



**Alaska State Medical Board**  
PO Box 110806, Juneau, AK 99811  
Phone: (907) 465-2550  
Email: [MedicalBoard@Alaska.Gov](mailto:MedicalBoard@Alaska.Gov)  
Website: [ProfessionalLicense.Alaska.Gov/StateMedicalBoard](http://ProfessionalLicense.Alaska.Gov/StateMedicalBoard)

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## Physician Assistant (PA) License Application Instructions

### PHYSICIAN ASSISTANT – CERTIFIED

To practice as a Physician Assistant - Certified, or to use the title, a person must be licensed under regulation 12 AAC 40.400 and authorized to practice under 12 AAC 40.408 by the State Medical Board. An approved Collaborative Plan must be on file with the State Medical Board in order to be authorized to practice.

***The following must be received by the division before your application for Physician Assistant Certified can be reviewed:***

#### 1. APPLICATION

A completed application, signed and notarized (#08-4226, pages 1-8).

#### 2. FEES

Fees made payable to "State of Alaska" in accordance with 12 AAC 02.250.

Nonrefundable Application Fee:	\$200.00
Permanent License Fee:	\$150.00
<hr/>	
Total Fees Due:	\$350.00

#### 3. AUTHORIZATION FOR RELEASE OF RECORDS

A completed Authorization for Release of Records form (#08-4226a).

#### 4. NCCPA CERTIFICATE

A certified true copy of current certification by the National Commission on Certification of Physician Assistants.

#### 5. VERIFICATION OF LICENSURE

Verification of Licensure sent directly from all licensing jurisdictions where the applicant holds or has ever held a license as any health care professional (e.g., physician assistant, nurse, MICP, dentist, optometrist, etc.).

#### 6. VERIFICATION OF PHYSICIAN ASSISTANT PROGRAM EDUCATION

A completed Verification of Physician Assistant Program Education form (#08-4226c).

#### 7. CLEARANCE REPORT - FSMB

Division staff will download a clearance report on your behalf from the Federation of State Medical Boards.

#### 8. COLLABORATIVE PLAN

An approved plan of collaboration with a physician licensed to practice in the State of Alaska (#08-4892).

***A certified true copy of your current NCCPA certificate must be maintained in your license file at all times, as well as a current copy of your DEA registration. Without these documents, you are not in compliance with regulations and may not practice.***

## PHYSICIAN ASSISTANT – GRADUATE

The graduate permit is valid only until the board receives notice that the applicant either failed to take or failed to pass the NCCPA examination.

**The following must be received by the division before your application for Physician Assistant Graduate can be reviewed:**

### 1. APPLICATION

A completed application, signed and notarized (#08-4226, pages 1-8).

### 2. FEES

Fees made payable to “State of Alaska” in accordance with 12 AAC 02.250.

Nonrefundable Application and License Fee:	\$100.00
<hr/> Total Fees Due:	\$100.00

### 3. AUTHORIZATION FOR RELEASE OF RECORDS

A completed Authorization for Release of Records form (#08-4226a).

### 4. VERIFICATION OF PHYSICIAN ASSISTANT PROGRAM EDUCATION

A completed Verification of Physician Assistant Program Education form (#08-4226c).

### 5. NCCPA ACCEPTANCE

Proof of having been accepted to sit for the NCCPA examination.

### 6. COLLABORATIVE PLAN

An approved plan of collaboration with a physician licensed to practice in the State of Alaska (#08-4892).

It is the responsibility of the Physician Assistant - Graduate to notify the board immediately upon receiving examination results. The graduate permit is valid only until the board receives notice that the applicant either failed to take or failed to pass the NCCPA examination.

A Physician Assistant - Graduate must be provided with continuous on-site supervision by either a licensed Physician Assistant - Certified or by a physician licensed to practice in Alaska. A Physician Assistant - Graduate may not prescribe controlled substances.

All applications must be accompanied by the appropriate fees. Personal checks, cashier’s checks, or money orders must be made payable to the State of Alaska. Incorrect fees will delay processing of your application.

### APPLICATION STATUS UPDATES

Our licensing examiner will send you a written status update upon the initial screening of the application.

### COMPLETION OF THE APPLICATION FORMS

Help us do a good job processing your application: type or print legibly all application documents. Please read the instructions and give careful thought before answering the questions in the application - remember - you are certifying that the information is truthful and correct. Make sure all notary seals are properly affixed on the application and all documentation has been properly certified as required. Provide all documents requested in the application; incomplete applications will delay processing.

