

Login

Physician Assistant Licensure Application

Notice for Military and Veteran Applicants:

Senate Bill 807, which became effective on September 1, 2015, allows for the waiver of application fees for any US military service member, active duty military spouse or military veteran. If you would like to be pre-qualified for this exemption, please visit this link to obtain the fee waiver request form: [Military Fee Waiver](#). Follow the instructions, and once submitted to the Board, allow 3 business days for processing. Approved waivers will be notified by email to proceed completing the online application.

Approved Pre-Qualified Military and Veteran Applicants:

If you have already received your pre-qualification email and have been issued a 6 digit Medical Board ID number, please continue through the application. If you are re-directed to TX.gov for payment, please double-check the Date of Birth and SSN number entered and make any corrections before re-submitting. If you are still re-directed to Texas.gov for payment, contact us at: Screen-CIC@tmb.state.tx.us

- Information you enter will automatically be saved at the end of every page.
- You must complete the application within 15 days or your information will be deleted.
- Some of the questions may direct you to download a supplemental form and submit along with any relevant records.
- Pay the license fee using one of the following:
 - MasterCard,
 - Visa,
 - Discover,
 - American Express, or
 - Electronic Check.

Check Your Eligibility

Application Checklist

FAQ

Processing times can vary depending on the acceptability of submitted items and the complexity of your application. Some of the factors that can increase complexity are “yes” answers to the professionalism questions on this application.

Enter to create a new application or to return to a saved application.

Asterisk (*) indicates a response required.

Identification

Asterisk (*) indicates a response required.

Full Name as you wish it to appear on your receipt*:

Your name, as entered in the next 4 fields, will be the name that appears on your license and your physician profile on the web site.

Applicant First Name*:

Applicant Middle Name:

Applicant Last Name*:

Suffix:

Social Security Number (XXX-XX-XXXX or XXXXXXXXXXX)*:

Alternate Names:

Email Address:

Gender*:

Country of Birth*:

If you were born in the United States, please select your state of birth:

US State of Birth:

Date of Birth (MM/DD/YYYY)*:

Race*:

Are you of Hispanic Origin?*

If you are a Texas high school graduate, please provide the county where your high school is located.

Texas High School County:

Select your Physician Assistant program from the drop down list below. If you are unable to locate your school, please select "Unknown" and be aware that this will delay the processing of your application.

PA School*:

Year of Graduation (or anticipated year of graduation) (YYYY)*:

NCCPA Certification Number (must be numeric, if pending, leave blank) :

Are you currently on active duty in the U.S. Military?

Expediting Factors

An applicant headquartered in Texas who is an active duty military service member, or the spouse of an active duty military service member, may be eligible for expedited handling.

If you think you may qualify please select the appropriate box:

Military Service Member (active duty):

Spouse of a Military Service Member (active duty):

Address

Please provide your mailing address. If you have a practice address, it must be a physical address (not a P.O. Box) and should be where you intend to work upon receipt of your Physician Assistant license. **It is your responsibility to notify the Board by updating your address in your MyTMB account if you have a change of address.** When entering a foreign address select "Other" for State and provide a Country.

Asterisk (*) indicates a response required.

Mailing address

Mailing Address 1:*

Mailing Address 2:

Mailing City: *

Mailing State:

Mailing Province:

Mailing Zip Code:*

Mailing Country:*

Telephone Number ###-###-####:*

Practice address

Practice Address 1:

Practice Address 2:

Practice City:

Practice State:

Practice Province:

Practice Zip Code:

Practice Country:

Telephone Number ###-###-####:

Work Experience

- Please account for all periods of work from the time you graduated from your Physician Assistant program to the present date.
- If you have ever have ever been a member of the medical staff of a licensed hospital, nursing home, clinic, health maintenance organization, or other hospital care facility with an organized medical staff as a physician assistant, you will need to enter this information.
- For Physician Assistants, the Facility/Employer Name field should include the name of your Supervising Physician.
- The Facility/Employer Name fields should include the name of your Supervising Physician.
- Include all periods of unemployment or employment outside the field of medicine. For periods of unemployment, use your home address.
- To indicate a current position, enter today's date as an end date.

Add Work Experience

Asterisk (*) indicates a response required.

Position*:
Department*:
Start Date (MM/YYYY)*:
End Date (MM/YYYY)*:
Facility/Employer Name*:
Street*:
City*:
State:
ZIP/Postal Code*:
Province:
Country*:
Phone Number:

Professional History

Attention: This is important. Be sure to disclose all relevant disciplinary actions, charges, or convictions. A false response to any of these questions may be grounds for disciplinary action or even denial of licensure. Avoid some of the common excuses heard from people who fail to disclose such as:

- My attorney told me I didn't have to disclose the criminal conduct or disciplinary actions.
- I didn't think the prior conduct had anything to do with the profession.
- I didn't think the disciplinary action, arrest, charges, or conviction was still on my record.
- I didn't think it was subject to disclosure because I received a deferred sentence judgment.

