Physician Assistant Steps

- Login
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Login

Physician Assistant Licensure Application

- Information you enter will be automatically saved at the end of every page.
- You must complete the application within 15 days or your information will be deleted.
- Some of the questions may direct you to download a supplemental form and submit it, along with any relevant records.
- Pay the license fee using one of the following:
  - MasterCard,
  - Visa,
  - Discover,
  - American Express, or
  - Electronic Check.

Check Your Eligibility

Application Checklist

FAQ

Processing times can vary depending on the acceptability of submitted items and the complexity of your application. Some of the factors that can increase complexity are "yes" answers to the professionalism questions on this application.

Enter to create a new application or to return to a saved application.

Asterisk (*) indicates response required.

Email:*

Date of Birth (MM/DD/YYYY):*

Continue

Physician Assistant Steps

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Identification

Asterisk (*) indicates response required.

For JP first and last name, provide your name as it is listed on either your current driver license, issued by a state driver license bureau in the United States, or your current passport. We will furnish this information to the testing center that administers the jurisprudence exam (JP). Your name must match exactly when you present your identification at the testing center, or you will not be allowed to take the exam.

JP First Name*

JP Last Name*

Full Name as you wish it to appear on your receipt*

Your name, as entered in the next 4 fields, will be the name that appears on your license and on the web site verification page.

Applicant First Name*:

Applicant Middle Name:

Applicant Last name*:

Suffix

Social Security Number (###-##-#### or #########)*

Alternate names

Email Address sandy@gmail.com

Gender *

- Male
- Female

Country of Birth* UNITED STATES

If you were born in the United States, please select your state of birth.

US State of Birth

Date of Birth (MM/DD/YYYY): 02/02/1978

Race*

Are you of Hispanic Origin? *

- Yes
- No

If you are a Texas high school graduate, please select the county where your high school is located.

Texas High School County

Select your Physician Assistant program from the drop down list below. If you are unable to locate your school, please select "Unknown" and be aware that this will delay the processing of your application.

PA School*

Year of Graduation (or anticipated year of graduation) (YYYY)*

NCCPA Certification Number (Must be numeric. If pending, leave blank.)

Are you currently on active duty in the U.S. Military?*

- Yes
- No

Expeding Factors

An applicant headquartered in Texas who is an active duty military service member, or the spouse of an active duty military service member, may be eligible for expedited handling.

If you think you may qualify please select the appropriate box:

- Military Service Member (active duty)
- Spouse of a Military Service Member (active duty)

Continue

Physician Assistant Steps

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Address

Please provide your mailing address. If you have a practice address, it must be a physical address (not a P.O. Box) and should be where you intend to work upon receipt of your Physician Assistant license. **It is your responsibility to notify the Board in writing if you have a change of address.**

All correspondence will be sent to the mailing address. When entering a foreign address, leave the State blank and provide a Country.

Asterisk (*) indicates response required.

Mailing Address

Mailing Address 1:*	
Mailing Address 2:	
Mailing City:*	
Mailing State:	
Mailing Province	
Mailing Zip Code:*	
Mailing Country:*	UNITED STATES
Telephone Number ###-###-####:*	

Practice Address

Practice Address 1:	
Practice Address 2:	
Practice City:	
Practice State:	
Practice Province	
Practice Zip Code:	
Practice Country:	UNITED STATES
Telephone Number ###-###-####:	

Continue

Physician Assistant Steps

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Work Experience.

- Please account for all periods of work from the time you graduated from your Physician Assistant program to the present date.
- If you have ever been a member of the medical staff of a licensed hospital, nursing home, clinic, health maintenance organization, or other hospital care facility with an organized medical staff as a physician assistant, you will need to enter this information.
- For Physician Assistants, the Facility/Employer Name field should include the name of your Supervising Physician.
- The Facility/Employer Name fields should include the name of your Supervising Physician.
- Include all periods of unemployment or employment outside the field of medicine. For periods of unemployment, use your home address.
- To indicate a current position, enter today's date as an end date.

Add Work Experience

Continue

Physician Assistant Steps

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Add Work Experience

Asterisk (*) indicates response required.

