

## Restricted Associate Osteopathic Physician and Surgeon

### APPLICANT INFORMATION

Full Legal Name: \_\_\_\_\_  
First Middle Last

All Previous Legal Names: \_\_\_\_\_

Other DOPL Licenses Held: \_\_\_\_\_

SSN:\* \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender:  Male  Female  
\* If you don't have a social security number, please follow the instructions on the last page.

Address: \_\_\_\_\_  
Street Address (including Apt/Unit/Ste #) and/or PO Box

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_

*Note: All Division notices and communication will be sent to this email.*

Please select one:

- I am a United States citizen.
- I am a non-citizen of the United States who is lawfully present.
- I am a foreign national not physically present in the United States.
- None of the above, please explain: \_\_\_\_\_

Driver License or State ID Card: \_\_\_\_\_  
State of Issue License Number Expiration Date

**NOTE:** If you do not hold a US Driver License or a US State ID, you must present a legible copy of your current and valid government issued document(s) showing evidence of lawful presence in the United States.

### AFFIDAVIT AND RELEASE

I certify that to the best of my knowledge, the information contained in the application and all supporting document(s) are true and correct, and discloses all material facts regarding the applicant, and that I will update or correct the application as necessary, prior to any action on my application.

I authorize all persons, organizations, governmental agencies, or any others not specifically listed, which are set forth directly or by reference in this application, to release to the Department of Commerce, State of Utah, any files, records, or information of any type reasonably required for the Department to properly evaluate my qualifications for licensure/certification/registration by the State of Utah.

I understand that it is the continuing responsibility of applicants and licensees to read, understand, and apply the requirements contained in all statutes and rules pertaining to the occupation or profession for which I am applying, and that failure to do so may result in civil, administrative, or criminal sanctions.

I understand that I am responsible to update the Department of any changes relating to my application/license/certification/registration.

I understand that if the application is not complete at the time of submission, it will delay approval and could result in a denial.

**I declare under criminal penalty under the law of Utah that this application is true and correct.**

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

## PRIVACY NOTICE

The information you provide on this form will be used to determine your eligibility for a license, registration, or certification in Utah. Failure to provide complete information as requested will result in the denial of your request as incomplete.

Information provided in this form is retained in accordance with state record retention laws. For specific information about the records retention for this form, please visit <https://dopl.utah.gov/records>

To comply with legal and regulatory requirements, we may share limited information about your license, registration, or certification with authorized parties. This may include government agencies, national databases, and contracted vendors. Shared information may include issue date, status, expiration date, disciplinary actions, and your name or other direct identifiers.

We may also share aggregated and de-identified data (e.g., education levels, exam pass rates, length of licensure, etc.) with relevant stakeholders for data analysis and reporting purposes.

## ACKNOWLEDGEMENT:

Your signature acknowledges receipt of this information.

Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## QUALIFYING QUESTIONNAIRE

**Do not leave any question blank.**

*DOPL may request additional documentation if the information submitted is insufficient.*

1.  Yes  No Have you EVER had a license, certificate, permit, or registration to practice a regulated profession denied, conditioned, curtailed, limited, restricted, suspended, revoked, reprimanded, resigned, or surrendered while under investigation, or otherwise **disciplined in any way**?

2.  Yes  No Do you CURRENTLY have **any criminal action active or pending**?

3.  Yes  No WITHIN THE PAST 10 YEARS, have you pled **guilty** to, **no contest** to, entered into a **plea in abeyance**, or been **convicted** of a **misdemeanor** in any jurisdiction?

4.  Yes  No Have you EVER pled **guilty** to, **no contest** to, entered into a **plea in abeyance**, or been **convicted** of a felony in any jurisdiction?

If you answered "Yes" to any of the above questions, enclose with this application complete information with respect to all circumstances and the final result, if such has been reached. If you answered "Yes" to questions 2, 3, or 4 you must submit the following for EACH and EVERY incident:

- personal account of the incident
- police report(s)
- court record(s)
- probation/parole officer report(s)

If you are unable to obtain any of the records required above, you must submit documentation on official letterhead from the police department and/or court indicating that the information is no longer available.

Please **DISCLOSE** the following:

- charges that were later held in abeyance (plea in abeyance), diverted, reduced, or dismissed.
- motor vehicle offenses such as driving while impaired or intoxicated.
- if you are restricted from possession, purchase, transfer, or ownership of a firearm or ammunition (even if your restriction is based on a non-reportable juvenile conviction).

You do **NOT** need to disclose:

- minor traffic offenses such as parking or speeding violations.
- juvenile offenses, unless you were tried as an adult.
- legally expunged or sealed criminal history incidents.

For more information, see DOPL's [criminal history FAQs](#).