All supplemental forms listed can be found on the Additional Forms section of our website.

Asterisk (*) indicates a response required.

Professional History

Question 1*

Have you ever been issued a Texas Physician Assistant License?	<input type="radio"/> Yes <input type="radio"/> No
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Question 2

List all states in which you have applied for or have been granted licensure or certification as any type of healthcare provider. Choose a type of license and state from the drop down lists below. If you are unable to locate your license type, please use "Unassigned", and be aware that this will delay the processing of your application. Use Form AA if you have more than five licenses.

Type of License:

State:

Type of License:

State:

Type of License:

State:

Arrest/Criminal History

If you answer "Yes" to any question in this section, you are required to submit Form R.

If you believe your offense was **sealed or expunged**, you **must** be able to provide a copy of the expunction or non-disclosure order if requested.

Question 3*

Have you ever been arrested? If you answer "Yes" to this question, you are required to submit <u>Form R</u> .	<input type="radio"/> Yes <input type="radio"/> No
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Question 4*

Have you ever been cited or ticketed for, or charged with any violation of the law? (Unless the offense involved alcohol or drugs, you may exclude: 1) traffic tickets; and, 2) violations with fines of \$250 or less.) If you answer "Yes" to this question, you are required to submit <u>Form R</u> .	<input type="radio"/> Yes <input type="radio"/> No
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Question 5*

Are you currently the subject of a grand jury or criminal investigation? If you answer "Yes" to this question, you are required to submit <u>Form R</u> .	<input type="radio"/> Yes <input type="radio"/> No
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Question 6*

Have you ever been convicted of an offense, placed on probation, or granted deferred adjudication or any other type of pretrial diversion? (Unless the offense involved alcohol or drugs, you may exclude: 1) traffic tickets; and, 2) violations with fines of \$250 or less.) If you answer "Yes" to this question, you are required to submit Form R.	<input type="radio"/> Yes <input type="radio"/> No
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Question 7

Left intentionally blank at this time.	
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Actions by Professional Licensing Entities

If you answer "Yes" to any question in this section, you are required to submit Form S.

Question 8*

Have you ever withdrawn an application for a professional license, permit or certification as a healthcare professional, or have you been determined ineligible for a professional license, permit or certification as a healthcare professional? If you answer "Yes" to this question, you are required to submit <u>Form S</u> .	<input type="radio"/> Yes <input type="radio"/> No
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Question 9*

Have you ever had limitations placed on a professional license, been disciplined, or allowed to resign or voluntarily surrender your license in lieu of action by any licensing authority in any state, province, territory, U.S. federal jurisdiction, or country? (This would include, but is not limited to , informal or confidential orders; consent orders; agreed orders; letters of warning; letters of education; or letters of concern.) If you answer "Yes" to this question, you are required to submit <u>Form S</u> .	<input type="radio"/> Yes <input type="radio"/> No
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Question 10*

Have you ever been the subject of an investigation based on any complaints, inquiries, grievances or formal or informal charges filed (regardless of the outcome) with or by any licensing authority in any state, province, territory, U.S. federal jurisdiction, or country? If you answer "Yes" to this question, you are required to submit <u>Form S</u> .	<input type="radio"/> Yes <input type="radio"/> No
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Question 11*

Are there now pending any investigations, complaints, inquiries, grievances or formal or informal charges with or by any licensing authority in any state, province, territory, U.S. federal jurisdiction, or country? If you answer "Yes" to this question, you are required to submit <u>Form S</u> .	<input type="radio"/> Yes <input type="radio"/> No
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Question 12*

Have you ever had restrictions placed on, been denied, or been required to surrender a federal or state controlled substance permit? If you answer "Yes" to this question, you are required to submit <u>Form S</u> .	<input type="radio"/> Yes <input type="radio"/> No
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Actions and Investigations in Training or During Employment

If you answer "Yes" to any question in this section, you are required to submit [Form U](#). If you believe that any action or investigation was not reportable, you **must** read the instruction on [Form U](#) before you answer "No" to ensure your full and honest disclosure. Warning: Failure to answer the following questions correctly may subject you to disciplinary action.

