Dear Physician Assistant:

Enclosed are the application form and detailed instructions for renewing your Maine Physician Assistant license and your registration certificate. Please complete the application and registration and return them with the indicated fees and other forms as soon as possible. See page 2 for instructions. Any licensee who must be contacted about a missing or incomplete application will be subject to a $100 late application processing fee. This fee will be applied to any licensee to whom a second notice must be sent. **I urge your immediate attention to the full completion and return of this application before the expiration date of your current license. The sooner we receive your complete application the sooner you will receive your renewed license.**

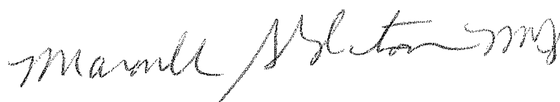
To maintain an Active status license you are required to report your continuing medical education (CME) activities as part of the application, and to meet certain CME requirements. A total of 100 hours of CME are required each 2 year cycle. Of those hours, 40 must be category I credits. Continuing medical education requirements are more fully explained in the enclosed instructions. A copy of the CME log submitted to the NCCPA or AAPA for recertification is acceptable in lieu of completing the attached report.

If you are a new licensee renewing for the first time, the year your license expires is determined by your year of birth. Licensees born in an odd year renew in odd years and licensees born in an even year renew in even years. If you have been licensed for less than 24 months, the CME credits you are required to submit are prorated accordingly. Please see the enclosed CME chart to determine the appropriate number of credits needed for renewal of your license.

The last page of the form contains a log for you to list each of your work sites. You may duplicate this page as necessary. Please provide full information for each work site. In addition, please submit a copy of the Plan of Supervision for each work site. Your application will not be complete without this information.

If you have any questions, please feel free to contact the Board office at (207) 287-3782.

Sincerely,



Maroulla Gleaton, M.D., Secretary
Maine Board of Licensure in Medicine

PHYSICIAN ASSISTANT RENEWAL APPLICATION INSTRUCTIONS

In order to successfully and timely renew your license, you must:

 Complete the renewal application, pages 5-8.

 Report CME credits earned.

 Renew your Primary Supervising Physician registration(s) and pay the $50 fee for each. If the registration occurred within one year of the renewal date of March 31, pay $25. Also, the total amount of registration fees is capped at $250.

 Terminate or have terminated registration of physicians no longer supervising you. Use the registration form (Form C) to do this.

 Submit your updated Plan(s) Of Supervision along with your renewal application.

 Pay the $200.00 license renewal fee

In addition to your license, you must be registered with at least one Primary Supervising Physician in order to practice medicine, but you may have multiple Primary Supervising Physicians. Enclosed is a Form C to register the delegated relationship. Photocopy as necessary. The registration form (Form C) is also available on the Board's website at http://www.docboard.org/me/licensure/FORM%20C%20PA.pdf. The Board will issue you a Certificate of Registration under the scope of your supervising physician's practice, which will be in effect for two years as long as you retain your license and working relationship with your registered primary supervising physician(s). Since Physician Assistants are permitted registration with more than one Primary Supervising Physician at more than one work site, we must document all P.A./supervisor relationships. <u>If you have more than one work location under the supervision of the same Primary Supervising Physician, these work locations are not considered multiple work sites and do not require separate registrations.</u> If you terminate your working relationship with a Primary Supervising Physician you must notify the board in writing by letter or by submitting a form C. Accuracy in our records protects you and your supervising physician(s) in any case where professional liability, competency, or conduct may be an issue. Also, we request that you please list all Primary Supervising Physician arrangements on the enclosed form (page 8). Photocopy as necessary. Please do not include Secondary Supervising Physicians there.

The Board's Rules and Regulations require a written Plan Of Supervision for each work site, prepared by the Physician Assistant and the Primary Supervising Physician (see Rules, Chapter 2, §7). The Plan of Supervision must be updated as necessary and, at the very least, when you renew your license. A copy of the Plan of Supervision must be available for review at each work site. Signatures of Secondary Supervising Physicians accepting responsibility for the Physician Assistant must be included in this document. **A copy of the Plan of Supervision, for each work site, must be submitted with the renewal application.**

<u>You may also use this form to withdraw your Maine license. See Question 16 on Page 10.</u>

PRORATED CME CREDITS NEEDED FOR FIRST RENEWALS

If you are a new licensee, please use the chart below to determine the appropriate number of continuing Medical Education credits needed for renewal of your license.

