

STATE OF MAINE
BOARD OF LICENSURE IN MEDICINE
137 STATE HOUSE STATION
AUGUSTA, ME 04333-0137
(207) 287-3601
medicine.pfr@maine.gov

STATE OF MAINE
BOARD OF OSTEOPATHIC LICENSURE
142 STATE HOUSE STATION
AUGUSTA, ME 04333-0142
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REQUIREMENTS FOR PHYSICIAN ASSISTANT LICENSURE

TO BE CONSIDERED FOR LICENSURE IN THE STATE OF MAINE, AN APPLICANT MUST SATISFY THE FOLLOWING REQUIREMENTS:

1. Submit an administratively complete application on forms approved by the Board;
2. Pay the appropriate uniform licensure fee (\$200);
3. Have successfully completed an educational program for physician assistants accredited by the American Medical Association Committee on Allied Health Education and Accreditation, or the Commission for Accreditation of the Allied Health Education Programs, or their successors;
4. Have no license, certification or registration as a physician assistant, or any other type or classification of health care provider license, certification or registration under current discipline, revocation, suspension, restriction or probation;
5. Have no cause existing that may be considered grounds for disciplinary action or denial of licensure as provided by law;
6. Pass, at the time of license application, a jurisprudence examination administered by the Board; and
7. Have passed the NCCPA certification examination and holds a current certification issued by the NCCPA that has not been subject to disciplinary action by the NCCPA at the time the license application is acted upon by the Board.

INSTRUCTIONS FOR PERMANENT LICENSE APPLICATION

HOW TO APPLY

Before you complete this application, please review the [Requirements for Licensure](#). APPLICATION FEES ARE NOT REFUNDABLE. Incomplete applications or those received without the required fee or documents will not be processed. Applications will not be reviewed until all appropriate materials are received. Please type or print clearly in ink.

The following statement is made pursuant to the Privacy Act of 1974, Section 7(b):

Disclosure of your social security number is mandatory for tax administration purposes pursuant to 36 M.R.S. § 175 as authorized by 42 U.S.C. § 405 (c)(2)(c)(i).

Disclosure of your social security number is mandatory for purposes of enforcement of child support orders pursuant to 10 M.R.S. § 8003(4-A) and as authorized by 42 U.S.C. § 405 (c)(2)(c)(ii).

Disclosure of your social security number will occur in accordance with National Practitioner Data Bank reporting requirements pursuant to 45 C.F.R. §§ 60.8, 60.9.

Any other disclosure of your social security number shall be as permitted by applicable law.

Procedures:

1. Board Application:

- (a) Complete Sections 1 through 8 of the State of Maine Uniform Application for Physician Assistant Licensure. You must respond to all components of the application as instructed.
- (b) The Board requires BOTH your HOME mailing address and phone number, and the address and phone number of the PRINCIPAL LOCATION WHERE YOU WILL BE RENDERING MEDICAL SERVICES. You may designate which of the two addresses you wish to be used to receive mailings from the Board (by checking the “contact at” box). If you fail to designate a contact address for mailings, all correspondence from the Board will be sent to your home address. Unless you specify otherwise, your business address will be the address circulated by the Board in listings and publications available to the general public, including the Internet. If you currently have no business address and you do not wish for your home address to be on the Internet, you must provide an alternate address, such as a Post Office box, or a mail drop. **If, subsequent to this application, your home or business contact information changes, you must immediately notify the Board. Immediately upon beginning to render medical services in Maine, you must provide the Board with your primary business address and phone number.**
- (c) **Complete Section 8, Affidavit of Applicant, in the presence of a Notary Public. The Notarial seal must cover a portion of the photograph, and the photo must fit within the box.**
- (d) Provide complete addresses in Section 6. Failure to do so will delay licensure.

2. Necessary Additional Documents

- (a) Copy of Diploma with original Notary signature
- (b) Original Transcript
- (c) Up to date curriculum vitae (education and work history)
- (d) Self-query NPDB Report - • Visit <https://www.npdb.hrsa.gov/ext/selfquery/SQHome.jsp> and begin the process for the self-query. Follow all instructions provided. After your self-query has been processed, a report will be e-mailed directly to you, followed by an original via US Mail. Please check the report to be sure the results were not rejected and that all information is correct. If the information is correct, you may forward the e-mail to the appropriate Board office at the email address above. You may forward the original sent via US Mail to the Board or retain it. Should you have any questions or need assistance, please call the NPDB directly at 800/767-6732 or via e-mail at help@npdb.hrsa.gov .

