



WYOMING BOARD OF MEDICINE

PHYSICIAN ASSISTANT APPLICATION

INSTRUCTIONS

The application must be completed in its entirety. Please type or legibly print the information. An incomplete or illegible application will delay processing. Applications received without the fee will be returned to the applicant. ***FAXES WILL NOT BE ACCEPTED.***

1. With the completed application, submit the following fee and documentation:
 - a. **APPLICATION FEE- \$200.00 (An additional \$100.00 must be included if requesting a temporary license, see below).** All fees must be submitted by *money order, certified check or cashier's check.*
 - b. Completed affidavit of authenticity and copy of Physician Assistant certificate.
2. **THE FOLLOWING DOCUMENTATION MUST BE REQUESTED DIRECTLY FROM THE APPROPRIATE SOURCE AND SUBMITTED DIRECTLY TO THE BOARD FROM THAT SOURCE.** Faxes will not be accepted. We will not accept these documents from the applicant:
 - a. Verification of graduation from a Physician Assistant training program accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) or its predecessor or successor organization (request form attached).
 - b. Verification from every state and country in which the applicant is or has been licensed to practice as a physician assistant (request form attached).
 - c. Verification of certification from the National Commission on Certification of Physician Assistants (please contact the NCCPA).
3. Please submit two (2) letters of reference meeting the following specifications:
 - a. Letters must be addressed to the Wyoming Board of Medicine, must be dated within the past 12 months and written on professional letterhead and signed. Signature stamps will not be accepted.
 - b. Letters must contain information as requested on the enclosed reference letter instruction sheet.
 - c. At least one letter should be from your most recent employment setting and shall be from a physician. One letter may be from another physician or physician assistant with whom you have previously practiced (if you are not currently employed, letters must be from instructors at your PA training program).
 - d. Letters from intended or prospective employers are NOT acceptable.

INSTRUCTIONS FOR SECURING A TEMPORARY LICENSE

Those holding a temporary license to practice prior to interviewing with the Physician Assistant Advisory Council should note that issuance of a temporary license does not guarantee the Council or the Board of Medicine will ultimately grant a full and unrestricted license. All temporary licenses expire prior to your interview with the Council. Though it happens infrequently, on occasion, applicants previously holding a temporary license have been denied licensure.

To secure a temporary license, the following documents must be received in Board office:

- a. Completed application and \$300.00 application fee (includes regular \$200.00 application fee plus \$100.00 temporary license fee) by money order, certified check or cashier's check.
- b. All required documentation for full licensure.
- c. Completed Primary Supervising Application(s) and completed Back-Up Supervising Application(s).

SECURING A TEMPORARY LICENSURE TAKES APPROXIMATELY TEN (10) DAYS AFTER THE APPLICATION AND ALL REQUIRED DOCUMENTATION ARE RECEIVED AND THE APPLICANT'S FILE IS COMPLETE.

Submit your application directly to:

Wyoming Board of Medicine
320 West 25th Street, Suite 103
Cheyenne, WY 82002
(307) 778-7053

SECTION 4. EDUCATION

College Area of Study Date & Type of Degree

Graduate Study Area of Study Date & Type of Degree
other than Medicine

SECTION 5. PHYSICIAN ASSISTANT EDUCATION

List name and location of institutions attended and dates:

Name and Location (City and State)	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 physician assistant 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 or have held practice privileges of any kind

Facility	Location	Date(s) Privileges Held

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
<p>A. Have you ever been convicted of, pled guilty to, pled <i>nolo contendere</i> 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 <u>not</u> including non-moving traffic violations or moving violations which did not involve alcohol or substance impairment?)</p> <p><i>If your answer to this question is "Yes" please provide a complete written explanation including:</i></p> <ol style="list-style-type: none"> 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. <p><u>Attach a copy of the sentencing order and any orders indicating that the sentence has been completed.</u></p>		

