GENERAL INFORMATION FOR PHYSICIAN ASSISTANT LICENSURE

Criminal History Background Check

Beginning in July 2007, the NM Medical Board will require that all applicants for initial licensure **submit fingerprints** and other information necessary for a state and national criminal background check, at their cost.

Like other state medical boards around the country, the NM Medical Board will conduct criminal background checks in order to fulfill its statutory mandate to protect the health and safety of the NM public. The applicant is responsible for any costs associated with obtaining fingerprints.

The criminal background check will not slow down your license application. An application for initial licensure will not be considered complete until the required fingerprint cards and forms have been received in the board office. However, completed applications will be processed pending the outcome of the background check, and licenses may be granted while the screening is still pending. If the background check reveals a felony or a violation of the Medical Practice Act the licensee will be notified and the Board will determine if the applicant is eligible for licensure or if disciplinary action will be taken against the licensee.

Fingerprint cards cannot be downloaded from the Board's web site.

Blank fingerprint cards will be sent to you upon receipt of your application and application fee.

Fees

The applicant fee of $150 plus the criminal background check fee of $36 for a total of $186 is payable in U.S. funds by cashier's check, money order, check MasterCard or Visa. Applications will not be processed until the application fee has been received. **All fees are nonrefundable.**

Education Requirements

All applicants must have graduated from a Physician Assistant program accredited by the Committee on Allied Health Education and Accreditation (CAHEA of the American Medical Association or its successor agency) and hold current NCCPA Certification. Physician Assistants not currently certified by NCCPA have a one-time grace period of one-year from the date of graduation from a program approved by ARC-PA or its successor agency to become certified.

INSTRUCTIONS FOR COMPLETING THE PHYSICIAN ASSISTANT APPLICATION

Procedures

Complete the application in its entirety. Please **type or print in black or blue ink.**

1. Board Application

   Complete all application pages (1-7). You must respond to **all** components of the application as instructed.

2. Physician Assistant Medical Education Certification

   You must have your Physician Assistant Program verify your degree. Affix a recent (less than 6 months) passport quality photograph of yourself in the designated space. **The completed verification, including the program's seal, must be sent directly to the Board office from the Physician Assistant Program.**

3. NCCPA Certification

   Board staff will verify NCCPA Certification.

4. Verification of Licensure / Registration

   You must have each state licensing authority that has ever issued you a Physician Assistant license or any other health related license/registration verify the standing of that license/registration directly to the Board. Use the enclosed form entitled "Verification of Licensure/Registration." Make photocopies as required. Complete the release on the top half of the form and send one copy to each jurisdiction. **These completed verifications must be sent directly to the Board office from the licensing authority.**

5. Letters of Recommendation

   You must have two (2) Professional Recommendation forms completed and sent directly to the Board by **physicians** licensed to practice medicine in the United States or Physician Assistant Program Directors, or the Director's designee who have personal knowledge of the applicant's moral character and competence to practice.

6. Work Experience Verification

   You must have the chief of staff or administrator in each and every hospital or health facility where you have held privileges or been employed during the past five (5) years complete the Work Experience Verification form(s) and return the completed form(s) directly to the New Mexico Medical Board.

7. Applicants Oath

   You must complete the form entitled "Applicant's Oath" in its entirety including affixing a recent (less than 6 months) color passport quality photograph of yourself in the designated space.

8. Supervising Physician Statement of Responsibility

   Upon employment, a Physician Assistant together with a New Mexico licensed physician, must submit a Completed "Supervising Physician Statement of Responsibility Form" directly to the Board office.

9. Submitting The Board Application

   Attach your payment to the front of the application. Make payment in U.S. funds to the New Mexico Medical Board. Do not send cash. Mail your application, appropriate fee, Applicant's Oath and any other Supporting documents to:

New Mexico Medical Board
2055 S. Pacheco Street
Building 400
Santa Fe, New Mexico 87505

10. Personal Interview

    If you are required to schedule an appointment for a personal interview with the Board or the Board's designee, you will be notified after your application and all required documents have been received and are complete in every detail.

11. License

    The initial license is valid until March 1 of the year following NCCPA Certification.

