disorders such as, but not limited to, orthopedic, visual, speech and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

II. QUESTIONS

Yes No

A. Have you ever been convicted of, pled guilty to, pled nolo contendere to, or are there charges pending against you for any crime including felonies, misdemeanors, municipal ordinances, and/or any military code of justice violations, including driving under the influence of any intoxicating substance but not including non-moving traffic violations or moving violations which did not involve alcohol or substance impairment?)

If your answer to this question is "Yes" please provide a complete written explanation including:

- a. the name and location of the court where you were charged and the docket number of your case;
- b. the offense(s) to which you pled or were found guilty;
- c. all terms of the sentence imposed;
- d. whether you have completed the sentence;
- e. the date the sentence was imposed; and
- f. if applicable, the name, address, and telephone number of your probation officer.

Attach a copy of the sentencing order and any orders indicating that the sentence has been completed.

	Yes	No
	<p>B. Do you have any medical condition which, in any way, impairs or limits, or might impair or limit your ability to safely and skillfully practice medicine?</p> <p><i>If your answer to this question is "Yes", please provide a complete written explanation including:</i></p> <ul style="list-style-type: none"> a. the diagnosis; b. the treatment plan and prognosis; c. the name, address, and telephone number of your treating physician; d. the manner in which the condition impairs your ability to safely and competently practice medicine; e. any restriction or conditions imposed upon your practice by any licensing agency or health care facility due to such condition; and f. how you intend to accommodate such condition in the practice you intend to conduct in the State of Wyoming? <p><u>Attach to your answer the most recent medical records and/or a written report from your treating physician describing the diagnosis, the current treatment regime, a prognosis and any limitations arising from such condition</u></p>	

	Yes	No
	<p>C. Within the past five (5) years have you been hospitalized for, missed work because of, or been significantly impaired by any mental or emotional condition?</p> <p><i>If your answer to this question is "Yes", please provide a complete written explanation including:</i></p> <ul style="list-style-type: none"> a. the circumstances and the diagnosis; b. the treatment you are undergoing; and prognosis; c. the name, address, and telephone number of your treating physician; d. the manner in which the condition impairs your ability to safely and competently practice medicine; e. any restriction or conditions imposed upon your practice by any licensing agency or health care facility due to such condition; and f. how you intend to accommodate such condition in the practice you intend to conduct in the State of Wyoming? <p><u>Attach to your answer the most recent medical records and/or a written report from your treating physician describing the diagnosis, the current treatment regime, a prognosis and any limitations arising from such condition.</u></p>	

	Yes	No
	<p>D. Within the last five (5) years have you been evaluated, diagnosed or treated in any manner for any substance use disorder including, but not limited to, alcohol, tranquilizers, sedatives, psychoactive medications, cocaine, marijuana, opiates, benzodiazepines or any other narcotic or potentially addicting substance?</p> <p>(If you have a fully executed contract with the Wyoming Professional Assistance program you may answer "NO" to this question)</p> <ul style="list-style-type: none"> a. the treatment; b. the name, address and telephone number of your treating physician; c. any restriction or conditions imposed upon your practice by any licensing agency or health care facility due to such condition; and d. how you intend to accommodate such condition in your practice you intend to conduct in the State of Wyoming <p>Attach to your answer any agreement between you and any professional assistance organization, AA or other rehabilitation and/or monitoring group.</p>	

	Yes	No
	<p>E. Have you been reprimanded, demoted, disciplined, cautioned, placed on probation, taken leave for any reason or terminated by any employer, educational institution or training program for any reason?</p> <p><i>If your answer to this question is "Yes" please provide a complete written explanation including:</i></p> <ul style="list-style-type: none"> a. the circumstances leading to the action; b. the effective date of the action; c. the name, title, address, and phone number of the person/s taking such action; and d. the resolution and/or current status of such action. <p>Attach to your answer any paperwork pertinent to this action.</p>	

