Commonwealth of the Northern Mariana Islands
HEALTH CARE PROFESSIONS LICENSING BOARD
P.O. Box 502078, Bldg., 1242 Pohnpei Court
Capitol Hill, Saipan, MP 96950
Tel No: (670) 664-4809 Fax: (670) 664-4814
Email: cnmi@cnmibpl-hcplb.net
Website: cnmibpl-hcplb.net

General Information

Completion of the Application Forms
All documents are to be certified or notarized true copies of original documents. Fax copies or documents sent via email are not accepted for documentation or verification in our licensing process. If copy of document is sent via fax or email, the original must be send via U.S. Postal Service to the Board's office.

Foreign Language Documents
All documents submitted in a foreign language shall be accompanied by an accurate translation in English. Each translated document shall bear the affidavit of the translator certifying that the translator is competent in both the language of the document and the English language and that the translation is a true and complete translation of the foreign language original, and sworn to before a notary public. Translation of any document relative to a person's application shall be at the expense of the applicant.

National Practitioner Data Bank (NPDB)
Attach the original report from the NPDB. To obtain the report, go to the NPDB-HIPDB website at www.npdb-hrsa.gov and click on Perform a Self-Query. If you are unable to go online, call NPDB at 1-800-767-6732 for assistance.

Confidentiality
The contents of licensing files are generally considered public records. If you believe that the additional information you are attaching to explain a "yes" answer should be considered confidential, state that in the attachment. A request for confidentiality may or may not be granted.

Federation Credentials Verification Service (FCVS)
The Board does not mandate that you use the FCVS. FCVS is NOT a requirement for filing a Physician's and Surgeon's Application. As part of your application, you may request FCVS to submit directly to the Board your Medical Professional Information Profile. You are required to complete the Board's application and provide all other necessary supporting documentation. We will review the information provided along with our application and determine on an individual basis the items that we will accept from FCVS.

Personal Interviews
Applicants for medical licensure may be required to have a personal interview either with an individual board member or with the full board. Should an interview be required, you will be notified and an interview scheduled. An interview may be required if, during the processing of your application, a question arises for which the board determines it requires additional information from you.

Processing Time
In general, average processing time for a permanent license is 4 – 6 weeks.

License Renewal
All licenses issued by the Board expired every two years following its issuance or renewal and becomes invalid after that date. Notification for license renewal is mailed or emailed to licensees at least sixty (60) days before the expiration date. You are required by regulations to keep your current address on file with the Board. There is a late fee of

$25.00 charged for every 1st of the month after the expiration date. Licenses, which have expired for failure to renew on or before the date required may be reinstated within one year of the expiration date. Each licensee whose license has expired and lapsed for more than one year by failure to renew must file a new application, meet present day requirements for licensure, and receive board approval.

Continuing Medical Education (CME)
All licensed physician assistants are required to complete fifty (50) Category I CME hours as a prerequisite to the renewal of their license ***during*** the 24 months prior to the expiration of his/her license. It shall be the responsibility of the licensee to obtain documentation, satisfactory to the Board, from the organization or institution, of his or her participation in the CME, and the number of credits earned. Licensure renewal shall be denied to any licensee who fails to provide satisfactory evidence of completion of CME requirements, or who falsely certifies attendance at and/or completion of the CME, as required herein.

NCCPA Certification
PAs shall maintain their national certification with NCCPA current in order to renew their CNMI license.

License Denial
If for any reason you are denied the license you are applying for, you are entitled to a hearing pursuant to the Commonwealth Administrative Procedures Act, 1 CMC § 9108-15.

Abandonment of Application
Your application shall be considered abandoned and shall be destroyed if you fail to provide evidence of continued efforts to complete the licensing process for one (1) year. If the application is deemed abandoned the applicant shall be required to reapply for licensure and comply with the licensing requirements in effect at the time of the reapplication.