THE NEW MEXICO MEDICAL SOCIETY

NMH&HSA
New Mexico Hospitals & Health Systems Association

The New Mexico Statewide Application for Physician/Practitioner Appointment©

Physician Assistant

Date of Application: ____________________

Application Fee:	**150.00**
Background Check Fee:	**36.00**
TOTAL COST:	**$ 186.00**

Demographics

Name			
	Last	First	Middle

Other Names Used	

Gender	M F	**Place of Birth**		**Citizenship**	
Immigration Status				**INS Certification #**	
***Social Security Number**				**Date of Birth**	
***NM Tax ID# (if applicable)**		Pending ☐			
***Fed. Tax ID# (if applicable)**		Pending ☐			
Current Practice Name					
Practice Limited to: (Clinical Specialty)					
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
*Office Manager or Contact Person:					
Foreign Languages (spoken fluently by practitioner)					
Foreign Languages (spoken fluently at Practice)					
* **E-Mail Address** (confidential)					
***Current Mailing Address** (if different from above -confidential unless no practice address indicated)					
*Street					
*City		*State		*Zip Code	
Telephone Number		Facsimile			
What are your immediate or future Practice Plans in New Mexico?					
Home Address (Required)		*Telephone Number			
Street					
*City		*State		*Zip	

*Information Confidential

Education (Please attach a separate sheet, if necessary.)

Undergraduate Education							
College or University							
City			State/Country		Zip Code:		
Dates Attended	From:	To:	Degree		Graduation Date		
College or University							
City			State/Country		Zip Code:		
Dates Attended	From:	To:	Degree		Graduation Date		
Professional / Medical Education							
College or University							
City			State/Country		Zip Code:		
Dates Attended	From:	To:	Degree		Graduation Date		
College or University							
City			State/Country		Zip Code:		
Dates Attended	From:	To:	Degree		Graduation Date		
Graduate Education							
College or University							
City			State/Country		Zip Code:		
Dates Attended	From:	To:	Degree		Graduation Date		
College or University							
City			State/Country		Zip Code:		
Dates Attended	From:	To:	Degree		Graduation Date		

Licensure-Registration-Certification Information

State Professional License/Certification Number							
State		Issue Date		Expiration Date		Pending	☐

All Other State License Numbers (regardless of status - attach separate list if necessary.)			
State	Number	Issue Year	Expiration Date

*Federal Drug Enforcement Admin. (DEA) Registration					N/A ☐
Number			Exp. Date		Pending ☐
*State Controlled Substance Registration (CSR)					N/A ☐
Number		State	Exp. Date		Pending ☐
*National Provider Identification Number					
Pending ☐					

Professional Liability Insurance (confidential information)

Do you have current liability insurance? ☐ Yes ☐ No

Current Carrier				Current ☐	Pending ☐
Address					
Dates Insured	From	To	Policy #		
			Coverage Limits		

Applicant Name ______________________________ **Date** ____________________

Work History

Please list all previous practice experience for the last 15 years, **including military or government service**, listing the most recent first. If military service, state type of discharge and rank achieved **and attach copy of discharge or separation documents**. Attach separate page, if necessary. Please provide written explanation for any gaps in work history of 6 months or more.

Location		From		To	
Street		Phone Number			
City		State		Zip Code	
Type of Practice		Contact Person			
Type of Discharge		Rank Achieved			
Location		From		To	
Street		Phone Number			
City		State		Zip Code	
Type of Practice		Contact Person			
Type of Discharge		Rank Achieved			
Location		From		To	
Street		Phone Number			
City		State		Zip Code	
Type of Practice		Contact Person			
Type of Discharge		Rank Achieved			
Location		From		To	
Street		Phone Number			
City		State		Zip Code	
Type of Practice		Contact Person			
Type of Discharge		Rank Achieved			

Hospital and Health Facility Affiliation History (other than postgraduate training) ☐ N/A

Please list hospital staff membership and/or healthcare organization affiliations in the past fifteen (15) years. If an institution is no longer in existence, please provide an alternative source of verification. Use separate page, if necessary. **Providers who do NOT have admitting privileges, please explain your procedures or the arrangements you make in instances when patients require admission to a hospital. If you are applying with a health plan, should arrangements include admitting coverage by another provider, a signed letter from the covering provider, including their primary admitting facility, is to be included with this application.**