**Failure to answer all questions completely and accurately, or the omission or falsification of information may be cause for denial of your application or disciplinary action if you are issued a license or permit by the board.**

**WHEN IN DOUBT, DISCLOSE ALL INFORMATION OR CALL OUR OFFICE.**

### CONFIDENTIALITY

The contents of licensing files are generally considered public records, unless required to be kept confidential by state or federal law.

### DENIAL OF LICENSE

The denial of an application for licensure may be reported to any person, professional licensing board, federal, state, or local government agency, or other entity making a relevant inquiry or as may be required by law.

### LICENSE APPLICATION PROCESSING STAFF

Please visit our website to find the contact information for your Licensing Examiner:  
*ProfessionalLicense.Alaska.Gov/StateMedicalBoard* or call (907)465-2550.

### LICENSING PROCESS

Submit your complete application to the board with fees and pertinent documents. The licensing examiner assembles the documents for your file and advises the applicant of the application status. Upon the completion of the application file when all documents have been received from other organizations, the file is forwarded to the board’s administrator who reviews the entire file. At the discretion of the administrator, a permit may be issued.

Applications will be processed in the order in which they are received in the board's office. Please ensure that you apply well in advance of your need for the permit or license. Board staff will not expedite one application before another.

#### **LICENSE RENEWAL**

All medical board licenses in Alaska are on a two-year cycle, with all licenses expiring December 31 of even-numbered years. One renewal notice will be sent via email or mail at least 30 days before license expiration to the last known email or mailing address of record, usually in late October. You are required by law to keep your current address on file with the division (12 AAC 02.900).

Failure to receive a renewal notice is not considered an excuse for non-renewal. A physician assistant not intending to practice medicine in Alaska may renew their license in an inactive status. If you practice in the state occasionally, you must renew your license in active status. An inactive status license prohibits you from practicing; however, if you wish to reactivate your inactive license, contact the licensing examiner for instructions. It is illegal to practice medicine in Alaska with an inactive or lapsed license or permit.

If a physician assistant does not have a current collaborative plan in place, they may still renew their license as active but not authorized to practice. At a later date, when the physician assistant enters into a new collaborative plan, the active license remains in place.

#### **OPIOID EDUCATION**

Attestation of opioid education related to pain management, opioid use and addiction is required to qualify for a new license in the State of Alaska, unless you do not hold a valid DEA registration. You must document compliance with the opioid education requirement on your application.

#### **PAYMENT OF CHILD SUPPORT**

If the Alaska Child Support Enforcement Division has determined that you are in arrears on child support, you may be issued a nonrenewable temporary license valid for 150 days. Contact Child Support Services at (907)269-6900 to resolve payment issues.

#### **PERFORMANCE ASSESSMENTS**

Regulation 12 AAC 40.430 specifies the nature and frequency of performance assessments to be conducted by collaborating physicians with their physician assistants. Please review that regulation and its requirements. Copies of the statute and regulations may be obtained from the Division of Corporations, Business, and Professional Licensing or from our website.

#### **PERSONAL INTERVIEWS**

Applicants for medical licensure in Alaska may be required to have a personal interview either with an individual board member or with the full board. Should an interview be required, you will be notified and an interview scheduled. An interview may be required if, during the processing of your application, a question arises for which the board determines it requires additional information from you.

#### **PLANS OF COLLABORATION**

Collaborative plans must be on file with the board no later than 14 days following the effective date (beginning date of employment) of the plan. Both the physician assistant and the collaborating physician must retain copies of their active collaborative plans for their records. There must be at least one alternate collaborating physician on each plan. Plans must also be maintained at the practice location and available for public scrutiny.

#### **PRACTICE REGULATIONS**

It is the responsibility of the Physician Assistant - Certified to learn the governing regulations under which they must practice. Copies of the statute and regulations may be obtained from the Division of Corporations, Business, and Professional Licensing.