Number of Months from Initial Licensure to Expiration	Total Hours Needed	Category I	Category II
4	**20**	**8**	**12**
5	**25**	**10**	**15**
6	**30**	**12**	**18**
7	**35**	**14**	**21**
8	**40**	**16**	**24**
9	**45**	**18**	**27**
10	**50**	**20**	**30**
11	**50**	**20**	**30**
12	**50**	**20**	**30**
13	**55**	**22**	**33**
14	**60**	**24**	**36**
15	**65**	**26**	**39**
16	**70**	**28**	**42**
17	**75**	**30**	**45**
18	**80**	**32**	**48**
19	**85**	**34**	**51**
20	**90**	**36**	**54**
21	**95**	**38**	**57**
22	**100**	**40**	**60**
23	**100**	**40**	**60**
24	**100**	**40**	**60**
25	**105**	**42**	**63**
26	**110**	**44**	**66**
27	**115**	**46**	**69**

You **must** maintain a file of your Continuing Medical Education activity, both current and historical. The board is not a repository for CME records. Please keep a copy of your CME log for your records.

FORM C INSTRUCTIONS

RETURN TO: MAINE BOARD OF LICENSURE IN MEDICINE
137 STATE HOUSE STATION
AUGUSTA, ME 04333-0137
TEL: (207) 287-3601 FAX: (207) 287-6590

Please refer to Chapters 2 and 3 of the Board's Rules, which are available upon request by contacting the Board, or at http://www.docboard.org/me/me_home.htm
A Physician Assistant (PA) must hold a valid license and a **Certificate of Registration, which documents the supervision relationship,** as described for PA's in Chapter 2, Section 2, B of the Board's Rules.

A. **Initial Registration:** Before you begin employment, each PA who is newly licensed or who has inactive status must be registered with a Primary Supervising Physician by filing a Form C registration with the Maine Board of Licensure in Medicine.

B. **Physician Assistant:** Each PA has **14 days** in which to notify the Board upon changing Primary Supervising Physicians or adding a Primary Supervising Physician. Effective January 1, 1998, a **$100 late registration fee** will be assessed if the Form C registration is not filed within 14 days of beginning employment. Both the Physician Assistant and Primary Supervising Physician must sign the form. The PA is responsible to notify the Board when the supervising relationship ends.

C. **Secondary Supervision:** In the temporary absence of the Primary Supervising Physician, the responsibility of the supervising of the named PA must be transferred to another licensed physician. The secondary supervisor must designate in writing in the written Plan of Supervision his/her willingness to accept the responsibility and liability for the performance of the named PA.

D. **Termination:** You may use this form to notify the Board when the Primary Supervising Physician relationship has terminated. Please use a separate page if more space is needed. State the date and reason for the termination and return the Board-issued Certificate of Registration after it has been signed by the Primary Supervising Physician.

FORM C: REGISTRATION OF PHYSICIAN ASSISTANT SUPERVISORY RELATIONSHIP

PLEASE PRINT OR TYPE ALL INFORMATION CLEARLY

____ ______________________

Physician Assistant Maine License No.

____ ______________________

Primary Supervising Physician Maine M.D. License No.

____

Primary Supervising Physician Email Address

Name/Address of Practice Setting: SUPERVISION START DATE:_____________

____

____

____

Tel:________________________________

Please check the appropriate box: Fee

[ ] First time registration with a New Primary Supervising Physician (PSP) $50
(The first time registration is valid only upon approval by the Board).

[ ] Change of Primary Supervising Physician relationship*. $50
(Registering a new PSP and terminating a relationship with a former PSP. Please refer to page 1, paragraph D, Termination.)

[ ] Renewal of Primary Supervising Physician relationship. File with license renewal. $50

[ ] Renewal of multiple Primary Supervising Physician relationships. $50 each
(Fee is per registration - not to exceed $250 per registration period.)
(Include Per Diem work or moonlighting work)

[ ] Renewal of Primary Supervising Physician relationship within 1 year of initial registration of relationship. File with license renewal. $25

[ ] *Termination of a Primary Supervising Physician relationship: fill out the fields below.