(1) Current Primary Admitting Facility (Hospital Name)					
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Appointment Dates	**From:**	**To:**			
Type of Appointment					
Privileges Assigned					
(2) Facility Name					
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Appointment Dates	**From:**	**To:**			
Type of Appointment					
Privileges Assigned					
(3) Facility Name					
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Appointment Dates	**From:**	**To:**			
Type of Appointment					
Privileges Assigned					

Applicant Name____ **Date**______________________________

(4) Facility Name					
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Appointment Dates	**From:**	**To:**			
Type of Appointment					
Privileges Assigned					
(5) Facility Name					
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Appointment Dates	**From:**	**To:**			
Type of Appointment					
Privileges Assigned					
(6) Facility Name					
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Appointment Dates	**From:**	**To:**			
Type of Appointment					
Privileges Assigned					
(7) Facility Name					
Street					
City		State		ZIP Code	
Telephone Number		Facsimile			
Appointment Dates	**From:**	**To:**			
Type of Appointment					
Privileges Assigned					
(8) Facility Name					
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Appointment Dates	**From:**	**To:**			
Type of Appointment					
Privileges Assigned					

Professional References Please list three professional peers familiar with your professional performance in the past 5 years, (not including current or impending partners or associates in practice).

(1) Name and Title					
Address					
City		State		Zip Code	
Telephone Number		Facsimile			
(2) Name and Title					
Address					
City		State		Zip Code	
Telephone Number		Facsimile			
(3) Name and Title					
Address					
City		State		Zip Code	
Telephone Number		Facsimile			

Applicant Name____________________________________ **Date**________________________

Licensing Exam: **Physician Assistant NCCPA:**

Date of Exam_______________________________ Date Passed:___________________________
Month/Year

Professional Practice Questions Please answer all of the following Yes or No questions. If you answer YES to any question, please give details including name, address, and telephone number of significant parties on a separate sheet of paper.

Question	Yes	No
1. Has your professional liability coverage ever been terminated by action of the insurance company except as a result of the company ceasing to offer insurance to physicians?	Yes ☐	No ☐
2. Have you ever been denied professional liability insurance coverage?	Yes ☐	No ☐
3. Has your professional liability carrier ever excluded any specific procedures from your coverage?	Yes ☐	No ☐
4. Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any professional organization?	Yes ☐	No ☐
5. Have you ever been excluded from or sanctioned by Medicare and/or Medicaid?	Yes ☐	No ☐
6. Have you ever been arrested? If so explain the circumstance, regardless of the outcome (i.e. expunged, dismissed, sealed, vacated).	Yes ☐	No ☐
7. Have you ever been named as a defendant in any criminal proceedings?	Yes ☐	No ☐
8. Have you ever been subject to investigation by a governmental entity or Board that either could have resulted or did result in licensure sanction or other adverse actions, irrespective of the outcome?	Yes ☐	No ☐
9. Have you ever been named in any formal requests for corrective actions filed by any healthcare entity where you have had an appointment (a request which could result in either formal or informal proceedings).	Yes ☐	No ☐
10. a. Have your privileges at any healthcare entity ever been voluntarily or involuntarily suspended, restricted, diminished, revoked, surrendered, or not renewed, except for medical records delinquency?	Yes ☐	No ☐
b. Have you ever agreed not to exercise your clinical privileges while under investigation?	Yes ☐	No ☐
11. Have you ever resigned from a healthcare entity to avoid modification, suspension, or termination of privileges, or while under investigation?	Yes ☐	No ☐
12. a. Has your application for licensure or license to practice in any jurisdiction ever been investigated, voluntarily or involuntarily limited, suspended, revoked, surrendered or denied?	Yes ☐	No ☐
b. Are any currently held licenses pending investigation or being challenged?	Yes ☐	No ☐
13. Have you ever been notified to appear before any licensing agency for a hearing or complaint of any nature?	Yes ☐	No ☐
14. Has your federal or state narcotics registration certificate in any jurisdiction ever been voluntarily or involuntarily limited (stipulations), suspended, revoked, restricted, or are there currently challenges to any of these items?	Yes ☐	No ☐