<p>F. Have you ever been or are you now under investigation or have any adverse charges or complaints been filed against you by any education training program or facility, medical licensing board, local, state, federal or military professional or disciplinary body or any hospital privileging or credentialing body, grievance committee or any other medical group, including medical societies and specialty boards?</p> <p>If your answer to this question is "Yes" please provide a complete written explanation including:</p> <ol style="list-style-type: none"> the charges against you; the name, address, and telephone number of the entity before whom such charges were brought; the date the action was initiated; the outcome of the action; any restriction or conditions imposed upon your practice as a result of the action; and how you intend to accommodate such restriction or condition in the practice you intend to conduct in the State of Wyoming <p>Attach to your answer all records of the action including final orders and/or findings.</p>	<p>Yes</p>	<p>No</p>
<p>G. Have you been denied licensure privileges or membership by any licensing board, hospital medical facility, professional society, specialty board or medical body?</p> <p>If your answer to this question is "Yes" please provide a complete written explanation including:</p> <ol style="list-style-type: none"> the basis for denial; the name, address, and telephone number of the entity which denied your application; and the date the denial was issued. <p>Attach to your answer all records of the application and denial process including final orders and/or findings.</p>	<p>Yes</p>	<p>No</p>
<p>H. Have you ever withdrawn an application for privileges or licensure in any jurisdiction?</p> <p>If your answer to this question is "Yes" please provide a complete explanation including:</p> <ol style="list-style-type: none"> the name, address and telephone number of the entity to which you had applied; the license, privilege or membership applied for; the date you withdrew the application; the reason for the withdrawal; and whether the withdrawal was permitted by the entity in lieu of a denial of the application. <p>Attach to your answer all records of the application and withdrawal process including final orders and/or findings.</p>	<p>Yes</p>	<p>No</p>
<p>I. Have any professional liability claims been filed against you?</p> <p>If your answer to this question is "Yes" please indicate how many and provide a complete written explanation for each claim including:</p> <ol style="list-style-type: none"> the name and location of the court where the action was filed and the docket number of the case; the allegations of the claim against you; the manner in which the claim was resolved; the amount, if any, paid to the claimant by you and/or your insurance carrier; and the date the claim was resolved. <p>Attach a copy of any final judgment, order or settlement documents that relate to the disposition of the claims against you.</p>	<p>Yes</p>	<p>No</p>
<p>J. Has a professional liability insurance carrier terminated your coverage?</p> <p>If your answer to this question is "Yes" please provide a complete written explanation including:</p> <ol style="list-style-type: none"> the name address and telephone number of the company which terminated coverage; the basis for termination; and the date of the termination. <p>Attach a copy of any correspondence or other documentation which relates to the denial of coverage.</p>	<p>Yes</p>	<p>No</p>

RETURN TO:

**Wyoming Board of Medicine
130 Hobbs Avenue, Suite A
Cheyenne, WY 82002**

Phone: (307) 778-7053

Fax: (307) 778-2069

Email: wyomedboard@state.wy.us

Web Site: <http://wyomedboard.state.wy.us>

Toll-Free within state: (800) 438-5784



WYOMING BOARD OF MEDICINE
PHYSICIAN ASSISTANT APPLICATION
AFFIDAVIT

Please read the following affidavit carefully. When you are certain of its provisions, initial the following paragraphs in the spaces provided in the right margin and sign the affidavit in the presence of a notary public.

AFFIDAVIT OF THE APPLICANT

I, _____, being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents and that the attached photograph is a true likeness of myself.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, previous and present employers, past and present business and professional associates and local, state, federal or foreign governmental agencies and instrumentalities to release to the Wyoming Board of Medicine any information, files or records requested by the Board in connection with the processing of this application. I further authorize the Wyoming Board of Medicine to release to the organizations, individuals and groups listed in this application any information which is material to my application.

Initial: _____

I have read the questions in the foregoing application and I have answered them completely, without reservations of any kind, and I declare under potential penalty of false swearing that my answers and all statements made by me herein are true and correct.

Initial: _____

Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license as a physician assistant in the State of Wyoming. I understand that should I violate any provision of the Medical Practice Act as it pertains to my duty as a physician assistant, my license may be subject to revocation or suspension.