Position*	
Department*	
Start Date(MM/YYYY)*	
End Date(MM/YYYY)*	
Facility/Employer Name*	
Facility/Employer Street*	
Facility/Employer City*	
Facility/Employer State	
Facility/Employer ZIP/Postal Code*	
Facility/Employer Province	
Facility/Employer Country*	UNITED STATES
Facility/Employer Phone Number(###-###-####)	

Submit Cancel

Physician Assistant Steps

- Login
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Professional History

Attention - This is important: Be sure to disclose all relevant discipinary actions, charges, or convictions. A false response to any of these questions may be grounds for disciplinary action, or even denial of licensure. Avoid some of the common excuses heard from people who fail to disclose, such as:

- My attorney told me I didn't have to disclose the criminal conduct or disciplinary actions.
- I didn't think the prior conduct had anything to do with the profession.
- I didn't think the disciplinary action, arrest, charges, or conviction was still on my record.
- I didn't think it was subject to disclosure because I received a deferred sentence/judgment

All supplemental forms listed can be found on the Additional Forms section of our website.

Asterisk (*) indicates response required.

Professional History

Question 1*

Have you ever been issued a Texas Physician Assistant License?

- ○ Yes
- ○ No

Question 2

List all states in which you have applied for or have been granted licensure or certification as any type of healthcare provider. Choose a type of license and state from the drop down lists below. If you are unable to locate your license type, please use "Unassigned", and be aware that this will delay the processing of your application. Use Form AA if you have more than five licenses.

Type of License	
State	
Type of License	
State	
Type of License	
State	
Type of License	
State	
Type of License	
State	

Arrest/Criminal History

If you answer "Yes" to any question in this section, you are required to submit Form R.

If you believe your offense was **sealed or expunged**, you **must** be able to provide a copy of the expunction or non-disclosure order if requested.

Question 3 *

Have you ever been arrested? If you answer "Yes" to this question, you are required to submit Form R.

- Yes
- No

Question 4 *

Have you ever been cited or ticketed for, or charged with any violation of the law? (Unless the offense involved alcohol or drugs, you may exclude: 1) traffic tickets; and, 2) violations with fines of $250 or less.) If you answer "Yes" to this question, you are required to submit Form R.

- Yes
- No

Question 5 *

Are you currently the subject of a grand jury or criminal investigation? If you answer "Yes" to this question, you are required to submit Form R.

- Yes
- No

Question 6 *

Have you ever been convicted of an offense, placed on probation, or granted deferred adjudication or any other type of pretrial diversion? (Unless the offense involved alcohol or drugs, you may exclude: 1) traffic tickets; and, 2) violations with fines of $250 or less.) If you answer "Yes" to this question, you are required to submit Form R.

- Yes
- No

Question 7

Left intentionally blank at this time.

Actions by Professional Licensing Entities

If you answer "Yes" to any question in this section, you are required to submit Form S.

Question 8 *

Have you ever withdrawn an application for a professional license, permit or certification as a healthcare professional, or have you been determined ineligible for a professional license, permit or certification as a healthcare professional? If you answer "Yes" to this question, you are required to submit Form S.

- Yes
- No

Question 9 *

Have you ever had limitations placed on a professional license, been disciplined, or allowed to resign or voluntarily surrender your license in lieu of action by any licensing authority in any state, province, territory, U.S. federal jurisdiction, or country? (This would include, **but is not limited to**, informal or confidential orders; consent orders; agreed orders; letters of warning; letters of education; or letters of concern.) If you answer "Yes" to this question, you are required to submit Form S.

- Yes
- No

Question 10 *

Have you **ever** been the subject of an investigation based on any complaints, inquiries, grievances or formal or informal charges filed (regardless of the outcome) with or by any licensing authority in any state, province, territory, U.S. federal jurisdiction, or country? If you answer "Yes" to this question, you are required to submit Form S.

- Yes
- No

Question 11 *

Are there now pending any investigations, complaints, inquiries, grievances or formal or informal charges with or by any licensing authority in any state, province, territory, U.S. federal jurisdiction, or country? If you answer "Yes" to this question, you are required to submit Form S.

