BOARD USE ONLY – DO NOT WRITE IN THIS SECTION	
DATE STAMP	**Receipt Number:**
	Amount:
	License Number:
	Initials/Date:

PAIN CLINIC APPLICATION
ADD, DELETE, OR REVISE
PHYSICIAN ASSISTANT

If you are adding more than one physician assistant, a $75 fee is required for EACH addition.

SECTION I: PAIN MANAGEMENT CLINIC - OFFICE INFORMATION

Corporate or Legal Name of Pain-Management Clinic:

_____

Doing Business As Name:

_____

Federal Tax Identification Number (FEI#) OR Employer Identification Number:

_____

Pain-Management Clinic Physical Address: ***(P.O. Boxes are not acceptable)***

_____
(Street) (Suite #)

_____
(City) State (Zip Code) (County)

Mailing Address:

_____
(Street) (Suite #)

_____
(City) State (Zip Code) (County)

Pain Management Clinic Telephone Number: _____

Pain Management Clinic Fax Number: _____

Pain Management Clinic Email Address: _____

1. List the business operating hours.

Business Operating Hours:

Monday	___: ___am/pm **to** _: ___am/pm
Tuesday	___: ___am/pm **to** _: ___am/pm
Wednesday	___: ___am/pm **to** _: ___am/pm
Thursday	___: ___am/pm **to** _: ___am/pm
Friday	___: ___am/pm **to** _: ___am/pm
Saturday	___: ___am/pm **to** _: ___am/pm
Sunday	___: ___am/pm **to** _: ___am/pm

2. Person to be contacted for communication, or notice and citation matters:

Name: _____Title: _____

Address: _____

Phone #: (____) _____-_____

EMAIL ADDRESS: _____

Managing Employee Name:	**License Number/Profession:**
Address:	
Telephone Number:	
DEA Number:	Email Address:

AFFILIATED PERSONNEL INFORMATION: Complete the section below for the physician assistant who will be employed at the clinic. If you have more than one physician assistant who you wish to add to your clinic, copy this sheet.

Physician Assistant Name:
License Number/Profession:
Address:
Telephone Number:
DEA Number: Email Address:
Supervising Physician Name:
Supervising Physician License Number:

___add physician assistant

___delete physician assistant

___revise hours of physician assistant

EFFECTIVE DATE:

_____

Hours Physician Assistant Present in Clinic:

Monday	___: ___am/pm **to** _: ___am/pm
Tuesday	___: ___am/pm **to** _: ___am/pm
Wednesday	___: ___am/pm **to** _: ___am/pm
Thursday	___: ___am/pm **to** _: ___am/pm
Friday	___: ___am/pm **to** _: ___am/pm
Saturday	___: ___am/pm **to** _: ___am/pm
Sunday	___: ___am/pm **to** _: ___am/pm

IF YOU ARE REVISING THE HOURS, LIST THE CURRENT APPROVED HOURS FOR THIS PHYSICIAN ASSISTANT HERE:

_____

_____

_____

_____

_____

_____

_____

If you wish to delete a physician assistant, please have the physician assistant, owner, or managing employee to sign here:

_____

Signature **Date**

Does the physician assisted listed above currently work at any other pain clinic? ____YES___NO

(This includes any pain clinic location, **other than the one identified on page 1**, even if it is one of your other locations)

If Yes, list pain clinic name: _____

Pain Clinic Location: _____

List hours present in clinic: _____

A. Will the physician assistant be prescribing controlled substances for this location? ___YES __NO

B. If yes, does the physician assistant have an approved job description for this location? ___YES __NO

SECTION IV: PERSONNEL CERTIFICATION FORM

INSTRUCTIONS:

This form should be completed if you are requesting to be **added as a physician assistant**.

All information requested on this form is mandatory. Failure to provide any and all of the requested information will result in an incomplete background investigation and rejection of the application. This information will be used to determine your qualifications to work in a pain clinic. This information may be shared with other government agencies upon receipt of an official request.

NAME: _____

SEX: ____**MALE** _____**FEMALE**

STREET ADDRESS: _____

_____

City **State** **Zip Code**

Date of Birth: _____

Social Security Number: _____

Telephone: _____

Fax: _____

Pain Clinic Name: _____

Position with the Pain Clinic: (check below all those that apply)

____Owner	____Principal	____Officer	____Agent
____Managing Employee	____Practicing Physician	____Physician Assistant	____APRN

The undersigned hereby swears, or affirms that all statements made herein are true and correct, and that all the provisions of the law and regulations based thereon will be faithfully observed.

Print Name: _____

Applicant Signature: _____

Date: _____