#### **PRACTICING IN ALASKA**

For information on physician assistant practice opportunities, you may wish to contact:

Alaska Academy of Physician Assistants  
4450 Cordova Street – Suite 110, Anchorage, AK 99503  
Office Phone (800)478-8684 or 907/646-0588  
Fax Phone (907)562-8641  
Email: [info@akapa.org](mailto:info@akapa.org)

#### **PRESCRIPTION DRUG MONITORING PROGRAM (PDMP)**

A licensee may not prescribe or dispense a controlled substance until registration with the PDMP is complete. All actively licensed practitioners with a DEA registration number valid in any state or practice location must register with the Alaska Prescription Drug Monitoring Program (PDMP) within 30 days of initial licensure and use the PDMP to review a patient's prescription history each time before prescribing, administering, or dispensing a federally scheduled II or III controlled substance. For more information, please visit [PDMP.Alaska.Gov](http://PDMP.Alaska.Gov)

#### **PROCESSING TIME**

In general, average processing time for a temporary physician assistant permit is six to eight weeks. Full licensure can take twelve to fourteen weeks or longer. PLEASE PLAN ACCORDINGLY. Application processing time depends to a large extent on the response time from other organizations. Time required also depends upon our workload and the volume of applications being processed. Because the length of processing time for your application may vary considerably, we urge you to be patient until our processing is complete and the permit is issued.

If there are any “yes” responses or if adverse information is received, it will typically take longer to gather and evaluate additional data. If the application is referred to the Investigations Unit for investigation of a particular issue, processing time is extended by the time required to complete an investigation. Since investigations must be prioritized, it may take longer to complete the file.

#### **SOCIAL SECURITY REQUIREMENT**

Alaska Statute 08.01.060(b) requires an applicant for an occupational license to provide a United States social security number. Applicants who are foreign citizens and are unable to obtain a social security number must contact the division office for instructions. Social security numbers are required by federal law to be held confidential; we do not release these numbers to the public.

#### **STALE DOCUMENTS**

If during the license application process certain documents become older than twelve months from the date the document was received in our office, that document is considered to be stale and must be resubmitted. Affected documents include the application document, verifications of licensure from other licensing jurisdictions, the DEA clearance report and the FSMB Board Action Data Bank report.

#### **TEMPORARY PERMIT**

Upon receipt of your initial application with payment and minimum required documents\*, your application will be forwarded to a supervisor for review and approval for a temporary permit. The temporary permit allows you to practice until your application is considered complete and eligible to be reviewed for full licensure.

During the six-month period of your temporary permit, the licensee is responsible for ensuring any remaining outstanding documents needed to complete the application are submitted to the division.

\*List of minimally required documents needed to issue a temporary permit include: a) Complete license application form & licensing fee; b) NCCPA Certification / Notification of SPEX Exam Eligibility (PA Graduates); c) Release of Information form.

#### **LICENSE VERIFICATION**

Your application must include primary source verification of license from every jurisdiction where you have held a license. Please work with each jurisdiction to ensure a primary source verification of license including any disciplinary actions is sent directly to the Alaska Medical Board. Many state boards offer primary source verification directly from their websites which you may download and forward to: [medicalboard@alaska.gov](mailto:medicalboard@alaska.gov). You may also wish to utilize the services of Veridoc, Inc. for the purpose of expediting your verifications of licensure from other states to the Alaska board for your application. To use this system, log on to their website at [www.veridoc.org](http://www.veridoc.org) for more information.

#### **WEBSITE ADDRESS**

The Division of Corporations, Business and Professional Licensing maintains a website where you may check to see if your license or permit has been issued. The address is *ProfessionalLicense.Alaska.Gov*

The medical board's website is *ProfessionalLicense.Alaska.Gov/StateMedicalBoard*

#### **WITHDRAWAL OF APPLICATIONS**

The board permits the withdrawal of an application that it has not yet considered at a board meeting. Should you wish to withdraw your application, please submit a request for withdrawal in writing stating the reason for the withdrawal. Such requests must be received before the first time the board reviews and considers the application. All withdrawals are reported to the Federation of State Medical Boards stating the reason for the withdrawal.

#### **PROFESSIONAL FITNESS QUESTIONS**

A “yes” response in the application does not mean your application will be denied. If you have responded “yes” to any question in the application, additional time will be required for the gathering and assessment of pertinent information. You can expedite this process by providing with your application complete explanations and documentation for any “yes” responses.

#### **HOW CAN YOU HELP?**

1. First and foremost: apply far enough in advance to allow for application processing.
2. If you are concerned about your application being received in our office, mail it Certified - Return Receipt.
3. Ensure the application is complete when you submit it and provide any necessary explanations with the application. Print legibly or type your application.
4. Provide complete explanations for any “yes” responses. It saves time if we don't have to contact you and request such information.
5. Provide a brief description for any malpractice claims describing the allegation, the nature of the case, your level of involvement, and the resolution of the case.