## PROFESSIONAL LICENSES

List all other licenses, registrations or certifications issued by any state, which you now hold or have ever held in any profession. *(Use additional sheets if necessary.)*

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

Issuing State: \_\_\_\_\_ License Status: \_\_\_\_\_ Issue Date: \_\_\_\_\_

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

Issuing State: \_\_\_\_\_ License Status: \_\_\_\_\_ Issue Date: \_\_\_\_\_

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

Issuing State: \_\_\_\_\_ License Status: \_\_\_\_\_ Issue Date: \_\_\_\_\_

## MEDICAL QUALIFYING QUESTIONNAIRE

**Read thoroughly and answer each question. Do not leave any question blank.**

*A "yes" answer does not necessarily mean you will not be granted a license; however, DOPL may request additional documentation if the information submitted is insufficient.*

**1. Have your rights, privileges, and/or participation ever been denied, conditioned, curtailed, limited, restricted, suspended or revoked in any way by:**

- Yes  No a hospital or health care facility
- Yes  No Medicaid, Medicare or any other state or federal health care payment reimbursement program
- Yes  No the Federal Drug Enforcement Administration or any state drug enforcement agency
- Yes  No malpractice insurance coverage
- Yes  No other entity: \_\_\_\_\_

**2. Have you ever been permitted to resign or surrender any rights, privileges and/or participation while under investigation or while action was pending against you from:**

- Yes  No a hospital or health care facility
- Yes  No Medicaid, Medicare or any other state or federal health care payment reimbursement program
- Yes  No The Federal Drug Enforcement Administration or any state drug enforcement agency
- Yes  No malpractice insurance coverage
- Yes  No other entity: \_\_\_\_\_

**3. Is any action pending against you now by:**

- Yes  No a hospital or health care facility
- Yes  No Medicaid, Medicare or any other state or federal health care payment reimbursement program
- Yes  No the Federal Drug Enforcement Administration or any state drug enforcement agency
- Yes  No malpractice insurance coverage
- Yes  No other entity: \_\_\_\_\_

**4.  Yes  No Have you been named as a defendant in a malpractice suit?**

**5.  Yes  No Have you ever had office monitoring, practice curtailments, individual surcharge assessments based upon specific claims history, or other limitation, restrictions or conditions imposed by any malpractice carrier?**

If you answered "Yes" to question 4 you must submit a complete narrative of the circumstances and a National Practitioner Data Bank report outlining all professional liability claims made against your license and any settlements paid by or on your behalf. *NPDB website: <http://www.npdb.hrsa.gov>.*

If you answered "Yes" to any of the above questions, enclose with this application complete information with respect to all circumstances and the final result, if such has been reached.

## UTAH CONTROLLED SUBSTANCE AFFIDAVIT

*If you are applying for a controlled substance license, you must read and sign the affidavit below.*

1. I have reviewed and understand that I must abide by the additional laws and rules that govern the practice of my profession as it pertains to controlled substances.
2. I understand that to qualify for controlled substance prescription privileges, my collaborative practice arrangement must authorize prescription privileges for Schedule III through V controlled substances.
3. I understand that there may be additional continuing education requirements for those who hold a controlled substance license.
4. I understand it is required that I hold a valid Federal Drug Enforcement Administration (DEA) registration.

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

**Note:** In addition to signing this affidavit, you must complete the items listed on the OPTIONAL CONTROLLED SUBSTANCE LICENSE checklist at the end of this application.

**DESIGNATION OF CONTACT PERSON FOR ACCESS TO MEDICAL RECORDS**

*You must provide both a primary and alternate contact person for access to medical records. This information is considered public information.*

Primary Contact: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ – \_\_\_\_\_ Email: \_\_\_\_\_

Alternate Contact: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ – \_\_\_\_\_ Email: \_\_\_\_\_

**Note:** *If a hospital, clinic, or other facility is the owner of your patient’s medical records, the facility’s records department may be listed as the primary contact. All applicants must still list a second, unique contact.*

Please identify the method of notifying patients of location of records: (check all that apply):

Phone  Mail  In Person  Other: \_\_\_\_\_

**FEDERATION CREDENTIALS VERIFICATION SERVICE (FCVS)**

I received notification from FSMB on \_\_\_\_\_ that my FCVS packet was complete. Initial: \_\_\_\_\_

**RESTRICTED ASSOCIATE OSTEOPATHIC PHYSICIAN LIMITATIONS**

I certify that,

1. I have successfully completed a program of professional education, having received an earned degree of Doctor of Osteopathic Medicine from an AOA accredited program.
2. I have successfully completed steps 1 & 2 of the United States Medical Licensing Examination, the Comprehensive Osteopathic Medical Licensing Examination, or equivalent steps of another board-approved medical licensing examination, within the immediately preceding two years *and* no more than three years past the date of graduation listed on my official transcript.
3. I am NOT currently enrolled in, nor have I completed, a residency program.

