

3062

RECEIVED (01/2016)

IRRC

STATE BOARD OF MEDICINE
REACTIVATION or STATUS CHANGE APPLICATION
ALLIED HEALTH PROFESSIONALS

2016 SEP -1 AM 9:55

Send to: STATE BOARD OF MEDICINE P.O. BOX 2649 HARRISBURG, PA 17105-2649 <u>www.dos.pa.gov/med</u> OR STATE BOARD OF MEDICINE 2601 North Third Street Harrisburg, PA 17110	Full Name	<small>Last</small>	<small>First</small>	<small>Middle</small>
	Address			
	Address			
	Address	<small>City</small>	<small>State</small>	<small>ZIP</small>
	Email:			
	License No.	Telephone No.		

Name Change

For a name change, indicate new name below and attach an 8 1/2 x 11 photocopy of a legal document verifying the name change (i.e., marriage certificate, divorce decree, legal document indicating retaking of a maiden name, etc.).

New Name: _____

LICENSES/CERTIFICATIONS EXPIRE EVERY EVEN NUMBERED YEAR
REGARDLESS OF REINSTATEMENT DATE

REQUESTING INACTIVE STATUS:

CURRENTLY ACTIVE STATUS REQUESTING INACTIVE STATUS.

I **do not** wish to practice my profession and wish to place my license/certification on an inactive status. I understand that to reactivate my license/certification I will need to meet the continuing education requirement mandated by my profession's law and/or regulations as well as any other re-entry training/testing or skills assessment require by the Board.

YOU MUST RETURN YOUR WALL AND WALLET CARD LICENSES. NO FEE IS REQUIRED

APPLICANTS MUST COMPLETE THE FOLLOWING:

1.

Enclose a check or money order, in the appropriate amount listed below, made payable to the "Commonwealth of Pennsylvania." If you have been practicing in Pennsylvania beyond the expiration date, include a late fee of \$5 per month or part of a month.
FEES ARE NOT REFUNDABLE. Check or money order must be in "US funds." **Note:** A processing fee of \$20.00 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment. Your cancelled check is your receipt of payment.

BIENNIAL REGISTRATION FEES

- Acupuncturist ----- \$40
- Athletic Trainer ----- \$37
- Genetic Counselor ----- \$125 **Fee includes \$75 renewal fee + \$50 reactivation fee.
- Nurse-Midwife ----- \$40
- Nurse-Midwife Prescriptive Authority ----- \$25
- Orthotist ----- \$125 **Fee includes \$75 renewal fee + \$50 reactivation fee.
- Orthotic Fitter ----- \$100 **Fee includes \$75 renewal fee + \$25 reactivation fee.
- Pedorthist ----- \$100 **Fee includes \$75 renewal fee + \$25 reactivation fee.
- Perfusionist ----- \$100 **Fee includes \$50 renewal fee + \$50 reactivation fee.
- Physician Assistant ----- \$40
- Practitioner of Oriental Medicine ----- \$40
- Prosthetist ----- \$125 **Fee includes \$75 renewal fee + \$50 reactivation fee.
- Respiratory Therapist ----- \$25

YOU MUST COMPLETE AND RETURN THIS PAGE OF THE APPLICATION

2.	Complete the legal questionnaire.
3.	If documents will be submitted to the Board under a name different from your present name, submit a copy of the legal document evidencing the name change (i.e., marriage license, divorce decree, etc.).
4.	Complete the Verification of Practice / Non-Practice form.
5.	Attach a current Curriculum Vitae listing <u>all</u> periods of employment or unemployment (i.e., child rearing, research, etc.) for at least the past 10 years. If your initial license in Pennsylvania was issued within the past 10 years, please provide activities from date of initial licensure to the present. <u>The list must be in chronological order, include the month and year, and indicate the state/territory in which the employment occurred.</u>
6.	Provide an official notification of information (Self Query) from the National Practitioner Data Bank. Please refer to the NPDB website for additional information. When you receive the "Response to your Self Query," forward the entire report directly to the Board Office. You should make a copy for your records.