**WHEN IN DOUBT, DISCLOSE AND EXPLAIN.**



THE STATE  
of **ALASKA**

Department of Commerce, Community, and Economic Development  
Division of Corporations, Business and Professional Licensing

**MED**

FOR DIVISION USE ONLY

**Alaska State Medical Board**  
PO Box 110806, Juneau, AK 99811  
Website: [ProfessionalLicense.Alaska.Gov/StateMedicalBoard](http://ProfessionalLicense.Alaska.Gov/StateMedicalBoard)

## Physician Assistant License Application

### PART I Payment of Fees

Required Fees:	<input type="checkbox"/> PA – <b>Certified</b> : Application and License Fee (\$200 is Non-Refundable)	<b>\$350.00</b>
	-or-	
	<input type="checkbox"/> PA – <b>Graduate</b> : Application and License Fee (\$100 is Non-Refundable)	<b>\$100.00</b>

### PART II Personal Information

Full Legal Name:			
Provide all other names used (maiden, nicknames, aliases). If any documentation will be received in a prior name, you must provide a certified true copy of the documentation showing proof of legal name change(s).			
<input type="checkbox"/> Not Applicable			
<input type="checkbox"/> Other Names Used: _____			
Residence Address:	Street	City	State Zip
Practice Address:	Street	City	State Zip
Which address do you want to use for your mailing address and for the public record?			<input type="checkbox"/> Residence Address <input type="checkbox"/> Practice Address
Contact Phone:		Date of Birth:	
Place of Birth:		Gender:	
<b>EMAIL AGREEMENT:</b> By choosing to receive correspondence on any matter affecting my license or other business with the Alaska Division of Corporations, Business and Professional Licensing, I agree to maintain an accurate email address through the MY LICENSE web page. I understand that failure to check my email account or to keep the email address in good standing may result in an inability to receive crucial information, potentially resulting in my inability to obtain or maintain licensure.			
Email Address:		Select One:	<input type="checkbox"/> Send my Correspondence Electronically <input type="checkbox"/> Send my Correspondence by Mail
<i>Note: If both boxes are selected above, you will receive correspondence electronically.</i>			
<b>SOCIAL SECURITY NUMBER:</b> AS 08.01.060 requires you to provide your United States Social Security Number. It is considered confidential information and will not be publicly disclosed; it may be used to verify inter-state licensure.			

**PART III Alaska License or Permit**

Complete the following if you have previously held a license or permit in Alaska.

<b>Previous License or Permit Type:</b>			
<b>Previous AK License or Permit Number:</b>		<b>Date Issued:</b>	

**PART IV Physician Assistant Education Information**

Identify the physician assistant program you completed. If you attended more than one program, list all.

<b>Name of Institution</b>	<b>Location (City, State)</b>	<b>Degree/Certificate Awarded</b>	<b>Date Awarded</b>

**PART V Additional Education**

Other than as a physician assistant, have you attended or completed any other education for any of the professions in the healing arts?

Yes  No

<b>Name of Institution</b>	<b>Location (City, State)</b>	<b>Degree/Certificate Awarded</b>	<b>Date Awarded</b>

**PART VI Opioid Education**

- I have received education in pain management, opioid use, and addiction. Upon renewal of my Alaska license, I will provide a Certificate of Completion that confirms at least two hours of credit covering all three areas of the required subject matter: pain management, opioid use, addiction.
- I request a waiver of the requirement for two hours of education in pain management, opioid use, and addiction until I apply for a DEA registration number.

**PART VII Military Service**

Have you ever been in the armed forces?

Yes  No

<b>Branch of Service:</b>		<b>Date of Commission:</b>	
<b>Location(s) Where You Served:</b>			
<b>Type of Discharge:</b>		<b>Date of Discharge:</b>	

## PART VIII DEA Registration and PDMP Acknowledgment

### 1. Providers with a DEA registration number valid to use in any state or practice location must register with the PDMP.

Do you have a DEA Registration number?

- a. **NO**, I do not have an active DEA registration number valid to use in any state or practice location. I understand if I obtain a DEA registration number, I must register with the Alaska PDMP within 30 days as required by the board. I will comply with mandatory use and refer to all applicable authorizing statutes and regulations. (Skip to Part IX)
- b. **YES**, I have an active DEA registration number valid to use in any state or practice location. I understand I must register with the Alaska PDMP within 30 days of receiving this license, as required by the board, and will comply with mandatory use as required by AS 17.30.200 and 12 AAC 40.967.
- I acknowledge I must review a patient's prescription history prior to prescribing, administering, or dispensing a federally scheduled II or III controlled substance. I understand that I must also review the patient's history once every 30 days for up to 90 days, and at least once every three months if treatment continues for more than 90 days.