Name of Former Primary Supervising Physician: ____

Effective Relationship End Date: __________________________

Reason for termination: ____

____

ATTESTATIONS

PHYSICIAN ASSISTANT

I have read, fully understand, and accept the responsibilities and liability of a Physician Assistant as described in 32 M.R.S.A. § 3270-A and § 3270-B and in the current Chapter 2 of the Rules of the Board of Licensure in Medicine. I affirm that a written Plan of Supervision addressing the technical requirements of supervision as set forth in Chapter 2, Section 6 of the Rules has been prepared and is available for inspection at the above named practice setting. I agree to notify the Board of Licensure in Medicine in writing no later than 14 days after the effective date of any change to or addition of a Primary Supervising Physician.

I hereby certify that to the best of my knowledge and belief the statements made in this application are true and correct.

______________________________________ ____________________________

Signature, Physician Assistant Date

____

Name Printed

PRIMARY SUPERVISING PHYSICIAN

I have read, fully understand, and accept the responsibilities and liability for the supervision of a Physician Assistant as described in 32 M.R.S.A. § 3270-A and § 3270-B and in the current Chapter 2 of the Rules of the Board of Licensure in Medicine. I affirm that a written Plan of Supervision addressing the technical requirements of supervision as set forth in Chapter 2, Section 5 of the Rules has been prepared and is available for inspection at the above named practice setting.
I hereby certify that to the best of my knowledge and belief the statements made in this application are true and correct.

______________________________________ ____________________________

Signature, Primary Supervising Physician Date

Maine Board of Licensure in Medicine

Physician Assistant License Renewal Application
FEE: $200.00

Fee: ________
Late: _______

161 Capitol St.
137 State House Station
Augusta, ME 04333-0137
Phone: 207-287-3601 Fax: 207-287-6590

Please remit fee with application by check/money order payable to "Maine Board of Licensure in Medicine".

Name: ________________________________ License No :_______________________________

Address: ______________________________

______________________________ Daytime Phone No: _________________________

______________________________ Email address: ____________________________

PERSONAL DATA UPDATE:

A. If the spelling of your name or date of birth, preprinted above, are not correct, please circle the error and legibly print the correct information.

B. The Board requires BOTH your HOME mailing address and phone number and the address and phone number of your PRINCIPAL PLACE OF MEDICAL PRACTICE. You may designate which of the two you wish to be used for mailings from the Board. **Unless you specify otherwise, your practice address will be the address circulated by the Board in listings and publications available to the general public, including the internet.**

I Prefer Board contact me at Home, or at Business. (H/B) ___

Home mailing address:

____
____
____
____

If your home address is incorrect, please correct here:

____
____
____

Telephone: ____

Practice mailing address:

____
____
____
____

If your practice address is incorrect, please correct here:

____
____
____

Telephone: ____

2. AFFIDAVIT OF APPLICANT:

I, ____, being duly sworn, depose and say that I am the person described and identified in this application.

I have carefully read the questions in this application and have answered them completely, without reservations of any kind, and declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension or revocation of my license to practice medicine and surgery in the state of Maine, or other discipline as the Board may determine.

I hereby authorize all hospitals, medical institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present) and all governmental agencies and instrumentalities (local, state, federal, and foreign) to release to this licensing Board any information, files or records required by the Board for its evaluation of any professional and ethical qualifications for licensure in the state of Maine. I hereby release any and all entities from responsibility regarding the information they release to the Board of Licensure in Medicine.

I hereby authorize the Board of Licensure in Medicine to transmit any information contained in the application, or information that may otherwise become available to them, to any agency, organization, hospital, or individual, who, in the judgment of the Board, has a legitimate interest in such information. I acknowledge my responsibility to notify the Maine Board of Licensure in Medicine of my subsequent change in my status from that reported here and, in particular, to notify the Board within 10 days of a change in my place of medical practice or residence.

P.A. Signature: ____

Date: ____

PROFESSIONAL HISTORY:

Circle each appropriate response. Every 'YES' response must be fully explained by a written statement on a separate 8.5"x 11" sheet of white paper. Each explanation must be referenced by question number, and must be signed, dated, and enclosed with your application.

NOTE TO PA/APPLICANT: PLEASE COMPLETE THIS FORM YOURSELF – DO NOT DELEGATE ITS COMPLETION.

HAVE YOU EVER:

YES NO

☐ ☐ 1. Had ANY licensing authority (INCLUDING MAINE) deny your application for any type of license, or take any disciplinary action against the license issued to you in that jurisdiction, including but not limited to warning, reprimand, fine, suspension, revocation, restrictions in permitted practice, or probation with or without monitoring?