(e) \$200 Application Fee

3. Malpractice Claims:

Your insurance carrier or attorney must provide an independent detailed explanation of all malpractice claims. This information must be received directly from the insurance company or attorney. This information is in addition to your personal explanation.

Application form items 19 & 20, regarding professional (malpractice) liability claims experience, are the questions most likely to generate follow-up letters from the Board staff and delay your licensure if not answered completely. Report all claims of which you have been noticed, as well as all claims from which you were dismissed as a defendant or for which your insurance company made a settlement of any kind with the plaintiff, or any claim for which a court found you liable in any degree. A reporting form is provided. Claims against a professional corporation are considered a claim against the individual licensee who provided the professional services in dispute. To be complete, your supplemental explanation must include, for each such claim reported, a full description using the Professional (Malpractice) Liability Claims Experience Form. See the following fictitious example:

Identity of Case: Burns v. John B. Doe, MD, Samuel E. Smith, MD, Topeka Woman's Hospital, Inc. et al.; Kansas Third Circuit Court, Topeka, Case #89-10203

Date/Place of Original Occurrence: June 4, 1990, Topeka Woman's Hospital

Malpractice Alleged by Claimant: Delayed diagnosis of ectopic pregnancy.

Summary of my Defense: I was a PGY II resident at the time. Dr. Samuel E. Smith, Chief of Obstetrics, Topeka

Woman's Hospital was attending physician in this case. I was named in the claim because my name appears in the chart

as the physician ordering ultrasonography on first hospital day.

Current Status of Case: Although a motion to dismiss me as a defendant is pending, my insurance company has offered a settlement on my behalf of \$15,000.00 on February 14, 1992. I have been told the plaintiff rejected this and the claim is still pending.

Name and Address of Insurance Company/Attorney Defending Case: Great Plains Physicians' Mutual Indemnity, Attn:

Jim Brown, Claims Manager, 4321 Ketcham Blvd., Rock Springs, SD 79104. I am also represented by William B.

Eagle, Eagle, Hare, P.A., 44 West River Drive, Suite 200, Topeka, KS 60301.

4. Submitting the Board Application:

- (a) Application and Registration Fee: Attach a check or postal money order in the amount of \$200.00 (payable to the appropriate Board) to the front of your application. **The application fee is non-refundable.**

(b) Mail your application, fee and supporting materials (if applicable) directly to the appropriate Board

5. Complete the jurisprudence examination. Instructions will be provided once your application is received.

OTHER IMPORTANT INFORMATION

1. We find that it takes on average **90** days to receive responses to all of the inquiries requested in order to have a completed application packet.
2. State Examination covering Maine law and Board rules and regulations (Jurisprudence Exam).

All applicants are required to complete a written examination, which is an open book exam. Instructions will be provided once your application is received.

3. Renewal date (License and Registration*).

The renewal date of your license and registration is determined by your date of birth. As a result, your first license and registration will typically not be for a full period of 2 years (depending on the timing of your application).

4. Time Expectations.

The process of verifying your credentials and qualifications takes an average of 90 days. Your Board application, scored written exam, and supporting documentation will be presented for review when deemed administratively complete. The Board usually meets every month to consider license applications.

*** A Registration of a supervising physician is NOT required for licensure only. However, a registration is required prior to rendering of any medical services in the State of Maine.**

PLEASE NOTE

Mandated Reporter Requirements for Suspected Child Abuse

Maine law requires that physicians immediately report or cause a report to be made to the Maine Department of Health and Human Services (DHHS) when the physician assistant knows or has reasonable cause to suspect that a child has been or is likely to be abused or neglected or that a suspicious child death has occurred. **In addition, if a child is under 6 months of age or otherwise non-ambulatory, Maine law requires physicians assistants to immediately report to DHHS if that child exhibits evidence of the following: fracture of a bone; substantial bruising or multiple bruises; subdural hematoma; burns; poisoning; or injury resulting in substantial bleeding, soft tissue swelling or impairment of an organ, except that the reporting of injuries occurring as a result of the delivery of a child attended by a licensed medical practitioner or the reporting of burns or other injuries occurring as a result of medical treatment following the delivery of the child when the child remains hospitalized following the delivery is not required.** Please refer to 22 M.R.S. § 4011-A for all reporting requirements.