If I have a change in DEA registration number or status, I also understand I must promptly submit the DEA Registration Status Change Form (#08-4763).

**If you're unsure of the DEA issue date, indicate January 1st of the estimated year.**

DEA Registration Number:		Issue Date:		Expiration Date:	
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### 2. Providers who directly dispense a federally scheduled II - IV controlled substance are required to report daily. Do you plan to directly dispense? Directly dispense means you deliver the substance directly to the user. Writing a prescription for a patient to fill at a pharmacy is NOT direct dispensing.

*Reporting does not apply to you if you directly dispense an outpatient supply of 24-hours or less in practice locations exempt under AS 17.30.200(t). Exempted facilities include health care facilities (defined in AS 18.07.111 or AS 18.20.499), correctional facilities, inpatient pharmacies, and emergency departments.*

*Per AS 11.71.900(8) "dispense" means to deliver a controlled substance to an ultimate user or research subject by or under the lawful order of a practitioner, including the prescribing, administering, packaging, labeling, or compounding necessary to prepare the substance for that delivery; "dispenser" means a practitioner who dispenses.*

- a. **YES**, I plan to directly dispense and acknowledge I must report daily per AS 17.30.200 and 12 AAC 52.865.
- b. **NO**, I do not plan to directly dispense and acknowledge that if I begin directly dispensing, I must report daily. (If you are not directly dispensing, the reporting criteria do not apply to you.)

## PART IX Professional License(s)

List all states, territories, provinces, or foreign countries in which you currently are or have ever been licensed as any health care professional. Include instructional and training permits.

State or Jurisdiction	License Number	Issue Date	License Status (Active, Lapsed)

**PART X Work History**

Provide a chronological listing of all medical and non-medical activities beginning with your graduation from high school or college, if appropriate, to the present date with no more than a 60-day gap in time. If necessary, make additional copies of this page, or continue to list your work history on a separate sheet labeled with your name and signed by you.

**Explain any gap in time of more than sixty (60) days duration.**

Start Date	End Date	Facility / Location	Activity

**PART XI Medical Malpractice History**

Have you ever had any claims of malpractice filed against you?  Yes  No

If “yes,” you must provide an explanation and support document for each case. Use the Medical Malpractice History Explanation Form (#08-4869) appended to this application.



## PART XII Professional Fitness Questions – Disciplinary History

The following questions must be answered. “Yes” answers may not automatically result in license denial.

**For each “yes” response to any question, you must provide an explanation and documentation.** Use the letter of explanation form (#08-4752) appended to this application; include full details, dates, locations, type of action, organizations or parties involved, and specific circumstances. A separate letter of explanation form must be provided for each “yes” answer documented below. Documentation includes copies of court orders, charging documents, board, or license actions, etc.

The contents of licensing files are generally considered public records, unless required to be kept confidential by state or federal law.

For the purposes of this application, the word “discipline” is used. There are many forms of disciplinary actions that may be imposed by organizations, schools, programs, licensing authorities, and other agencies. Such disciplinary actions may include but not be limited to: Suspension, Surrender, Revocation, Probation, Academic Probation, Reprimand, Censure, Restricted License, Limited License, Conditioned License, or Letters of Counseling, Concern, Advice, Warning, Caution, Admonishment, Reprimand, etc. You must include non-reported disciplinary actions. Failure to disclose past history may be grounds for disciplinary sanctions.