Schedule of Fees

Application Fee	$100.00	Replacement of License	$75.00
License Fee	$100.00	Replacement of Card	$25.00
Temporary License Fee	$100.00	Verification of License	$25.00
Renewal License Fee	$100.00	Letter of Good Standing	$25.00
Delinquent Fee (each month)	$25.00		

Requirements for Licensing of Physician Assistants

Applicants for Physician Assistant (PA) – U.S. or Canada

- Bachelor's degree as Physician Assistant or Physician Associate in an ARC- PA-accredited school, or graduated from a physician assistant or surgeon assistant accredited program, or the Canadian Medical Service School.

- Satisfactory completion of the PANCE administered by NCCPA.

  Items/Documents required when applying:
  - Application form
  - Application non-refundable fee of $100
    (Cashier's Check or Money Order made payable to "CNMI Treasurer")
  - Evidence of degree
  - Evidence of current NCCPA certificate
  - NPDB Report (within 60 days of application date) and/or
  - FSMB Discipline Report

PA's Practice Agreement
The Board will issue a physician assistant license when the applicant meets the requirements set forth above. However, a physician assistant may not practice until a Practice Agreement has been filed and approved by the Board. You can request for a Practice Agreement form from the Board's office.

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Attach a recent 2x2 ID photo here taken within 6 months of the application.

APPLICATION FOR PHYSICIAN ASSISTANT LICENSE

☐ Initial	☐ Endorsement	☐ Temporary

HCPLB STAFF USE ONLY
Date Received:

APPLICATION INFORMATION – Please Type or Print

1. Last:	First:	Middle:	**2.** Social Security No:
3. Birthdate: (Mo/Day/Yr)	**4.** Color of Eyes: Color of Hair:	**5.** Height: Weight:	**6.** Sex:
7. Mailing Address:		**8.** Email Address:	
9. Residence Address:		**10.** Phone No: (W): (H):	
11. NPI # (if available):		**12.** Citizenship: ____U.S. ____Other Specify:	

13. EDUCATION – (*Provide an original, notarized or certified copy of your degree*)

Name of Schools	Location (City/State or Country)	Degree Earned	Dates (Mo/Yr) From	To

14. PA PROGRAMS ATTENDED – *(Provide an original, notarized or certified letter or certificates of training)*

Name of Place	Location (City/State or Country)	Dates (Mo/Yr) From	To

15. EXAMINATION – *(List examination(s) you have taken and passed)*

Examination	Date	Result (Pass/Fail)

16. LICENSES – (*List of all jurisdiction where you are licensed or applied for a license*.)

Name of Jurisdiction	Date Issued	Expiration Date	License Number	Current Status

17. HOSPITAL/CLINIC AFFILIATIONS (if none state "None")

Name of Hospital	Location (City/State or Country)	Dates (Mo/Yr) From	To

18. Name/Address of Intended Employment within the CNMI:

If you answer "yes" for any of items 19-36 you must attach a detailed explanation on a separate sheet, which includes state or country where action is pending or took place, relevant dates, action taken and reasons for such action. (Include Findings of Fact, Conclusion of Law, Final Order and whether you have been reinstated. If reinstated, date and conditions of license.)

19. Have you ever been charged with, or been found to have committed dishonorable, unprofessional conduct, negligence, incompetence, misconduct, or repeated negligent acts or malpractice by any licensing board, hospital or clinic?	Yes ☐	No ☐
20. Has a claim or an action ever been filed against you as a physician assistant which resulted in a malpractice settlement, judgment, or arbitration award of $25.000 or more?	Yes ☐	No ☐
21. Has any licensing board, hospital or clinic, or disciplinary authority refused to issue you a license, renew your license, suspended, revoked, accepted surrender of your license, placed on probation or conditioned your license, held by you now or previously, or ever fined or otherwise disciplined you ?	Yes ☐	No ☐
22. Is there any ongoing or pending investigation against you?	Yes ☐	No ☐
23. Is there any disciplinary action pending against you?	Yes ☐	No ☐

