

# Wyoming Board of Medicine

*Application to Renew Wyoming  
Physician Assistant License for the period  
January 1, 2012 through December 31, 2012*

**CHECK ONE BOX:**

- Renew my license (Submit \$125 fee )  
 Do not renew my license (State reason):  
 \_\_\_\_\_

**Note to Physician Assistant: Please carefully proofread your responses on this form before submitting it.  
 You are responsible for all information on this form, including any errors or omissions.**

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 PA Certificate No.: \_\_\_\_\_

**IMPORTANT:** Failure to (a) answer any question, (b) provide specific details regarding affirmative answers, or (c) enclose the required \$125 renewal fee, will delay the processing of your application for renewal.

**Answer questions ONLY as they relate to the period January 1, 2011, through present.**

<b>I. DISCIPLINARY, COMPETENCY AND HEALTH INFORMATION:</b>	<b>Yes</b>	<b>No</b>
<p><b>A. Since January 1, 2011, have you been convicted of, pled guilty or nolo contendere to, or had or have charges pending against you for any crime including felonies, misdemeanors, municipal ordinances, and/or Military Code of Justice violations (including, but not limited to, driving under the influence of any intoxicating substance, but not including non-moving traffic violations or moving violations which do not involve alcohol or substance impairment)?</b></p> <p><i>If your answer to this question is "Yes," please provide a complete written explanation including, but not limited to:</i></p> <p>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 of which you were found guilty;                      c. All terms of the sentence imposed, including fines, restitution, etc.;                      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.  <u>Attach to this renewal application form a copy of the sentencing order and any orders indicating that the sentence has been completed.</u></p>	<input type="checkbox"/>	<input type="checkbox"/>
	<b>Yes</b>	<b>No</b>
<p><b>B. Since January 1, 2011, have you developed any medical condition which, in any way, impairs or limits, or might impair or limit, your ability to safely and skillfully practice medicine?</b></p> <p><i>If your answer to this question is "Yes," please provide a complete written explanation for each such condition including, but not limited to:</i></p> <p>a. The diagnosis;                      b. The treatment plan and prognosis;                      c. The name, address and telephone number of your treating physician(s);                      d. The manner in which the condition impairs or may impair your ability to safely and competently practice medicine;                      e. Any restrictions or conditions imposed upon your practice by any licensing agency or health care facility due to such condition; and,                      f. How you are accommodating the condition in your practice.  <u>Attach to this renewal application form the most recent medical records and/or a written report from your treating physician(s) describing the diagnosis, the current treatment regime, a prognosis and any limitations arising from the condition.</u></p>	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
<p><b>C. Since January 1, 2011, have you been hospitalized for, missed work because of, or been significantly impaired by any mental or emotional condition?</b></p> <p><i>If your answer to this question is "Yes," please provide a complete written explanation for each such condition including, but not limited to:</i></p> <ul style="list-style-type: none"> <li>a. The circumstances and the diagnosis;</li> <li>b. The treatment you are undergoing and the prognosis;</li> <li>c. The name, address and telephone number of your treating professional(s);</li> <li>d. The manner in which the condition impairs or may impair your ability to safely and competently practice medicine;</li> <li>e. Any restrictions or conditions imposed upon your practice by any licensing agency or health care facility due to such condition; and,</li> <li>f. How you are accommodating the condition in your practice.</li> </ul> <p><u>Attach to this renewal application form the most recent medical records and/or a written report from your treating professional(s) describing the diagnosis, the current treatment regime, a prognosis and any limitations arising from the condition.</u></p>	<input type="checkbox"/>	<input type="checkbox"/>
<p><b>D. Since January 1, 2011, have you been evaluated, diagnosed or treated for any substance abuse disorder including, but not limited to, alcohol, tranquilizers, sedatives, psychoactive medications, cocaine, marijuana, opiates, benzodiazepines or any other narcotic or potentially-addicting substance? NOTE: If you have a fully-executed contract in force with the Wyoming Professional Assistance Program ("WPAP"), you may answer "No" to this question.</b></p> <p><i>If your answer to this question is "Yes," please provide a complete written explanation for each such substance including, but not limited to:</i></p> <ul style="list-style-type: none"> <li>a. The substance(s) in question;</li> <li>b. The treatment you are undergoing and the prognosis;</li> <li>c. The name, address and telephone number of your treating professional(s);</li> <li>d. Any restrictions or conditions imposed upon your practice by any licensing agency or health care facility due to such condition; and,</li> <li>e. How you are accommodating the condition in your practice.</li> </ul> <p><u>Attach to this renewal application form any agreement between you and any professional assistance program, Alcoholics Anonymous, or any other rehabilitation and/or monitoring group.</u></p>	<input type="checkbox"/>	<input type="checkbox"/>
<p><b>E. Since January 1, 2011, have you been reprimanded, demoted, disciplined, cautioned, placed on probation, been placed on or taken leave (except vacation leave), or been terminated by any employer, educational institution or training program for any reason?</b></p> <p><i>If your answer to this question is "Yes," please provide a complete written explanation for each such action taken against you including, but not limited to:</i></p> <ul style="list-style-type: none"> <li>a. A detailed description of the circumstances and event(s) leading to the action(s);</li> <li>b. The effective date of the action(s);</li> <li>c. The name, address and telephone number of the persons and/or entities taking action(s);</li> <li>d. Any restrictions or conditions imposed upon your practice due to such action(s);</li> <li>e. The resolution and/or current status of such action(s); and,</li> <li>f. How you are accommodating the action(s) in your practice.</li> </ul> <p><u>Attach to this renewal application form all documents pertinent to the action(s).</u></p>	<input type="checkbox"/>	<input type="checkbox"/>
<p><b>F. Since January 1, 2011, have you been under investigation or had or have any adverse charges or complaints filed against you by: any education training program or facility; medical licensing board; local, state, federal or military professional or disciplinary body; any hospital privileging or credentialing body or grievance committee; or any other medical group, including medical societies and specialty boards?</b></p> <p><i>If your answer to this question is "Yes," please provide a complete written explanation for each such action taken against you including, but not limited to: (CONTINUED ON PAGE 3)</i></p>	<input type="checkbox"/>	<input type="checkbox"/>

