State of Utah
Department of Commerce
Division of Occupational and Professional Licensing

Physician Assistant: Notification of Change

APPLICANT INFORMATION

Full Legal Name: ______________________________
First *Middle* *Last*

All Previous Legal Names: ______________________________

Other DOPL Licenses Held: ______________________________

SSN: ____________ **Date of Birth:** ____________ **Gender:** ☐ Male ☐ Female

Address: ______________________________
Street Address (including Apt/Unit/Ste #) and/or PO Box

____
City *State* *ZIP Code*

Phone: ____________ **Email:** ____________

Please Select ONE:

☐ I am a United States citizen OR a non-citizen of the United States who is lawfully present.
☐ I am a foreign national not physically present in the United States.
☐ None of the above, please explain: ______________________________

Driver License or State ID Card ______________________________
State of Issue *License Number* *Expiration Date*

NOTE: If you do not hold a US Driver License or a US State ID, you must present a legible copy of your current and valid government issued document(s) showing evidence of lawful presence in the United States.

AFFIDAVIT AND RELEASE

1. I certify that I am qualified in all respects for the license for which I am applying in this application.

2. I certify that to the best of my knowledge, the information contained in the application and all supporting document(s) are true and correct, discloses all material facts regarding the applicant, and that I will update or correct the application as necessary, prior to any action on my application.

3. I authorize all persons, organizations, governmental agencies, or any others not specifically listed, which are set forth directly or by reference in this application, to release to the Division of Occupational and Professional Licensing, State of Utah, any files, records, or information of any type reasonably required for the Division to properly evaluate my qualifications for licensure/certification/registration by the State of Utah.

4. I understand that it is the continuing responsibility of applicants and licensees to read, understand, and apply the requirements contained in all statutes and rules pertaining to the occupation or profession for which I am applying, and that failure to do so may result in civil, administrative, or criminal sanctions.

5. I certify that I do not currently pose a direct threat to myself, to my clients, or to the public health, safety or welfare because of any circumstance or condition.

6. I understand that I am responsible to update the Division of any changes relating to my license/certification/registration.

Signature of Applicant: ______________________________ Date ____________

AFFIDAVIT OF PRACTICE

Please note: All current and proposed supervisors and substitute supervisors must be listed in ***one*** of the sections below. Use additional sheets as necessary. Supervision cannot begin until approved by the Division.

CURRENT SUPERVISION

Please list your current approved supervisors and all substitute supervisors that should remain associated with your licensing record. Use additional sheets if necessary. ***Do not list new supervisors or supervisors you wish to remove in this section (see the sections below).***

Name	License Number	Select One:
		☐ Supervisor ☐ Substitute Supervisor
		☐ Supervisor ☐ Substitute Supervisor
		☐ Supervisor ☐ Substitute Supervisor
		☐ Supervisor ☐ Substitute Supervisor

NEW SUPERVISION

Complete only one of the supervision options below:

***Option 1:* To be completed by applicants who will be practicing in Utah upon approval of this change.**

You must complete a separate form for each primary supervisor. If more than two substitute supervisors, please attach a separate sheet with the name and license number of each additional supervisor.

Applicant's Name: ______________________________

Supervising Physician: ____________________ **License Number:** ____________

Telephone Number: ____________________ **Email:** ____________________

Substitute Supervising Physician: ____________________ **License Number:** ____________

Substitute Supervising Physician: ____________________ **License Number** ____________

Total Number of PAs supervised (including the applicant)**:** __________ **Full-Time Equivalent:** __________

Percentage of Direct Supervision for this applicant: ____________________

We, the undersigned, declare under penalty of perjury we have completed a "Delegation of Services Agreement" that meets the requirements of R156-70a-501 and have reviewed the agreement with each substitute supervising physician. A copy of the agreement is on file at each of the PAs Utah practice sites and will be made available to DOPL upon request.

Signature of Applicant: ______________________________ Date ____________

Signature of Supervisor: ______________________________ Date: ____________

***Option 2:* To be completed by applicants who will not immediately begin practice in Utah.**

I declare under penalty of perjury that I will not be practicing as a Physician Assistant in Utah at this time. If, at any future time, I choose to practice in Utah, I agree to complete and submit to DOPL a "Notification of Change" form. I understand that I must receive approval from DOPL before I begin practice with the proposed supervisor(s).

Signature of Applicant: ______________________________ Date ____________

REMOVAL OF SUPERVISION

Please list all supervisors and substitute supervisors you are no longer practicing with, and would like to remove from your licensing record:

Name	License Number	Select One:
		☐ Supervisor ☐ Substitute Supervisor
		☐ Supervisor ☐ Substitute Supervisor
		☐ Supervisor ☐ Substitute Supervisor
		☐ Supervisor ☐ Substitute Supervisor

Completed forms may be emailed to b1@utah.gov.