- Yes
- No

Question 12 *

Have you ever had restrictions placed on, been denied, or been required to surrender a federal or state controlled substance permit? If you answer "Yes" to this question, you are required to submit Form S.

- Yes
- No

Actions and Investigations in Training or During Employment

If you answer "Yes" to any question in this section, you are required to submit Form U. If you believe that any action or investigation was not reportable, you **must** read the instruction on Form U before you answer "No" to ensure your full and honest disclosure. Warning: Failure to answer the following questions correctly may subject you to disciplinary action.

Has any academic program, health care entity or professional organization ever taken against you, through either oral or written communication, any of the following public or private actions:

Question 13a *

limitation, reduction, suspension, revocation or denial of privileges? If you answer "Yes" to this question, you are required to submit Form U.

- Yes
- No

Question 13b *

warning, censure, reprimand, or formal admonishment? If you answer "Yes" to this question, you are required to submit Form U.

- Yes
- No

Question 13c *

additional limitations or requirements placed on you based on your clinical performance, academic performance, discipline, or for **any** other reason? If you answer "Yes" to this question, you are required to submit Form U.

- Yes
- No

Question 13d *

placement on academic or disciplinary probation? If you answer "Yes" to this question, you are required to submit Form U.

- Yes
- No

Question 13e *

request of termination, withdrawal or resignation? If you answer "Yes" to this question, you are required to submit Form U.

- Yes
- No

Question 13f *

acceptance of voluntary resignation in lieu of further investigations or other action? If you answer "Yes" to this question, you are required to submit Form U.

- Yes
- No

Question 14 *

Are any such actions listed in questions 13a through 13f pending? If you answer "Yes" to this question, you are required to submit Form U.

- Yes
- No

Question 15 *

Are you currently under investigation by any academic program, health care entity or professional organization? If you answer "Yes" to this question, you are required to submit Form U.

- Yes
- No

Malpractice History

If you answer "Yes" to any questions in this section, you are required to submit Form I and Form V.

Question 16 *

Has a complaint ever been filed against you in a court (i.e., a lawsuit) seeking damages relating to your conduct in providing or failing to provide a medical or health care service? If you answer "Yes" to this question, you are required to have Form I completed by every malpractice carrier who has insured you and you are required to submit Form V.

- ○ Yes
- ○ No

Question 17 *

Has there been:
(a) a settlement of a claim without the filing of a lawsuit, or
(b) a settlement of a lawsuit
made by you or on your behalf involving damages relating to your conduct in providing or failing to provide a medical or health care service? If you answer "Yes" to this question, you are required to have Form I completed by every malpractice carrier who has insured you and you are required to submit Form V.

- ○ Yes
- ○ No

Question 18 *

While serving in the U.S. military or the Public Health Service, or while employed, contracted or privileged by a federal facility was a complaint filed in court (i.e., a lawsuit) seeking damages relating to your conduct in providing or failing to provide a medical or health care service? If you answer "Yes" to this question, you are required to have Form I completed for each complaint and you are required to submit Form V.

- ○ Yes
- ○ No

If you answered Yes to Question 16, 17, or 18 above, what is the total number of cases?

Enter the number here: _____

Mental and Physical Health

If you answer "Yes" to any of the following questions, you are required to submit Form W.

Question 19a *

Within the past five (5) years, have you abused or have you been addicted to alcohol or drugs or have you been treated for alcohol or other substance abuse or dependency? If you answer "Yes" to this question, you are required to submit Form W.

- ○ Yes
- ○ No

Question 19b *

Within the past five (5) years, have you been diagnosed with or treated for any of the following: schizophrenia or any other psychotic disorder, delusional disorder, bipolar or manic depressive mood disorder, major depression, personality disorder, or any other mental condition which impaired your behavior, judgment, or ability to function in school, work or other important life activities? If you answer "Yes" to this question, you are required to submit Form W.

- ○ Yes
- ○ No

Question 19c *

Within the past five (5) years, have you had or do you currently have any physical or neurological condition, including any disease or condition generally regarded as chronic by the medical community, which impaired or does impair your behavior, judgment, or ability to function in school, work or other important life activities? If you answer "Yes" to this question, you are required to submit Form W.

