

Bureau of Professional and Occupational Affairs

State Boards of Medicine and Osteopathic Medicine

Job Aid for Written Agreement Initiated By Physician Assistant

Version 1.1 08-2022

These steps can be followed for Written Agreement applications initiated by Physician Assistant

Step No	Action
1.	Go to https://www.pals.pa.gov
	Select Login
	DEPARTMENT OF STATE DEPARTMENT OF STATE DEPARTMENT OF STATE Department of state Welcome to the Pennsylvania Licensing System (PALS) Nrv Nrv Verification of License Verification of License Verification of License Verification of License Anadatory Reporting by Leonoes Verification of License Application for Solie Proprietor Architecture Firm. Denotes To Sole Proprietor Architecture Firm.
2.	 The Physician Assistant will need to Log into PALS by entering their User ID and Password and clicking LOGIN. a. The Dashboard screen will be displayed. b. In the Professional License Details section, click on the green pencil icon next to your license number.
	TEST, TEST
	Address Email address SSN 1 MAIN ST 000 HARRISBURG, PENNSYLVANIA, United States, 17110 000
	Professional License Details
	Change License Number Name Board/Commission License Type \$ Status \$ Issue Date \$ MA0603 ① TEST TEST Medicine Medical Physician Asst Active 3/15/2021 Showing 110 1 of 1 entries
	c. On the Change Options (License) pop-up, select Written Agreement .
	Change Options (License)
	Verification/Certification X Inactivate Duplicate License Written Agreement

	Be advised: Please refer to the State Board of Medicine law			
	Please refer to the State Board of Medicine law			
		s and regulations for specific questions regarding application require	ments.	
	WHAT YOU NEED TO COMPLETE THIS APPLIC Click on 1 for more information To email or	ATION: print the application checklist instruction click here.		
	Application			
	Application Fee	Charaldist House		
	Proof Of Insurance	Checklist Items		
	Written Agreement			
	IMPORTANT INFORMATION:			
	Upon submission of a complete application, th	e Board will issue a letter authorizing the physician assistant to temp		agreement submitted with
		items will result in a denial of temporary approval and the application quested information including complete answers to all questions wit		
	Submission or an application with all re Proof of current liability insurance cover		n supporting documentation.	
		d for 120 days ONLY while the written agreement is being evaluated	or final Board approval. A physician assistant cannot practice prior	to the Board issuing a te
				-
	PHYSICIAN ASSISTANT DETAILS:			
	License Number MA3279863			
	Last Name	First Name		Middle Name
	DEMO	CECILIA		
	Street			
	122 DEMO ST			
	123 DEMO ST City	State		Zip
4.	Enter the Primary Sup	ervisor License number. N		must be
4.	City Enter the Primary Sup under the same Board System will display the Please enter a valid Medical Physician and Surgeon L Ucense Number M03429698	ervisor License number. N d as the physician assistant e Supervising Physician det icense Number. License Number should include the full number (i.e. M	. Press the [Tab] key on th ails:	must be
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	QUESTIONS SECTION:
	Please provide the following information for questions below.
	Specialties of the Primary Supervisor:
	Will a group of physicians supervise the physician assistant?
	○ Yes ○ No Will the physician assistant prescribe and dispense drugs/therapeutic devices?
	○ Yes ○ No
	The supervising physician, whether primary or secondary, must countersign 100% of the patient records completed by the physician • 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 speciality.
	WRITTEN AGREEMENT:
	Describe the physician assistant's scope of practice.
	Provide the nature and degree of supervision the supervising physician will provide to the physician assistant.
	Enter the primary practice address:
	City:
	State:
	Select 🗸
	Zip Code:
	Enter the primary practice telephone number:
-	In the CONFIRMATION STATEMENT SECTION mark the 'I CONFIRM' check box and type you
	In the CONFIRMATION STATEMENT SECTION mark the 'I CONFIRM' check box and type you name in the Signature box
	name in the Signature box
	name in the Signature box CONFIRMATION STATEMENT SECTION:
	name in the Signature box CONFIRMATION STATEMENT SECTION: • I verify that I have reviewed the Medical Practice Act and Regulations of the State Board of Medicine.
	name in the Signature box CONFIRMATION STATEMENT SECTION: 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 termin
	name in the Signature box CONFIRMATION STATEMENT SECTION: 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 termin I verify that the statements in this application and written agreement are true and carried to the best of my knowledge, information and belief.
	name in the Signature box CONFIRMATION STATEMENT SECTION: 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 termin I verify that the statements in this application and written agreement are true and carried to the best of my knowledge, information and belief.
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	dical services to the patients under the care of the primary supervisor or the care of the substitute supervisor(s) and WILL NOT practice if the primary supervisor or an authorized substitut IE READ AND AGREE TO THE TERMS ABOVE. Date 8/2/2019	e supervisor is not available.
Save		SEND TO SUPERVISING PHYSIC
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		New Provider Application		
		To request approval for CE, School, Program Sponsors, Pre-Licensure Education or Request PA-SUPPORT Curriculum	Request Approval	
		My Queue		
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10.		RITTEN AGREEMENT APPLICATION is displayed. Click of ew the requirements for each of the checklist items. Re		
		plication that has been completed by the physician assis		
		information that has been entered.		
	MEDICIN	IE WRITTEN AGREEMENT APPLICATION		
	Be ad	lvised:		
	Please	refer to the State Board of Medicine laws and regulations 😽 specific questions regarding application require	ements.	
	WHAT	YOU NEED TO COMPLETE THIS APPLICATION:		
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		Application 9		
		Application Fee 0		
		Proof Of Insurance 0		
	•	Written Agreement 🚯		
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Lwill provide all substitute supervising physicians with a copy of the approved supervising written agreement, The physician assistant identified in that application will only work under my supervision or the supervision of the designated substitute phys The physician assistant will only provide medical services to the patients under my care of the primary and substitute supervisor(s) and WILL substitute supervisor is not available. Signature Physician and Surgeon All 2019	-
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16.	Click Submit
	Comments:
	Save
17.	
	[Add to Cart] button
	Review Your Application
	You cannot make any changes to your application once it is submitted to the Board/Commission.
	MEDICINE WRITTEN AGREEMENT APPLICATION
	WHAT YOU NEED TO COMPLETE THIS APPLICATION: Click on Θ for more information. To email or print the application checklist instruction click here.
	Application 0 Application Fee 0
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10.	The checkout page will be displayed.
	a. Select the check box for the application
	 b. Select the All fees are non-refundable checkbox c. Click on the [Proceed to Payment] button

