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
Phone: (907) 465-2550
Fax: (907) 465-2974
Website: *ProfessionalLicense.Alaska.Gov/StateMedicalBoard*

Physician Assistant License Renewal Application

January 1, 2023 – December 31, 2024

- Your license lapses after December 31, 2022. There is no grace period — it is illegal to work if your license has lapsed.
- Mail or fax your application with payment. Emailed applications will not be accepted.
- Make checks and money orders payable to the State of Alaska or use the attached credit card payment form.
- Plan on a 4–6-week processing time for correct and complete renewal applications.
- Once the renewal is processed, your license certificate will be available for printing via the MY LICENSE self-service portal.

PART I Payment of Fees

Renewal Fees: (Active License)	☐ Full-Term Biennial License Renewal *(For licenses first issued on or before April 1, 2021)*	**$250.00**
	☐ Prorated License Renewal *(For licenses first issued on or after January 1, 2022)*	**$125.00**
Renewal Fees: (Inactive License)	☐ Inactive License Renewal	**$175.00**
PDMP Fees:	☐ I have an active DEA registration number valid in any state or practice location.	**$ 0.00**
	☐ I do not have an active DEA registration number valid in any state or practice location.	**$ 0.00**

PART II Personal Information

Full Legal Name: Name change: ☐		**AK Physician Assistant License Number:**	
If you have had a legal name change since your last license was issued, you must complete a Change of Name form.			
Mailing Address: Address change: ☐	P.O. Box or Street / City / State / Zip		
Contact Phone:		**Date of Birth:**	

EMAIL AGREEMENT: 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:**	☐ Send my Correspondence Electronically ☐ Send my Correspondence by Mail

Note: If both boxes are selected above, you will receive correspondence electronically.

SOCIAL SECURITY NUMBER: AS 08.01.100 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 Professional License(s)

Please list all states, territories, provinces, or foreign countries in which you currently are licensed as any health care professional.

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

PART IV National Certification (NCCPA)

National Commission on Certification of Physician Assistants (NCCPA) Certificate:
Regulation 12 AAC 40.470 requires that you maintain current certification by the National Commission on Certification of Physician Assistants and have met the continuing medical education and recertification requirements of the NCCPA, including the recertification examination.

☐ I attest that I am currently certified by the NCCPA. I understand that if I am audited I will be required to provide a copy of my certification letter.

You may request a copy of your current certification letter from *www.nccpa.net*

NCCPA ID:	

PART V 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 VII.)

☐ **b.** **YES**, I have an active DEA registration number valid to use in any state or practice location. I have not registered with the PDMP and acknowledge I must do so within 30 days of renewing this license.

☐ 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 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:	

☐ **c.** **YES,** I have an active DEA registration number valid to use in any state or practice location and am registered with the PDMP.

☐ 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 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:	

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 VI AWARxE

ACCOUNT

Before proceeding with this application, login to your PDMP account at *alaska.pmpaware.net* and indicate the following:

- ☐ I have logged into my account.
- ☐ I have verified my healthcare specialty is accurately listed and appropriate to my profession.
- ☐ I have verified my contact information is correct.
- ☐ I have verified my DEA number is accurate.

DELEGATES

Please review and verify the delegates listed on your account. Select only one (1) of the options below:

- ☐ I have verified no delegates exist in my account.

-OR-

- ☐ I have verified that all delegates listed on my account are accurate.

Please list the delegate(s) name and license number(s). Be sure to include alpha-characters, if applicable.

Delegate Name:		License Number:	
Delegate Name:		License Number:	
Delegate Name:		License Number:	
Delegate Name:		License Number:	
Delegate Name:		License Number:	
Delegate Name:		License Number:	
Delegate Name:		License Number:	
Delegate Name:		License Number:	
Delegate Name:		License Number:	
Delegate Name:		License Number:	

PART VII Professional Fitness Questions

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. If you believe that the additional information you are attaching to explain a “yes” answer should be considered confidential, state that in the attachment. A request for confidentiality may or may not be granted.

When in doubt, disclose and explain.

Since the date your last Alaska license was issued or renewed:

1. Has your professional license been denied, revoked, suspended, surrendered, fined, stipulated, placed on probation, reprimanded, or been otherwise restricted or disciplined in any jurisdiction(including Alaska), including military authorities, or is any such action pending?

☐ **Yes**
☐ **No**

2. Have you voluntarily or involuntarily surrendered or restricted your professional license in any jurisdiction (including Alaska) for any reason or is any such action pending?

