Registered Physician Assistant Form 5

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
Division of Professional Licensing Services
89 Washington Avenue
Albany, NY 12234-1000
www.op.nysed.gov

Department Use Only

Application for Limited Permit

APPLICANT INSTRUCTIONS

1. After submitting an application for licensure as a registered physician assistant in New York State, you may file an application for a limited permit to practice pending receipt of the license. A limited permit authorizes practice as a physician assistant under supervision of a physician licensed and currently registered in New York State. When applying for a limited permit, it is your responsibility to ensure that your prospective supervisor fully completes the Certification of Supervision, Section II**.**
2. Complete Section I and forward the form to your employer. Be sure to sign and date item 9. Limited permits expire one year from the date of issue. You should be certain you are ready to begin practice when you apply for the limited permit.
3. Submit this application with a check or money order for the required fee of $105 made payable to the New York State Education Department, to the Office of the Professions at the address at the end of this form. If you have not already done so, you must submit an Application for Licensure (Form 1) and the licensure fee with this form and the limited permit fee. The permit application cannot be approved until all required documents have been received and approved. **You may not begin practice until the limited permit is issued. The Limited Permit fee is not refundable.**
4. If you change or add employers or supervisors after the permit is issued, you must obtain a new permit. You may obtain a new permit by completing, with your prospective employer, a new form 5 and returning it to the Office of the Professions. A fee is not required for a new permit issued as a result of a change in employment. An additional fee of $105 is required for an extension.

1 | **23** | **$105** | **PR**

Permit number

Date issued

Date expires

Initials

SECTION I: APPLICANT INFORMATION

2 **Social Security Number**
(Leave this blank if you do not have a U.S. Social Security Number)

3 **Birth Date** Month Day Year

4 **Print Name**

Last

First

Middle

5 **Mailing Address** (You must notify the Department promptly of any address or name changes.)

Line 1

Line 2

Line 3

City

State Zip Code

Country/ Province

6 **Telephone/E-Mail Address**

Daytime Phone

Area Code Phone Number

E-Mail Address (Please print clearly)

7 **I am applying for:**

- ☐ Original permit
- ☐ Additional/change of supervisor (No fee required)
- ☐ Additional/change of employer (No fee required)
- ☐ Extension

8 Name of prospective employer: _____

9 **ATTESTATION**

I declare and affirm that the statements made in the foregoing application are true, complete and correct. Any false or misleading information in, or in connection with, my application may be cause for denial of permit and licensure and may result in criminal prosecution.

_____ _____
Signature of applicant *Date*

SECTION II: INSTRUCTIONS TO THE SUPERVISING PHYSICIAN

1. By completing the information below, you are certifying that the permittee will be employed under the supervision of a physician who is licensed and currently registered to practice in New York State and that the employer agrees to abide by the conditions stipulated on the permit.
2. Limited permits expire one year from the date of issuance, or upon notice to the applicant by the Department that the application for licensure has been denied. See applicant instructions for further information.
3. If applicant requests more than one employer at the same time, a separate Form 5 must be completed by each supervising physician and each employer or physician.
4. The applicant may not practice as a physician assistant until the limited permit is issued.

CERTIFICATION OF SUPERVISION - *(To Be Completed By Supervisor)*

1. Applicant's name: _____

2. Employer:

Name: _____
(Enter full name - no initials)

Street: _____

City: _____ State: _____ Zip code: _____ - _____

Telephone: _____ Fax: _____ E-mail: _____

3. If practice site is <u>different</u> from employer address (item 2), provide that address:

Name: _____

Street: _____

City: _____ State: _____ Zip code: _____ - _____

Telephone: _____ Fax: _____ E-mail: _____

4. Direct supervision will be provided by:

Name of supervising physician: _____
(Please print or type)

CERTIFICATION

I certify that the applicant named above will be employed under my supervision. I am a licensed physician currently registered in New York State and agree to abide by the conditions stipulated on the permit.

I declare and affirm that the statements made in the foregoing certification are true, complete and correct. Any false or misleading information in, or in connection with this certification may be cause for disciplinary action against my license.

Signature of supervising physician _____

Date _____ / _____ / _____ N.Y. License No. _____

Employer or appointed designee: _____
(Please print or type)

Signature of employer: _____ Date: _____ / _____ / _____
mo. day yr.

Mail this form and appropriate fee to: New York State Education Department, Office of the Professions, PO Box 22063, Albany, NY 12201. DO NOT SEND CASH. Make check or money order payable to the New York State Education Department.