Applicant Name ____ **Date**_____________________________

Question	Yes	No
15. Have you ever been involved in a settlement, medical malpractice claim or suit, or have you ever received written notice of intent to file such a suit? **If yes, please provide the following information on the attached Malpractice History form for each case:** • Name, age, sex of patient/claimant. • Date(s) and type of treatment and/or surgery, which led to the allegations against you. • Nature of allegations in claims/suits. Specify whether a suit was ever filed. • Names of other practitioners and hospital, if any, involved in claims or suit. • Disposition or current status of claim or suit (be specific). • Name of insurance carrier defending you. • Name of defense attorney.	Yes ☐	No ☐
16. Have you ever been reported to the National Practitioner Data Bank?	Yes ☐	No ☐
17. Are you now, or were you in the past, addicted to, abusive of, or in treatment for abuse of any controlled substances, habit-forming drugs, illegal drugs, prescription medication or alcohol?	Yes ☐	No ☐
18. In the five (5) years prior to this application, have you had any physical injury or disease, or mental illness or impairment, which you are currently under treatment for or could reasonably be expected to affect your on-going ability to practice medicine safely and competently? **If yes, please have your treating physician send the NM Medical Board a letter regarding your diagnosis and treatment.**	Yes ☐	No ☐
19. Have you ever, for any reason:		
a) Resigned from a physician assistant program?	Yes ☐	No ☐
b) Withdrawn from a physician assistant program?	Yes ☐	No ☐
c) Been suspended, dismissed, or expelled from physician assistant program?	Yes ☐	No ☐
d) Been placed on probation or remediation, including academic probation or remediation, by a physician assistant program?	Yes ☐	No ☐
e) Taken a leave of absence or break from, or had any interruptions or extensions in, a physician assistant program for any personal or professional reason (including illness or disability, pregnancy or maternity, any academic issue, etc)?	Yes ☐	No ☐

If you answer YES to any question, please give details including name, address, and telephone number of significant parties on a separate sheet of paper.

Applicant Name ______________________________ **Date**____________________

New Mexico Medical Board
2055 S. Pacheco St. Bldg. 400
Santa Fe, NM 87505 (505) 476-7220

APPLICANT'S OATH

I, ____, hereby certify that I am the person pictured below and named in this application for a license to practice as a Physician Assistant in the State of New Mexico; that all statements I have made herein are true; that I am the original and lawful possessor and person named in the various forms and credentials furnished to the New Mexico Medical Board (Board) with my application.

I acknowledge and state that I have read the Information and Instructions that accompanied this application and I have answered all questions truthfully. I understand that the fee I submitted is not refundable.

I authorize and request every person, hospital, clinic, community, governmental agency, court, association, institution or other organization having control of any documents, records, and other information pertaining to me, to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Board or their agents or representatives to inspect and make copies of such documents, records and other information, in connection with this application.

I hereby release, discharge, and exonerate the Board, and their agents or representatives, and any person furnishing information, from any and all liability of every nature and kind arising out of the furnishing or inspection of such documents, records, other information, or the investigation made by the Board. I authorize the Board to release information, material, documents, orders, or the like relating to me or to this application to any other agency of the State of New Mexico or the appropriate licensing agency of any other state or Territory of the United States or any agency of the United States government.

ATTACH RECENT PASSPORT-QUALITY* PHOTOGRAPH THAT WILL FIT IN THIS SPACE

____
Applicant Signature   Date

*Passport-quality color photograph taken within six months prior to filing the application, approximate size 2 x 2 inches, head and shoulders only, full face, front view, plain white or off-white background, standard photo stock paper, scanned or computer-generated photographs should have no visible pixels or dots.

Applicant Name ____ **Date** ___________________________

New Mexico Medical Board
2055 S. Pacheco St.
Building 400
Santa Fe, NM 87505
(505) 476-7220

PHYSICIAN ASSISTANT EDUCATION CERTIFICATION

APPLICANT INSTRUCTIONS: Please complete the waiver for release of information and forward this form to your university/medical school(s) or university of graduation for verification.

Waiver for Release of Information

I authorize the medical school/university listed below to provide any and all information pertaining to my medical education at your institution.

