

**Registered Physician Assistant Form**

The University of the State of New York  
 THE STATE EDUCATION DEPARTMENT  
 Office of the Professions  
 Division of Professional Licensing Services  
 89 Washington Avenue  
 Albany, NY 12234-1000  
 www.op.nysed.gov

Department Use Only

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**Application for Licensure**

Applicants Must Complete All Four Pages Of This Application In Ink

1      23      \$115      ER

2 Social Security Number  
 (Leave this blank if you do not have a U.S. Social Security Number)

NYS License Number  
 011264

3 Birth Date Month Day Year

Date Issued  
 6-14-07

4 Print Name Exactly As You Wish It To Appear On Your License

Initials  
 RP

Last Canale  
 First Megan  
 Middle Marie

6 Telephone/E-Mail Address

Daytime Phone  
 Area Code Phone Number

5 Mailing Address (You must notify the Department promptly of any address or name changes.)

E-Mail Address (Please print clearly)

Line 1  
 Line 2  
 Line 3  
 City  
 State Zip Code  
 Country/Province

7 Have you ever been found guilty after trial, or pleaded guilty, no contest, or nolo contendere to a crime (felony or misdemeanor) in any court? YES NO

8 Are criminal charges pending against you in any court? YES NO

9 Has any licensing or disciplinary authority refused to issue you a license or ever revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, refused to renew a professional license or certificate held by you now or previously, or ever fined, censured, reprimanded or otherwise disciplined you? YES NO

10 Are charges pending against you in any jurisdiction for any sort of professional misconduct? YES NO

11 Has any hospital or licensed 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your professional training, employment, or privileges or have you ever voluntarily or involuntarily resigned or withdrawn from such association to avoid imposition of such measures?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

NOTE: If you answer "Yes" to any questions numbered 7-11, submit a letter giving a complete detailed explanation. Include copies of any court records (conviction record), and, if you possess one, a copy of the "Certificate of Relief from Disabilities" or your "Certificate of Good Conduct."

12 Have you ever taken the Physician Assistant National Certifying Examination (PANCE)?  YES  NO

Date of Exam 05 / 16 / 2006 Date Certified 05 / 25 / 2006  
 mo. day yr. mo. day yr.

13 In the spaces below, give an accurate record of your educational preparation. Be sure to complete items A-D for each school. Please print. Attach additional sheets if necessary.

A. NAME OF SCHOOLS ATTENDED AND LOCATIONS	B. NUMBER OF YEARS ATTENDED	C. ATTENDANCE		D. TITLE OF DIPLOMA OR DEGREE OBTAINED
		Entrance Date	Leaving Date	
High School 1. Athens Area High School School Name Athens City PA State/Country 2. _____ School Name _____ City _____ State/Country	4	08/97 mo/yr	06/00 mo/yr	High School Diploma
Postsecondary School(s) including preprofessional and professional education programs 1. The Pennsylvania State University School Name University Park City PA State/Country 2. Saint Francis University School Name Loretto City PA State/Country 3. _____ School Name _____ City _____ State/Country		09/00 mo/yr	05/04 mo/yr	Bachelor of Science Biobehavioral Health
		06/04 mo/yr	05/06 mo/yr	Master of Physician Assistant Sciences

\*Note: If your professional school was located outside the U.S. and you have a copy of your degree/diploma in the original language, attach a copy to this form.

14 Do you now hold, or have you ever held, a license or certificate to practice any profession in any jurisdiction?  YES  NO

If yes, list each license/certificate, state or jurisdiction and provide appropriate information in the columns below. A Form 3 must be submitted for each license/certificate listed.

Professional Title	State or Jurisdiction	Date License/Certificate Issued	License/Certificate Number	Limitations On License/Certificate
Physician Assistant	North Carolina	11-17-06	0010-00712	None

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**CHILD SUPPORT OBLIGATION:**

Everyone applying for or renewing a professional license, permit, or registration must file a written statement that, as of the date of the filing, he or she is, or is not, under an obligation to pay child support\*. Individuals who are four months or more in arrears in child support may be subject to suspension of their business, professional and/or driver's licenses. The intentional submission of false written statements for the purpose of frustrating or defeating the lawful enforcement of support obligations is punishable under section 175.35 of the Penal Law.

You must complete this section before we can issue the credential for which you have applied. Individuals who are not in compliance with their obligation to pay child support can be issued a credential for no more than six months in order to comply with their child support obligations.

Check only A or B below. If you check B, you must check one of the five statements listed below it.

A  I am not under an obligation to pay child support:

OR

B  I am under an obligation to pay child support *and* (please check only one of the following)

- I am current and am not four months or more in arrears in the payment of child support; or,  
 I am making payments by income execution or by court agreed payment plan or by a plan agreed to by the parties; or,  
 The child support obligation is the subject of a pending court proceeding; or,  
 I am receiving public assistance or supplemental security income; or,  
 None of the above four statements apply.

