STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

APPLICATION FOR PHYSICIAN ASSISTANT TEMPORARY PERMIT

FEE: $150.00

RECENT GRADUATES MAY APPLY FOR A TEMPORARY PERMIT WHICH AUTHORIZES THEM TO PRACTICE AS A PHYSICIAN ASSISTANT ONLY IN THOSE SETTINGS WHERE THE SUPERVISING PHYSICIAN IS PHYSICALLY PRESENT ON THE PREMISES AND IS IMMEDIATELY AVAILABLE TO THE PHYSICIAN ASSISTANT WHEN NEEDED. THE TEMPORARY PERMIT DOES NOT AUTHORIZE THE HOLDER TO PRESCRIBE OR DISPENSE DRUGS AND SHALL BE VALID ONLY UNTIL THE ISSUANCE OF THE RESULTS OF THE FIRST CERTIFICATION EXAMINATION SCHEDULED BY THE NCCPA FOLLOWING THE APPLICANTS' GRADUATION FROM AN ACCREDITED PHYSICIAN ASSISTANT PROGRAM. THE TEMPORARY PERMIT IS NOT RENEWABLE. INDIVIDUALS WHO DO NOT SUCCESSFULLY COMPLETE THE EXAMINATION, OR WHO DO NOT ATTEND THE EXAMINATION, CANNOT BE ISSUED A NEW TEMPORARY PERMIT.

NAME:_____
FIRST MI LAST MAIDEN

ADDRESS:_____
NO & STREET CITY STATE ZIP CODE

U.S. SOCIAL SECURITY NO._____/_____/_____

DATE OF BIRTH:_____

TELEPHONE NO.:_____
WHERE YOU CAN BE REACHED MON. - FRI. 8:30a.m.-4:30, p.m.M-F

HAVE YOU EVER TAKEN THE CERTIFICATION EXAMINATION OF THE NATIONAL COMMISSION ON CERTIFICATION OF PHYSICIAN ASSISTANTS (NCCPA)? _____(YES OR NO)

IF YES - WHAT WAS THE DATE OF EXAMINATION? _____

IF NO - WHAT IS THE DATE WHEN THE EXAMINATION WILL BE TAKEN?_____

WHAT IS THE NAME OF THE PHYSICIAN WHO WILL SUPERVISE YOUR WORK UNDER THE TEMPORARY PERMIT?_____

Pursuant to Public Law 100-93, the Federal Government requires all states to report disciplinary actions to the Inspector General for Health and Human Services or risk losing Federal medicaid contributions. Although the disclosure of your social security number on this application is voluntary, Public Law 100-93 also requires the Department of Public Health to request the disclosure of your number as data that would then be available to the National Practitioner Data Bank in the event that disciplinary action should be taken against your Connecticut license. You are not required by any law to disclose your social security number, but should you decide to do so, it will be used for identification purposes only, including verifying and retrieving information.

All of the above statements contained herein are true and correct to the best of my knowledge and belief

_____ _____

SIGNATURE DATE

On this_____day of_____20____,_____(applicant's name) personally appeared before me, who being duly sworn says that she/he is the person referred to in the foregoing application and that the statements made herein are true in every respect.

_____

APPLICANT SIGNATURE

Sworn to before me this_____day of_____20_____.

_____

SIGNATURE OF NOTARY PUBLIC

My Commission expires_____.

THIS APPLICATION TOGETHER WITH THE FEE OF $150.00 IN THE FORM OF A CERTIFIED CHECK OR MONEY ORDER MADE PAYABLE TO “TREASURER, STATE OF CT” SHOULD BE SENT TO:

DEPARTMENT OF PUBLIC HEALTH
PHYSICIAN ASSISTANT LICENSURE- REMITTANCE UNIT
410 CAPITOL AVE., **MS# 12MQA**
P.O. BOX 340308
HARTFORD, CT 06134