Mandated Reporter Training and additional information regarding mandated reporting can be found at:

<http://www.maine.gov/dhhs/ocfs/cps/>

Maine Prescription Monitoring Program (PMP)

As of August 1, 2014, Maine law requires all Allopathic Physicians, Osteopathic Physicians, Dentists, Physician Assistants, Podiatrists, and Advanced Practice Registered Nurses who are licensed to prescribe scheduled medications to register with the Prescription Monitoring Program (PMP). To register, please go to the Prescription Monitoring Program website: <http://www.maine.gov/pmp> Download, complete and sign a registration form located within the yellow box. You may mail, scan and email or fax a signed form to the information located on the form. Please note there are two types of registration forms available, 1) Data Requester form for active prescribers with a DEA number and, 2) Sub-Account form for assistants/non-prescribing health professionals.

As of January 1, 2017, upon initial prescription of a benzodiazepine or an opioid medication to a person and every 90 days for as long as that prescription is renewed, a prescriber shall check prescription monitoring information for records related to that person.

More PMP information is available at:

<http://www.maine.gov/dhhs/samhs/osa/data/pmp/prescriber.htm> **Prescribers should make regular use of the PMP**

Maximum Opioid Medication Limits

As of July 29, 2016, an individual may not prescribe to a patient any combination of opioid medication in an aggregate amount in excess of 100 morphine milligram equivalents of opioid medication per day unless the patient meets certain exceptions. For more information, visit the Boards' websites.

Your application is a public record for the purposes of the Maine Freedom of Access Law (1 MRS section 401 et seq.). Public records must be made available to any person upon request. The application for licensure is a public record and information supplied as part of the application, other than those items exempted by law such as social security number and credit card information, is public information.

Section 3. NCCPA Qualifying Exam

Certificate #: _____ Date: _____ Location: _____

*if you are scheduled to sit for the examination, please provide proof of the date you will be taking the examination.

Have you ever taken the exam and failed? YES NO Dates: _____

Section 4. License History

State	License Number	Issue Date	Expiration Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Section 5. Professional Work Experience

List in chronological order all professional work experience since your graduation from a PA program. Include all periods of time from the date of graduation whether or not engaged in activities related to your profession as a physician assistant. Please include month and year. If you graduated from a PA program more than 10 years prior to this application, please only include your professional work experience for the 10 years immediately preceding this application.

From/to (Month/Year)	Name & Address of Institution Place of Practice or Other	Degree/Certificate Nature of Experience
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Section 6. References

Please furnish the names and addresses of two persons under whose supervision you have worked as a Physician Assistant during the most recent periods of employment (or preceptors, if you are applying as a new graduate from a PA program) . These references will be contacted for a professional assessment.

Name: _____ Title: _____

Address:

Name: _____ Title: _____

Address:

Section 7. Personal Data

Check off (X) 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 such explanation must be cross-referenced with the question number, and must be signed, dated, and enclosed with your application.**

YES NO

1. Have you EVER 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, probation with or without monitoring?
2. Have you EVER agreed with any licensing authority to voluntarily follow practice limitations, restrictions, guidelines, to make reports or to complete specific continuing education or course work?
3. Have you EVER been notified of the existence of allegations, investigations and/or complaints involving you, filed with or by ANY licensing authority (INCLUDING MAINE), which allegations, investigations and/or complaints remain open as of the date of this application?
4. Have you EVER left a medical licensing jurisdiction (INCLUDING MAINE) while a complaint, investigation or allegation was pending?
5. Have you EVER been denied registration, or had your ability to prescribe or dispense controlled substances modified, restricted, suspended, revoked, or voluntarily suspended by, or surrendered to:
- a) The U. S. Drug Enforcement Administration (US DEA)?

YES NO

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

6. Has there EVER been a finding by any state or federal court or governmental agency that you violated any rule or law regulating the practice of health care?

7. Has there EVER been a finding against you in any inquiry, investigation, or administrative or judicial proceeding by an employer, educational institution, professional organization, or licensing authority, or in connection with an employment disciplinary or termination procedure?

8. Have you EVER received a sanction or entered into any settlement agreement or integrity agreement related to Medicare, TRICARE or any state Medicaid program?