- Yes
- No

Question 19d *

Within the past five (5) years, have you been diagnosed with or treated for pedophilia, exhibitionism, voyeurism, frotteurism, or sexual sadism? If you answer "Yes" to this question, you are required to submit Form W.

- Yes
- No

Question 20

If you answered "Yes" to questions 19a or 19b, are the limitations caused by your mental condition or substance abuse/dependency problem reduced or ameliorated because you receive ongoing treatment (with or without medication) or because you participate in a monitoring program? If you answer "Yes" to this question, include the details on Form W.

- Yes
- No

Continue

Physician Assistant Steps

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Review

Please review your information carefully and use the links on the left hand side to return to any section that needs modification. Click the "Continue" button at the bottom of the page when you are ready to move on. You may print this page if necessary.

Asterisk (*) indicates response required.

Identification

For JP first and last name, provide your name as it is listed on either your current driver license, issued by a state driver license bureau in the United States, or your current passport. We will furnish this information to the testing center that administers the jurisprudence exam (JP). Your name must match exactly when you present your identification at the testing center, or you will not be allowed to take the exam.

JP First Name* Sandy

JP Last Name* Smith

Full Name as you wish it to appear on your receipt* Sandy A Smith

Your name, as entered in the next 4 fields, will be the name that appears on your license and on the web site verification page.

Applicant First Name* Sandy

Applicant Middle Name A

Applicant Last name* Smith

Suffix

Alternate names Sandra

Email Address sandy@gmail.com

Gender *

- Male
- Female

Country of Birth* UNITED STATES

If you were born in the United States, please select your state of birth.

US State of Birth TEXAS

Date of Birth (MM/DD/YYYY)* 02/02/1978

Race* White

Are you of Hispanic Origin? *

- Yes
- No

If you are a Texas high school graduate, please select the county where your high school is located.

Texas High School County AUSTIN

Select your Physician Assistant program from the drop down list below. If you are unable to locate your school, please select "Unknown" and be aware that this will delay the processing of your application.

PA School* UNIV OF TEXAS MEDICAL BRANCH, GALVESTON

Year of Graduation (YYYY)* 2012

NCCAOM Certification Number 123456

Are you currently on active duty in the U.S. Military?*

- ( ) Yes
- (•) No

Expeding Factors

An applicant headquartered in Texas who is an active duty military service member, or the spouse of an active duty military service member, may be eligible for expedited handling.

If you think you may qualify please select the appropriate box:

- [ ] Military Service Member (active duty)
- [ ] Spouse of a Military Service Member (active duty)

Address

Mailing Address

Mailing Address 1:*	1234 Street
Mailing Address 2:	
Mailing City:*	Austin
Mailing State:	TEXAS
Mailing Zip Code:*	78701
Province:	
Mailing Country:*	UNITED STATES
Telephone Number ###-###-####:*	5121112222

Practice Address

Practice Address 1:	
Practice Address 2:	
Practice City:	
Practice State:	TEXAS
Practice Zip Code:	
Practice Province:	
Practice Country:	UNITED STATES
Telephone Number ###-###-####:	

Work Experience

Position	Department	Start Date	End Date	Name
Physician Assistant - Clinic Practice	Dermatology	01/2012	02/2013	Jones Clinic

Professional History

Question 1*

Have you ever been issued a Texas Physician Assistant License?

- ○ Yes
- ◉ No

Question 2

List all states in which you have applied for or have been granted licensure or certification as any type of healthcare provider. Choose a type of license and state from the drop down lists below. If you are unable to locate your license type, please use "Unassigned", and be aware that this will delay the processing of your application. Use Form AA if you have more than five licenses.

Type of License	Physician Assistant
State	HAWAII
Type of License	
State	
Type of License	
State	
Type of License	
State	
Type of License	
State	

Arrest/Criminal History

If you answer "Yes" to any question in this section, you are required to submit Form R.

If you believe your offense was **sealed or expunged**, you **must** be able to provide a copy of the expunction or non-disclosure order if requested.