\*New York State General Obligations Law, Section 3-503

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**STUDENT LOAN DISCLOSURE:**

The State Education Department is required\* to ask these questions about any student loans made or guaranteed by the New York State Higher Education Services Corporation, and to forward any "yes" responses to the New York State Higher Education Services Corporation. Your license application is not complete without this information.

(a) Do you have any outstanding loans made or guaranteed by the New York State Higher Education Services Corporation?

Yes  No

(b) If you have such a loan(s), is any part in default?

Yes  No

\*New York State Education Law, Section 6501-a

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**CITIZENSHIP/IMMIGRATION STATUS:**

Federal Law limits the issuance of professional licenses, registrations and limited permits to United States citizens or qualified aliens. To comply with this Federal law, complete this section of this form and check the appropriate box below which indicates your citizenship/immigration status.

I AM: (Check one box)

- A. A United States citizen or National.
- B. An Alien lawfully admitted for permanent residence in the United States.
- C. An alien granted asylum under Section 208 of the Immigration and Nationality Act.
- D. A refugee granted asylum under Section 207 of the Immigration and Nationality Act.
- E. An alien paroled into the United States under Section 212 (d)(5) of the Immigration and Nationality Act for a period of at least 1 year.
- F. An alien whose deportation is being withheld under Section 243 (h) of the Immigration and Nationality Act.
- G. An alien granted conditional entry pursuant to Section 203 (a)(7) of the Immigration and Nationality Act as in effect prior to April 1980.
- H. Non Immigrant (Temporarily in U.S.)  
Please list Visa type or Immigration status or attach a copy of your passport if you are not required to have a Visa to enter the United States:  
\_\_\_\_\_

If you checked any of the boxes from B-H, enter your alien registration number or control number issued by the United States Citizenship and Immigration Services (USCIS): \_\_\_\_\_

USCIS number

QUESTIONS ABOUT YOUR IMMIGRATION STATUS AND WHETHER OR NOT IT IS A QUALIFYING STATUS UNDER FEDERAL LAW SHOULD BE DIRECTED TO THE U.S. CITIZENSHIP AND IMMIGRATION SERVICES (USCIS) BY CALLING 1-800-375-5283, OR VISIT THEIR WEB SITE AT WWW.USCIS.GOV.

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**GENDER AND ETHNICITY: (This item is optional.)**

Information on gender and ethnicity is sought solely to allow the Education Department to collect and analyze data concerning diversity in the licensed professions. The ethnic and gender data you provide will be used only for statistical, research, and program evaluation purposes. It will not be released to the public. This information has absolutely no bearing on your qualification for licensure.

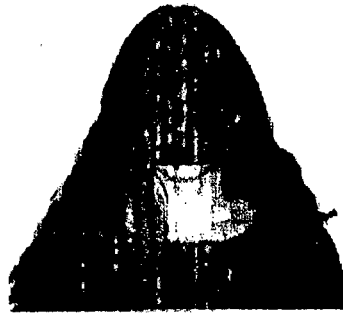
GENDER:  Male  Female

ETHNICITY:  White (not Hispanic)  Black (not Hispanic)  Asian  Hispanic  Native American

19 I give permission to the New York State Education Department to release my examination results to my professional school for the confidential purposes of program review and institution research and planning. I may rescind this authority at any time by notifying the Division of Professional Licensing Services in writing.

Yes  No Please initial: MMC

20 PHOTOGRAPH REQUIREMENT:



Date of photo: 01-10-07

21 AFFIDAVIT WITH ACKNOWLEDGMENT (Notarization required.)

APPLICANT

I declare and affirm that the statements made in this application, including accompanying documents, are true, complete and correct. I understand that any false or misleading information in, or in connection with, my application may be cause for denial or loss of licensure and may result in criminal prosecution.

Signature of the applicant: Megan Canale

NOTARY

State of North Carolina County of Randolph  
On the 8 day of May in the year 2007 before me, the undersigned, personally appeared Megan Marie Canale, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to this application and acknowledged to me that he/she executed the application and swore that the statements made by him/her in the application and all supporting materials are true, complete, and correct.

Notary Public signature Medinda R. Mabe

Notary ID number \_\_\_\_\_

Expiration date 10 / 29 / 08  
Month Day Year

Mail this form and appropriate fee to: New York State Education Department, Office of the Professions, PO Box 22063, Albany, NY 12201. DO NOT SEND CASH. Make check or money order payable to the New York State Education Department.