<p>a. The charge(s) against you;  b. A detailed description of the circumstances and event(s) leading to the action(s);  c. The effective date of the action(s);  d. The name, address and telephone number of the persons and/or entities taking action(s);  e. Any restrictions or conditions imposed upon your practice due to such action(s);  f. The resolution and/or current status of such action(s); and,  g. How you are accommodating the action(s) in your practice.</p> <p>Attach to this renewal application form all documents pertinent to the action(s).</p>		
	<b>Yes</b>	<b>No</b>
<p><b>G. Since January 1, 2011, have you been denied licensure, privileges or membership by any licensing board, hospital medical facility, professional society, specialty board, or medical body?</b></p>	<input type="checkbox"/>	<input type="checkbox"/>
<p><i>If your answer to this question is "Yes," please provide a complete written explanation for each denial including, but not limited to:</i></p> <p>a. The basis for denial;  b. A detailed description of the circumstances and event(s) leading to the denial(s);  c. The name, address and telephone number of the entity making the denial(s);  d. The date the denial was issued.</p> <p>Attach to this renewal application form all records of the application and denial process including, but not limited to, final orders and/or findings.</p>		
	<b>Yes</b>	<b>No</b>
<p><b>H. Since January 1, 2011, have you withdrawn an application for licensure or privileges in any jurisdiction?</b></p>	<input type="checkbox"/>	<input type="checkbox"/>
<p><i>If your answer to this question is "Yes," please provide a complete written explanation for each withdrawal including, but not limited to:</i></p> <p>a. The name, address and telephone number of the entity to which you had applied;  b. The license, privileges or membership applied for;  c. The date you withdrew the application;  d. The reason for your withdrawal; and,  e. Whether the withdrawal was permitted by the entity in lieu of a denial of your application.</p> <p>Attach to this renewal application form all records of the application process and your withdrawal including, but not limited to, final orders and/or findings.</p>		
	<b>Yes</b>	<b>No</b>
<p><b>I. Since July 1, 2011, have you entered into any agreements, consent decrees, stipulations, conditions or restrictions with any other licensing boards?</b></p>	<input type="checkbox"/>	<input type="checkbox"/>
<p><i>If your answer to this question is "Yes," please provide a written explanation for each situation including, but not limited to:</i></p> <p>a. A detailed description of the circumstances and event(s) leading to the agreement, consent decree, stipulation, condition or restriction;  b. The name, address and telephone number of the licensing board with which you have the agreement, consent decree, etc.  c. The effective date of the action(s);  d. The resolution and/or current status of each agreement, consent decree, etc.; and,  g. How you are accommodating the agreement, consent decree, etc. in your practice.</p> <p>Attach to this renewal application form all documents related to such actions including, but not limited to, the final agreement(s), consent decree(s), stipulation(s), condition(s), and restriction(s) and related orders and/or findings.</p>		