Has any academic program, health care entity or professional organization ever taken against you, through either oral or written communication, any of the following public or private actions:

Question 13a*

limitation, reduction, suspension, revocation or denial of privileges? If you answer "Yes" to this question, you are required to submit Form U .	<input type="radio"/> Yes <input type="radio"/> No
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Question 13b*

warning, censure, reprimand, or formal admonishment? If you answer "Yes" to this question, you are required to submit Form U .	<input type="radio"/> Yes <input type="radio"/> No
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Question 13c*

additional limitations or requirements placed on you based on your clinical performance, academic performance, discipline, or for any other reason? If you answer "Yes" to this question, you are required to submit Form U .	<input type="radio"/> Yes <input type="radio"/> No
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Question 13d*

placement on academic or disciplinary probation? If you answer "Yes" to this question, you are required to submit Form U .	<input type="radio"/> Yes <input type="radio"/> No
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Question 13e*

request of termination, withdrawal or resignation? If you answer "Yes" to this question, you are required to submit Form U .	<input type="radio"/> Yes <input type="radio"/> No
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Question 13f*

acceptance of voluntary resignation in lieu of further investigations or other action? If you answer "Yes" to this question, you are required to submit Form U .	<input type="radio"/> Yes <input type="radio"/> No
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Question 14*

Are any such actions listed in questions 13a through 13f pending? If you answer "Yes" to this question, you are required to submit Form U .	<input type="radio"/> Yes <input type="radio"/> No
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Question 15*

Are you currently under investigation by any academic program, health care entity or professional organization? If you answer "Yes" to this question, you are required to submit <u>Form U</u> .	<input type="radio"/> Yes <input type="radio"/> No
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Malpractice History

If you answer "Yes" to any questions in this section, you are required to submit Form I and Form V.

Question 16*

Has a complaint ever been filed against you in a court (i.e. a lawsuit) seeking damages relating to your conduct in providing or failing to provide a medical or health care service? If you answer "Yes" to this question, you are required to have <u>Form I</u> completed by every malpractice carrier who has insured you and you are required to submit <u>Form V</u> .	<input type="radio"/> Yes <input type="radio"/> No
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Question 17*

Has there been: (a) a settlement of a claim without the filing of a lawsuit, or (b) a settlement of a lawsuit made by you or on your behalf involving damages relating to your conduct in providing or failing to provide a medical or health care service? If you answer "Yes" to this question, you are required to have <u>Form I</u> completed by every malpractice carrier who has insured you and you are required to submit <u>Form V</u> .	<input type="radio"/> Yes <input type="radio"/> No
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Question 18*

While serving in the U.S. military or the Public Health Service, or while employed, contracted or privileged by a federal facility was a complaint filed in court (i.e., a lawsuit) seeking damages relating to your conduct in providing or failing to provide a medical or health care service? If you answer "Yes" to this question, you are required to have <u>Form I</u> completed for each complaint and you are required to submit <u>Form V</u> .	<input type="radio"/> Yes <input type="radio"/> No
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If you answered Yes to Question 44, 45, or 46 above, what is the total number of cases?

Enter the number here:

Mental and Physical Health

If you answer "Yes" to the following question, you are required to submit Form W.

Question 19*

Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner?	<input type="radio"/> Yes <input type="radio"/> No
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The Texas Physician Health Program (TXPHP) is a confidential program that promotes wellness and the treatment of health conditions that may compromise the ability to practice with reasonable skill and safety. TXPHP is a resource available for all licensees who may suffer from a condition that is or could impair their ability to practice.

TXPHP does not itself treat those who participate, but facilitates a participant's treatment and provides monitoring as needed. Examples of conditions that TXPHP can monitor include: substance abuse and addiction issues, mental health issues, and other medical conditions that may interrupt a licensee's practice. In addition to monitoring, TXPHP provides education, recognition, and assistance in diagnosis, treatment, and management of licensees' potentially impairing conditions.

You may contact TXPHP for further information on the program by calling (512) 305-7462 or via email at info@txphp.state.tx.us. Downloadable self-report forms can be found on the TXPHP website, <http://www.txphp.state.tx.us/>, under the "Forms" section of the website.

Attestation

I hereby certify that: I am the person herein named subscribing to this application; that I have read the complete application, know the full content thereof, and declare under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct. Further, I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past, present, and future), business or professional associates (past, present, and future) and all governmental agencies (local, state, federal, or foreign) to release to the Texas Physician Assistant Board or its successors any information, files or records, including medical records, educational records, and records of psychiatric treatment and treatment for drug and/or alcohol abuse or dependency, requested by the Board in connection with this application; necessary to determine my professional competence, professional conduct, and/or physical and mental ability to safely engage in the practice of my profession. I further authorize the Texas Physician Assistant Board or its successors to release to the organizations, individuals, or groups listed above any information, which is material to this application, or any subsequent licensure. **I hereby affirm that I will provide the Board with updated information to be received by the Board within 15 days of my becoming aware of any event that occurs after submission of my application that renders any response, although complete and correct when made, no longer complete or correct. Further, failure to provide updates may result in an adverse action against my application.**

I understand that falsification or misrepresentation of any item or response on this application or any supplemental information is a sufficient basis for denying my application, revoking a license, a determination of ineligibility, or another adverse action against my application or revoking my license after issuance.

I agree to these terms