# Effective January 30, 2018, the New Mexico Medical Board made changes to 16.10.15 NMAC "Physician Assistants: Licensure and Practice Requirements"

## Significant changes to rule are:

• Expanded licensure status may be requested by physician assistants who have more than three years of physician assistant licensed practice which will allow the physician assistant to work in "collaboration" with another physician (MD) in PRIMARY CARE only.

• "Primary Care" is defined as health care provided by a healthcare provider who typically acts as the first contact and principle point of continuing care for patients and coordinates other specialist care or services that the patient my require.

• Primary care specialties are defined as combined internal medicine and pediatrics, family medicine, general internal medicine, geriatrics (gerontology), general obstetrics and gynecology, and general pediatrics.

• "Collaboration" is defined as the process by which a licensed physician (MD or DO) and a physician assistant jointly contribute to the health care and medical treatment of patients, provided that each collaborator performs actions the collaborator is licensed or otherwise authorized to perform.

• PAs with less than three years of experience or those working in specialties other than primary care as defined by the rule must practice under the supervision of a New Mexico licensed physician (MD).

• Section 12 (16.10.15.12) of the rule addresses the qualifications for collaborative physician assistant licensure and the licensure process.

• To review the rule in its entirety, please refer to the New Mexico Medical Board Website at www.nmmb.state.nm.us and the link to the Rules and Statutes www.nmmb.state.nm.us/governing.html

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# COLLABORATIVE WORK EXPERIENCE VERIFICATION

I am applying for a medical license as a Collaborative Physician Assistant in the State of New Mexico. The New Mexico Medical Board requires this form to be completed by my supervising physician(s) (MD) verifying at least 3 years of clinical practice supervised by a licensed physician. I hereby authorize release of all information in your files, favorable or otherwise, DIRECTLY to the NMMB. Please email completed form to licensing@nmmb.nm.gov

Applicant Name

Applicant Signature

Address

***Dates of Practice mm/yy to mm/yy (must be provided by applicant)**

City/State/Zip

Telephone Number

**The section below must be completed by the supervising physician (MD).** Letters of Recommendation are ***NOT*** accepted in lieu of this form.

Type or Print Name of the supervising physician (MD) completing this form

Phone

Email address

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 derogatory/disciplinary information regarding this applicant? ___Yes ___No
4. Are the dates of supervised practice provided by the applicant on this form accurate? * ___Yes ___No

***If not, please provide correct dates***: Beginning _____ (Month/Year) Ending _____ (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

Signature of person completing this form — 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.*