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<b>II. LIABILITY INFORMATION:</b>		<b>Yes</b>	<b>No</b>
<b>A. Since January 1, 2011, have any professional liability claims been filed against you?</b>		<input type="checkbox"/>	<input type="checkbox"/>
<p><i>If your answer to this question is "Yes," please indicate how many claims have been filed and provide a complete written explanation for each claim including, but not limited to:</i></p> <p>a. The name and location of the court where the action was filed and the docket number of the case;</p> <p>b. The allegations of the claim against you;</p> <p>c. If applicable, the date and manner in which the claim was resolved; and,</p> <p>d. The amount, if any, paid to the claimant by you and/or your insurance carrier;</p> <p><u>Attach to this renewal application form all records of the application process and your withdrawal including, but not limited to, final orders and/or findings.</u></p>			
		<b>Yes</b>	<b>No</b>
<b>B. Since January 1, 2011, has any professional liability insurance carrier terminated your coverage?</b>		<input type="checkbox"/>	<input type="checkbox"/>
<p><i>If your answer to this question is "Yes," please provide a complete written explanation including, but not limited to:</i></p> <p>a. The name, address and telephone number of the company which terminated coverage;</p> <p>b. The basis for termination; and,</p> <p>c. The effective date of the termination.</p> <p><u>Attach to this renewal application form all records of the application process and your withdrawal including, but not limited to, final orders and/or findings.</u></p>			

<b>III. DEMOGRAPHIC INFORMATION:</b>			
<b>A. ADDRESS</b>			
Office Address: (Published in Directory and on Web Site)			
City:		State:	ZIP:
Office Phone:	Fax:	E-mail: (Not published)	
<b>All Board correspondence with you will be sent to this address:</b>			
Mailing Address: (NOT published in Directory or on Web)			
City:		State:	ZIP:

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**IV. SUPERVISION INFORMATION:** [**PLEASE NOTE:** If you do not correctly list your supervising physician(s) below, your renewal form will be returned to you for correction, which will delay your renewal. All supervising physicians **MUST** be listed as either primary or back-up, and the listing must match the Board's file. If you have any questions regarding the physician(s) on file as your supervisor(s), please contact the Board office at 307-778-7053 or [carrie.drummond@wyo.gov](mailto:carrie.drummond@wyo.gov)]

**A. PRIMARY SUPERVISING PHYSICIAN(S):**

Physician Name	Physician Address
1.	
2.	
3.	
4.	
5.	
6.	

**B. BACK-UP SUPERVISING PHYSICIAN(S):**

Physician Name	Physician Address
1.	
2.	
3.	
4.	
5.	
6.	

**By my signature I certify that all information provided in this renewal application and any materials submitted herewith is true and accurate. I understand that the omission or misrepresentation of any information on this renewal application or attached materials constitutes grounds for possible investigation of, disciplinary action affecting, and denial of, renewal of my license to practice medicine in Wyoming.**

Signature	Printed/Typed Name	Date

**RETURN WITH \$125 RENEWAL FEE TO:**

Wyoming Board of Medicine  
 320 W. 25<sup>th</sup> St., Suite 200  
 Cheyenne, WY 82002

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