



## ALABAMA STATE BOARD OF MEDICAL EXAMINERS

Post Office Box 946  
Montgomery, Alabama 36101-0946  
848 Washington Avenue  
Montgomery, Alabama 36104

William M. Perkins, Executive Director

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### INSTRUCTIONS FOR THE ALABAMA MILITARY SPECIAL SERVICE ASSISTANT TO PHYSICIAN LICENSE

The Alabama State Board of Medical Examiners created a temporary license that is available to assistants to physicians or their spouses who are relocated or stationed in Alabama under official military orders. The applicant must meet the eligibility requirements to qualify for the Military Special Service License. An assistant to physician who is issued a Military Special Service License shall apply for a full assistant to physician license within 12 months of the issuance of the temporary license. **A Military Special Service License shall expire 12 months after the issuance of the license.**

#### Eligibility Requirements:

- Is either active duty, reserve, or transitioning member of a branch of the United States Armed Forces, including the National Guard, or the spouse or surviving spouse of the aforementioned individual
- Must possess a full unrestricted assistant to physician license in another state, District of Columbia, a territory of the United States, or a province of Canada
- Have graduated from a training program accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA), Committee on Allied Health Education and Accreditation (CAHEA), the Commission on Accreditation of Allied Health Education Programs (CAAHEP), or the Accreditation Review Committee for the Anesthesiologist Assistant (ARC-AA), or their successor agencies
- Successful completion of the Physician Assistant National Certification Examination as administered by the National Commission on Certification of Physician Assistants. Anesthesiologist Assistants must have successfully completed the National Certifying Examination for Anesthesiologist Assistants as administered by the National Commission for Certification of Anesthesiologist Assistants
- No history of disciplinary action against your assistant to physician license, excluding any action related to the non-payment of fees related to a license
- No criminal history
- No suspension or revocation of controlled substances license, certificate, or permit
- Not currently under investigation
- Must be a U.S. Citizen, national, or lawfully present alien

Applicants must submit proof of two of the following qualifiers at the time of application:

- Active or reserve service member's official military orders
- Transitioning service member's DD Form 214 or NGB Form 22
- Deceased service member's DD Form 214 or NGB Form 22 and death certificate if the physician is a spouse of a service member
- Marriage certificate substantiating marriage to the service member if the assistant to physician is a spouse of a service member

Applicants must also complete the attached application in its entirety and submit as an attachment via email with a copy of a valid photo ID to the address below:

[PAADept@albme.gov](mailto:PAADept@albme.gov)

Once your application has been submitted, please allow 10 days for the processing and issuance of the Military Special Service License.

To practice or offer to practice as an assistant to physician, each person shall be licensed by and registered by the Board in accordance with Chapter 540-X-7 Assistants to Physicians. To apply for registration to a physician, please access <https://www.albme.gov/licensing/pa-aa/license-registration/> to obtain the required forms.



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**Application for Military Special Service Assistant to Physician License**

To apply for a Military Special Service Assistant to Physician license, please answer the questions below:

**Applicant Identification:**

Full Legal Name: \_\_\_\_\_  
(First) (Middle) (Last) (Suffix)

Mailing Address: \_\_\_\_\_  
(Mailing Address) (City) (State) (Zip)

Office Address: \_\_\_\_\_  
(Office Address) (City) (State) (Zip)

Practice Address: \_\_\_\_\_  
(Practice Address) (City) (State) (Zip)

Date of Birth: \_\_\_\_\_ Gender: Male \_\_\_\_\_ Female \_\_\_\_\_  
(mm/dd/yyyy)

Office telephone number: \_\_\_\_\_ Cell phone number: \_\_\_\_\_

Email address delegated by applicant to receive correspondence: \_\_\_\_\_

Social Security Number: \_\_\_\_\_  
###-##-####

**Education:**

Assistant to Physician Training Program: \_\_\_\_\_  
Full Name of Program (no abbreviations or acronyms)

(Training program must be accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA), Committee on Allied Health Education and Accreditation (CAHEA), the Commission on Accreditation of Allied Health Education Programs (CAAHEP), or the Accreditation Review Committee for the Anesthesiologist Assistant (ARC-AA), or their successor agencies.)