☐ ☐ 2. Been notified of the existence of allegations involving you, filed with or by ANY licensing authority (INCLUDING MAINE), which allegations remain open as of the date of this application?

SINCE YOUR LAST RENEWAL APPLICATION:

YES NO

☐ ☐ 3. Have you left a medical licensing jurisdiction (INCLUDING MAINE) while a complaint or allegation was pending?

4. Have you been denied registration or had your ability to prescribe or dispense controlled substances modified, restricted (except by administrative rule or statute in a jurisdiction), suspended, revoked, or voluntarily suspended by -

☐ ☐ a) U. S. Drug Enforcement Administration (DEA)?

☐ ☐ b) Any state/territory of the U. S., INCLUDING MAINE?

☐ ☐ 5. Have you received a sanction from Medicare or from any state Medicaid program?

6. The purpose of the following questions is to determine the current fitness of the applicant to practice medicine. The following inquiries concern medical, mental health, and addiction issues. This information is treated confidentially by the Board.

The mere fact of treatment for medical, mental health or addiction(s) is not, in itself, a basis on which an applicant is ordinarily denied licensure when he/she has demonstrated personal responsibility and maturity in dealing with these issues. The Board encourages applicants who may benefit from such treatment to seek it.

The Board may deny a license to applicants whose ability to function in the practice of medicine or whose behavior, judgment, and understanding is impaired by a medical, mental health or addictive condition.

SINCE YOUR LAST RENEWAL APPLICATION:

YES NO

☐ ☐ a. Have you been diagnosed with or treated for a medical, mental health, or addictive condition which in any way currently limits or impairs your ability to practice medicine or to function as a physician assistant?

☐ ☐ b. Have you been diagnosed with or treated for any medical, mental health, or addictive disorder that impaired your behavior, judgment, understanding, or ability to function in school, work or other important life activities?

☐ ☐ c. Are you now, or have you been dependent upon alcohol or habituating drugs or undergone treatment for such?

☐ ☐ d. If any of your answers to questions 6(a-c) is "Yes," are the limitations or impairments caused by your medical, mental health, or addictive condition reduced or improved because you receive ongoing professional treatment (with or without medication) or because you participate in a professional monitoring program?

☐ ☐ e. Have you raised the issue of consumption of drugs or alcohol or the issue of a medical, mental health or addictive disorder as a defense or in mitigation of, or as an explanation for your actions in the course of any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination action (educational, employer, government agency, professional organization, or licensing authority)?

☐ ☐ f. Are you currently engaged in the illegal use of drugs or misuse of any drugs?

☐ ☐ g. Have you been diagnosed with or treated for any type of sexual behavior disorder?

SINCE YOUR LAST RENEWAL APPLICATION:

YES NO

☐ ☐ 7. Have you been charged, summonsed, indicted, arrested, or convicted of any criminal offense, including when those events have been deferred, set aside, dismissed, expunged or issued a stay of execution? Please include motor vehicle offenses but not minor traffic or parking violations.

☐ ☐ 8. Have you applied for hospital, HMO or other health care entity privileges which were denied?

☐ ☐ 9. Have you had your staff privileges or employment at any hospital, nursing home, HMO, or other health care entity terminated, revoked, reduced, restricted in any way, suspended, made subject to probation, limited in any way, or withdrawn involuntarily?

☐ ☐ 10. Have you voluntarily surrendered privileges or resigned from staff membership during peer review or investigation or to avoid peer review or investigation?

☐ ☐ 11. Have you been deselected from a managed care organization physician assistant panel?

☐ ☐ 12. Have you been disciplined by a professional society or resigned while an accusation was pending?

☐ ☐ 13. Have you been named as a party or a defendant, or as an employee of a party or a defendant, in a medical malpractice liability claim or lawsuit, including nuisance suits settled, adjudicated by a court in favor of the other party, or settled by your insurance company/representatives without your express consent?

☐ ☐ 14. Do you have any open malpractice claims?

☐ ☐ 15. Do you practice medicine within the State of Maine without active medical staff privileges at a Maine hospital?

☐ 16. I request to WITHDRAW my Maine license from registration. I acknowledge that reinstatement of this license is not possible after 5 years; however I may then apply anew for a Maine Physician Assistant license.
(In order to apply for withdrawal you must complete the entire form, and date, sign, and return it by the due date, omitting payment of the renewal application fee.)