Initial: _____

I have read the Wyoming Medical Practice Act for Physician Assistants. I have also reviewed the Board's regulations concerning W.S. 33-26-501 et seq as they pertain to physician assistants and I agree to abide by them. I understand that:

Initial: _____

- 1) Physician assistants may prescribe medications only as an agent of the supervising physician. PAs may prescribe Schedule II-V drugs under the supervising physician's authority and dispense prepackaged medication in rural clinics when pharmacy services are not physically available.
- 2) PAs may practice only under the supervision of a Wyoming licensed physician approved by the Board.
- 3) In the absence of a physician who is approved by the Board to supervise a PA's work, the PA may not legally practice.
- 4) I understand the definitions of direct and indirect supervision and shall apply these standards to the work situation.
- 5) The Board of Medicine grants PAs one year in which to successfully complete national certification. The Board requires proof that certification is current and verification is obtained directly from the NCCPA office on the Certificate of NCCPA Certification form.
- 6) I will inform the Board of Medicine of any changes of employment or supervision.

Initial: _____

Physician Assistant Signature

Date

Paste in this space a photograph of yourself, head and shoulders view, taken within three months of the date of application.

County of _____

State of _____

Subscribed and sworn to before me this _____ day of _____ 20_____.

My commission expires: _____

Notary Public Signature

SEAL

Return to:
Wyoming Board of Medicine
130 Hobbs Avenue, Suite A
Cheyenne, WY 82002



WYOMING BOARD OF MEDICINE

130 Hobbs Ave., Suite A
Cheyenne, WY 82002
Phone: (307) 778-7053

Citizenship and Alien Status Declaration

TO THE APPLICANT: Pursuant to federal law, before the State of Wyoming Board of Medicine may issue a license, the applicant must certify his or her legal presence in the United States. The applicant must provide proof that he or she is either: (A) a citizen or national of the United States; or, (B) a qualified alien or non-immigrant lawfully present in the United States who is eligible to receive a professional license as defined in Personal Responsibility and Work Opportunities Reconciliation Act of 1996, 8 U.S.C. § 1601, *et seq.*

Applicants must submit the required proof of legal presence documentation with their application for a Wyoming medical license. **Applicants should ONLY submit a legible photocopy of the document(s). DO NOT SUBMIT THE ORIGINAL DOCUMENT(S).**

Failure to submit this form and required document(s) will delay processing of your application.

Section 1 – Applicant Information

Applicant's Name (Printed): _____

Section 2 – Citizenship/Immigration Status Declaration

- Are you a citizen or national of the United States? Yes No
If No, go to Sections 3 and 4, below.
If Yes, where were you born (City, State, and Country):

- To establish proof of citizenship or nationality, attach and submit a legible and unaltered photocopy of one of the documents on **List A** (see Page 2).
- Go to Section 4, below.

Section 3 – Alien Status Declaration

Indicate your alien status below and submit legible and unaltered photocopies of documents proving such status. The alien status documents for each category as set forth on **List B** (see Page 2) are the most commonly-used documents that the U.S. Immigration and Naturalization Service provides to aliens in those categories.

- | | |
|--|---|
| <input type="checkbox"/> An alien lawfully admitted for permanent residence under the Immigration and Naturalization Act (INA). | <input type="checkbox"/> An alien whose deportation is being withheld under Section 243(h) of the INA. |
| <input type="checkbox"/> An alien who is granted asylum under Section 208 of the INA. | <input type="checkbox"/> An alien paroled into the United States for at least one year under Section 212(d)(5) of the INA. |
| <input type="checkbox"/> A refugee admitted to the United States under Section 207 of the INA. | <input type="checkbox"/> An alien who has been declared a "battered alien." |
| <input type="checkbox"/> An alien who is granted conditional entry under Section 203(a)(7) of the INA as in effect prior to April 1, 1980. | <input type="checkbox"/> An alien not in the preceding seven (7) categories who has been admitted to the United States for a limited period of time (a non-immigrant). Non-immigrants are persons who have temporary status for a specific purpose. |

Section 4 – Declaration

I declare under penalty of perjury under the laws of the State of Wyoming that the answers I have given are true and correct to the best of my knowledge.