### When in doubt, disclose and explain.

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| <b>1.</b> Have you ever been convicted of a crime (felony or misdemeanor) in any jurisdiction of the United States, including military, or any international jurisdiction?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Is any such action pending?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>2.</b> Have you ever been charged with a crime (felony or misdemeanor) in any jurisdiction of the United States, including military, or any international jurisdiction that did not result in acquittal or dismissal?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Is any such action pending?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>3.</b> Relating to the practice of medicine, has there ever been a finding of, or have you ever been found guilty of, professional misconduct, unprofessional conduct, incompetence, or negligence, by any jurisdiction of the United States, including military, or any international jurisdiction? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Is any such action pending?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>4.</b> Relating to the practice of medicine, have you ever had charges filed against you alleging professional misconduct, unprofessional conduct, incompetence, or negligence, in any jurisdiction of the United States, including military, or any international jurisdiction?                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Is any such action pending?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>5.</b> Has any hospital or other health care facility disciplined, restricted, or terminated your professional training, employment, or privileges, or investigated a complaint or accusation regarding your practice (except for late medical records)?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Is any such action pending?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>6.</b> Have you ever voluntarily or involuntarily resigned or withdrawn from professional training, from employment, or your privileges from any hospital or other health care facility to avoid the imposition of disciplinary sanction, restriction, or termination?                               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Is any such action pending?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>7.</b> Have you ever been disciplined by a medical school or post-graduate training program, including academic probation? (Please read definition of “discipline” on page 5.)   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Is any such action pending?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>8.</b> Have you ever had a license to practice medicine disciplined by any authority including a state medical board or a military authority (except for late medical records)? (Please read definition of “discipline” on page 5.)  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Is any such action pending?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

**PART XII Professional Fitness Questions – Disciplinary History** *(continued)*

9. Have you ever been under investigation or inquiry by any medical licensing jurisdiction or authority?  Yes  No

Is any such action pending?  Yes  No

10. Have you ever had a medical license application denied by any medical licensing jurisdiction or authority?  Yes  No

Is any such action pending?  Yes  No

11. Have you ever voluntarily or involuntarily withdrawn an application for a license to practice medicine in any United States jurisdiction or any international jurisdiction?  Yes  No

Is any such action pending?  Yes  No

12. Have you voluntarily or involuntarily surrendered or suspended your license to practice medicine in any United States jurisdiction or any international jurisdiction?  Yes  No

Is any such action pending?  Yes  No

13. Have you ever voluntarily or involuntarily agreed to any limitations, restrictions, or conditions to your license to practice medicine?  Yes  No

Is any such action pending?  Yes  No

14. Has your employment by a clinic, hospital, or other health care organization ever been terminated involuntarily as a result of an actual or potential investigation or as grounds for disciplinary proceedings?  Yes  No

Is any such action pending?  Yes  No

15. Have you ever had a DEA registration revoked or restricted?  Yes  No

Is any such action pending?  Yes  No

I certify that all answers provided above are true and correct.

"Yes" Answers

**If you answered "yes" to any of the above questions,** you must submit signed and dated documentation explaining the specific circumstance(s) of the incident(s).

## PART XIII Professional Fitness Question – Personal History

The following question must be answered. A **“Yes” response requires an explanation and documentation.** Use the letter of explanation form (#08-4752) appended to this application; include full details, dates of onset, duration, prognosis, treatment.

You must also have your **treating physician** submit a letter directly to the Board; the letter must include the following information:

- Summary of your condition (including explanation, dates of onset and significant events, and frequency of contact with you)
- Medication history
- Impact on your ability to practice safely and competently

When in doubt about your response, disclose and provide the required explanation and documents. Applications submitted without the required attachments will be considered incomplete and will not be processed. The contents of licensing files are generally considered public records, unless required to be kept confidential by state or federal law.

### For the purposes of the question in this section:

“Medical Condition” includes physiological, mental, or psychological conditions or disorders such as, but not limited to, orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

“Currently” does not mean on the day of, or even in the weeks or months preceding the completion of this application; rather, “currently” means recently enough so that the event, condition, behavior, impairment, limitation, etc., may have an ongoing impact on the applicant’s ability to practice medicine in a competent manner.

Are you currently suffering from any condition, mental or physical, that impairs your judgement or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner?

Yes  No

"Yes" Answer

**If you answered “yes” to the above question,** in addition to your personal statement, you must have your treating physician submit a statement indicating your ability to safely practice medicine. Applications submitted without the appropriate attachments will be considered incomplete and will not be processed.

## PART XIV Alaska Law

- I hereby certify I have reviewed, understand and will abide by the statutes and regulations applicable to my profession (AS 08.64 and 12 AAC 40).



THE STATE of ALASKA

Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing

MED

FOR DIVISION USE ONLY

Alaska State Medical Board

PO Box 110806, Juneau, AK 99811

Website: ProfessionalLicense.Alaska.Gov/StateMedicalBoard

Notary Signature Page

Form with fields for Applicant Name, Alaska License Number (if known), and a checkbox for Application in Process.

