

Bureau of Professional and Occupational Affairs

State Boards of Medicine and Osteopathic Medicine

Job Aid for Written Agreement Initiated By Physician and Surgeon

Version 1.0 08-2022



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

| Be advised: Please refer to the State Board of Medicine la | | |
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| Please refer to the State Board of Medicine la | | |
| | aws and regulations for specific questions regarding application require | ments. |
| Click on O for more information To email | JCATION: or print the application checklist instruction click here. | |
| Application | | |
| Application Fee | | \searrow |
| Proof Of Insurance | Checklist items | |
| Written Agreement | | |
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| PRIMARY SUPERVISOR DETAILS: | | |
| License Number | | |
| MD3382903 | | |
| Last Name | First Name | Middle Name |
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| Street | ALDEIN | |
| Street 123 DEMO ST | | 7. |
| Street 123 DEMO ST City HARRISBURG | State Pennsylvania | Zip 17101 |
| Street 123 DEMO ST City HARRISBURG Enter the Physician Ass under the same Board | sistant License number. Note | ^{Zip} 17101 : This license number must be Press the [Tab] key on the |
| Street 123 DEMO ST City HARRISBURG Enter the Physician Ass under the same Board keyboard. System will PHYSICIAN ASSISTANT DETAILS: Please enter a valid Physician Assistant License Number License Number License Number License Number License Number License Number | State Pennsylvania sistant License number. Note l as the supervising physician. display the Physician Assistan | ^{Zip} 17101 : This license number must b . Press the [Tab] key on the t details: |
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| Please provide the following information for questions be Specialties of the Primary Supervisor: | | | | |
| Will a group of physicians supervise the physician assistant | | | | |
| Yes No Will the physician assistant prescribe and dispense drugs/th | peutic devices? | | | |
| Yes No The supervising physician, whether primary or secondary, r The first 12 meetrs of the physician assistant's error | t countersign 100% of the patient records compl | leted by the physician within a reasonable | time, which shall not exceed ten days during each of the follow | ving cases: |
| The first 12 months of the physician assistant's pract The first 12 months of the physician assistant's pract | in a new specialty. | <u>G</u> | | |
| WRITTEN AGREEME | NT: | | | |
| Describe the physician assistant's | cope of practice. | | | |
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| Provide the nature and degree of | inervision the supervising | physician will provide to the | e nhysician assistant | |
| Thomas and address of the second seco | ipervision the supervising | , physician will provide to an | | |
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| Show 10 v entries | checklist and upload documents to the B | oard/Commission. | | | | Search | |
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| 9. | 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. Scroll to the My Queue section, click on the [Review] button. The application will also show in the Activities Section. However, you must use the My Queue section. |
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| | Show 10 🔽 entries Search: |
| | Description Requested Date Actions Requested Date |
| | Review-DOROTHY DEMO -For-MEDICINE WRITTEN AGREEMENT APPLICATION from ALBERT DEMO |
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| | to review the requirements for each of the checklist items. Review the information in the application that has been completed by the supervising physician and surgeon. You cannot make edits to the information that the supervising physician has completed. If there are any errors, please contact the supervising physician. The supervising physician will need to make the corrections in the application and resend to you. |
| | MEDICINE WRITTEN AGREEMENT APPLICATION |
| | |
| | Be advised: |
| | Please refer to the State Board of Medicine laws and regulations ω specific questions regarding application requirements. |
| | WHAT YOU NEED TO COMPLETE THIS APPLICATION: |
| | Click on the the term of the term of the application checklist instruction click here. |
| | |
| | • Application ree |
| | Proof Of Insurance |
| | Written Agreement |
| 11 | In the CONFIDMATION STATEMENT SECTION meril the (I CONFIDM) should have and the survey |
| 11. | In the CONFIRMATION STATEMENT SECTION mark the TCONFIRM check box and type your |
| | name in the Signature hox |

| [| CONFIRMATION STATEMENT SEC I verify that I have reviewed I recognize that I am obliga I verify that the statements I understand that false state registration. I will only work under the p Will only provide medical substitute supervisor is not I CONFIRM THAT I HAVE REA | TION: the Medical Practice Act and Regulation ted to comply with all provisions of the in this application and written agreeme ements are made subject to the penalti rimary supervisor's supervision or the s services to the patients under the care of available. | ons of the State Board of Medicine Act and Regulations including the ent are true and correct to the bes les of 18 Pa. C.S. Section 4904 rela supervision of the designated sub: of the primary supervisor or the ca | ose provisions tha tof my knowledg ting to unsworn fa stitute physician a stitute physician a | t require me to e, information ; alsification to au ssistant superv te supervisor(s) | notify the Board of the termination and belief. uthorities and may result in the sus risor(s). and WILL NOT practice if the prim |
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| | iignature Please type your name. | | | Date 8/1/2019 | | |
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| | Document Type | Document Name | Size | Progress | Status | Actions |
| | Proof Of Insurance The physician assistant will need to upload, where prompted, proof of professional liability insurance coverage through self-insurance, personally purchased insurance or insurance provided by their employer for the minimum amount of \$1,000,000.00 per occurrence or claims made. This proof of insurance/certificate must include the physician | Attachment.pdf | 0.41 MB | | | C Upland 2 C |

| | Comments: |
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| 15. | User will be redirected to the Dashboard page. The application will be displayed in the My Queue section as REVIEW AND SUBMIT TO BOARD |
| 16. | In the Dashboard page, at the top left corner, click on the Person icon and then click on the Logout option: |