I understand that,

1. I must enter into a collaborative practice arrangement, approved by the Division, before I can practice medicine in Utah; and if I fail to do so, my license will be canceled after six months.
2. I understand that my Restricted Associate Osteopathic Physician and Surgeon license will only be valid in Utah. I acknowledge that a Restricted Associate Osteopathic Physician and Surgeon license is not eligible for compact license privileges.

I have reviewed and I certify that I will abide by *all* of the laws and rules that govern the practice of my profession, including, but not limited to:

[58-68—Utah Osteopathic Medical Practice Act](#)      [58-37—Utah Controlled Substances Act](#)  
[R156-68—Utah Osteopathic Medical Practice Act Rule](#)      [R156-37—Utah Controlled Substance Act Rule](#)

**I attest to all these under criminal penalty under the law of Utah.**

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

## CRIMINAL HISTORY DISCLOSURE STATEMENT

Fingerprints submitted with this application are used to complete a search through the files of the Utah Bureau of Criminal Identification (BCI) and the Federal Bureau of Investigations (FBI). Prior to submitting fingerprints, you must read and acknowledge, by signing the affidavit below, the Privacy Act Statement found at: <https://www.fbi.gov/services/cjis/compact-council/privacy-act-statement>. Physical copies of this statement may also be obtained upon request from the Division.

The criminal record information obtained by this search will be used by Division staff to evaluate your ability to obtain licensure in Utah. You may challenge or review your criminal record. For additional information regarding the challenge or review process, please see below.

By signing below, you acknowledge receipt of this information and consent to the background check process described above.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Please see our website, [www.dopl.utah.gov/fingerprints.html](http://www.dopl.utah.gov/fingerprints.html), for required information and approved locations to obtain fingerprints.

Completed fingerprint cards can be mailed to:

**Division of Professional Licensing**  
**P.O. Box 146741**  
**Salt Lake City, UT 84114-6741**

**REVIEW OF YOUR CRIMINAL RECORD:** If you wish to review or challenge the accuracy of the information in your [FBI record](#), you should contact the agency that contributed the information in question. You may also direct the challenge to the FBI. Please see their website at:

<https://www.fbi.gov/services/cjis/identity-history-summary-checks>. You may also contact them via mail at: FBI: CJIS Division, Attn. Criminal History Analysis Team 1, 1000 Custer Hollow Road, Clarksburg, WV 26306. The FBI will forward the challenge to the respective agency.

If you wish to review or challenge the accuracy of the information in your [BCI record](#), you must complete the required "Record Challenge Form", available at: <https://bci.utah.gov/criminal-records/criminal-records-forms/>, and submit it directly to BCI.

Agency review of a licensing decision based on your criminal record may be obtained by filing a written request for agency review with the Executive Director of the Department of Commerce within thirty (30) days after notification of the decision. Any such request must comply with the requirements of [Utah Code § 63G-4-301](#) and [Utah Admin. Code R151-4-902](#).

## APPLICATION CHECKLIST AND INSTRUCTIONS

*This checklist is for your convenience; you do not need to include it with your application.*

**NOTE:** *Incomplete applications will be denied.*

Your application is classified as a public record and may be available for inspection by the public, except with regard to the release of information, which is sub-classified as controlled, private, or protected under the Government Records Access and Management Act or restricted by other law.

***If you do not have a valid Social Security number***, you must submit your Individual Taxpayer Identification Number (ITIN), Alien Registration Number (A-number), or a copy of an unexpired government issued passport from your country of residence and an intent-to-hire letter from a Utah based employer ([Utah Admin. Code R156-1-301](#)). Submission of the above documents may require additional documents to demonstrate lawful presence ([Utah Code § 63G-12-402 \(3\)\(k\)](#)).

### **ALL APPLICANTS**

All applicants are required to submit the following items to complete the application:

- \$210.00 non-refundable application processing fee, made payable to "DOPL".
- Supporting documentation for any "yes" answers provided on the "Qualifying Questionnaire".
- Fingerprints to be used by DOPL for a fingerprint search through the files of the Utah Bureau of Criminal Identification (BCI) and the Federal Bureau of Investigations (FBI). Please see our website, [www.dopl.utah.gov/fingerprints.html](http://www.dopl.utah.gov/fingerprints.html), for required information and approved locations to obtain fingerprints.
- Request an application packet from Federation Credentials Verification Service (FCVS). FCVS may be contacted via phone at 1-888-ASK-FCVS or their website at <https://www.fsmb.org/fcvs/>.

***YOU MUST HAVE RECEIVED AN EMAIL FROM FSMB WITH NOTICE THAT THE FCVS PACKET HAS BEEN RELEASED TO UTAH PRIOR TO SUBMITTING THIS APPLICATION.***

- Complete the "Collaborative Practice Agreement".

