Regular Mailing Address	Courier Delivery Address
STATE BOARD OF MEDICINE **P.O. BOX 2649** **HARRISBURG, PA 17105-2649** **Email:** st-medicine@pa.gov	**STATE BOARD OF MEDICINE** **2601 NORTH THIRD STREET** **HARRISBURG, PA 17110** **717-783-1400/717-787-2381**

APPLICATION FOR APPROVAL OF A SATELLITE LOCATION

A SATELLITE LOCATION IS A LOCATION OTHER THAN THE PRIMARY PLACE AT WHICH THE SUPERVISING PHYSICIAN OR THE PHYSICIAN ASSISTANT PROVIDES MEDICAL SERVICES TO PATIENTS. THIS LOCATION MUST MEET THE FOLLOWING CRITERIA:

- The physician assistant will be utilized in an area of medical need.
- There is adequate provision for direct communication between the physician assistant and the supervising physician and that the distance between the location where the physician provides services and the satellite location is not so great as to prohibit or impede appropriate support services.
- The supervising physician shall review directly with the patient the progress of the patient's care as needed based upon the patient's medical condition and prognosis or as requested by the patient.
- The supervising physician will visit the satellite location at least once every 10 days and devote enough time onsite to provide supervision and personally review the records of patients seen by the physician assistant in this setting. The supervising physician shall notate those patients records as reviewed.

Submit the $25 fee via check or money order, made payable to the "Commonwealth of Pennsylvania." **FEES ARE NOT REFUNDABLE.** Note: A processing fee of $20 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.

PLEASE NOTE: If a pending application is older than one year from the date submitted and the applicant wishes to continue the application process, the Board shall require the applicant to submit a new application including the required fee. In order to complete the application process, many of the supporting documents associated with the application cannot be more than six months from the date of issuance.

TO BE COMPLETED BY PHYSICIAN ASSISTANT SUPERVISING PHYSICIAN

(Please print or type)

NAME OF SUPERVISING PHYSICIAN:	Last:	First:	Middle:
SATELLITE LOCATION:	Street:		
City:		State:	ZIP:
WRITTEN AGREEMENT #:			
NAME OF PHYSICIAN ASSISTANT TO BE EMPLOYED AT SATELLITE LOCATION:	Last	First	Middle
LICENSE NUMBER #:			

INSTRUCTIONS

Please provide the following information for questions 1, 2 and 3 on 8.5" x 11" sheets and attach to this form. Number each section on the attachment. For approval to establish a satellite location operated by a physician assistant, specific permission is required from the State Board of Medicine.

1.	Describe how the area in which you wish to establish a satellite location is an area of medical need.
2.	Describe how there will be adequate provisions for direct communication between you and the physician assistant. Confirm that the distance between the location where you provide services and the satellite location will not be so great as to prohibit or impede appropriate support services.
3.	Will you visit the satellite location at least every 10 days and devote enough time onsite to provide supervision and personally review the records of patients seen by the physician assistant in this setting?

FAILURE TO MAINTAIN THE STANDARDS ENUMERATED ABOVE IN NO. 2 AND 3 MAY RESULT NOT ONLY IN THE LOSS OF THE PRIVILEGE TO MAINTAIN A SATELLITE LOCATION, BUT ALSO IN DISCIPLINARY ACTION AGAINST THE PHYSICIAN ASSISTANT AND THE PHYSICIAN ASSISTANT SUPERVISING PHYSICIAN.

VERIFICATION

I verify that the statements in this application 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 license or certificate.

_____ _____

SIGNATURE OF SUPERVISING PHYSICIAN **DATE**

_____

PRINTED NAME OF SUPERVISING PHYSICIAN

_____ _____

SIGNATURE OF PHYSICIAN ASSISTANT **DATE**

_____

PRINTED NAME OF PHYSICIAN ASSISTANT