Applicant's Signature:____Date of Birth ________/_______/______

Print or Type Name: _______________________________________Soc Sec # _____________________________

Other Name(s) ____

Name of Medical School: ____

Address: ______________________________________City ____________________State_______ Country_______

Please complete this form and forward it DIRECTLY to NMMB, 2055 S. Pacheco St., Bldg. 400, Santa Fe, NM 87505.

I hereby certify that the Physician Assistant Degree issued by ____________________________________, was
Program Name
conferred upon ____, on ______________________________ and
Applicants Name Date of Graduation

that the photograph which appears below is a true likeness of the applicant.

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. ***All questions must be answered***. ***If you answer "YES" to any of the questions below, please enclose an explanation.***

1. Did the applicant take any leaves of absence or breaks from his/her medical education? ___Yes ___No
2. Was the applicant ever placed on probation? ___Yes ___No
3. Was the applicant ever disciplined or under investigation? ___Yes ___No
4. Were any negative reports ever filed by instructors regarding the applicant? ___Yes ___No

ATTACH
RECENT PASSPORT
STYLE PHOTOGRAPH
THAT
WILL FIT IN
THIS SPACE

____
Program Director/Administrator (Type or Print)

____
Program Director/Administrator Signature

____
Physician Assistant Program Address City/State/Zip

INSTRUCTIONS TO PHYSICIAN ASSISTANT PROGRAM OFFICIAL

This form will not be accepted if returned by the applicant.
Please complete this certification, including affixing the school seal partially covering the attached photograph, and return **directly** to the above address.
Thank you for your cooperation.

New Mexico Medical Board
2055 S. Pacheco St.
Building 400
Santa Fe, NM 87505
(505) 476-7220

PROFESSIONAL RECOMMENDATION

The New Mexico Medical Board requires the completion of this Professional Recommendation by a Physician, Physician Assistant, Program Director or the Director's designee who have personal knowledge of my moral character and competence to practice as a Physician Assistant. This form is required as part of my application for licensure. ***All*** elements in the section below ***must*** be completed. The lower half of the form may be used for narrative comment. This is my authorization to release all information in your files, favorable or otherwise, DIRECTLY to the NMMB, 2055 S. Pacheco St., Bldg. 400, Santa Fe, NM 87505.

Applicant's Name:_______________________________ Date of Birth ____ ___/_______/______

Applicant' Signature: _______________________________ Date:_______________________

Address: _______________________________ City ______________________ State________

ALL ELEMENTS IN THIS SECTION MUST BE COMPLETED BY THE RECOMMENDING INDIVIDUAL
The information on this form is NOT a public document.

1. Date and type of service: This individual served with me as_______________________________

from ___________________ to _______________________ at ___________________________
Month/Year Month/Year Location

2. Please evaluate: (Please indicate with check mark)

		Poor	Fair	Good	Superior
Professional knowledge	________				
Clinical judgment	________				
Relationship with patients	________				
Ethical/professional conduct	________				
Ability to communicate	________				
Clinical skills	________				

3. Recommendation: (please indicate with a check mark)
   1. Recommend highly and without reservation ________________
   2. Recommend as qualified and competent ________________
   3. Recommend with some reservation (explain) ________________
   4. Concerns (explain) ________________

4. Of particular value in evaluating the candidate is information regarding any notable strengths and weaknesses (including personal demeanor). We would appreciate your comments.
____
____

5. The above report is based on: (please indicate with check mark)
   1. Close personal observation ____________ 3. A composite of evaluations __________
   2. General impression ____________ 4. Other __________

Name (Please Print): ___________________________Title: __________________Phone:______________

Signature: _______________________________________ Date: ________________________

New Mexico Medical Board
2055 S. Pacheco St.
Building 400
Santa Fe, NM 87505
(505) 476-7220

WORK EXPERIENCE VERIFICATION

I am applying for a medical license in the State of New Mexico. The New Mexico Medical Board requires this form to be completed by the Chief of Staff or facility's administrative staff. I hereby authorize release of all information in your files, favorable or otherwise, DIRECTLY to the NMMB, **2055 S. Pacheco St., Bldg. 400, Santa Fe, NM 87505.**

Applicant Name	Applicant Signature
Address	***Dates of Privilege/Employment mm/yy to mm/yy (must be provided)**
City/State/Zip	Telephone Number

The section below should be completed by the chief of staff or facility's administrative staff.
Letters of Recommendation are ***NOT*** accepted in lieu of this form.

