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

Physician Assistant Specializing in Mental Health Care

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: _____

QUALIFYING QUESTIONNAIRE

Do not leave any question blank.

DOPL may request additional documentation if the information submitted is insufficient.

1. ☐ Yes ☐ No Have you EVER had a license, certificate, permit, or registration to practice a regulated profession denied, conditioned, curtailed, limited, restricted, suspended, revoked, reprimanded, resigned, or surrendered while under investigation, or otherwise **disciplined in any way**?

2. ☒ Yes ☒ No Do you CURRENTLY have **any criminal action active or pending**?

3. ☐ Yes ☐ No WITHIN THE PAST 10 YEARS, have you pled **guilty** to, **no contest** to, entered into a **plea in abeyance,** or been **convicted** of **a misdemeanor** in any jurisdiction?

4. ☐ Yes ☐ No Have you EVER pled **guilty** to, **no contest** to, entered into a **plea in abeyance**, or been **convicted** of a **felony** in any jurisdiction?

If you answered "Yes" to any of the above questions, enclose with this application complete information with respect to all circumstances and the final result, if such has been reached. If you answered "Yes" to questions 2, 3, or 4 you must submit the following for EACH and EVERY incident:

- personal account of the incident
- police report(s)
- court record(s)
- probation/parole officer report(s)

If you are unable to obtain any of the records required above, you must submit documentation on official letterhead from the police department and/or court indicating that the information is no longer available.

NOTE:

- **DISCLOSE** charges that were later held in abeyance, diverted, reduced, or dismissed.
- **DISCLOSE** motor vehicle offenses such as driving while impaired or intoxicated. But you do not need to disclose minor traffic offenses such as parking or speeding violations.
- You do **not need to disclose** juvenile offenses, unless you were tried as an adult.
- **DISCLOSE** if you are restricted from possession, purchase, transfer, or ownership of a firearm or ammunition (even if your restriction is based on a non-reportable juvenile conviction).
- You do **not need to disclose** legally expunged or sealed criminal history incidents.

For more information, see DOPL's criminal history FAQs.

MEDICAL QUALIFYING QUESTIONNAIRE

Read thoroughly, and answer each question. Do not leave any question blank.

A "yes" answer does not necessarily mean you will not be granted a license; however, DOPL may request additional documentation if the information submitted is insufficient.

1. Have your rights, privileges, and/or participation ever been denied, conditioned, curtailed, limited, restricted, suspended or revoked in any way by:

- ☐ Yes ☐ No a hospital or health care facility
- ☐ Yes ☐ No Medicaid, Medicare or any other state or federal health care payment reimbursement program
- ☐ Yes ☐ No the Federal Drug Enforcement Administration or any state drug enforcement agency
- ☐ Yes ☐ No malpractice insurance coverage
- ☐ Yes ☐ No other entity: _____

2. Have you ever been permitted to resign or surrender any rights, privileges and/or participation while under investigation or while action was pending against you from:

- ☐ Yes ☐ No a hospital or health care facility
- ☐ Yes ☐ No Medicaid, Medicare or any other state or federal health care payment reimbursement program
- ☐ Yes ☐ No the Federal Drug Enforcement Administration or any state drug enforcement agency
- ☐ Yes ☐ No malpractice insurance coverage
- ☐ Yes ☐ No other entity: _____

3. Is any action pending against you now by:

- ☐ Yes ☐ No a hospital or health care facility
- ☐ Yes ☐ No Medicaid, Medicare or any other state or federal health care payment reimbursement program
- ☐ Yes ☐ No the Federal Drug Enforcement Administration or any state drug enforcement agency
- ☐ Yes ☐ No malpractice insurance coverage
- ☐ Yes ☐ No other entity: _____

4. ☐ Yes ☐ No Have you been named as a defendant in a malpractice suit?

5. ☐ Yes ☐ No Have you ever had office monitoring, practice curtailments, individual surcharge assessments based upon specific claims history, or other limitation, restrictions or conditions imposed by any malpractice carrier?

If you answered **"Yes"** to question 4 you must submit a complete narrative of the circumstances and a National Practitioner Data Bank report outlining all professional liability claims made against your license and any settlements paid by or on your behalf. *NPDB website: http://www.npdb.hrsa.gov.*

If you answered **"Yes"** to any of the above questions, enclose with this application complete information with respect to all circumstances and the final result, if such has been reached.

Completion of Clinical Practice

Each supervisor must complete a separate form. Make additional copies as needed.

APPLICANT INFORMATION

To be completed by the applicant:

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

Mailing Address: _____
Street/PO Box *City* *State/Zip*

License Number: _____ **Issuing State:** _____

Date passed the PANCE: _____

PRACTICE INFORMATION

To be completed by the supervisor:

Supervisor: _____

License Number: _____ **State of Issue:** _____

Telephone Number: _____ **Email:** _____

Practice Location: _____

Dates of Supervision: _____ to _____
(MM/DD/YYYY) *(MM/DD/YYYY)*

Total Clinical Hours: _____

Were any of the hours identified above completed as part of an approved education program in mental health?

☐ Yes / ☐ No If **YES**, number of hours completed as part of the program: _____

I certify that I am (select one):

- ☐ a mental health therapist who has been trained in and has at least two years of practice experience in psychotherapy
- ☐ a physician who is board certified in psychiatry

I certify that I supervised the above named applicant while completing the clinical training hours identified on this form. I further certify that the supervision provided and the collaborative clinical practice met the requirements of Utah Code 58-70a-307, 58-70a-501.1, and 58-70a-501.2.

Signature of Supervisor: _____ Date: _____

Note: Each supervisor must complete a separate form. Do not sign a form that contains hours supervised by a different licensee.

APPLICATION CHECKLIST AND INSTRUCTIONS

This checklist is for your convenience; you do not need to include it with your application.
NOTE: Incomplete applications will be denied.

Your application is classified as a public record and may be available for inspection by the public, except with regard to the release of information which is sub-classified as controlled, private, or protected under the Government Records Access and Management Act or restricted by other law.

The following items are required to complete your application:

- ☐ If you do not hold a Utah Physician Assistant license, you must submit a complete application for Utah licensure. Applications may be submitted online or the downloadable form can be found on our website.
- ☐ Documentation of meeting the education requirements. Submit official transcripts documenting completion of one of the following:
  - an accredited doctorate level academic program for physician assistants approved by the division in collaboration with the board;
  - a post-graduate certificate program for physician assistants to practice within psychiatric and mental health care that is approved by the division in collaboration with the board; or
  - a post-graduate residency in psychiatry and additional clinical practice or coursework in accordance with requirements approved by the division in collaboration with the board
- ☐ A copy of your current Certification of Added Qualification in Psychiatry issued by the NCCPA.
- ☐ A "Completion of Clinical Practice" form found in this application from each clinical practice supervisor, documenting at least 10,000 hours of clinical practice that meets the requirements of Utah Code 58-70a-501.1 (4).

Submit the above items with your completed application to:

In person or via express delivery:
Division of Occupational and Professional Licensing
Heber M Wells Building, 1st Floor Lobby
160 E 300 S
Salt Lake City, UT 84111

US Postal Service:
Division of Occupational and Professional Licensing
PO BOX 146741
Salt Lake City, UT 84114-6741