☐ **Yes**
☐ **No**

3. Have your staff privileges been denied, reduced, restricted, removed, or otherwise disciplined by any hospital, clinic, or other health care organization (for other than late medical records), or is any such action pending?

☐ **Yes**
☐ **No**

4. Have you been convicted of a crime or are you currently charged with committing a crime? For purposes of this question, “crime” includes a misdemeanor, felony, or a military offense, including but not limited to, driving under the influence (DUI) or driving while intoxicated (DWI), driving without a license, reckless driving, or driving with a suspended or revoked license. “Convicted” includes having been found guilty by verdict of a judge or jury, having entered a plea of guilty, nolo contendere or no contest, or having been given probation, a suspended imposition of sentence, or a fine.

☐ **Yes**
☐ **No**

5. Have you been the subject of an investigation by any licensing jurisdiction (including Alaska) or are you currently under investigation by any licensing jurisdiction (including Alaska) or is any such action pending?

☐ **Yes**
☐ **No**

6. Have you withdrawn an application for a license from a state licensing agency or for privileges from a hospital while under inquiry or investigation?

☐ **Yes**
☐ **No**

7. Have you been notified of any complaint or allegations involving you filed with or by any licensing authority, including Alaska, which complaint or allegations remain open as of the date of this application?

☐ **Yes**
☐ **No**

8. Have you experienced, been diagnosed with, been evaluated for, or treated for any alcohol or other chemical abuse, dependency, or impairment?

☐ **Yes**
☐ **No**

9. Have you experienced, been diagnosed with, been evaluated for, or treated for any physical or mental condition which may impair or interfere with your ability to safely practice medicine?

☐ **Yes**
☐ **No**

10. Has a medical malpractice claim been resolved or a civil action been terminated in which damages have been paid or are to be paid by you or on your behalf to a claimant or plaintiff, whether by judgment or under settlement?

☐ **Yes**
☐ **No**

PART VII Professional Fitness Questions (continued)

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. If you believe that the additional information you are attaching to explain a "yes" answer should be considered confidential, state that in the attachment. A request for confidentiality may or may not be granted.

When in doubt, disclose and explain.

Since the date your last Alaska license was issued or renewed:

11.	If you responded "yes" to question 10, has such settlement already been reported to the Board?	☐ **Yes** ☐ **No**
12.	Have you been investigated or disciplined by the Drug Enforcement Administration or have you surrendered your federal or any state-controlled substance registration for any reason or is any such action pending?	☐ **Yes** ☐ **No**

"Yes" Answers	**If you answered "yes" to questions 8 or 9,** in addition to your personal statement, you must submit a statement from your health care provider indicating your ability to safely practice medicine. Applications submitted without the appropriate attachments will be considered incomplete and will not be processed.
Random Audit	The board will audit a percentage of the license renewals. If your license is randomly selected for audit, you will be sent a letter and required to submit documentation and proof that you satisfied the requirements as you stated on this renewal form. Save your documents for at least four years to respond to any audits.

PART VIII Verification of Collaborative Plan

☐ ACTIVE - I attest that I have an active collaborative plan with a physician licensed in Alaska. I understand that if I am audited, I will be required to provide proof of an active collaborative plan.

Primary Physician Name:		**Collaborative Plan Number:**	
Collaborative Plan Start Date:		**Collaborative Plan End Date:**	

☐ NO COLLABORATIVE PLAN - My license status is currently "Not Authorized to Practice - No Collaborative Plan." I am not practicing under any current/active collaborative plans.

☐ REMOVE EXISTING COLLABORATIVE PLAN - My license status is "active" with one or more current collaborative plans on record. However, I am not practicing under any current/active collaborative plans. Please remove all collaborative plan relationships from my license record. I understand my license will be renewed as "Not Authorized to Practice - No Collaborative Plan." I understand I may not practice until I file a new collaborative plan with the division.

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Signature Page

Applicant Name:	

PART IX Agreement

I hereby certify that I am the person herein named and subscribing to this application and that I have read the complete application, and I know the full content thereof. I declare that all of the information contained herein, and evidence or other documents submitted herewith are true and correct.

I agree to inform the Alaska State Medical Board within 30 days of any change in my credentialing or privilege status in any hospital or other health care facility; any disciplinary actions or restrictions , or investigation of a complaint or accusation regarding my practice (except for late medical records); or any criminal charge or conviction.

I understand that 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, certificate, or permit to practice in the state of Alaska.