Question 3 *

Have you ever been arrested? If you answer "Yes" to this question, you are required to submit Form R.

- ○ Yes
- ◉ No

Question 4 *

Have you ever been cited or ticketed for, or charged with any violation of the law? (Unless the offense involved alcohol or drugs, you may exclude: 1) traffic tickets; and, 2) violations with fines of $250 or less.) If you answer "Yes" to this question, you are required to submit Form R.

- ○ Yes
- ◉ No

Question 5 *

Are you currently the subject of a grand jury or criminal investigation? If you answer "Yes" to this question, you are required to submit Form R.

- ○ Yes
- ◉ No

Question 6 *

Have you ever been convicted of an offense, placed on probation, or granted deferred adjudication or any other type of pretrial diversion? (Unless the offense involved alcohol or drugs, you may exclude: 1) traffic tickets; and, 2) violations with fines of $250 or less.) If you answer "Yes" to this question, you are required to submit Form R.

- Yes
- (•) No

Question 7

Left intentionally blank at this time.

Actions by Professional Licensing Entities

If you answer "Yes" to any question in this section, you are required to submit Form S.

Question 8 *

Have you ever withdrawn an application for a professional license, permit or certification as a healthcare professional, or have you been determined ineligible for a professional license, permit or certification as a healthcare professional? If you answer "Yes" to this question, you are required to submit Form S.

- Yes
- (•) No

Question 9 *

Have you ever had limitations placed on a professional license, been disciplined, or allowed to resign or voluntarily surrender your license in lieu of action by any licensing authority in any state, province, territory, U.S. federal jurisdiction, or country? (This would include, **but is not limited to**, informal or confidential orders; consent orders; agreed orders; letters of warning; letters of education; or letters of concern.) If you answer "Yes" to this question, you are required to submit Form S.

- Yes
- (•) No

Question 10 *

Have you **ever** been the subject of an investigation based on any complaints, inquiries, grievances or formal or informal charges filed (regardless of the outcome) with or by any licensing authority in any state, province, territory, U.S. federal jurisdiction, or country? If you answer "Yes" to this question, you are required to submit Form S.

- Yes
- (•) No

Question 11 *

Are there now pending any investigations, complaints, inquiries, grievances or formal or informal charges with or by any licensing authority in any state, province, territory, U.S. federal jurisdiction, or country? If you answer "Yes" to this question, you are required to submit Form S.

- Yes
- (•) No

Question 12 *

Have you ever had restrictions placed on, been denied, or been required to surrender a federal or state controlled substance permit? If you answer "Yes" to this question, you are required to submit Form S.

- ○ Yes
- ◉ No

Actions and Investigations in Training or During Employment

If you answer "Yes" to any question in this section, you are required to submit Form U. If you believe that any action or investigation was not reportable, you **must** read the instruction on Form U before you answer "No" to ensure your full and honest disclosure. Warning: Failure to answer the following questions correctly may subject you to a disciplinary action.

Has any academic program, health care entity or professional organization ever taken against you, through either oral or written communication, any of the following public or private actions:

Question 13a *

limitation, reduction, suspension, revocation or denial of privileges? If you answer "Yes" to this question, you are required to submit Form U.

- ○ Yes
- ◉ No

Question13b *

warning, censure, reprimand, or formal admonishment? If you answer "Yes" to this question, you are required to submit Form U.

- ○ Yes
- ◉ No

Question 13c *

additional limitations or requirements placed on you based on your clinical performance, academic performance, discipline, or for **any** other reason? If you answer "Yes" to this question, you are required to submit Form U.

- ○ Yes
- ◉ No

Question 13d *

placement on academic or disciplinary probation? If you answer "Yes" to this question, you are required to submit Form U.

- ○ Yes
- ◉ No

Question 13e *

request of termination, withdrawal or resignation? If you answer "Yes" to this question, you are required to submit Form U.

- ○ Yes
- ◉ No

Question 13f *

acceptance of voluntary resignation in lieu of further investigations or other action? If you answer "Yes" to this question, you are required to submit Form U.