### **OPTIONAL CONTROLLED SUBSTANCE LICENSE**

If your practice in the state of Utah will include administering, possessing, or prescribing of controlled substances, you must apply for a Utah Controlled Substance License by submitting the following:

- \$100.00 non-refundable application processing fee, made payable to "DOPL".
- Complete the "Utah Controlled Substance Affidavit" found in this application.  
*\*NOTE: In addition to the Utah Controlled Substance License, you must hold a valid Federal Drug Enforcement Administration (DEA) registration.*

Deliver completed application to:

By US Postal Service:  
**Division of Professional Licensing  
PO BOX 146741  
Salt Lake City, UT 84114-6741**

By in-person or express delivery:  
**Division of Professional Licensing  
Heber M Wells Building, 1st Floor  
160 E 300 S  
Salt Lake City, UT 84111**

## Restricted Associate Osteopathic Physician Collaborative Practice Agreement

Page 1 of 4

A complete collaborative practice agreement consists of these written criteria, jointly developed by all parties involved, that permits an associate physician, working under the direction or review of a collaborating physician, to provide primary care services, and any additional pages.

Collaboration duration from \_\_\_\_\_ to \_\_\_\_\_.

### RESTRICTED ASSOCIATE OSTEOPATHIC PHYSICIAN INFORMATION

Name: \_\_\_\_\_  
First Middle Last

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ – \_\_\_\_\_ Email: \_\_\_\_\_

Specialty/Board Certification(s): \_\_\_\_\_

### COLLABORATING PHYSICIAN INFORMATION

Name: \_\_\_\_\_ License # \_\_\_\_\_  
First Middle Last

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ – \_\_\_\_\_ Email: \_\_\_\_\_

Specialty/Board Certification(s): \_\_\_\_\_

Total number of restricted physicians associated with collaborating physician: \_\_\_\_\_

### ESTABLISHMENT INFORMATION

If there are additional practice sites, please attach a complete list of all locations.

**Note:** a physical copy of the complete **Collaborative Practice Agreement** must be available at all locations

Establishment Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ – \_\_\_\_\_ Email: \_\_\_\_\_

The Collaborative Practice Agreement must adhere to requirements listed in the Utah Osteopathic Medical Practice Act, Utah Code§ 58-68-807 and the Utah Osteopathic Medical Practice Act Rule, Utah Admin. Code R156-68-807.

It is the responsibility of all parties involved to familiarize themselves with the law.

*A complete collaborative practice agreement, including all additional sheets, must be maintained at each practice site. Any change, amendment, update, or correction to this collaborative practice agreement must be submitted to the Division within 10 days of the changes.*

**Restricted Associate Osteopathic Physician Collaborative Practice Agreement**  
*Page 2 of 4*

**MANNER OF COLLABORATION**

Specify the manner of collaboration including how the collaborating physician and the associate physician shall maintain geographic proximity and engage in collaborative practice consistent with each professional's skill, training, education, and competence.  
*(attach additional pages if necessary)*

*A copy of the entire "Collaboration Agreement" is required to be available at the practice site(s).  
The agreement must accurately reflect current practices.*

## Restricted Associate Osteopathic Physician Collaborative Practice Agreement

Page 3 of 4

List procedures for providing oversight of the associate physician during the absence, incapacity, infirmity, or emergency of the collaborating physician.  
*(attach additional pages if necessary)*

Please define procedures addressing how situations outside the associate physician's scope of practice will be handled.  
*(attach additional pages if necessary)*

*A copy of the entire "Collaboration Agreement" is required to be available at the practice site(s).  
The agreement must accurately reflect current practices.*

**Restricted Associate Osteopathic Physician Collaborative Practice Agreement**  
*Page 4 of 4*

Describe the associate physician's controlled substance prescriptive authority Schedule III through V, and provide a comprehensive list of all of the controlled substances the collaborating physician authorizes the associate physician to prescribe (*attach additional pages if necessary*):

Describe your plan establishing educational methods and programs that the associate physician shall complete throughout the duration of the collaborative practice arrangement that will facilitate the advancement of the associate physician's medical knowledge and abilities. (*attach additional pages if necessary*)

*A copy of the entire Collaboration Agreement, including all additional pages, is required to be available at the practice site(s).  
The agreement must accurately reflect current practices.*

**MANNER OF COLLABORATION**

I understand that a collaborating physician is responsible, at all times, for the oversight of the activities of, and accepts responsibility for, the primary care services rendered by the associate Physician. I understand that before rendering any health care services the Division must approve this collaborative practice arrangement contract. As a signatory to this agreement, I will maintain required licensure and any required DEA registration and comply with the laws, rules, standards, and ethics of the profession.

**I declare under criminal penalty under the law of Utah that the foregoing is true and correct.**

Signature of Associate Physician: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Collaborating Physician: \_\_\_\_\_ Date: \_\_\_\_\_