	Check Out : You may continue adding additional items to your cart. Click here 🖓 to go to the dashboard.
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	Once your transaction is complete you will receive a confirmation message and reference number. This may take a few moments. Please do not close your browser or navigate away from this page until the confirmation is received OR YOUR TRANSACTION MAY NOT BE COMPLETED.
19.	In the Payment page, enter the payment details as prompted.
	Pay With Your Credit Card
	Cardholder Name
	Credit Card Number
	Expiry Date (MMYY)
	Security Code Present CVV2 is the Visa term for the 3-digit security code on the
20.	Click on the [Pay With Your Credit Card] button

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	Country	
	United States	
	Email	
	A confirmation email will be sent to this address.	
	Pay With Your Credit Card	
1		
21.	The Confirmation page is displayed. Application number will be displaye	d in the
	Payment Summary	
	Confirmation	
	Thank you for your payment. Your payment has been processed - please print this page for your records.	
	Your application is not complete until the Board receives the completed checklist items below. Click Download to print the required documents for licensure. It is your responsibility to maintain a copy of this application at board.	nd all documents submitted to the board or re
	Payment Summary	
	Receipt Number: PAID0000741600 Payment Date: 08/01/2019	
	Application No # AA00011559180 (Medicine/Written Agreement/ Application) - 08/01/2019	
	CheckList Name Status	Download
	Application Pending Review	Jownoau 🛃
	Application Fee Completed	
	Proof Of Insurance Pending Review	
	Written Agreement Pending Review	
	To email or print the application checklist instruction click here.	
22.	Click on the Dashboard icon on the top left side	

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26. You can follow the status of the application by logging into your dashboard and going to the Activities Section. If the application status indicates **Pending Review**, the application is pending review by Board Staff. If the status changes to **Need Action**, expand the checklist by clicking on the plus sign next to the application number. The items will be noted which indicate a discrepancy.

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	Application	Lan Discrepanc	y 8/7/2019	Please follow all directions. Any discrepancies will cause a de not completed within six months, updates of certain sections		
	Application Fee	Completed	8/6/2019	An application fee of \$35.00 is required. Please note that all fe	ees are non-refundable.	
1	Proof Of Insurance	M Discrepanc	y 8/7/2019	The physician assistant will need to upload, where prompted insurance, personally purchased insurance or insurance prov per occurrence or claims made. This proof of insurance/cer that they are covered under this policy while performing p	ided by their employer for the r tificate must include the physi	minimum amount of \$1. ician assistant's name
1	Written Agreement	Discrepance	8/7/2019	Describe the functions/tasks to be delegated to the physician of supervision and direction you will provide to the physician physician assistant.		
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28.		ll need to respond to the discrepancy by uploading supporting documents to r the discrepancy.
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