

**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 may 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](http://www.nmmb.state.nm.us) and the link to the Rules and Statutes [www.nmmb.state.nm.us/governing.html](http://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](mailto: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 \_\_\_\_\_

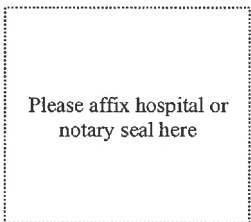
Address \_\_\_\_\_

City / State / Zip \_\_\_\_\_

- This evaluation is based on:  Observation of applicant  Review of personnel file
- In your estimation, is there any reason why this applicant should not be licensed to practice?  Yes  No
- To your knowledge, is there any derogatory/disciplinary information regarding this applicant?  Yes  No
- Are the dates of supervised practice 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.**



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.