Continuing Education

7.	<u>ALL HEALTH-RELATED LICENSEES:</u> Act 31 of 2014 requires that licensees complete at least 2 hours of Board-approved continuing education in child abuse recognition and reporting requirements. Details can be found at www.dos.pa.gov For a list of Board-approved providers, choose the "Act 31 Mandated Child Abuse Reporter Training" link. <u>Verification of completion must be sent electronically directly from the course provider. Please note that it may take 7-10 days for the provider to submit the records to the Board office.</u>
8.	<u>FOR ATHLETIC TRAINERS ONLY:</u> In order to reactivate your license and be in compliance with the Board's continuing education requirements, you will need to provide a copy of your current BOC certification.
9.	<u>FOR GENETIC COUNSELORS – ORTHOTISTS – ORTHOTIC FITTERS – PEDORTHISTS – PERFUSIONISTS – PROSTHETISTS & RESPIRATORY THERAPISTS:</u> In order to reactivate your license and be in compliance with the Board's continuing education requirements, you will need to provide proof of meeting the Board's continuing education requirements. Continuing education requirements can be found at www.dos.pa.gov/med .
10.	<u>FOR NURSE-MIDWIVES WITH PRESCRIPTIVE AUTHORITY ONLY:</u> In order to reactivate your prescriptive authority certification and be in compliance with the Board's continuing education requirements, you will need to provide proof of meeting the current continuing education requirements. Continuing education requirements can be found at www.dos.pa.gov/med . PLEASE NOTE: In addition, you will be required to complete and submit the "Additional Prescriptive Authority Collaborative Agreement" application (including the fee).
11.	<u>FOR PHYSICIAN ASSISTANTS ONLY:</u> In order to reactivate your license and be in compliance with the Board's continuing education requirements, you will need to provide a copy of your current NCCPA certification.

Professional Liability Insurance

12.	<u>ALL Acupuncturists – Genetic Counselors – Orthotists – Orthotic Fitters – Pedorthists – Perfusionist – Prosthetists & Practitioners of Oriental Medicine:</u> Shall provide proof of professional liability insurance coverage through self-insurance, personally purchased insurance or insurance provided by your employer for the minimum amount of \$1,000,000.00 per occurrence or claims made. This proof of insurance/certificate must include your name and indicate that you are covered under this policy while performing services governed by your license in the Commonwealth of Pennsylvania.
-----	---

PLEASE NOTE

If this application is not completed **within six months**, updates of certain sections and/or supporting documents will be required.

A reactivation application for a Pennsylvania license/certification which has been inactive/expired for four years or more will require a review by the full Board. Please note that the Board has the authority to place conditions on your return to practice in order to protect the health, safety and welfare of the public.

The Board may require applicants who have not actively practiced for four years or more and are requesting reactivation of an expired/inactive license/certification to successfully complete a clinical skills evaluation and/or retraining program. This may delay the reactivation of your license until an approved skills evaluation and/or retraining program has been successfully completed.

LEGAL QUESTIONS

THE FOLLOWING LICENSE REACTIVATION QUESTIONS MUST BE ANSWERED. If you answer "YES" to #2 through #12, provide complete details on a separate sheet as well as certified copies of relevant documents. **Sign and date below.**

		Yes	No
1.	Do you hold or have you ever held a license, certificate, permit, registration or other authorization to practice a profession or occupation in any state or jurisdiction? If you answered yes, provide the profession and state or jurisdiction. LIST: _____		
2.	Have you withdrawn an application for a professional or occupational license, certificate, permit or registration, had an application denied or refused, or for disciplinary reasons agreed not to apply or reapply for a professional or occupational license, certificate, permit or registration in any state or jurisdiction?		
3.	Have you had disciplinary action taken against a professional or occupational license, certificate, permit, registration or other authorization to practice a profession or occupation issued to you in any state or jurisdiction or have you agreed to voluntary surrender in lieu of discipline?		
4.	Do you currently have any disciplinary charges pending against your professional or occupational license, certificate, permit or registration in any state or jurisdiction?		
5.	Have you been convicted (found guilty, pled guilty or pled nolo contendere), received probation without verdict or accelerated rehabilitative disposition (ARD), as to any criminal charges, felony or misdemeanor, including any drug law violations? Note: You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.		
6.	Do you currently have any criminal charges pending and unresolved in any state or jurisdiction?		
7.	Have you ever had practice privileges denied, revoked, suspended, or restricted by a hospital or any health care facility?		
8.	Have you had your DEA registration denied, revoked or restricted?		
9.	Have you had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority?		
10.	Have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?		
11.	Have you engaged in the intemperate or habitual use or abuse of alcohol or narcotics, hallucinogenics or other drugs or substances that may impair judgment or coordination?		
12.	Have you been the subject of a civil malpractice lawsuit? If yes, please submit a copy of the entire Civil Complaint, which must include the filing date and the date you were served. Submit a statement which includes complete details of the complaints that have been filed against you. **If you previously reported the complaint(s) to the Board provide the docket number(s) _____		

Verification of Information

I verify that this application is in the original format as supplied by the Department of State and has not been altered or otherwise modified in any way. I am aware of the criminal penalties for tampering with public records or information under 18 Pa. C.S. Section 4911. I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa C.S. § 4904 (relating to unsworn falsification to authorities) and may result in the suspension, revocation, or denial of my license, certificate, permit or registration.

Full Name (Please Print) _____

Signature of Licensee (Mandatory) _____ Date _____

Social Security Number _____ DOB: _____

Name of University/School _____ Year of Graduation: _____

YOU MUST COMPLETE AND RETURN THIS PAGE OF THE APPLICATION