CONTINUING MEDICAL EDUCATION REPORT

[Refer to Chapter 2, §13 of the Rules of the Maine Board of Licensure in Medicine for specific definitions. See ftp://ftp.maine.gov/pub/sos/cec/rcn/apa/02/373/373c002.doc]

For reporting CME credits earned during the previous 24 months.

The Board will allow up to 6 months to secure Category I credits from NCCPA. You must request the extension in writing with your renewal application.

The Board will routinely and regularly audit CME credits claimed. Failure to provide proof of CME credits claimed upon request by the Board may be ground for discipline. **Therefore, it is vitally important that you retain documentation of all CME claimed.**

All CME taken outside the United States or Canada and all audited reports with discrepancies will be referred to the Board's Licensure Committee for assessment.

CATEGORY I

Category I activities are those planned CME programs sponsored or co-sponsored by an organization or institution and that have been accredited by one or more of the following agencies: American Academy of Physician Assistants; the American Medical Association Council on Medical Education; the Accreditation Council for Continuing Medical Education, and/or the American Academy of Family Practice. At least forty (40) CME credits must be in Category 1.

Total Category I Credits Earned_________

CATEGORY II

Category II includes programs with non-accredited sponsorship, i.e., Medical Teaching, Papers, Books, Publications, and Exhibits. Also included are non-supervised individual CME activities and other meritorious learning experiences. Sixty (60) Category II credits are required unless more than 40 Category I credits are reported.

NOTE: Category I credits may be substituted for Category II credits.

Total Category II Credits Earned_________

Please note that 32MRSA, §3282-A,2,(A) states that ground for discipline includes the practice of fraud or deceit in obtaining a license.

AFFIDAVIT: I CERTIFY THAT THIS IS A TRUE AND CORRECT REPORT OF MY CME ACTIVITY.

Date: ____________________________ Physician Assistant Signature: ____

List all Registered Primary Supervising Physicians here.

Physician Assistant Name: **License No:**

Full Name of Primary Supervising Physician: ______________________________
Practice Name (i.e., Dept. or Service, Clinic, Group, etc.): ______________________________
Facility/Institution Name (if applicable): ______________________________
Street Address: ______________________________
Town, State: ______________________ Zip: ______________
Business Phone: ______________________ Extension: ______________

Practice specialty of Primary Supervising Physician
____
Setting:
- ☐ Solo Private Practice
- ☐ Group Practice
- ☐ Organized Health Care Delivery System

Full Name of Primary Supervising Physician: ______________________________
Practice Name (i.e., Dept. or Service, Clinic, Group, etc.): ______________________________
Facility/Institution Name (if applicable): ______________________________
Street Address: ______________________________
Town, State: ______________________ Zip: ______________
Business Phone: ______________________ Extension: ______________

Practice specialty of Primary Supervising Physician
____
Setting:
- ☐ Solo Private Practice
- ☐ Group Practice
- ☐ Organized Health Care Delivery System

Full Name of Primary Supervising Physician: ______________________________
Practice Name (i.e., Dept. or Service, Clinic, Group, etc.): ______________________________
Facility/Institution Name (if applicable): ______________________________
Street Address: ______________________________
Town, State: ______________________ Zip: ______________
Business Phone: ______________________ Extension: ______________

Practice specialty of Primary Supervising Physician
____
Setting:
- ☐ Solo Private Practice
- ☐ Group Practice
- ☐ Organized Health Care Delivery System

Full Name of Primary Supervising Physician: ______________________________
Practice Name (i.e., Dept. or Service, Clinic, Group, etc.): ______________________________
Facility/Institution Name (if applicable): ______________________________
Street Address: ______________________________
Town, State: ______________________ Zip: ______________
Business Phone: ______________________ Extension: ______________

Practice specialty of Primary Supervising Physician
____
Setting:
- ☐ Solo Private Practice
- ☐ Group Practice
- ☐ Organized Health Care Delivery System

Full Name of Primary Supervising Physician: ______________________________
Practice Name (i.e., Dept. or Service, Clinic, Group, etc.): ______________________________
Facility/Institution Name (if applicable): ______________________________
Street Address: ______________________________
Town, State: ______________________ Zip: ______________
Business Phone: ______________________ Extension: ______________

Practice specialty of Primary Supervising Physician
____
Setting:
- ☐ Solo Private Practice
- ☐ Group Practice
- ☐ Organized Health Care Delivery System