24. Has any hospital or health facility restricted or terminated your professional training, employment, or privileges or have you ever voluntarily or involuntarily resigned or withdrawn from such association to avoid imposition of such measures?	Yes ☐	No ☐
25. Have your DEA or state-controlled substance registration ever been denied, suspended, restricted, or terminated?	Yes ☐	No ☐
26. Have you ever entered into any arrangement or plea or agreement in lieu of a federal prosecution for a drug violation regulated by the DEA?	Yes ☐	No ☐
27. Have you ever been terminated, sanctioned, and penalized, had to repay monies to or been denied provider participation in any Medicaid, Medicare or other publicly funded healthcare program?	Yes ☐	No ☐
28. Has your ability to practice as a physician assistant in a competent and safe manner ever been impaired or limited by any condition, behavior, impairment, or limitation of a physical, mental, or emotional nature?	Yes ☐	No ☐
29. Have you used or are you currently using any chemical substance(s), legal or illegal, that in any way impaired or limited, or is currently impairing or limiting, your ability to as a physician assistant in a safe and competent manner?	Yes ☐	No ☐
30. Have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program?	Yes ☐	No ☐
31. Have you been treated for or had a recurrence or a diagnosed addictive disorder?	Yes ☐	No ☐
32. Have you ever been diagnosed with a neurological or other physical condition that would impair your ability to practice medicine safely?	Yes ☐	No ☐
33. Do you have any other condition in which in any way impairs or limits your ability to practice as a physician assistant?	Yes ☐	No ☐
34. Have you ever been found guilty, pleaded guilty, no contest, or nolo contendere to a crime involving moral turpitude or crime related to the practice as a physician assistant, or felony in any court?	Yes ☐	No ☐
35. Is criminal action pending against you in any court?	Yes ☐	No ☐
36. Are you required to register as a Sex Offender?	Yes ☐	No ☐

37. **DECLARATION:**

I hereby certify that I am the person herein named subscribing to this application. I have read the complete application, and I know the full content hereof. I declare that all of the information contained herein and evidence or other credentials submitted herewith are true and correct. I understand that any falsification or misrepresentation of any item or response in this application, or any attachment hereto or falsification on misrepresentation of credentials to support this application, is
sufficient grounds for denying, revoking, or otherwise disciplining a license to practice as a physician assistant in the Commonwealth of the Northern Mariana Islands. I further certify that I have read and will abide by P.L. 15-105 and the Regulations for Licensing of Physician Assistants.

_____ _____

Signature of Applicant Date

Please complete the application form and attach all original, certified or notarized documents and a non-refundable application fee of $100.00 (money order or cashier's check make payable to "CNMI Treasurer"). Do not send cash.

2021

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ (print name), do hereby authorize a disclosure of records concerning myself to the Health Care Professions Licensing Board (HCPLB). This release includes records of a public, private or confidential nature.

I acknowledge that the information released to the HCPLB may include material that is protected by federal and/or state laws applicable to substance abuse and mental health information. If applicable, I specifically authorize the release of confidential information to and from the HCPLB relating to substance abuse or dependence and/or mental health.

I further agree that the HCPLB may receive confidential information and records, including, but not limited to the following records:

- Medical Records
- Education Records
- Personnel or employment records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Post-graduate training (internship, residency, and fellowship) records, including records or any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Any information the HCPLB deems reasonably necessary for the purposes set forth in this release.

Release of Liability:
I do hereby irrevocably and unconditionally release, covenant not to sue, and forever discharge any person or entity, including but not limited to any medical school , residency or fellowship training program, hospital, health care provider, health care facility, licensing board, impaired practitioner program, agency, or organization, which releases information to the HCPLB pursuant to this release from any liability, claim, or cause of action arising out of the release of such information. I further irrevocably and unconditionally release, covenant not to sue, and forever discharge the HCPLB, the Commonwealth of the Northern Mariana Islands, and its employees and agents from any liability, claim, or cause of action arising out of the collection or release of information pursuant to this release.

A photocopy of this release form will be valid as an original thereof, even though the photocopy does not contain an original writing of my signature.

I have read and fully understand the contents of this "Authorization to Release Information".

_____ _____
Signature of Applicant Date