North Dakota Board of Medicine
Physician Assistant Petition for a Board Approved Practice

1. **Name:**

2. **ND PA License Number:**

3. **Will you be practicing at a state or federal facility?**
   a. ☐ YES ☐ NO

   If YES, skip to signature section at the end of the form.
   If NO, continue with the remaining questions.

Please complete and verify the following information to seek Board approval for a practice that:

i. does not currently have an established credentialling and privileging process, **OR**
ii. is not licensed health care facility, **OR**
iii. is not physician owned.

The Board will consider the petition at its next regularly scheduled meeting, and if approved, an Agreement to Practice will be sent to you for signature, along with a signature from the Chair of the Board. Please note that the Board will only consider approval for physician assistant private practices that provide primary care in rural and/or medically underserved areas and will not consider applications for physician assistant owned cosmetic or "medi-spa" clinics or telemedicine practice. It will be the applicant's responsibility to verify that their business complies with all laws and rules of North Dakota.

4. **Years of full-time PA practice**: (2080 hours/year or more is considered full-time)

5. **Proposed Practice Location(s) in North Dakota:**
   a. City/town:
   b. County:
   c. What is the ND location's HPSA score? HPSA Find (hrsa.gov):

   For HPSA score between 10-14 – please provide additional information and explanation on how and why the area has a need for the primary care practice. The Board will not consider an area of practice with a HPSA score of 9 or below for approval.

6. **Proposed practice type**: (family medicine, internal medicine, etc.)

7. **Your experience related to the proposed practice type:**
   a. Years or hours of experience in this type of practice setting:

b. Describe your previous experience in this type of practice:

c. Other training related to this type of practice (courses, certifications, etc.)

8. Are you, or will you, be credentialed: (you must have at least one, but fill out all that apply)

a. at a nearby facility? ☐ YES ☐ NO If yes, name of nearby facility:

b. with an insurance company? ☐ YES ☐ NO If yes, name of insurance company(ies):

9. Collaborating Physician Information:

a. Name of collaborating physician:

b. Collaborating physician ND license number:

c. Collaborating physician board certification(s) (family medicine, internal medicine, etc.)

d. **Attach the collaboration agreement to this petition.**
    i. The agreement must provide details on how collaboration will occur between the PA and the physician and also include:
        a. A process for evaluation of the PA's practice.
        b. Means by which the collaborating physician will be available to the PA for communication.

- **Please attach any further information about the proposed practice that you feel is pertinent to this petition.**

- **Email this form and any supporting documentation to Marijo Demott at bripplinger@ndbom.org, mail or fax to:**
    - North Dakota Board of Medicine
      Attn: Beth Ripplinger
      4204 Boulder Ridge Rd Suite 260
      Bismarck ND 58503-6162
      Fax: 701-989-6392

Signature: **Date:**