- ○ Yes
- ◉ No

Question 14 *

Are any such actions listed in questions 13a through 13f pending? If you answer "Yes" to this question, you are required to submit Form U.

- ○ Yes
- ◉ No

Question 15 *

Are you currently under investigation by any academic program, health care entity or professional organization? If you answer "Yes" to this question, you are required to submit Form U.

- ○ Yes
- ◉ No

Malpractice History

If you answer "Yes" to any questions in this section, you are required to submit Form I and Form V.

Question 16 *

Has a complaint ever been filed against you in a court (i.e., a lawsuit) seeking damages relating to your conduct in providing or failing to provide a medical or health care service? If you answer "Yes" to this question, you are required to have Form I completed by every malpractice carrier who has insured you and you are required to submit Form V.

- ○ Yes
- ◉ No

Question 17 *

Has there been:
(a) a settlement of a claim without the filing of a lawsuit, or
(b) a settlement of a lawsuit
made by you or on your behalf involving damages relating to your conduct in providing or failing to provide a medical or health care service? If you answer "Yes" to this question, you are required to have Form I completed by every malpractice carrier who has insured you and you are required to submit Form V.

- ○ Yes
- ◉ No

Question 18 *

While serving in the U.S. military or the Public Health Service, or while employed, contracted or privileged by a federal facility was a complaint filed in court (i.e., a lawsuit) seeking damages relating to your conduct in providing or failing to provide a medical or health care service? If you answer "Yes" to this question, you are required to have Form I completed for each complaint and you are required to submit Form V.

- ○ Yes
- ◉ No

If you answered Yes to Question 16, 17, or 18 above, what is the total number of cases?

Enter the number here:

Mental and Physical Health

If you answer "Yes" to any of the following questions, you are required to submit Form W.

Question 19a *

Within the past five (5) years, have you abused or have you been addicted to alcohol or drugs or have you been treated for alcohol or other substance abuse or dependency? If you answer "Yes" to this question, you are required to submit Form W.

- Yes
- (•) No

Question 19b *

Within the past five (5) years, have you been diagnosed with or treated for any of the following: schizophrenia or any other psychotic disorder, delusional disorder, bipolar or manic depressive mood disorder, major depression, personality disorder, or any other mental condition which impaired your behavior, judgment, or ability to function in school, work or other important life activities? If you answer "Yes" to this question, you are required to submit Form W.

- Yes
- (•) No

Question 19c *

Within the past five (5) years, have you had or do you currently have any physical or neurological condition, including any disease or condition generally regarded as chronic by the medical community, which impaired or does impair your behavior, judgment, or ability to function in school, work or other important life activities? If you answer "Yes" to this question, you are required to submit Form W.

- Yes
- (•) No

Question 19d *

Within the past five (5) years, have you been diagnosed with or treated for pedophilia, exhibitionism, voyeurism, frotteurism, or sexual sadism? If you answer "Yes" to this question, you are required to submit Form W.

- Yes
- (•) No

Question 20

If you answered "Yes" to questions 19a or 19b, are the limitations caused by your mental condition or substance abuse/dependency problem reduced or ameliorated because you receive ongoing treatment (with or without medication) or because you participate in a monitoring program? If you answer "Yes" to this question, you are required to submit Form W.

- Yes
- (•) No

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Attestation

I hereby certify that: I am the person herein named subscribing to this application; that I have read the complete application, know the full content thereof, and declare under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct. Further, I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past, present, and future), business or professional associates (past, present, and future) and all governmental agencies (local, state, federal, or foreign) to release to the Texas Physician Assistant Board or its successors any information, files or records, including medical records, educational records, and records of psychiatric treatment and treatment for drug and/or alcohol abuse or dependency, requested by the Board in connection with this application; necessary to determine my professional competence, professional conduct, and/or physical and mental ability to safely engage in the practice of my profession. I further authorize the Texas Physician Assistant Board or its successors to release to the organizations, individuals, or groups listed above any information, which is material to this application, or any subsequent licensure. **I hereby affirm that I will provide the Board with updated information to be received by the Board within 15 days of my becoming aware of any event that occurs after submission of my application that renders any response, although complete and correct when made, no longer complete or correct. Further, failure to provide updates may result in an adverse action against my application.**

I understand that falsification or misrepresentation of any item or response on this application or any supplemental information is a sufficient basis for denying my application, revoking a license, a determination of ineligibility, or another adverse action against my application or revoking my license after issuance.

