Regular Mailing Address STATE BOARD OF OSTEOPATHIC MEDICINE P.O. BOX 2649 HARRISBURG, PA 17105-2649 717-783-4858 Email: st-osteopathic@pa.gov	**Courier Delivery Address** STATE BOARD OF OSTEOPATHIC 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 OSTEOPATHIC 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 $145.00 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 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.

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. A complete application includes the below items. Failure to provide one or more of the following items will result in a denial of temporary approval, and the application will require additional processing time.

- Correct fee.
- Completion of a current and correct application form with all requested information including signatures, dates, and complete answers to all questions with supporting documentation.
- Proof of current liability insurance coverage for the physician assistant.

The temporary authorization to practice is valid for **120 days ONLY** while the written agreement is being evaluated for final Board approval.

Provide proof of professional liability insurance coverage for the physician assistant through self-insurance, personally purchased insurance or insurance provided by the employer for the minimum amount of $1,000,000.00 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 Pennsylvania. Proof of insurance must be provided in order for the Board to issue temporary authorization to practice.**

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 OSTEOPATHIC 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 Osteopathic Medicine.
- I verify that I have reviewed the Osteopathic Medical Practice Act and Regulations of the State Board of Osteopathic 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. § 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.**

PENNSYLVANIA STATE BOARD OF OSTEOPATHIC MEDICINE

WRITTEN AGREEMENT

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

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.	Provide the details describing the time, place and manner of supervision and direction you will provide the physician assistant, including the frequency of personal contact with the physician assistant.
3.	If the physician assistant will practice in a hospital and/or a surgical center, provide the name and address of each hospital/surgical center below. If more than three hospitals/surgical centers, please provide this information on a separate sheet of paper.

Name of Hospital/Surgical Center	Address
Name of Hospital/Surgical Center	Address
Name of Hospital/Surgical Center	Address

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

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.

5.	**Proof of professional liability insurance coverage for the physician assistant named above ($1,000,000 per occurrence or claims made) is included with this written agreement application.**	Yes	No

PENNSYLVANIA STATE BOARD OF OSTEOPATHIC MEDICINE

PATIENT RECORD REVIEW PLAN

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

The supervising physician, whether primary or secondary, 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).

INSTRUCTIONS: If you answer Yes in Section A you do not need to complete Section B. If you answer No in Section A then you must complete Section B.

SECTION A

	Yes	No
I will countersign 100% chart review of the physician assistant's patient records within the required 10 day period.		

SECTION B

	Yes	No
I have been registered as a substitute supervisor for the above identified physician assistant's practice in the same specialty for at least six months and I intend to deviate from the 100% chart review of the physician assistant's patient records within the required 10 day period?		

If you intend to deviate from the 100% chart review, 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.**.

DO NOT SUBMIT CHANGES TO PATIENT RECORD REVIEW PLAN PRIOR THE COMPLETION OF THE INITIAL PERIOD OF THE NEW SUPERVISION AGREEMENT.

	Last	First	Middle
NAME – PRIMARY SUPERVISING PHYSICIAN:			

		Date
PRIMARY SUPERVISING PHYSICIAN SIGNATURE:		