



**WYOMING BOARD OF MEDICINE  
INSTRUCTIONS FOR A VOLUNTEER PHYSICIAN  
ASSISTANT LICENSE**

**The following must be provided to the Board:**

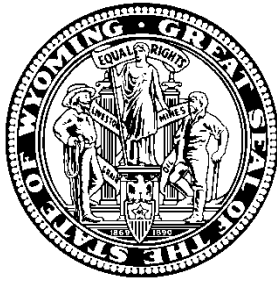
1. A completed application submitted with the non-refundable fee of \$50.00 made payable to: Wyoming Board of Medicine.
2. A letter from the Wyoming camp/facility/program in which the applicant will be practicing, without remuneration, verifying the applicant's name and dates of practice.
3. An original verification of licensure in good standing from the state in which the applicant currently practices. Verification from any other source will not be accepted.
4. Licenses will be issued within 7-10 days after the required documents and completed application have been received.

**Please Note:**

*Volunteer licenses are granted for a period not to exceed 21 consecutive days in a calendar year.*

**Submit your completed application and payment to:**

**Wyoming Board of Medicine**  
320 West 25<sup>th</sup> Street, Suite 200  
Cheyenne, WY 82002  
(307)778-7053



## WYOMING BOARD OF MEDICINE APPLICATION FOR VOLUNTEER PHYSICIAN ASSISTANT LICENSE

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### PERSONAL INFORMATION (Please Print):

Full Name: \_\_\_\_\_ Circle One: PA / PA-C

Mailing Address \_\_\_\_\_ Telephone: \_\_\_\_\_

City/State/Zip Code \_\_\_\_\_ SSN: \_\_\_\_\_

Current Business Address: \_\_\_\_\_

City/State/Zip Code \_\_\_\_\_ Telephone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

Email address: \_\_\_\_\_

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### EDUCATIONAL INFORMATION

PA School: \_\_\_\_\_ Date of Graduation: \_\_\_\_\_

NCCPA Certified? YES/NO Certification Expiration Date: \_\_\_\_\_

Area of Practice/Specialty: \_\_\_\_\_

**Please list the name and address of your current supervising physician in the state where you primarily practice:**

Supervising Physician Name & Degree (MD/DO): \_\_\_\_\_

Address \_\_\_\_\_ City, State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone Number \_\_\_\_\_

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### LICENSURE INFORMATION\*

State in which you presently practice and hold a current/active license: \_\_\_\_\_

License Number: \_\_\_\_\_ Issue Date: \_\_\_\_\_ Status: \_\_\_\_\_

*\*Verification of good standing from the state in which you currently practice in must be received directly from the licensing board.*

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**CAMP / FACILITY/ PROGRAM INFORMATION**

List the name and address of the camp/facility/program where you are volunteering your services:

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip Code \_\_\_\_\_

Contact Name: \_\_\_\_\_

**DATES OF PRACTICE IN THE STATE OF WYOMING:**

Beginning:\* \_\_\_\_\_ Ending\* \_\_\_\_\_

**\*Volunteer licenses are granted for a period not to exceed 21 consecutive days in a calendar year.**

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 false swearing, falsification, and/or omission of information 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, or if I accept any remuneration for providing clinical services in Wyoming, my license may be subject to revocation, suspension or restriction or other disciplinary action.

\_\_\_\_\_  
Signature of Applicant

County of \_\_\_\_\_

State of \_\_\_\_\_

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

\_\_\_\_\_  
Notary Public

Seal