MEDICAL
LICENSURE
GROUP

PHYSICIAN ASSISTANT ACQUISITION FORM

Please complete this form and return to Admin@MedicalLicensureGroup.com

Contact Information

Name (First Middle Last Suffix) ______________________________, PA

Maiden or Previous Names(s) ______________________________

Date of Change ______________________ Reason for Change ______________________

Home Address ______________________ City, State Zip ______________________

Work Address ______________________ City, State Zip ______________________

Home Email ______________________ Cell Phone ______________________

Work Email ______________________ Work Phone ______________________

Other Contact ______________________ Home Phone ______________________

Preferred Contact Method ○ Work ○ Cell/Home ○ Work Email ○ Home Email

Preferred Mailing Address ○ Work ○ Home

Identifying Information

Date of Birth ______________________ Place of Birth ______________________

Citizenship Status ______________________ Eye Color ______________________

Hair Color ______________________ Height Ft __________ In __________ Weight __________

Race ______________________ Social Security Number ______________________

Gender ○ Male ○ Female Naturalization Date (if applicable) ______________________

U.S Military Service

○ Yes ○ No

Branch ______________________ Rank ______________________

Dates of Service From ______________________ To ______________________

Discharge Status ______________________ Discharge Date ______________________

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Education Information

Starting with high school, list in chronological order all schools, colleges, universities attended, whether completed or not.

Name	City/State	Month/Year From-To	Major/Degree

Examination History

Indicate which licensing examination you took. (PANCE, NCCPA, etc.)

Examination	Date of Exam	Number of Attempts

Medical Licenses

List ALL states where you hold or have held a license to practice, regardless of the current status.

State	Type	License Number	Issue Date	Expiration Date	Status

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Federal DEA Registration Number

List ALL states where you hold an active DEA.

State	Number	Issue Date	Expiration Date

Practice History

List in chronological order all professional practice experience including private or group practice, hospital appointments, etc. Explain any unaccounted for periods of time exceeding 30 days.

Facility Name	City/State	Month/Year From-To	Position

Supervising Physician

Provide the requested information for a supervising physician in each state that you are applying to that requires one. (All states except ND, UT and, WY)

Name	State	License Number	Phone/Email

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Adverse Actions

Attach details for any affirmative answers.

Has a claim for malpractice ever been made against you, regardless of the outcome? ○ Yes ○ No

If yes, how many? ___________

Any adverse actions taken against you by a school/university, hospital, licensing board, etc.? ○ Yes ○ No

Been arrested, charged or convicted of a violation of any local, state, or federal statute? ○ Yes ○ No

Note: Failure to report such events could result in processing delays, fines by the board, or denial of license!

Useful Information

Please use the space below to provide any information that will be useful to us during the application process (e.g. - closed facilities, timeline gaps, relocation dates, etc.)

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PHYSICIAN ASSISTANT SERVICE AGREEMENT

OFFICE USE ONLY ______________________

I, ________________________________ (the undersigned), am hiring you (Medical Licensure Group, LLC) to assist me in applying for state medical licensure, registrations, and credentials as specified below (the "Services") or as requested from time to time either verbally or in writing by myself, my employer or representatives. I agree to provide you all information and documents required for you to perform the Services, whether directly or via my employer or representatives. I affirm such information is and will be accurate and complete and such documents will be true, correct, and complete copies. I am aware of, and remain responsible for, the deadlines and eligibility requirements for each license, registration, or credential for which I am applying with your assistance. I agree to pay any fees or other charges required or imposed by the licensing boards to file or process my applications for licensure, registration, or credentials that are the subject of the Services. I acknowledge you have no authority to grant or cause to be granted any licensure, registration, or credential and, therefore, you will not be liable to me or any other person regarding the final outcome of my applications for licensure, registration, or credentials. I further acknowledge that you make no guarantee of any timelines in which any license, registration or credential will be granted. I acknowledge I have read and agree to the additional terms and conditions specified at www.MedicalLicensureGroup.com/terms-and-conditions/.

State Licensure Services

○ **Initial License or Reinstatement ($750/ea)**

State(s)________________________________

○ **Express Processing ($200/ea)**

Accelerated application preparation

State(s) ________________________________

Note: State Medical Boards review applications in date order

○ **Completion ($550/ea)**

For already-submitted applications

State(s)________________________________

Additional Services

○ **Controlled Substance Reg (CSR) ($125/ea)**

AL, CT, DE, DC, HI, ID, IL, IN, IA, LA, MD, MA, MI, MO, NV, NJ, NM, OK, RI, SC, SD, UT, WY

CSR State(s) ____________________________

○ **DEA Registration ($125/ea)**

○ **Initial/New** State(s)______________________

○ **Modification** State(s)______________________

○ **Credentialing ($550/ea)**

Number of Applications ____________________

Other Helpful Services

○ **License Maintenance & Renewal ($225/ea)**

Renewal of currently-active license

State(s)________________________________

○ **CSR Renewal ($125/ea)**

State(s)______________

○ **DEA Renewal ($125/ea)**

State(s)______________

○ **Curriculum Vitae Preparation ($95)**

○ **Portfolio Management ($550)**

Collection and storage of entire professional history

○ **Portfolio Maintenance ($225/yr)**

Documents reviewed/updated annually

By signing below, I have read and agree to the above statement and terms and conditions.

Signature____ Date:________________

Tel (850) 433-4600 | Fax (904) 212-0886 | Admin@MedicalLicensureGroup.com | 4400 Bayou Blvd., Suite 32B, Pensacola, FL 32503