I agree to these terms. ☐

Continue

Physician Assistant Steps

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Payment

- Credit Card
- Electronic Check

Continue

Physician Assistant Steps

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In order to complete the payment for your application, you will leave the TMB website and be directed to the Texas.gov payment processing site. Texas.gov, the official website of the State of Texas, processes online transactions on behalf of State Agencies. Your bill will indicate that this transaction has been charged to **TMB PA Application**.

No financial information is seen, processed, or stored by the Texas Medical Board.

The payment portion of the online application system is handled by Texas.gov, the official website of Texas. The price of this service includes funds that support the ongoing operations and enhancements of Texas.gov, which is provided by a third party in partnership with the State, as well as processing fees. Texas.gov will remit the amount paid to the Texas Medical Board on your behalf. Please note that the Texas.gov portion is non-refundable.

The total amount you will pay will be $209.87.

I understand and accept the above terms of payment.

Please press the continue button to begin entering payment information (NOTE: the payment process may take several minutes to finish. Please be patient and DO NOT click the back button or close your browser).

I understand and accept the above terms of payment. ☐

Press to continue

Texas Medical Board
TMB Store

Payment Process

You have selected to pay by credit card. Complete Customer Billing Information and enter Credit Card Information.

Transaction Summary

Description		Amount
TMB PA Application	Texas.gov Price	$209.87

Customer Billing Information

Complete all required fields [*]

Name *

Company Name

Billing Address *

Billing Address 2

Billing City *

Country * United States

State * Texas

ZIP/Postal Code *

Phone Number *
###-###-#### or ##########

Email Address *
Please enter your email address.

Receipt Email Addresses
Enter the email addresses you want copies of the confirmation receipt sent to.

Credit Card Information

Complete all required fields [*]

Credit Card Type * Select a Card

Credit Card Number *

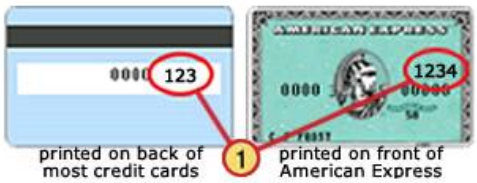
Expiration Date * Select a Month Select a Year

Expiration Date *

Select a Month | Select a Year

Name on Credit Card *
exactly as it appears on the card

Verification Code *
(1)



Continue | Cancel Payment

Texas Medical Board
TMB Store

Payment Verification

Review payment information. You may edit Billing and Payment Method here if needed. When complete, select Make Payment. You will receive a printable receipt at the end of your successful payment transaction.

Transaction Summary

Description		Amount
TMB PA Application	Texas.gov Price	$209.87

Customer Billing Information

Customer Name	Sandy Smith
Company Name	
Billing Address	1234 Street
Billing Address 2	
Billing City	Austin
Country	US
State	TX
ZIP/Postal Code	78701
Phone Number	512-111-1111
Email Address	[redacted]
Receipt Email Addresses	

Payment Method

Credit Card Type	VISA
Credit Card Number	******6781
Expiration Date	01 2016
Name on Credit Card	Sandy Smith
Verification Code	***

Verification

Enter the characters from the above image:

Make Payment | Cancel Payment | Edit

Physician Assistant Steps

- Login
- Identification
- Address
- Work Experience
- Professional History
- Review

Receipt:

Please allow 2 business days for processing of your application and fee.

Send written changes to:
Texas Medical Board
P.O. Box 2029
MC-906
Austin, TX 78768-2029
Fax: 888-790-0621

Trace Number	503PRE503000420
Transaction Date	3/18/2015
Pay Type	CC
Name:	Sandy Smith
Billing Name:	Sandy Smith
Billing Address:	1234 STREET
Billing State:	TX
Billing Zip Code:	78701
Registration Fee:	$205.00
Total paid:	$209.87