Regular Mailing Address
STATE BOARD OF OSTEOPATHIC MEDICINE
P.O. BOX 2649
HARRISBURG, PA 17105-2649
Email: st-osteopathic@pa.gov

Courier Delivery Address
STATE BOARD OF OSTEOPATHIC MEDICINE
2601 NORTH THIRD STREET
HARRISBURG, PA 17110
717-783-4858

WRITTEN AGREEMENT CHANGE FORM

This form is to be completed when reporting a change to an existing, approved Osteopathic physician assistant supervisor written agreement. A separate form must be completed for each written agreement (OX) number. ALL SIGNATURES MUST BE ORIGINAL. Please duplicate this form, as needed.

Please complete a separate form for each written agreement to be changed.

DELETING A PHYSICIAN ASSISTANT – DISSOLVING A WRITTEN AGREEMENT

IF DELETING A PHYSICIAN ASSISTANT OR DISSOLVING A WRITTEN AGREEMENT, ONLY THE SIGNATURE OF THE PHYSICIAN OR THE PHYSICIAN ASSISTANT IS REQUIRED ON THE CHANGE FORM

- **DELETE:**
  - Complete Sections A and C. The signature of the physician assistant **OR** the primary supervisor is required.

  If you wish to supervise a new physician assistant, you must complete and submit the **Application for Registration as a Supervising Physician**.

CHANGES IN PROTOCOL

IF MAKING ANY OF THE FOLLOWING CHANGES TO THE WRITTEN AGREEMENT, THE SIGNATURES OF BOTH THE SUPERVISING PHYSICIAN AND THE PHYSICIAN ASSISTANT WILL BE REQUIRED ON THE CHANGE FORM. THE REQUESTED CHANGES CANNOT BE IMPLEMENTED UNTIL THE BOARD APPROVES YOUR REQUEST.

- All changes require completion of Sections A, B, and D. The signatures of the primary supervisor and physician assistant are required.

- **CHANGING JOB DUTIES:**
  - **ADD**:
    - Provide a list of all the added duties to be delegated to the physician assistant. Describe the manner of supervision and the direction you will provide the physician assistant.
  - **DELETE:**
    - Submit a list of all the deleted duties.

- **CHANGING 100% COUNTER SIGNATURE OF PATIENT RECORDS**
  - Complete Sections A, B, D, and E. Until your request has been approved by the Board, you must continue to countersign 100% of the physician assistant's patient charts within the required 10 day period.

- **CHANGING PRESCRIBING/DISPENSING PRIVILEGES**
  - On an 8.5" x 11" sheet of paper, submit a list of all categories that the physician assistant **WILL NOT** prescribe/dispense.
  - Select the schedules the physician assistant will prescribe/dispense.

- **CHANGING PRIMARY PRACTICE ADDRESS CURRENTLY ON FILE WITH THE BOARD**
  - Submit the name and address of the location (NOTE: All future mailings from the Board will be sent to this address.)

- **ADDING/DELETING HOSPITAL/SURGICAL CENTER PRACTICE LOCATIONS**
  - Submit a list of the names and addresses of the hospitals/surgical centers on a separate sheet of paper.
  - Only hospital/surgical center practice locations need to be filed with the Board. Additional locations need not be listed.

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A. PRIMARY SUPERVISOR'S NAME	**Last**	**First**	**Middle**
WRITTEN AGREEMENT (OX) NUMBER TO BE CHANGED			
B. NAME OF PHYSICIAN ASSISTANT **CURRENTLY** WORKING UNDER THIS AGREEMENT	**Last**	**First**	**Middle**
LICENSE NUMBER OF PHYSICIAN ASSISTANT (OA) CURRENTLY WORKING UNDER THIS AGREEMENT			
C. NAME OF PHYSICIAN ASSISTANT WHO WILL BE **DELETED** FROM THIS AGREEMENT	**Last**	**First**	**Middle**
LICENSE NUMBER OF PHYSICIAN ASSISTANT (OA) WHO WILL BE **DELETED** FROM THIS AGREEMENT			

If you answer Yes to any of the following questions, please follow all directions outlined on the instruction page.

D. WILL THERE BE ANY CHANGE IN JOB DUTIES:	**Yes**	**No**
WILL THERE BE ANY CHANGE TO THE PRESCRIBING/DISPENSING PRIVILEGES:	**Yes**	**No**
WILL THERE BE A CHANGE IN SUPERVISION:	**Yes**	**No**

IF CHANGING THE PRESCRIBING/DISPENSING PRIVILEGES, CHECK THE CONTROLLED SUBSTANCE THAT WILL BE PRESCRIBED AND DISPENSED.

NOTE: Physician Assistants are not permitted to prescribe/dispense Schedule 1 controlled substances.

- ☐ NONE
- ☐ SCHEDULE II
- ☐ SCHEDULE III
- ☐ SCHEDULE IV
- ☐ SCHEDULE V

IS THE ADDRESS OF THE PRIMARY PRACTICE LOCATION CHANGING?	**Yes**	**No**
ARE YOU ADDING A HOSPITAL/SURGICAL CENTER PRACTICE LOCATIONS?	**Yes**	**No**
ARE YOU REQUESTING APPROVAL TO DEVIATE FROM COUNTERSIGNING 100% OF THE PHYSICIAN ASSISTANT'S PATIENT RECORDS WITHIN THE REQUIRED 10 DAYS?	**Yes**	**No**

SIGNATURE OF PRIMARY SUPERVISOR:		Date
SIGNATURE OF PHYSICIAN ASSISTANT:		Date

PENNSYLVANIA STATE BOARD OF OSTEOPATHIC MEDICINE

E. **If you wish to change your current patient record review plan, complete and submit this form with the applicable attachments.**

Patient Record Review Plan

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

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.

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?	Yes	No

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**.

NAME – PRIMARY SUPERVISING PHYSICIAN:	Last	First	Middle
PRIMARY SUPERVISING PHYSICIAN SIGNATURE:			Date