PAB PHYSICIAN ASSISTANT BOARD

BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR

DEPARTMENT OF CONSUMER AFFAIRS • PHYSICIAN ASSISTANT BOARD

2005 Evergreen Street, Suite 2250, Sacramento, CA 95815

P (916) 561-8780 | F (916) 263-2671 | paboard@dca.ca.gov | www.pab.ca.gov

APPLICATION FOR LICENSURE ATTESTATION

PHOTOGRAPH

INSTRUCTIONS

Photographs must be no more than 30 days old, and must be of head and shoulders only.

Tape a 2" x 2" color **PASSPORT** photo in this space.

Scanned, altered, or self-printed photos are not acceptable.

NOTICE OF COLLECTION OF PERSONAL INFORMATION

All items in this application are mandatory; none are voluntary. **Failure to provide any of the requested information will delay the processing of your application and may result in the application being rejected as incomplete**. The information provided will be used to determine your qualifications for licensure per Section 3519 of the California Business and Professions Code and Title 16, California Code of Regulations sections 1399.506, which authorizes the collection of this information. The information on your application may be transferred to other medical licensing authorities, the Federation of State Medical Boards, other governmental or law enforcement agencies to perform their statutory or constitutional duties, or otherwise transferred or disclosed as provided in California Civil Code Section 1798.24. You have the right to review your application and your files, except for information that is exempt from disclosure as provided in the California Public Records Act or as otherwise provided by the California Information Practices Act. Certain information provided may be disclosed to a member of the public, upon request, under the California Public Records Act or pursuant to court order. The Executive Officer is responsible for maintaining the information in this form and may be contacted at 2005 Evergreen Street, Suite 2250, Sacramento, CA 95815-3893, telephone number (916) 561-8780, regarding questions about this notice or access to records.

CERTIFICATION

I hereby certify, under penalty of perjury under the laws of the State of California that I have read the questions in the foregoing application and that all information, statements, attachments, and representations provided by me in this application are true and correct. By submitting this application and signing below, I am granting permission to the Board or its assignees and agents to verify the information provided and to perform any investigation pertaining to the information I have provided as the Board deems necessary.

My signature on this application, or copy thereof, authorizes the National Practitioner Data Bank, the National Commission on Certification of Physician Assistants, and the Federal Drug Enforcement Agency to release any and all information required by the Physician Assistant Board of California.

NOTICE: FALSIFICATION OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT HERETO IS GROUNDS FOR DENYING OR REVOKING A LICENSE.

Original signature only; electronic or printed signatures are not acceptable.

SIGNATURE OF APPLICANT:_____ **DATE:**_____

PRINT NAME: _____