PART XV Notarized Signature

I certify the information in this application is true and correct to the best of my knowledge. I understand if information is provided in the Criminal History Report from the State of Alaska, or FBI, that I did not report, the issuance of my license may be delayed or denied.

I understand any falsification or misrepresentation of any item or response in this application, or any attachment hereto, or falsification or misrepresentation of documents to support this application, is sufficient grounds for denying, revoking, or otherwise disciplining a license or permit to practice in the state of Alaska.

I further understand it is a Class A misdemeanor under Alaska Statute 11.56.210 to falsify an application and commit the crime of unsworn falsification.

A person who makes a false statement on this application may be subject to civil and criminal penalties, including prosecution for perjury (AS 11.56.200 & AS 11.56.230).

Notarization table with fields for Applicant Printed Name, Applicant Signature, Notary Public for State of, Notary Signature, Subscribed and Sworn to Before me on this Day, and My Commission Expires.

Current Passport-Type Photo

Notary Seal



**Alaska State Medical Board**  
PO Box 110806, Juneau, AK 99811  
Phone: (907) 465-2550  
Email: [MedicalBoard@Alaska.Gov](mailto:MedicalBoard@Alaska.Gov)  
Website: [ProfessionalLicense.Alaska.Gov/StateMedicalBoard](http://ProfessionalLicense.Alaska.Gov/StateMedicalBoard)

## Authorization for Release of Records

I hereby authorize the Alaska Division of Corporations, Business, and Professional Licensing and its investigators to examine my employment and education records including all training which pertains to my medical practice, and any records pertaining to litigation, judgments, suits, and/or settlements, and any law enforcement records pertaining to me and discuss them with persons having possession of them. I also expressly permit and authorize the release of any and all such records pertaining to me to the Alaska Division of Corporations, Business, and Professional Licensing and its investigators. This release also applies to all records that pertain to credentialing records at facilities at which I have applied for or held privileges to practice medicine.

I authorize the division to discuss these records with persons or organizations that are considered appropriate by the division in connection with an official investigation, and to provide copies of these records to those persons or organizations deemed appropriate by the division.

I request that upon presentation of this release, or a Certified True Copy thereof, that you provide copies of those records to the division and/or its investigators, and/or representatives of the Office of the Attorney General of the State of Alaska.

This authorization expires one (1) year from the date of my signature below.

<b>Name:</b>	First	Middle	Last
<b>Full Address:</b>	P.O. Box or Street	City	State Zip
<b>Phone:</b>			<b>Date of Birth:</b>
<b>Email:</b>			
<b>Signature:</b>			<b>Date Signed:</b>



THE STATE  
of

**ALASKA**

Department of Commerce, Community, and Economic Development  
Division of Corporations, Business and Professional Licensing

**Alaska State Medical Board**

PO Box 110806, Juneau, AK 99811

Phone: (907) 465-2550

Email: [MedicalBoard@Alaska.Gov](mailto:MedicalBoard@Alaska.Gov)

Website: [ProfessionalLicense.Alaska.Gov/StateMedicalBoard](http://ProfessionalLicense.Alaska.Gov/StateMedicalBoard)

## Verification of Physician Assistant Program Education



**Applicant:**

Complete the identifying information below and forward a copy of this form to the program or school which awarded your physician assistant diploma.

<b>Applicant Name:</b>		<b>Date of Birth:</b>	
<b>Maiden or Other Names Used:</b>			
<b>Mailing Address:</b>	P.O. Box or Street	City	State Zip
<b>Full Program or School Name:</b>		<b>Program Location:</b>	
<b>Applicant Signature:</b>		<b>Date Signed:</b>	



**Program or School Staff:**

Complete this bottom part for the applicant identified above and return the form directly to the Alaska State Medical Board at the letterhead address. All information requested below must be provided; if any space is left blank, the document will be returned to you for completion.

<b>Exact Date on Diploma or Certificate:</b>	
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1. The physician assistant program included at least two hours of education in pain management and opioid use and addiction.  Yes  No

2. During this physician assistant's education, was he/she ever investigated by the program/school or disciplined by the program/school for any reason? Disciplinary actions include but are not limited to being placed on probation, issued a letter of reprimand, censured, suspended, restricted, or otherwise disciplined.  Yes  No

"Yes" Answers

**If you answered "yes" to question 2,** please attach a detailed explanation or documentation signed and dated by the person whose signature appears below.