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

Applicant Signature:		**Date Signed:**	

General Information

APPLICATION PROCESSING:
The average time to process a paper application varies by program but can take several weeks from the date it is received in this office complete with all correct forms, supporting documents and appropriate fees paid. When the application is complete and correct, and all supporting documents have been received and all fees have been paid, the license will be issued. Start the process far enough in advance to allow for processing time. Applications are reviewed in order of receipt in our office, and walk-in customers should not expect immediate review.

LICENSE TERM:
If you choose not to renew your license, it will lapse. Licenses are issued for a two-year period and expire on December 31 of even-numbered years, regardless of the date of issuance, except licenses issued within 90 days of the expiration date are issued to the next biennial expiration date. One renewal notice will be mailed at least 30 days before license expiration to the last known address of record.

PROFESSIONAL FITNESS QUESTIONS:
A "yes" response in the application does not mean your application will be denied. If you have responded "yes" to any professional fitness questions in the application, be sure to submit a signed and dated explanation, and the charging document and judgement.

RANDOM AUDIT:
If your program requires continuing education, the Division will audit a percentage of the license renewals. If your license is randomly selected for audit, a letter will be sent with instructions to submit documentation as proof you satisfied the continuing competency requirements as stated on this renewal form. Licensees are randomly selected by computer and may be randomly selected as often as the computer program chooses. You must save your documents for at least four years so you can respond to audits.

ADDRESS OR NAME CHANGE:
In accordance with 12 AAC 02.900, it is the applicant's/licensee's responsibility to notify the Division, in writing, of changes of address or name. Name and address change notification forms are available on the Division's website. The address of record with the division will be used to send renewals and all other official notifications and correspondence. The name appearing on the license must be your current legal name.

SOCIAL SECURITY NUMBERS:
AS 08.01.060 and 08.01.100 require that a U.S. Social Security Number be on file with the division before a professional license is issued or renewed for an individual. If you do not have a U.S. Social Security Number, please complete the Request for Exemption from Social Security Number Requirement form (#08-4372) located at *ProfessionalLicense.Alaska.Gov* or contact the division for a copy of the form. This form is required with every application if you do not have a U.S. Social Security Number.

PUBLIC INFORMATION:
Please be aware that all information on the application form will be available to the public, unless required to be kept confidential by state or federal law. Information about current licensees, including mailing addresses, is available on the division's website at *ProfessionalLicense.Alaska.Gov* under License Search.

ABANDONED APPLICATIONS:
Under 12 AAC 02.910, an application is considered abandoned when 12 months have elapsed since correspondence was last received from or on behalf of the applicant. An abandoned application is denied without prejudice. At the time of abandonment, the division will send notification to the last known address of the applicant, who has 30 days to submit a written request for a refund of biennial license and other fees paid. The application fee will not be refunded. If no request for refund is received within that timeframe, no refund will be issued, and all fees will be forfeited.

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.

PRESCRIPTION DRUG MONITORING PROGRAM:
All actively licensed practitioners with a DEA registration number valid to use 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. Providers 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. For more information, please visit *PDMP.Alaska.Gov*

STATUTES AND REGULATIONS:

The complete set of statutes and regulations for this program are available by written request or online at the division's website: *ProfessionalLicense.Alaska.Gov*

If you would like to receive notice of all proposed regulation changes for your program, please send a request in writing with your name, preferred contact method (mail or email), and the specific program you want to be updated on to the address below.

Regulations Specialist
Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing
EMAIL: *RegulationsAndPublicComment@Alaska.Gov*

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Letter of Explanation for a Professional Fitness "Yes" Answer

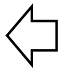
Use this form only to explain and document any professional fitness "yes" answers. A "yes" answer is not necessarily disqualifying but concealing one may be.

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 public records. If you believe that the additional information you are attaching to explain a "yes" answer should be considered confidential, state that in the attachment. A request for confidentiality may or may not be granted according to state law.

☐  **Write the professional fitness question number you are answering "yes" to in the box.**

Location of Incident:		**Date of Incident:**	
Explanation of Incident: When in doubt, disclose and explain. *Make copies as necessary.*			

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.

Full Name:		**Program:**	
Signature:		**Date Signed:**	

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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**

☐ Application Fee: ____________________ __________

☐ License or Renewal Fee: ____________________ __________

☐ 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: ____________________ **2.** Expiration Date: ____________________ **3.** Security Code: ____________________	All 3 fields **MUST** be completed! This section will be destroyed after the payment is processed.