II. QUESTIONS (Continued)		
<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>If your answer to this question is "Yes", please provide a complete written explanation including:</p> <ol style="list-style-type: none"> the diagnosis; the treatment plan and prognosis; the name, address, and telephone number of your treating physician; the manner in which the condition impairs your ability to safely and competently practice medicine; any restriction or conditions imposed upon your practice by any licensing agency or health care facility due to such condition; and 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>If your answer to this question is "Yes", please provide a complete written explanation including:</p> <ol style="list-style-type: none"> the circumstances and the diagnosis; treatment you are undergoing; and prognosis; name, address, and telephone number of your treating physician; manner in which the condition impairs your ability to safely and competently practice medicine; any restriction or conditions imposed upon your practice by any licensing agency or health care due to such condition; and 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 your answer to this question is "Yes", please provide a complete written explanation including (If you have a fully executed contract with the Wyoming Professional Assistance program you may answer "NO" to this question):</p> <ol style="list-style-type: none"> the treatment; the name, address and telephone number of your treating physician; any restriction or conditions imposed upon your practice by any licensing agency or health care facility due to such condition; and how you intend to accommodate such condition in your practice you intend to conduct in the State of Wyoming <p><u>Attach to your answer any agreement between you and any professional assistance organization, AA or other rehabilitation and/or monitoring group.</u></p>	Yes	No
<p>E. Have you ever 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>If your answer to this question is "Yes" please provide a complete written explanation including:</p> <ol style="list-style-type: none"> the circumstances leading to the action; the effective date of the action; the name, title, address, and phone number of the person/s taking such action; and the resolution and/or current status of such action. <p><u>Attach to your answer any paperwork pertinent to this action.</u></p>	Yes	No
<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><u>Attach to your answer all records of the action including final orders and/or findings.</u></p>	Yes	No
<p>G. Have you ever 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><u>Attach to your answer all records of the application and denial process including final orders and/or findings.</u></p>	Yes	No

II. QUESTIONS (Continued)			
H. Have you ever withdrawn an application for privileges or licensure in any jurisdiction? If your answer to this question is "Yes" please provide a complete explanation including: <ol style="list-style-type: none"> a. the name, address and telephone number of the entity to which you had applied; b. the license, privilege or membership applied for; c. the date you withdrew the application; d. the reason for the withdrawal; and e. whether the withdrawal was permitted by the entity in lieu of a denial of the application. Attach to your answer all records of the application and withdrawal process including final orders and/or findings.	Yes	No	
I. Have any professional liability claims ever been filed against you? If your answer to this question is "Yes" please indicate how many and provide a complete written explanation for each claim including: <ol style="list-style-type: none"> a. the name and location of the court where the action was filed and the docket number of the case; b. the allegations of the claim against you; c. the manner in which the claim was resolved; d. the amount, if any, paid to the claimant by you and/or your insurance carrier; and e. the date the claim was resolved. Attach a copy of any final judgment, order or settlement documents that relate to the disposition of the claims against you.	Yes	No	
J. Has a professional liability insurance carrier ever terminated your coverage? If your answer to this question is "Yes" please provide a complete written explanation including: <ol style="list-style-type: none"> a. the name address and telephone number of the company which terminated coverage; b. the basis for termination; and c. the date of the termination. Attach a copy of any correspondence or other documentation which relates to the termination or denial of coverage.	Yes	No	

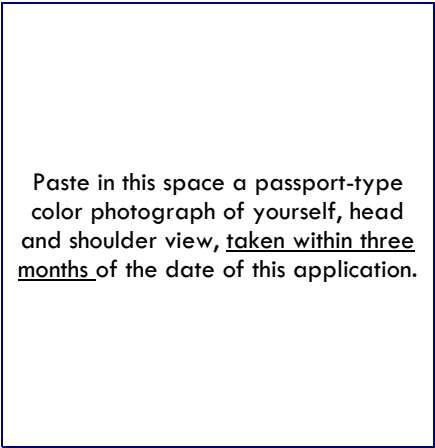
SECTION 10. AFFIDAVIT – PLEASE READ CAREFULLY BEFORE SIGNING

I, _____, being first duly sworn, certify under oath that I am the person named in this application and supporting documents and that I am the person named in the various forms and credentials furnished in support of this application and that all documents, forms or copies furnished or to be furnished are absolutely true and accurate.

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 all 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 above any information which is or may be material to my application.

I have carefully read the questions in the foregoing application and have answered them completely, without reservation of any kind, and I declare under potential penalty of false swearing that my answer and all statements are true and correct and current as of the date of this application. I hereby agree that any false or incorrect statement shall constitute cause for denial, suspension or revocation of my license to practice medicine and surgery in the State of Wyoming and may have criminal ramifications. I further agree to furnish to the Wyoming Board of Medicine any and all additional information pertaining to questions in this application which may come to light after the date of this application. Moreover, I understand that should I violate any provision of the Medical Practice Act of the State of Wyoming, my license may be subject to revocation, suspension or restriction or other disciplinary action.