| PALS | | | | | | | |
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| | Select the [Yes] radio button | | |
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| | b. In the Signature box, type your na | ame | |
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| | VERIFICATION SECTION: | | |
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| | I will direct and exercise supervision over the named physician assistant in accordance I verify that I have reviewed the Medical Practice Act and Regulations of the State Board | with the rules and regulations of the State Board of Medicine. I of Medicine. | |
| | I recognize that I am obligated to comply with all provisions of the Act and Regulations physician accident. | including those provisions that require me to notify the Board o | |
| | Projection assistant. I recognize that <u>I retain full professional and legal responsibility for the performance of</u> I verify that the statements in this application and written agreement are true and corro | the physician assistant and the care and treatment of the physic act 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. 4904 | relating to unsworn falsification to authorities and may result in | |
| | I will provide all substitute supervising physicians with a copy of the approved super | vising written agreement. | |
| | The physician assistant identified in that application will only work under my supervisa The physician assistant will only provide medical services to the patients under my car substitute supervisor is not available. | on or the supervision of the designated substitute physician assi e of the primary and substitute supervisor(s) <u>and WILL NOT prac</u> | |
| | I agree with the details of this written agreement and wish to submit this application to the Bo | ard for Approval. | |
| | Signature | Date | |
| | DEMO USER | 8/1/2019 | |
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| | Pay With Your Credit Card Cardholder Name Credit Card Number Credit Card Number VISA Security Code Present VV2 is the Visa term for the 3-digit security code on the |
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| 23. | Click on the [Pay With Your Credit Card] button |
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| 24. | The Confirmation page is displayed. Application number will be displayed in the |
| | Payment Summary |

| | Confirmation | | | |
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| 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 | ad to print the required documents for licensure | . It is your responsibility to maintain a co | ppy of this application and all | |
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| Payment Summary | > | | | |
| Receipt Number: PAID0000741604 Payment Date: | 08/01/2019 | | | |
| Application No # AA0001359183 (Medicin / Written Agreement/ Application) - 08/01/2019 | | | * | |
| CheckList Name | | Status | Download | |
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| Written Agreement | | Pending Review | | |
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26. User will be redirected to the **Dashboard** page. The application will be displayed in the Activities section in the Submitted Status. The application will stay in the Submitted Status until it is evaluated by Board Staff. Click 🔮 to view application checklist and upload documents to the Board/Commission. Show 10 v entries Reference Number License Type Board/Commission ¢ AA0001359183 Medicine 🚯 MEDICINE WRITTEN AGREEMENT APPLICATION 葦 Written Agreement Showing 1 to 1 of 1 entries Previous You will need to print a copy of the application that was submitted. Expand the checklist 27. by clicking on the plus sign next to the application number. Click 😌 to view application checklist and upload documents to the Board/Commission. Show 10 🗸 entries Search: Reference Number Board/Commission ٨ License Type License No 🝦 Description Status Action ٩ 0 * 🗄 A0001359302 Medicine 🕦 Written Agreement MEDICINE WRITTEN AGREEMENT APPLICATION Need Action 🗸 28. Click on the download button next to the Application Checklist Item. Show 10 🗸 entries Search Reference Number Board/Commission Description Status Action MEDICINE WRITTEN AGREEMENT AA0001359302 Medicine 🚯 Written Agreement Need Action 圭 * APPLICATION Please follow all directions. Any discrepancies will cause a delay in the approval of the written agreement. If this application is Application 8/7/2019 epancy not completed within six months, updates of certain sections and supporting documents will be required. An application fee of \$35.00 is required. Please note that all fees are non-refundable. 8/6/2019 Application Fee Completed The physician assistant will need to upload, where prompted, proof of professional liability insurance coverage through selfinsurance, personally purchased insurance or insurance provided by their employer for the minimum amount of \$1,000,000.0 Proof Of Insurance 8/7/2019 epancy per occurrence or claims made. This proof of insurance/certificate must include the physician assistant's name and indicate that they are covered under this policy while performing physician assistant services in the Commonwealth of Pennsylvan Describe the functions/tasks to be delegated to the physician assistant. Provide the details describing the time, place and Written Agreement Discrepancy 8/7/2019 of supervision and direction you will provide to the physician assistant, including the frequency of personal contact with the physician assistant.

| | Activities | | | | | | | ſ |
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| | Click 😌 to view application che | ecklist and upload docume | nts to the Board/Commission. | | | | | |
| | Show 10 🗸 entries | | | | | | Search: | |
| | Reference Number | Board/Commissio | n 🛊 License Type 🛊 | License No | Description | \$ Status | \$ \$ \$ | Act |
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| | Application | Land Discrep | bancy 8/7/2019 | Please follow a not completed | Il directions. Any discrepancies will cause a del within six months, updates of certain sections a | ay in the approval of the written and supporting documents will I | n agreement. If this a be required. | pplicati |
| | Application Fee | Comple | eted 8/6/2019 | An application | fee of \$35.00 is required. Please note that all fee | es are non-refundable. | | |
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| | | | | The physician | assistant will need to upload, where prompted, | proof of professional liability in: | surance coverage thr | ough se |
| | Proof Of Insurance | M Discrep | bancy 8/7/2019 | The physician insurance, per per occurrence that they are o | assistant will need to upload, where prompted, sonally purchased insurance or insurance provi e or claims made. This proof of insurance/certi overed under this policy while performing ph | proof of professional liability in: ded by their employer for the mi ficate must include the physici ysician assistant services in the | surance coverage thr inimum amount of \$1 ian assistant's name e Commonwealth of | ough se 1,000,00 e and in Pennsy |
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