

**AGREEMENT TO UPDATE APPLICATION INFORMATION**

By signing this section of the North Dakota Board of Medicine licensure application form, I agree that:

If any of the information supplied on this application form changes or becomes inaccurate or incomplete before I am granted a license to practice as a physician assistant in North Dakota, I will immediately provide the corrected information to the North Dakota Board of Medicine.

Failure to provide such corrected information to the Board will constitute the use of a fraudulent, deceitful, dishonest, or immoral practice in connection with the North Dakota licensing requirements and will, therefore, be a violation of Sec. 50-03-01-11, North Dakota Administrative Code, which will subject me to disciplinary action or denial of licensure.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

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**AFFIDAVIT:**

I, \_\_\_\_\_, being duly sworn, depose and say that I am the person referred to in the foregoing application and the supporting documents attached hereto.

I have carefully read the questions in this application and have answered them completely, without reservation of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice as a physician assistant in the State of North Dakota.

Furthermore, I hereby authorize all hospitals, clinics, institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present) and all government agencies (local, state, federal or foreign) to release to the North Dakota Board of Medicine any information which is material to this application or any subsequent registration, certification or licensure.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date