	Date	
Signature of Applicant		
State of _____		
County of _____		
Subscribed and sworn to before me this _____ day of _____, 20____		
(Notary Public)		
Seal		



**RETURN WITH SUPPORTING DOCUMENTATION AND FEE(S) TO:
 Wyoming Board of Medicine • 320 W. 25th Street, Suite 103 • Cheyenne, WY 82002 • (307) 778-7053**



Wyoming Board of Medicine

AFFADAVIT OF AUTHENTICITY FOR PHYSICIAN ASSISTANT EDUCATION DIPLOMA

I, _____, being first duly sworn, do hereby certify under oath that the copy of my diploma from _____ is a true and genuine document and that I am the rightful possessor of the diploma and the identical person named in the diploma.

Further, I certify under oath, that this diploma was obtained by pursuing a regular course of study or examination at the _____ School of _____.

Further, affiant sayeth not.

Dated this _____ day of _____ 20_____.

Signature of Applicant

NOTARY

State of _____

County of _____

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

(Notary Public)

My Commission expires _____

SEAL



Wyoming Board of Medicine

CERTIFICATE OF PHYSICIAN ASSISTANT EDUCATION

I,		, hereby authorize
		to furnish to the Wyoming Board of Medicine
Name of School		
the required information necessary for licensure in the State of Wyoming.		
Signature		Social Security Number
Type or Print Full Name		Current Address
Date		City, State, Zip

Physician Assistant School:

Please provide a statement below addressing periods of study and date diploma or certification was awarded. Please return this completed form directly to the Wyoming Board of Medicine.

Signature		Name of School
Title		Address
Date		City, State, Zip
<input type="checkbox"/>	Check here if no seal is available	
		Telephone

Seal



Wyoming Board of Medicine

REFERENCE LETTER INSTRUCTION SHEET

APPLICANT: Please forward one instruction sheet to each of the two (2) people who will be writing a letter of recommendation on your behalf.

Letter or Recommendation for _____
(Applicant)

AUTHOR PLEASE NOTE: Letters from physicians with whom the applicant has a prospective financial, business or current family relationship will not be accepted. Further, for letters of recommendation to be acceptable, they must meet all of ALL of the following criteria:

1. Must be typed or printed legibly on your professional letterhead;
2. Must be addressed to the Wyoming Board of Medicine. Letters addressed to "To Whom it May Concern" will not be accepted;
3. Must have current date;
4. Must contain the following information outlined below:
 - a. your name, address, telephone number, and professional affiliation
 - b. length of acquaintance with applicant and in what capacity
 - c. applicant's medical acumen, experience and abilities:
 1. indicate applicant's strengths
 2. indicate if you have ever notice or become aware of any difficulties or shortcomings;
 - d. applicant's interactions with patients, colleagues and staff;
 - e. any instances that you are aware of in which applicant has been sanctioned in any fashion
by any licensing, privileging, credentialing or academic body;
 - f. any circumstances that you are aware of that might impede applicant's ability to safely and skillfully practice medicine, and

Must be signed and mailed by the author directly to:

**Wyoming Board of Medicine
320 West 25th Street, Ste 103
Cheyenne, WY 82002**

All letters must have an original signature; letters with signature stamps will not be accepted. Please call if you have questions or comments. (307) 778-7053.

Please feel free to add any additional comments you wish regarding this applicant. Thank your for your time and effort.



WYOMING BOARD OF MEDICINE
PHYSICIAN ASSISTANT LICENSE VERIFICATION
REQUEST FORM

I, _____, hereby authorize the State Board of
 _____ to furnish to the Wyoming Board of Medicine the
 required information necessary for licensure as a physician assistant in Wyoming.

 Signature License No. Social Security No.

 Address City, State Zip Code

This section to be completed by State Medical/Physician Assistant Licensing Board:

FULL NAME OF
 LICENSEE: _____
 GRADUATE OF: _____ DATE: _____
 LICENSE NUMBER: _____ ISSUE DATE _____
 EXPIRATION DATE: _____ STATUS: _____

Is this individual certified by the NCCPA? YES _____ NO _____ Certification Date _____
 Is the applicant currently the subject of a pending investigation by a licensing or disciplinary
 authority in your state? YES _____ NO _____

Have formal disciplinary proceedings been initiated against applicant or applicant's license by a
 licensing or disciplinary authority in your state? YES _____ NO _____

Has the applicant ever been warned, censured or in any other manner disciplined or has the
 applicant's license ever been revoked, suspended or in any other manner limited by a licensing or
 disciplinary authority in your state? YES _____ NO _____

IF YES TO ANY OF THE ABOVE QUESTIONS, PLEASE ATTACH DETAILS AND CERTIFIED
 COPIES OF ORDERS.

SIGNATURE _____ TITLE _____

NAME OF BOARD _____ DATE _____

SEAL

Please Return To:
 Wyoming Board of Medicine
 320 West 25th Street, Suite 103
 Cheyenne, WY 82002