9. The purpose of the following questions is to determine the current fitness of the applicant to render medical services. The following inquiries concern medical, mental health, and substance misuse issues. This information is treated confidentially by the Board. The mere fact of treatment for medical, mental health or substance misuse 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 substance misuse or a medical or mental health condition.

a. Do you have a mental or physical condition that currently impairs your ability to safely and competently render medical services?

b. Within the last five (5) years have you been diagnosed with or treated for any medical or mental health disorder that impaired your behavior, judgment, understanding, or ability to function in school, work or other important life activities?

c. Do you currently use any chemical substance(s), including alcohol, which in any way impairs or limits your ability to practice your profession with reasonable skill and safety?

If any of your answers to questions 9(a-c) is “Yes,” are the limitations or impairments caused by your medical, mental health, or substance misuse condition reduced or improved because you receive ongoing professional treatment (with or without medication) or because you participate in a professional monitoring program? Current voluntary participation in the Medical Professionals Health Program or similar program will be kept confidential.

d. Are you currently engaged in the illegal use of illicit drugs or prescription drugs that have not been prescribed to you pursuant to a legitimate healthcare provider-patient relationship? “Legitimate” means “Being in compliance with the law or in accordance with established and accepted standards.”

e. Have you EVER used illegal drugs or prescription drugs that have not been prescribed to you pursuant to a legitimate healthcare provider-patient relationship?

YES NO

- f. Have you ever obtained illegal drugs or prescription drugs that were not prescribed to you pursuant to a legitimate healthcare provider-patient relationship?
- g. Have you EVER furnished or provided illegal drugs to anyone other than medical marijuana per applicable state law?
- h. Have you EVER furnished prescription drugs to or written a prescription for anyone without having a legitimate physician assistant-patient relationship (This includes conduct for which you may NOT have been adjudicated in any civil, administrative or criminal proceeding)?
- i. Have you EVER been found in any civil, administrative or criminal proceeding to have:
- Possessed, used, prescribed for use, or distributed any drugs in any way other than for legitimate or therapeutic purposes?
- Diverted any drugs?
- Violated any drug law?
- Prescribed any controlled substances for yourself or family/household members?
- j. Within the last five (5) years have you EVER raised the issue of consumption of drugs or alcohol or the issue of a medical, mental health or substance misuse 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)?
10. Have you EVER 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 such as Operating Under the Influence, but not minor traffic or parking violations.
11. Have you EVER applied for hospital, HMO or other health care entity privileges which were denied?
12. Have you EVER had your staff privileges or employment at any hospital, long term care facility, 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?
13. Have you EVER voluntarily surrendered privileges or resigned from staff membership during peer review or investigation or to avoid peer review or investigation?
14. Have you EVER resigned from employment in lieu of termination or while under investigation?

YES NO

15. Have you EVER been terminated or suspended from any employment?
16. Have you EVER been deselected from a managed care organization panel?
17. Have you EVER been disciplined by a professional society or resigned while an accusation was pending?
18. Have you EVER endangered the safety of others, breached fiduciary obligations, or violated workplace conduct rules?
19. Have you EVER been named in any medical malpractice liability claim or lawsuit adjudicated by a court in favor of the other party, or settled by you or your insurance company/representatives with or without your express consent?
20. Do you have any open/pending malpractice claims?
21. Do you intend to render medical services within the State of Maine without active medical staff privileges at a Maine hospital?
22. Do you plan to practice telemedicine in Maine? If so, please provide a short description of your plan to practice with Maine Patients, including your practice protocols, your physical practice location, your publicly available telemedicine website portal, and whether you will be combining in-person medical practice with telemedicine.
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Section 8. Affidavit

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 render medical services and surgery in the state of Maine, or other discipline as the Board may determine. I hereby affirm that if any of the answers to any of the foregoing questions changes after this application is filed and before a license is issued that I shall immediately contact the Board and update the information.

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 or the Board of Osteopathic Licensure.

I hereby authorize the Board of Licensure in Medicine or the Board of Osteopathic Licensure 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.

Signature of Applicant

Date

Signature of Notary

Attach Current
Passport-Type Photo

Here

Notary Commission Expires:

Notary's
Seal

1) APPLICANTS MUST SIGN THEIR FULL NAME IN THE PRESENCE OF A NOTARY PUBLIC.

Professional (Malpractice) Liability Claims Experience

Duplicate For Multiple Claims

My Name:

Identity of Case:

Date and Place of Original Occurrence:

Malpractice Alleged By Claimant:

Summary of My Defense:

Current Status of Case (Include payment amount):

Name and Address of Insurance Company and/or Attorney Defending the Case:
