



STATE OF TENNESSEE  
DEPARTMENT OF HEALTH  
HEALTH RELATED BOARDS  
665 MAINSTREAM DRIVE  
NASHVILLE, TENNESSEE 37243  
www.tennessee.gov

TENNESSEE BOARD OF MEDICAL EXAMINERS  
COMMITTEE ON PHYSICIAN ASSISTANTS

(800) 778-4123, ext. 532-4384 or (615) 532-3202, ext. 532-4384

APPLICATION INSTRUCTIONS FOR LICENSURE AS A PHYSICIAN ASSISTANT  
LICENSURE APPLICATION CHECK SHEET

Provided below is a checklist for your personal use and convenience containing all the things you must do to receive consideration for issuance of a Tennessee license to practice. **NOTE: All submissions must be executed and dated less than one (1) year before receipt or they will be rejected by the Committee.**

**ALL APPLICATION FEES ARE NON-REFUNDABLE.**

- |  | <b>Done</b> |
|--|-------------|
| 1. Complete, have notarized, and mail the application pages 1 through 6.   | _____       |
| 2. Attach to the application a clear, recognizable, recently taken, signed and notarized passport photograph of yourself.  | _____       |
| 3. Complete and mail Attachment 1 to the institution at which you completed your physician assistant program.  | _____       |
| 4. If you are or have ever been licensed, certified, registered, or permitted by any state to practice as a physician assistant or other health professional, you must complete and mail Attachment 2 to each and every state. Copies of Attachment 2 may be duplicated to accommodate each request.       | _____       |
| 5. If you are certified by the national Commission on Certification of Physician Assistants, you must complete and mail Attachment 3 to the NCCPA.   | _____       |
| 6. If you have a supervising physician, submit Attachment 4 along with your application. Attachment 4 <u>must</u> be signed by the supervising physician and must be submitted prior to beginning practice.  | _____       |
| 7. If completing Attachment 5, one (1) copy must be mailed to our office and a copy must be mailed to the Tennessee Board of Pharmacy, 220 Athens Way, Suite 240, Plaza 1 MetroCenter, Nashville, TN 37243.  | _____       |
| 8. Submit two (2) <u>original</u> letters of recommendation on letterhead from medical professionals who can attest to your character as a physician assistant. These letters must identify the individuals as medical professionals and <b>must be originals</b> on signatory's letterhead.               | _____       |
| 9. Please complete the enclosed practitioner profile questionnaire and mail back with the application for licensure.   | _____       |
| 10. Attach to the application a check or money order in the amount of \$335 made payable to the Committee on Physician Assistants. If requesting temporary certification or temporary authorization, attach to the application a check or money order in the amount of \$385. All fees are non-refundable. | _____       |
| 11. If your supervising physician authorizes you to prescribe controlled drugs you <u>must</u> have a Federal Drug Enforcement Administration (DEA) number. A DEA number may be obtained by calling (800) 882-9539.  | _____       |
| 12. Effective June 1, 2006 applicants for initial licensure in Tennessee must obtain a criminal background check. For instructions please visit our website at <a href="http://tennessee.gov/health/article/CBC-instructions">http://tennessee.gov/health/article/CBC-instructions</a>                     | _____       |

13. Complete and submit along with your application the Practitioner Profile Questionnaire which is online at <http://tn.gov/assets/entities/health/attachments/PH-3585.pdf>. You are required by law update your profile within 30 days of any change as long as you have an active license. Failure to do so may subject you to disciplinary action. \_\_\_\_\_
14. The “Save Act” requires The Tennessee Department of health (including all Boards, Commissions, and contractors), along with every local health department in the State, to verify that every adult applicant, for a professional license is either a U.S. citizen, a “qualified alien,” or a nonimmigrant who meets the requirements set out in 8 U.S.C. 1621. Attachment 6 must be completed and submitted before this application can be processed. \_\_\_\_\_

### UNDERSTANDING THE APPLICATION PROCESS

1. **All application fees are non-refundable.**
2. All documents and fees required to be submitted by you or which must be requested from the appropriate institutions in this application process, must be mailed directly to:  
  

**Tennessee Board of Medical Examiners  
665 Mainstream Drive  
Nashville, TN 37243 (37228 for courier service only)**
3. **Allow fourteen (14) working days** for information mailed to our office to be received and placed in your file. Federal Express or special courier services will not appreciably reduce the processing time. Additionally, if Federal Express or special courier services are used, you will be responsible for charges incurred. The Board asks that you please give the Board office every consideration in this matter.
4. If necessary documentation has not been received when your application has been received by the Board office, an initial deficiency letter will be sent to you by certified mail. The supporting documentation requested in the letter must be received in the Board office sixty (60) days from the date of the initial deficiency letter. **(Files not completed within sixty (60) days will be closed.)**
5. Absent any complicating factors, the average application processing time is six (6) weeks. Once the application is completed, your file will be reviewed and an initial licensure determination made. You will be promptly notified by letter of the initial determination.
6. **If an address change occurs at any time during the application process, you must notify the Board office, in writing, immediately.**
7. It is recommended that you do not make arrangements to accept employment as a physician assistant in Tennessee until you are granted a license, temporary certificate, or temporary authorization by the Committee on Physician Assistants.
8. All practicing PAs must have a written protocol outlining the range of services under which they practice in their respective medical communities.

Thank you for your cooperation. We will make every effort to work your application in a timely manner.

**For Office Use Only**

3628-001	\$325
3628-006	\$ 10
	\$335
3628-001	\$375
3628-006	\$ 10
	\$385



**STATE OF TENNESSEE  
DEPARTMENT OF HEALTH  
HEALTH RELATED BOARDS  
665 MAINSTREAM DRIVE  
NASHVILLE, TENNESSEE 37243**

**BOARD OF MEDICAL EXAMINERS  
COMMITTEE ON PHYSICIAN ASSISTANTS  
(800) 778-4123, ext. 532-4384 or (615) 532-3202, ext. 532-4384**

**APPLICATION FOR LICENSURE**

Choose the appropriate licensure category for which you are applying. Check the appropriate subcategory which applies to your application. See the Practice Act and the rules and regulations to determine the requirements for each category of practitioner and temporary certification.

<input type="checkbox"/>	Physician Assistant Licensure by Exam or Reciprocity (attach \$335 payment) (NCCPA Certified)
<input type="checkbox"/>	Apply with request for temporary certificate (attach \$385 payment) (Graduate/Not NCCPA Certified)

**PERSONAL INFORMATION**

**PLEASE PRINT IN INK**

Name as it will appear on license: \_\_\_\_\_  
(First) (Middle) (Last)

Social Security Number: \_\_\_\_\_ Date of Birth: Mo. \_\_\_\_ Day \_\_\_\_ Yr. \_\_\_\_

Present Mailing Address: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Place of Birth: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Sex: (optional, for statistical purposes only)  
Female \_\_\_\_\_  
Male \_\_\_\_\_

U. S. Citizen: Yes\* \_\_\_\_\_ No\* \_\_\_\_\_

Email address: \_\_\_\_\_

Do you wish to receive notification, including renewal notification, from the Department of Health via email? Y N

**EDUCATIONAL AND EMPLOYMENT INFORMATION**

Please provide the following information for all educational institutions you have attended beyond high school. Use the back of [this page](#) if you need additional space. (SEND **ATTACHMENT #1** TO THE EDUCATIONAL INSTITUTION WHERE YOU COMPLETED YOUR PROGRAM)

From: _____	To: _____		
Mo/Yr	Mo/Yr	Educational Inst./Phys. Asst. Program	Location
From: _____	To: _____		
Mo/Yr	Mo/Yr	Educational Inst./Phys. Asst. Program	Location
From: _____	To: _____		
Mo/Yr	Mo/Yr	Educational Inst./Phys. Asst. Program	Location
From: _____	To: _____		
Mo/Yr	Mo/Yr	Educational Inst./Phys. Asst. Program	Location

Please complete your entire employment history starting with the most current position first. Use the back of [this page](#) if you need additional space.

**DATES**

**LOCATION**

From: _____	To: _____		
Mo/Yr	Mo/Yr	City/State	Position/Duties
From: _____	To: _____		
Mo/Yr	Mo/Yr	City/State	Position/Duties
From: _____	To: _____		
Mo/Yr	Mo/Yr	City/State	Position/Duties
From: _____	To: _____		
Mo/Yr	Mo/Yr	City/State	Position/Duties
From: _____	To: _____		
Mo/Yr	Mo/Yr	City/State	Position/Duties
From: _____	To: _____		
Mo/Yr	Mo/Yr	City/State	Position/Duties
From: _____	To: _____		
Mo/Yr	Mo/Yr	City/State	Position/Duties

**LICENSURE INFORMATION**

List below all states, countries, provinces in which you have ever been or currently are licensed, permitted, or certified as a Physician Assistant. Submit a copy of **Attachment 2** to all such states, countries, or provinces regarding such licensure, certification, or permit. Us the back of this page if you need additional space.

STATE	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List below **ALL** state, countries, or provinces in which you hold or have ever held a license as a health professional other than a Physician Assistant. Submit a copy of attachment #2 to all such state, country, or province regarding such licensure. Additional pages may be added if necessary.

STATE	PROFESSION	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

- |   |       |       |
|---|-------|-------|
|   | Yes   | No    |
| 1. Are you certified (NCCPA) by the National Commission on the Certification of Physician Assistants? If so, complete <b>Attachment 3</b> and send it to the NCCPA. | _____ | _____ |
| 2. Have you ever applied for a physician assistant license in Tennessee?  | _____ | _____ |
| 3. Have you ever received a temporary permit or license in Tennessee?   | _____ | _____ |

**COMPETENCY INFORMATION**

**PLEASE ANSWER THE FOLLOWING QUESTIONS.** If any answers to the questions in this part are in the affirmative, attach an explanation on a separate sheet. ***In support of your explanation, the final documents or orders from the issuing states, courts, or agencies must be submitted along with this application.***

For the purposes of these questions, the following phrases or words have the following meanings:

1. **"Ability to practice your profession"** to be construed to include all of the following:
  - a. The cognitive capacity to exercise reasoned professional judgments, to learn, and keep abreast of developments in your profession;
  - b. The ability to communicate those judgments and information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
  - c. The physical capability to perform tasks and procedures required of your profession, with or without the use of aids or devices, such as corrective lenses or hearing aids.
2. **"Medical Condition"** includes physiological, mental or psychological conditions or disorders, such as, but not limited to; orthopedic, visual, speech and/or hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV, tuberculosis, drug addiction, and alcoholism.
3. **"Chemical substances"** is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.
4. **"Currently"** does not mean on the day of or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee or within the past two (2) years.
5. **"Illegal use of controlled substances"** means the use of controlled substances obtained illegally (e.g., heroin, or cocaine) as well as the use of controlled substances that are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

**QUESTIONS:**

**YES NO**

- |    |  |     |     |
|----|--|-----|-----|
| 1. | Do you currently have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety?  | ___ | ___ |
| a. | If yes, are they reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program?  | ___ | ___ |
| b. | If you have any limitations or impairments caused by an existing medical condition, are they reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? | ___ | ___ |

*[If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individual assessment of the nature, the severity, and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure.]*

**COMPETENCY INFORMATION CONTINUED**

<b>QUESTIONS:</b>		<b>YES</b>	<b>NO</b>
2.	Do you currently use chemical substances?  If yes, do they in any way impair or limit your ability to practice medicine with reasonable skill and safety?  Please list: _____ _____	_____	_____
3.	Are you currently engaged in the illegal use of controlled substances?  If yes, are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you in order to assure that you are not engaged in the illegal use of controlled substances?	_____	_____
4.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, or voyeurism?	_____	_____
5.	If you have ever held or applied for a license or certificate to practice medicine in any state, country, or province, has or was it ever been denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	_____	_____
6.	If you have ever had staff privileges at any hospital or health care facility have they ever been revoked, suspended, curtailed, restricted, limited, otherwise disciplined, or voluntarily surrendered under threat of restriction or disciplinary action? *	_____	_____
7.	Have you ever been convicted of a felony or a misdemeanor other than a minor traffic violation?	_____	_____
8.	Have you ever been rejected or censured by a professional society?	_____	_____
9.	In relation to the performance of your professional services in any profession:		
	a. Have you ever had a final judgment rendered <u>against</u> you;	* _____	_____
	b. Have you ever had settlement of any legal action rendered <u>against</u> you; or	* _____	_____
	c. Are there any legal actions pending <u>against</u> you or to which you are a party?	* _____	_____
10.	If you have ever held a license or certificate in any health care profession, has it ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action? *	_____	_____
11.	Have you ever failed a licensure or certification exam? If yes, please describe the circumstances: _____ _____	_____	_____

**APPLICANT: FILL OUT THE FOLLOWING AFFIDAVIT IN THE PRESENCE OF A NOTARY PUBLIC**

**AFFIDAVIT AND RELEASE**

I, \_\_\_\_\_, PA, of \_\_\_\_\_  
(Applicant's Name) (City) (State)

being duly sworn and identified as the person referred to in this application attests to the truth of each statement made in said application. I further swear that I have read and understand the law and the Rules and Regulations regarding the practice of my profession, which are posted on the Board's Internet site and/or were provided to me by the Board office, and agree to abide by them in the practice of my profession in the State of Tennessee.

**I HEREBY:**

**SIGNIFY** my willingness to appear to answer such questions as the Board may find necessary, which may include a full Board interview.

**RELEASE** to the Committee, its staff, and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice my profession.

**AUTHORIZE** the Committee, its staff, and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others, and other qualifications.

**RELEASE** from liability the Committee, the Board, its staff, and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character, and other qualifications for licensure.

**ACKNOWLEDGE** that I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical, other qualifications, and for resolving any doubts about such qualifications.

**AUTHORIZE** release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

**THIS CERTIFIES THAT THE INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.**

\_\_\_\_\_  
**SIGNATURE**

\_\_\_\_\_  
**DATE**

Sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_

\_\_\_\_\_  
**NOTARY PUBLIC**

Affix Seal Here

My Commission expires \_\_\_\_\_

ATTACHMENT 1



STATE OF TENNESSEE  
DEPARTMENT OF HEALTH  
HEALTH RELATED BOARDS  
665 MAINSTREAM DRIVE  
NASHVILLE, TENNESSEE 37243

COMMITTEE ON PHYSICIAN ASSISTANTS  
(800) 778-4123, ext. 532-4384 or (615) 532-3202, ext. 532-4384

EDUCATION VERIFICATION

**APPLICANT:** Supply the information requested in this box and then mail this entire form to the school at which you completed your physician assistant program. **NOTE:** Most schools require a fee, so you may want to contact the institution before mailing this form so that you can attach their fee..

Full Name:	_____	_____	_____
	(Last)	(First)	(Middle/Maiden)
Address:	_____	Social Security Number:	____ - ____ - ____
	_____		
	_____		
Student Identification Number:	_____		
Year of Graduation:	_____		
Degree Obtained:	_____	Date Degree Conferred:	_____

TO WHOM IT MAY CONCERN:

I am applying for a license to practice as a physician assistant in the State of Tennessee. Please forward an original graduate transcript of courses, grades, and degree bearing the institution's official seal to:

**Board of Medical Examiners  
Committee on Physician Assistants  
665 Mainstream Drive  
Nashville, TN 37243 (37228 for courier service only)**

Thank you for your cooperation and prompt response.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

ATTACHMENT 2



STATE OF TENNESSEE  
DEPARTMENT OF HEALTH  
HEALTH RELATED BOARDS  
665 MAINSTREAM DRIVE  
NASHVILLE, TENNESSEE 37243

COMMITTEE ON PHYSICIAN ASSISTANTS  
(800) 778-4123, ext. 532-4384 or (615) 532-3202, ext. 532-4384  
[www.tennessee.gov/health](http://www.tennessee.gov/health)

CLEARANCE FROM OTHER STATE LICENSURE BOARDS

**APPLICANT:** Please provide the information requested in the top box and then mail one form to the licensure board in EACH state where you hold OR HAVE EVER HELD a license to practice any profession. (You may copy this form.) **NOTE:** Some states require a fee for providing clearance information. To expedite your application, you may wish to contact the applicable state(s).

\_\_\_\_\_ was granted a license to practice \_\_\_\_\_  
(Name of Applicant) (Profession)  
with license number \_\_\_\_\_ on \_\_\_\_\_ in the State of \_\_\_\_\_.  
(Date)

The Committee on Physician Assistants of Tennessee requests that I submit evidence of the current status of that license in your state. You are hereby authorized to release any information in your files, favorable or otherwise, directly to:

Committee on Physician Assistants  
665 Mainstream Drive  
Nashville, TN 37243

Date: \_\_\_\_\_

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Applicant's typed or printed name

ADMINISTRATIVE OFFICE OF STATE LICENSURE BOARD, PLEASE COMPLETE:

Name In Full As It Appears On License:

License Number \_\_\_\_\_ Profession \_\_\_\_\_ Date Issued \_\_\_\_\_

Basis of issuance: \_\_\_\_\_ Endorsement/Reciprocity with \_\_\_\_\_  
(Check One) (State)

\_\_\_\_\_ Written Examination \_\_\_\_\_  
(Name of Exam)

The License is currently active and registered? Yes \_\_\_\_\_ No \_\_\_\_\_

Is there any derogatory information on file? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, an explanation must be attached.

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

ATTACHMENT 3



STATE OF TENNESSEE  
DEPARTMENT OF HEALTH  
HEALTH RELATED BOARDS  
665 MAINSTREAM DRIVE  
NASHVILLE, TENNESSEE 37243

COMMITTEE ON PHYSICIAN ASSISTANTS  
(800) 778-4123, ext. 532-4384 or (615) 532-3202, ext. 532-4384  
[www.tennessee.gov/health](http://www.tennessee.gov/health)

NCCPA VERIFICATION

Only if or when you are credentialed with the NCCPA, please complete this form and mail it to the address below:

NATIONAL COMMISSION ON CERTIFICATION OF  
PHYSICIAN ASSISTANTS  
12000 Findley Road, Suite 100  
Johns Creek, GA 30097

To Be Completed By Applicant (Please Print In Ink)

Dear NCCPA Official:

I am applying for a license to practice as a Physician Assistant in the State of Tennessee. The State Board of Medical Examiners' Committee on Physician Assistants requires that a credential letter be **forwarded directly to their** office by the NCCPA.

Applicants Name: \_\_\_\_\_  
(First) (Middle) (Last)

Social Security Number: \_\_\_\_\_ Credential # \_\_\_\_\_

PLEASE MAIL CREDENTIAL VERIFICATION DIRECTLY TO:

Committee on Physician Assistants  
665 Mainstream Drive  
Nashville, Tennessee 37243



STATE OF TENNESSEE  
DEPARTMENT OF HEALTH  
HEALTH RELATED BOARDS  
665 MAINSTREAM DRIVE  
NASHVILLE, TENNESSEE 37243

COMMITTEE ON PHYSICIAN ASSISTANTS  
(800) 778-4123, ext. 532-4384 or (615) 532-3202, ext. 532-4384

**SUPERVISING PHYSICIANS**

This section must be completed by the supervising physician(s).  
(This page may be duplicated if necessary)

List all practice settings:

1) **Setting:**

\_\_\_\_\_  
Supervising Physician Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Tennessee Medical License Number

2) **Setting:**

\_\_\_\_\_  
Supervising Physician Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Tennessee Medical License Number

3) **Setting:**

\_\_\_\_\_  
Supervising Physician Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Tennessee Medical License Number

4) **Setting:**

\_\_\_\_\_  
Supervising Physician Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Tennessee Medical License Number

**ATTACHMENT 5**

**TENNESSEE BOARD OF MEDICAL EXAMINERS'  
COMMITTEE ON PHYSICIAN ASSISTANTS**

**AUTHORIZATION FOR PRESCRIBING FOR PHYSICIAN ASSISTANTS**

**Supervising Physician**

\_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

City State Zip Code

Phone Number \_\_\_\_\_

Field of Practice \_\_\_\_\_

Medical License Number \_\_\_\_\_

**Physician Assistant**

\_\_\_\_\_

Field of Practice \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

City State Zip Code

Phone Number \_\_\_\_\_ TN License Number \_\_\_\_\_

Check the class of drugs you desire to delegate:

- |  |   |
|--|---|
| _____ Analgesics                               | _____ Enzymes                                 |
| _____ Anesthetics                              | _____ Expectorants and Cough Preparations     |
| _____ Antihistamines                           | _____ Eye, Ear, Nose, and Throat Preparations |
| _____ Anti-infective Agents                    | _____ Gastrointestinal Drugs                  |
| _____ Anti-inflammatory Agents                 | _____ Hormones and Synthetic Substitutes      |
| _____ Anti-neoplastic Agents                   | _____ Hyperglycemic Agents                    |
| _____ Antispasmodics and Anticholinergics      | _____ Migraine Preparations                   |
| _____ Antivirals                               | _____ Muscle Relaxant Preparations            |
| _____ Arthritis Medications                    | _____ Narcotic Antagonists                    |
| _____ Autonomic Drugs                          | _____ Oxytocics                               |
| _____ Blood Derivatives                        | _____ Psychotropics                           |
| _____ Blood Formation and Coagulation          | _____ Serum, Toxoids, and Vaccine             |
| _____ Birth Control Drugs and Devices          | _____ Skin and Mucous Membrane Preparations   |
| _____ Bronchodilators/Anti-asthma Drugs        | _____ Smoking Cessation Aids                  |
| _____ Cardiovascular Drugs                     | _____ Smooth Muscle Relaxants                 |
| _____ Central Nervous system Drugs             | _____ Spasmolytic Agents                      |
| _____ Contraceptives                           | _____ Sympathomimetics and Combination        |
| _____ Diabetic Agents                          | _____ Vitamins                                |
| _____ Diagnostic Agents                        | _____ Unclassified Therapeutic                |
| _____ Decongestants                            | _____ Other _____                             |
| _____ Electrolytic, Caloric, and Water Balance | _____   |
|  | _____   |

Check the type **and** schedule of controlled drugs you desire to delegate:

<u>Type</u>	<u>Schedule II</u>	<u>Schedule III</u>	<u>Schedule IV</u>	<u>Schedule V</u>
_____ None	_____	_____	_____	_____
_____ Barbiturates	_____	_____	_____	_____
_____ Benzodiazepines	_____	_____	_____	_____
_____ Depressants	_____	_____	_____	_____
_____ Narcotics	_____	_____	_____	_____
_____ Stimulants	_____	_____	_____	_____
_____ Other (Please List)	_____			
	_____			
	_____			

I, \_\_\_\_\_ MD/DO, License Number \_\_\_\_\_  
Please print

do hereby delegate the above prescribing authority to \_\_\_\_\_ PA of whom I am the supervising physician and will assume the responsibility according to TCA §63-19-107.

I, \_\_\_\_\_ PA do hereby accept the delegated function of prescribing authorization and will utilize it as such according to TCA §63-19-107.

\_\_\_\_\_  
 Signature of Physician Assistant Date

\_\_\_\_\_  
 Signature of Supervising Physician Date



STATE OF TENNESSEE  
DEPARTMENT OF HEALTH  
HEALTH RELATED BOARDS  
665 MAINSTREAM DRIVE  
NASHVILLE, TN 37243

DECLARATION OF CITIZENSHIP  
MUST ACCOMPANY ALL APPLICATIONS FOR INITIAL LICENSURE OR REINSTATEMENT OF LICENSURE

The "SAVE Act" requires Tennessee Department of Health (including all Boards, Commissions, and contractors), along with every local health department in the State, to verify that every *adult* applicant for a professional license is either a U.S. citizen, a "qualified alien," or a nonimmigrant who meets the requirements set out at 8 U.S.C. 1621.

I am a(n) \_\_\_\_\_  
Healthcare Profession (Please Print) License number if applicable

Please Print Legibly

1. Name: \_\_\_\_\_  
Last First Middle Maiden\_
2. Mailing Address: \_\_\_\_\_
3. Phone Number: Home: (\_\_\_\_)\_\_\_\_-\_\_\_\_ Office: (\_\_\_\_)\_\_\_\_-\_\_\_\_ Fax: (\_\_\_\_)\_\_\_\_-\_\_\_\_
4. I am a United States Citizen: \_\_\_Yes \_\_\_No
5. I am a foreign national not physically present in the United States \_\_\_Yes \_\_\_No. If you answered yes, to this question please sign this form in the presence of a notary and return it with your application. No further documentation is required.
6. Applicants Claiming United States Citizenship **MUST** provide one of the following:
  - a) Tennessee Driver's License, or photo ID issued by Department of Safety.
  - b) A valid driver license or ID issued by another state, provided its issuance requirements meet Department of Safety criteria.
  - c) An official birth certificate issued by a U.S. state, territory, or other jurisdiction. Puerto Rican birth certificates issued before July 1, 2010 do not count.
  - d) A federally issued birth certificate.
  - e) A valid, unexpired U.S. passport.
  - f) A report of birth abroad of a U.S. citizen.
  - g) A certificate of citizenship.
  - h) A certificate of naturalization.
  - i) A U.S. citizen ID card.
  - j) Any successor document to #'s a-i above.
  - k) SSN that the entity or local health department may verify with the Social Security Administration in accordance with federal law.
7. If you checked "No" in question 4 please indicate from the list below which category applies to you: (circle one)
  - a) Permanent Residents

- b) A nonimmigrant applicant for a professional or commercial license whose visa for entry into the United States is related to such employment, or a nonimmigrant under the Immigration and Nationality Act (8 U.S.C. 1101 *et seq.*).
- c) Asylees who meet the qualifications set out in 8 U.S.C. 1158
- d) Refugees who meet the qualifications set out in 8 U.S.C. 1157
- e) Persons who have been "paroled into the United States," under 8 U.S.C. 1182(d)(5) or whose deportation has been withheld under 8 U.S.C. 1253.
- f) Cuban or Haitian entrants as defined by section 501(e) of the Refugee Education Assistance Act of 1980
- g) Persons granted conditional entry into the U.S. under 8 U.S.C. 1153(a)(7) before April 1, 1980, because of persecution or fear of persecution on account of race, religion, or political opinion or because of being uprooted by catastrophic national calamity.
- h) An alien who has been "battered" or subjected to "extreme cruelty" by a parent or spouse as defined by 8 U.S.C. 1641(c), and also meets the qualifications set out 8 U.S.C. 1641(c)(1)(B). Under the circumstances set out in 8 U.S.C. 1641(c)(2) and (3), victims' children, or the parents of children who are victims, may also apply for benefits as qualified aliens.

Applicants claiming **qualified alien status** (question 7 above), please submit two of the following forms of "documentation of identity and immigration status" as determined by U.S. Homeland Security to be acceptable for verification through the SAVE program. Common types of documents used to verify immigration status are listed below. (Note: If you can provide only one document, your status will be verified through the U.S. Department of Homeland Security's SAVE program):

I-327 (Reentry Permit)

I-551 (Permanent Resident Card or "Green Card")

I-571 (Refugee Travel Document)

I-766 (Employment Authorization Card)

Machine Readable Immigrant Visa (with Temporary I-551 language)

Temporary I-551 stamp (on passport or I-94)

I-94 (Arrival/Departure record)

Unexpired foreign passport

WT/WB Admission Stamp in unexpired foreign passport

I-20 (Certificate of Eligibility for Nonimmigrant F(1) student status- "student visa")

DS2019 (Certificate of Eligibility for Exchange Visitor (J-1) Status)

I affirm under the penalty of perjury that the above is true and correct.

Signed this \_\_\_\_ day of \_\_\_\_\_, 20\_\_.

\_\_\_\_\_  
Signature

Sworn to before me this \_\_\_\_ day of \_\_\_\_\_, 20\_\_.

\_\_\_\_\_  
NOTARY PUBLIC

AFFIX SEAL HERE

My Commission Expires: \_\_\_\_\_

**If an applicant is discovered to be an unqualified alien, or otherwise ineligible for benefits under the Act, all recurring benefits provided to that applicant must be immediately terminated. Anyone who purposefully makes a false, fictitious, or fraudulent claim of U.S. citizenship or qualified alien status will be liable under the Tennessee Medicaid False Claims Act, or Tennessee's False Claims Act. Any person who conspires to defraud the state or any local health department by securing a false claim allowed or paid to another person in violation of the Act may be liable under Tennessee's False Claims Act. Upon discovery of an applicant's false, fictitious, or fraudulent claim of U.S. citizenship, state governmental entities and local health departments must also file a criminal complaint with the United States Attorney.**