Type or Print Name of person completing this form

Title

Name of Institution

Address

City / State / Zip

1. This evaluation is based on: ___Observation of applicant ___Review of personnel file
2. In your estimation, is there any reason why this applicant should not be licensed to practice? ___Yes ___No
3. To your knowledge, is there any mental or physical reason why this applicant should not be licensed? ___Yes ___No
4. To your knowledge, is there any derogatory/disciplinary information regarding this applicant? ___Yes ___No
5. Are the dates of privilege/employment provided by the applicant on this form accurate? * ___Yes ___No

***If not, please provide correct dates**: Beginning ____________________ Ending ________________
Month/Year Month/Year

If you answered "YES" to questions 2, 3, and/or 4, please provide a written explanation and/or any supporting documentation that may be relevant.

Please affix hospital or notary seal here

Printed name of person completing this form Signature Date

Signature of Notary (if applicable) Date

My commission expires:______________________________

Please note on this form if there is no hospital or notary seal available.
Please return this form directly to the address above
Thank you for your cooperation.

New Mexico Medical Board
2055 S. Pacheco St.
Building 400
Santa Fe, NM 87505
(505) 476-7220

VERIFICATION OF LICENSURE

I am applying for medical licensure in the State of New Mexico. The New Mexico Medical Board requires that your Board complete this form or its equivalent so that I may be considered for licensure. This is my authorization to release all information in your files, favorable or otherwise, to the NMMB, **2055 S. Pacheco St., Bldg. 400, Santa Fe, NM 87505**

Print/Type Full Name ______________________ Signature ______________________ Date ________

License Number ______________ Date Issued ______________ Address ______________________

City ______________ State ________ Zip Code ________

THE SECTION BELOW SHOULD BE COMPLETED BY THE MEDICAL BOARD

Name of Licensing Authority: ____

Name of Licensee: ____

License Number: ____________________ Issue Date: __________________ Expiration Date: __________________

1. Is license current? ___Yes ___No If "No" why not? ______________________________
2. Has licensee ever been disciplined by your Board? ____Yes ____No

   If "Yes": Revoked ___Yes ___No Suspended ___Yes ___No

   Stipulated ___Yes ___No On Probation ___Yes ___No

   Dates:____
3. Has his licensee's license ever been:
   - Allowed to lapse for non-payment of fees? ___Yes ___No
   - Placed on Retired or Inactive status? ___Yes ___No
   - Surrendered Voluntarily? ___Yes ___No
4. Are there any formal charges pending against this license? ___Yes ___No
5. Has licensee ever been investigated or requested to appear before your Board for any serious matter? ___Yes ___No

If you answered "YES" to questions 3-6 please provide a written explanation below, and attach a copy of all supporting documentation (e.g., Board order, complaint, etc.).

____

____

Signature of Board Official ______________________ Date ________

Title ______________________ Phone Number ______________________

Revised 10/07

New Mexico Medical Board
2055 South Pacheco Street, Bldg, 400
Santa Fe, NM 87505
(505) 476-7220 voice (505) 476-7233 fax

☐ New Applicant ☐ Replacing Previous Employer ☐ Change of Supervising Physician ☐ Adding Alternate Supervisors

SUPERVISING PHYSICIAN STATEMENT OF RESPOSIBILITY

THIS SECTION TO BE COMPLETE BY PHYSICIAN ASSISTANT

Name: ____
Last First Mi Maiden

Home: ____
Number and Street

____
City State Zip/Postal Code

Office Telephone: (   ) ____________________ Home Telephone: (   ) ____________________

Fax Number: ( ) ____________________ E-Mail Address: ____________________

Physician Assistant Signature: ______________________________
NM License Number

THIS SECTION TO BE COMPLETED BY SUPERVISING PHYSICIAN

Name: ____
Supervising Physician (Print or Type) NM License Number Field of Practice

Business Name: ____

____
Address

____
City State Zip/Postal Code

Business Telephone: (____)____________________Fax Number: (____)____________________

Supervision Beginning Date: ____________________ Supervision Ending Date: ____________________
(Board must approve) (If known)

Payment Information: *Fee $25* **($25 fee does not apply for new applicants)**

_______ Master Card _______ Visa _______ Check _______ Money Order

Credit Card #: ______________________________ Exp Date: ____________________

Physician Assistant's Name License Number

ALTERNATE SUPERVISING PHYSICIAN:

In my Absence, the following physician (s) agrees to serve as alternate supervising physician (s) for the above-named physician assistant. Copy if needed.

