Regular Mailing Address
STATE BOARD OF MEDICINE
P.O. BOX 2649
HARRISBURG, PA 17105-2649
717-783-1400/717-787-2381
Email: st-medicine@pa.gov

Courier Delivery Address
STATE BOARD OF MEDICINE
2601 NORTH THIRD STREET
HARRISBURG, PA 17110

APPLICATION FOR REGISTRATION AS A SUPERVISING PHYSICIAN

THIS APPLICATION IS FOR USE ONLY BY A PRIMARY SUPERVISING PHYSICIAN LICENSED BY THE PENNSYLVANIA STATE BOARD OF MEDICINE.

PLEASE PRINT OR TYPE ALL INFORMATION. If the written agreement is identical for all supervisors, submit one application for each physician assistant. Attach the fee and written agreement.

FEE. Submit the $35.00 fee. Make check or money order payable to the "Commonwealth of Pennsylvania." **FEES ARE NOT REFUNDABLE. The fee cannot be transferred to another application. Note:** A processing fee of $20.00 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment. Your cancelled check is your receipt of payment.

PLEASE NOTE: If this application is not completed **within six months**, updates of certain sections and/or supporting documents will be required. If the application has not been completed within one year from the date it was received, applicants will be required to submit a new application (**another application processing fee**) and supporting documents, as necessary.

PLEASE NOTE: Upon receipt of a **complete** application, the Board will issue a letter authorizing the physician assistant to temporarily commence practice in accordance with the pending written agreement submitted with this application. The temporary authorization to practice is valid for **120 days ONLY** while the written agreement is being evaluated for final Board approval.

PLEASE ALLOW AT LEAST 120 DAYS FOR PROCESSING OF THE WRITTEN AGREEMENT FINAL APPROVAL.

PLEASE NOTE: A PHYSICIAN ASSISTANT CANNOT PRACTICE PRIOR TO THE BOARD ISSUING A TEMPORARY AUTHORITY TO PRACTICE

PRIMARY SUPERVISING PHYSICIAN NAME:	Last	First	Middle
PRIMARY SUPERVISING PHYSICIAN LICENSE NUMBER:		**PRACTICE TELEPHONE NUMBER:**	
PRACTICE ADDRESS:	Street		
City	State	ZIP	
SUBSTITUTE SUPERVISOR NAME:	Last	First	Middle
SUBSTITUTE SUPERVISOR'S LICENSE NUMBER:			
PHYSICIAN ASSISTANT NAME:	Last	First	Middle
PHYSICIAN ASSISTANT LICENSE NUMBER:			

PENNSYLVANIA STATE BOARD OF MEDICINE

PRIMARY SUPERVISING PHYSICIAN MUST COMPLETE THIS SECTION:

LIST YOUR SPECIALTIES:			
DO YOU HOLD HOSPITAL STAFF PRIVILEGES?	Yes	No	
IF YES, LIST HOSPITAL(S):			

VERIFICATION

- I will direct and exercise supervision over the named physician assistant in accordance with the rules and regulations of the State Board of Medicine.
- I verify that I have reviewed the Medical Practice Act and Regulations of the State Board of Medicine.
- I recognize that I am obligated to comply with all provisions of the Act and Regulations including those provisions that require me to notify the Board of the termination of my agreement to supervise the physician assistant.
- I recognize that I retain full professional and legal responsibility for the performance of the physician assistant and the care and treatment of the physician assistant's patients.
- I verify that the statements in this application and written agreement are true and correct to the best of my knowledge, information and belief.
- I understand that false statements are made subject to the penalties of 18 Pa. C.S. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my registration.
- **I will provide all substitute supervising physicians with a copy of the approved supervising written agreement**.
- The physician assistant identified in this application will only work with the primary supervising physician and his/her substitute physician assistant supervisor(s).
- The physician assistant will only provide medical services to the patients under the care of the primary and substitute supervisor(s) **and WILL NOT practice if the supervising physician or an authorized substitute supervisor is not available**.

PRIMARY SUPERVISING PHYSICIAN (Printed Name):		
PRIMARY SUPERVISING PHYSICIAN SIGNATURE:		Date
PHYSICIAN ASSISTANT (Printed Name):		
PHYSICIAN ASSISTANT SIGNATURE:		Date

PLEASE NOTE: The primary supervisor's responsibilities include:

- **Providing a copy of the final, Board approved written agreement to all substitute supervisors.**
- **Maintaining a current list of all locations where the physician assistant will perform duties.**
- **Maintaining a current list of all substitute supervisors under which the physician assistant will work.**
- **Notifying the Board of changes to the primary practice location utilizing a written agreement change form.**
- **Ensuring that the physician assistant will not practice without supervision by either the primary supervisor or an authorized substitute supervisor.**

(01/2014)

PENNSYLVANIA STATE BOARD OF MEDICINE

WRITTEN AGREEMENT

	Last	First	Middle
NAME - PRIMARY SUPERVISING PHYSICIAN:			
NAME – SUBSTITUTE SUPERVISING PHYSICIAN:			
NAME – PHYSICIAN ASSISTANT:			

INSTRUCTIONS: Please provide the following information (typed) for question 1 on 8.5" x 11" sheets of paper and attach to this form. The information on this agreement must be agreed to by all supervisors (primary and substitute).

1.	Describe the functions/tasks to be delegated to the physician assistant.
2.	On-site supervision and direction will be provided to the physician assistant ____________________ (daily, every other day, once per week, etc.).
3.	If the physician assistant will practice in a hospital, provide the name and address of each hospital below. If more than three hospitals, please provide this information on a separate sheet of paper.

Name of Hospital	Address
Name of Hospital	Address
Name of Hospital	Address

		Yes	No
4.	Will the physician assistant prescribe and dispense drugs/therapeutic devices?		

If yes, please identify which categories of controlled substances may be prescribed and dispensed?

☐ None ☐ Schedule II ☐ Schedule III ☐ Schedule IV ☐ Schedule V

List below any specific drugs that the physician assistant **WILL NOT** be permitted to prescribe/dispense.

PENNSYLVANIA STATE BOARD OF MEDICINE

PATIENT RECORD REVIEW PLAN

	Last	First	Middle
NAME - PRIMARY SUPERVISING PHYSICIAN:			
NAME – PHYSICIAN ASSISTANT:			

VERIFICATION

The supervising physician must countersign 100% of the patient records completed by the physician assistant within a reasonable time, which shall not exceed ten days during each of the following cases:

- The first 12 months of the physician assistant's practice post graduation and after obtaining licensure.
- The first 12 months of the physician assistant's practice in a new specialty.
- The first 6 months of the physician assistant's practice in the same specialty under a new primary supervisor (unless, the new primary supervisor was registered as a substitute supervisor for at least six months under another written agreement).

I verify that I have read the above requirements and that I will countersign 100% of the patient records for the required time frame.

	Yes	No
After you have countersigned 100% of the patient records for the required time frame(s) listed above, will you continue to countersign 100% of the patient records within the required 10 day period?		

If NO, provide specific details below regarding how you will select patient records for review and with what frequency you will review patient records. This information should include specifics such as the percentage of patient charts, specific types or categories of patient cases, etc. Use additional 8 ½" x 11" paper, if necessary.

I affirm that the number of patient records reviewed shall be sufficient to assure adequate review of the physician assistant's practice. Deviation from 100% chart review will require Board approval **PRIOR TO IMPLEMENTING THE NEW REVIEW PLAN.**

	Last	First	Middle
PRIMARY SUPERVISING PHYSICIAN			

		Date
PRIMARY SUPERVISING PHYSICIAN SIGNATURE:		