Board Seal	<b>Signature:</b>		<b>Date Signed:</b>	
	<b>Printed Name:</b>		<b>Title:</b>	
	<b>Email:</b>		<b>Phone:</b>	



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## Medical Malpractice History Explanation

Use this form to list and explain your history of malpractice claims filed against you. Include all settlements, judgements, award and claims, even if no money was paid.

Provide documents to corroborate your explanation, including a copy of the order for settlement, dismissal, or removal from the case.

Please do not send all of the motions or filings for a case.

Letters from attorneys or insurance carriers may be submitted to corroborate explanations but may not be substituted for this required explanation.

<b>Location of Incident:</b>		<b>Date of Occurrence:</b>	
<b>Date of Case Closure:</b>		<b>Amount of Settlement:</b>	
<b>If there was a monetary settlement, upon what basis was it awarded ?</b> (e.g., Attorney/Insurance Company recommended)			
<b>Nature of Allegation and Description of the Case:</b>			
<b>Practitioner Explanation and Response to Allegation:</b>			
<b>What was the overall final injury to the patient? (e.g., disability or death)</b>			

<b>Full Name:</b>			
<b>Signature:</b>		<b>Date Signed:</b>	



**Professional Licensing**  
PO Box 110806, Juneau, AK 99811  
Phone: (907) 465-2550  
Email: [License@Alaska.Gov](mailto:License@Alaska.Gov)  
Website: [ProfessionalLicense.Alaska.Gov](http://ProfessionalLicense.Alaska.Gov)

## Letter of Explanation for a Professional Fitness “Yes” Answer

Use this form only to explain and document any professional fitness “yes” answers. A “yes” answer is not necessarily disqualifying but concealing one may be.

Each “yes” answer requires a separate explanation and associated documentation. Submit all relevant documentation with this form, even if you have previously provided it.

- **Explanations** include full details, dates, locations, type of action, organizations or parties involved, and specific circumstances. If the space provided is insufficient, make additional copies as needed.
- **Documentation** includes copies of court orders, charging documents, board or license actions, decisions against your professional certification, satisfaction of consent agreements (fines paid, community service completed, off probation, etc.), and fitness to practice letters (statement from your provider that you are safe to practice if you check “yes” to any of the questions regarding mental or physical health, or drug or alcohol abuse or addiction).
- **Disciplinary actions** may include, but not be limited to, suspension, surrender, revocation, probation, academic probation, reprimand, censure, restricted license, limited license, conditioned license, or letters of counseling, concern, advice, warning, caution, admonishment, or reprimand.

If you have multiple “yes” answers or multiple incidents for any professional fitness question, you must use a separate copy of this form and provide a full explanation and documentation for each incident.

The contents of licensing files are generally considered public records, unless required to be kept confidential by state or federal law.



Write the professional fitness question number you are answering “yes” to in the box.

<b>Location of Incident:</b>		<b>Date of Incident:</b>	
<b>Explanation of Incident:</b> When in doubt, disclose and explain. <i>Make copies as necessary.</i>			

**Did you attach all applicable documents associated with this incident?**

- Court Orders     
  Consent Agreements     
  Disciplinary Actions     
  Charging Documents  
 Court Records     
  Fitness to Practice     
  All Other Documentation Related to This Incident  
 I have additional incidents for this “yes” answer, or “yes” answers to other Professional Fitness questions and have attached a separate copy of this form for each incident.

<b>Full Name:</b>		<b>Program:</b>	
<b>Signature:</b>		<b>Date Signed:</b>	





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FOR DIVISION USE ONLY

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Phone: (907) 465-2550

## Credit Card Payment Form

All major credit cards are accepted. For security purposes, do not email credit card information. Include this credit card payment form with your application.

Name of Applicant or Licensee:			
Profession Type (e.g., Acupuncture):		License Number (if applicable):	
I wish to make payment by credit card for the following (check all that apply):			AMOUNT
<input type="checkbox"/>	Application Fee:		
<input type="checkbox"/>	License or Renewal Fee:		
<input type="checkbox"/>	Other (fine, exam, etc.):		
1.			
2.			
			TOTAL:

Name (as shown on credit card):			
Mailing Address:			
Phone Number:		Email (Optional):	
Signature of Credit Card Holder:			

**CREDIT CARD INFO: Your payment cannot be processed unless all fields are completed.**

1. Credit Card Number:		All 3 fields MUST be completed. This section will be destroyed after the payment is processed.
2. Expiration Date:		
3. Security Code:		