Completion date: \_\_\_\_\_  
(mm/dd/yyyy)

(Physician Assistants must have successfully completed the Physician Assistant National Certification Examination as

administered by the National Commission on Certification of Physician Assistants. Anesthesiologist Assistants must have successfully completed the National Certifying Examination for Anesthesiologist Assistants as administered by the National Commission for Certification of Anesthesiologist Assistants.)

Date PANCE taken: \_\_\_\_\_

Date of original certification with NCCPA: \_\_\_\_\_

NCCPA ID Number: \_\_\_\_\_

Physician Assistants must possess a full and unrestricted Physician Assistant license issued by the appropriate licensing board of another state, the District of Columbia, a territory of the United States, or a province of Canada.

If licensed in multiple states, only use one.

License Number: \_\_\_\_\_

Expiration date: \_\_\_\_\_

(mm/dd/yyyy)

Date of Original Licensure: \_\_\_\_\_ (not renewal)

(mm/dd/yyyy)

Licensing State/District/Territory/Province: \_\_\_\_\_

**Please select your qualifier for the Military Special Service License by initialing and affirming.**

I hereby swear (affirm) that I am either:

\_\_\_\_\_ Active duty

\_\_\_\_\_ Reserve

\_\_\_\_\_ Transitioning member of the United States Armed Forces, including the National Guard. \*

\_\_\_\_\_ The spouse of the aforementioned or a surviving spouse of a service member who, at the time of his or her death, was serving on active duty.

\*A transitioning service member is defined as a member of the United States Armed Forces, including the National Guard, on active duty status or on separation leave who is within 24 months of retirement or 12 months of separation.

**Affirmations:**

I. \_\_\_\_\_ I hereby swear (affirm) that I currently possess a full and unrestricted license to practice as an assistant to physician that has been issued by the medical licensing authority of a state, the District of Columbia, a territory of the United States, or a province of Canada.

II. \_\_\_\_\_ I hereby swear (affirm) that I have never been convicted, received adjudication, community supervision, or deferred disposition of any felony offense or any crime related to fraud, violence, sexual violations, or related to health care.

- III. \_\_\_\_\_ I hereby swear (affirm) that my assistant to physician license has never been subjected to discipline by a licensing agency in any state, federal, or foreign jurisdiction, excluding any action related to the non- payment of fees related to a license.
- IV. \_\_\_\_\_ I hereby swear (affirm) that my controlled substance license or permit has never been suspended or revoked by a state or the United States Drug Enforcement Administration.
- V. \_\_\_\_\_ I hereby swear (affirm) that I am not currently under investigation by a licensing agency or law enforcement authority in any state, federal, or foreign jurisdiction.
- VI. \_\_\_\_\_ I hereby swear (affirm) that I am either (1) a United States citizen; (2) a national of the United States; or (3) an alien lawfully present in the United States.
- VII. \_\_\_\_\_ I hereby swear (affirm) that I will apply for an assistant to physician license within twelve (12) months of the issuance of my Military Special Service Assistant to Physician license.

I swear (affirm) that the information set forth in this application is true and correct to the best of my knowledge, information, and belief.

Signature of Assistant to Physician: \_\_\_\_\_ Date: \_\_\_\_\_

(For electronic signature) I understand and agree that by typing my name, I am providing an electronic signature that has the same legal effect as a written signature pursuant to Ala. Code §§ 8-1A-2 and 8-1A-7. I attest that the foregoing information has been provided by me and is true and correct to the best of my knowledge, information, and belief.

**Knowingly providing false information to the Alabama State Board of Medical Examiners is a violation of Ala. Code § 34-24-302(a)(8).**

**Please email completed form as an attachment to [PAAADept@albme.gov](mailto:PAAADept@albme.gov).**