Physician Name	NM License Number	Field of Practice	Signature
Physician Name	NM License Number	Field of Practice	Signature
Physician Name	NM License Number	Field of Practice	Signature
Physician Name	NM License Number	Field of Practice	Signature
Physician Name	NM License Number	Field of Practice	Signature
Physician Name	NM License Number	Field of Practice	Signature
Physician Name	NM License Number	Field of Practice	Signature
Physician Name	NM License Number	Field of Practice	Signature
Physician Name	NM License Number	Field of Practice	Signature
Physician Name	NM License Number	Field of Practice	Signature

I certify that I am the supervising physician named in this document and assume full responsibility for the supervision of the physician assistant named above. I also acknowledge that I have read and understand the rules pertaining to the supervision of a physician assistant. I further acknowledge that in submitting these forms to the New Mexico Medical Board. I agree that supervision will be in accordance with the New Mexico Medical Practice Act and Rules.

Signature of Supervising Physician Date

Approved By: ____

Signature Title Date

Effective date of Supervision: _______/_______/_______

New Mexico Medical Board
2055 South Pacheco Street, Bldg, 400
Santa Fe, NM 87505
(505) 476-7220 voice (505) 476-7233 fax

☐ New Applicant ☐ Replacing Previous Employer ☐ Change of Supervising Physician ☐ Adding Alternate Supervisors

Payment Information: *Fee $25* **($25 fee does not apply for new applicants)**

SUPERVISING PHYSICIAN STATEMENT OF RESPONSIBILITY

THIS SECTION TO BE COMPLETE BY PHYSICIAN ASSISTANT

Name: ____
Last First Mi Maiden

Home: ____
Number and Street

____
City State Zip/Postal Code

Office Telephone: (   ) ____________________ Home Telephone: (   ) ____________________

Fax Number: ( ) ____________________ E-Mail Address: ____________________

Physician Assistant Signature: ______________________________
NM License Number

THIS SECTION TO BE COMPLETED BY SUPERVISING PHYSICIAN

Name: ____
Supervising Physician (Print or Type) NM License Number Field of Practice

Business Name: ____

____
Address

____
City State Zip/Postal Code

Business Telephone: (____) ____________________ Fax Number: (____) ____________________

Supervision Beginning Date: ____________________ Supervision Ending Date: ____________________
(Board must approve) (If known)

Credit card payment information page attached.
Please return completed page if you choose to pay by Visa or MasterCard.

Thank you!

____

Physician Assistant's Name License Number

ALTERNATE SUPERVISING PHYSICIAN:
In my Absence, the following physician (s) agrees to serve as alternate supervising physician (s) for the above-named physician assistant. Copy if needed.

Physician Name	NM License Number	Field of Practice	Signature
Physician Name	NM License Number	Field of Practice	Signature
Physician Name	NM License Number	Field of Practice	Signature
Physician Name	NM License Number	Field of Practice	Signature
Physician Name	NM License Number	Field of Practice	Signature
Physician Name	NM License Number	Field of Practice	Signature
Physician Name	NM License Number	Field of Practice	Signature
Physician Name	NM License Number	Field of Practice	Signature
Physician Name	NM License Number	Field of Practice	Signature
Physician Name	NM License Number	Field of Practice	Signature

I certify that I am the supervising physician named in this document and assume full responsibility for the supervision of the physician assistant named above. I also acknowledge that I have read and understand the rules pertaining to the supervision of a physician assistant. I further acknowledge that in submitting these forms to the New Mexico Medical Board. I agree that supervision will be in accordance with the New Mexico Medical Practice Act and Rules.

Signature of Supervising Physician Date

Approved By: ____

Signature Title Date

Effective date of Supervision: _______/_______/_______