Applicant's Signature

Date

LIST A – ACCEPTABLE DOCUMENTS TO ESTABLISH U.S. CITIZENSHIP/IMMIGRATION STATUS

A person who is a citizen of the United States as evidenced by one of the following:

1. A copy of a birth certificate issued in or by a city, county, state, or other governmental entity within the United States or its outlying possessions.
2. A U.S. Certificate of Birth Abroad (FS-545, DS-135) or a Report of Birth Abroad of a U.S. Citizen (FS-240).
3. A birth certificate or passport issued from:
 - Puerto Rico, on or after January 13, 1941;
 - Guam, on or after January 17, 1917;
 - U.S. Virgin Islands, on or after January 17, 1917;
 - Northern Mariana Islands, after November 4, 1986;
 - American Samoa;
4. Swain's Island; or,
5. District of Columbia.
4. A U.S. passport (expired or unexpired).
5. Certificate of Naturalization (N-550, N-57, N-578).
6. Certificate of Citizenship (N-560, N-561, N-645).
7. U.S. Citizen Identification Card (I-179, I-197).
8. An individual Fee Register Receipt (Form-G-711) that shows that the person has filed an application for a New Naturalization or Citizenship Paper (Form N-565).
9. Any other document which establishes a U.S. place of birth or indicates U.S. citizenship.

LIST B – ACCEPTABLE DOCUMENTS TO ESTABLISH ALIEN STATUS

An alien lawfully admitted for permanent residence under the Immigration and Naturalization Act (INA) must submit supporting documentation (legible copy of the front and backside of the document) to establish legal presence under one of the following categories:

1. An alien lawfully admitted for permanent residence under the Immigration and Naturalization Act (INA). Evidence includes:
 - INS Form I-551 (Alien Registration Receipt Card commonly known as a "green card"); or
 - Unexpired Temporary I-551 stamp in foreign passport or on INS Form I-94.
2. An alien who is granted asylum under Section 208 of the INA. Evidence includes:
 - INS Form I-94 annotated with stamp showing grant of asylum under Section 208 of the INA;
 - INS Form I-688B (Employment Authorization Card) annotated "274a.12(a)(5)";
 - INS Form I-766 (Employment Authorization Document) annotated "A5";
 - Grant Letter from the Asylum Office of INS; or
 - Order of an immigration judge granting asylum.
3. A refugee admitted to the United States under Section 207 of the INA. Evidence includes:
 - INS Form I-94 annotated with stamp showing admission under Section 207 of the INA;
 - INS Form I-688B (Employment Authorization Card) annotated "274a.12(a)(3)";
 - INS Form I-766 (Employment Authorization Document) annotated "A3"; or
 - INS Form I-571 (Refugee Travel Document).
4. An alien paroled into the United States for at least one year under Section 212(d)(5) of the INA. Evidence includes:
 - INS Form I-94 with stamp showing admission for at least one year under Section 212(d)(5) of the INA.
5. An alien whose deportation is being withheld under Section 243(h) of the INA (as in effect immediately prior to September 30, 1996) or Section 241(b)(3) of such Act (as amended by Section 305(a) of Division C of Public Law 104-208). Evidence includes:
 - INS Form I-668B (Employment Authorization Card) annotated "274a.12(a)(10)";
 - INS Form I-766 (Employment Authorization Document) annotated "A10"; or
 - Order from an immigration judge showing deportation withheld under Section 243(h) of the INA as in effect prior to April 1, 1997, or removal withheld under Section 241(b)(3) of the INA.
6. An alien who is granted conditional entry under Section 203(a)(7) of the INA as in effect prior to April 1, 1980. Evidence includes:
 - INS Form I-94 with stamp showing admission under Section 203(a)(7) of the INA;
 - INS Form I-688B (Employment Authorization Card) annotated "274a.12(a)(3)"; or
 - INS Form I-766 (Employment Authorization Document) annotated "A3".
7. An alien who is a Cuban or Haitian entrant (as defined in Section 501(e) of the Refugee Education Assistance Act of 1980). Evidence includes:
 - INS Form I-551 (Alien Registration Receipt Card, commonly known as a "green card") with the code CU6, CU7, or CH6;
 - Unexpired temporary I-551 stamp in foreign passport or on INS Form I-94 with code CU6 or CU7; or
 - INS Form I-94 with stamp showing parole as "Cuban/Haitian Entrant" under Section 212(d)(5) of the INA.
8. An alien paroled into the United States for less than one year under Section 212(d)(5) of the INA. Evidence includes:
 - INS Form I-94 showing this status.
9. An alien who has been declared a battered alien. Evidence includes:
 - INS petition and supporting documentation