**Registered Physician  
Assistant Form 2**

The University of the State of New York  
THE STATE EDUCATION DEPARTMENT  
Office of the Professions  
Division of Professional Licensing Services  
89 Washington Avenue  
Albany, NY 12234-1000

RECEIVED

MAY 31 2007

*Handwritten initials and a circular stamp.*

**CERTIFICATION OF PROFESSIONAL EDUCATION**

**APPLICANT INSTRUCTIONS**

1. Complete Section I in ink. Enter your name as it appears on your Licensure Application (Form 1). Be sure to sign and date item 8.
2. Send this form to the institution(s) you attended for completion of Section II and the certification. Be sure to include any fee required by the institution. A separate Certification of Professional Education should be submitted for each professional educational program you attended.
3. This form must be signed by the registrar of the institution and both pages of this form must be returned directly in a sealed school envelope to the Office of the Professions at the address at the end of this form. Forms returned by the applicant will not be accepted.

**Section I: Applicant Information**

1 Social Security Number [REDACTED]  
*(Leave this blank if you do not have a U.S. Social Security Number)*

2 Birth Date [REDACTED]  
mo. day yr.

3 Print Your Name Exactly As It Appears On Your Licensure Application (Form 1)

Last Canale  
First Megan  
Middle Marie

4 Mailing Address (You must notify the Department promptly of any address or name changes.)

Line 1 [REDACTED]  
Line 2 [REDACTED]  
Line 3 [REDACTED]  
City [REDACTED]  
State [REDACTED] Zip Code [REDACTED]  
Country/Province United States

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UNIT II  
2007 JUN -4 PM 3:02

5 Print name under which certificate or degree was awarded: Megan Marie Canale

6 Professional school attended: Saint Francis University

7 Title of certificate or degree: Master of Physician Assistant Sciences Date awarded: 5 / 7 / 05  
mo. day yr.

8 I request and give my permission to the institution listed in item 6 above to complete the information on this form and send any documentation requested, including that requested on this form (e.g. an official transcript), to the New York State Education Department.

Applicant's signature: Megan Canale, PA-C Date: 05 / 22 / 07  
mo. day yr.

Section II: Certification Of Professional Education

INSTRUCTIONS TO INSTITUTION REGISTRAR:

- 1. Complete Part A or Part B to document the applicant's education.
- 2. Complete Part C (Certification) and return both pages of this form directly to the Office of the Professions at the address at the end of this form. Do not return this form to the applicant.

Part A - Programs Registered By New York State As Licensure Qualifying Or Accredited By The Accreditation Review Commission On Education For The Physician Assistant (ARC-PA) At The Time The Applicant Completed The Program.

To be completed only by those schools at which the applicant completed a physician assistant program registered by the New York State Education Department as licensure qualifying or accredited by the ARC-PA.

It is certified that Megan Marie Canale

Master of (Name of applicant - See Section I, Item 5)

was awarded the credential of Physician Assistant Science on 5 / 7 / 06  
(Title of credential) mo. day yr.

OR

on \_\_\_ / \_\_\_ / \_\_\_ this institution determined that the above-named student met all requirements for the credential and the

institution has agreed to award the credential of \_\_\_\_\_  
(Title of credential)

Part B - All Other Programs.

An official transcript or marksheet giving courses completed by year and grades and a syllabus of the course of studies completed must be attached.

- (1) Date of applicant's entrance, and either the applicant's date of completion of studies or withdrawal from the school:

Entrance date: 5 / 1 / 04  Completion date: 5 / 7 / 06  Withdrawal date: \_\_\_ / \_\_\_ / \_\_\_  
mo. day yr. mo. day yr. mo. day yr.

- (2) Did the student complete at least 32 semester hours of classroom work?  Yes  No If "No", number of clock hours: \_\_\_\_\_

- (2) Did the student complete 1,800 clock hours of supervised clinical training?  Yes  No If "No", number of clock hours: \_\_\_\_\_

- (3) Credential Awarded: Master of Physician Assistant Science

- (4) Date credential awarded: 5 / 7 / 06

Name of accrediting body or official organization that recognizes this program: St. Francis University

Address of accrediting body or organization that recognizes the program: P.O. Box 600

Loretto, PA 15940

Part C - Certification:

I hereby certify that to the best of my knowledge and belief the information in Section II is a true statement of the educational record of the individual named on this form.

Signature of Registrar *Stephen Rombouts* Date 05 / 31 / 2007  
mo. day yr.

Type or print name Stephen Rombouts

Title or official position Registrar

Institution St. Francis University

Address P.O. Box 600, Loretto PA 15940

(INSTITUTION SEAL)

Telephone number [REDACTED] Fax [REDACTED]

E-mail [REDACTED]

Return Directly to: New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Physician Assistant Unit, 89 Washington Avenue, Albany, NY 12234-1000.