IDAHO STATE BOARD OF MEDICINE COVID-19 RESPONSE
COVID-19 RESPONSE MODIFIED SUPERVISING PHYSICIAN ATTESTATION

The supervising physician(s) must complete and sign an attestation to the physician assistants' education, qualifications and clinical abilities to provide health care and perform procedures according to the community standard of care as required by the Medical Practice Act and Rules. Supervising Physician must complete and maintain the Modified DOS Form, which is a roster of Physician Assistants supervised, at all clinical locations and at the physician's address on record.

The following must be legible. Use additional sheets, if necessary.

I, ____ being first duly sworn, declare under penalty of perjury as follows:

1. I am a physician who holds a current active license issued by the Board of Medicine to practice medicine and surgery or osteopathic medicine and surgery in Idaho and in good standing with no restrictions upon or actions taken against my license.

2. I attest to the education, qualifications and clinical abilities of my physician assistant(s), to provide health care and perform procedures pursuant to the community standard of care.

3. I attest to the qualifications and abilities of my physician assistant(s), to prescribe according to the community standard of care and under my general supervision.

4. I attest to my qualifications and clinical abilities to perform and supervise the provision of health care pursuant to the community standard of care.

5. I attest that I will conduct regularly scheduled conferences with the physician assistant(s) I am supervising.

6. I attest that I will be available to the physician assistant(s) I am supervising in person or by telephone.

7. I attest that there is a procedure for providing physician backup to the physician assistant in an emergency situation and procedures or protocols for addressing situations that may arise that fall outside the scope of practice of the physician assistant(s).

8. I attest that I will review a representative sample of the physician assistant's records periodically.

9. I attest that a copy of the Supervising Physician/Physician Assistant COVID-19 Roster is on file at each of the practice sites and at my address of record.

By signing this form, Supervising Physician accepts responsibility for all aspects of the performance of the physician assistant(s) and for the supervision of such performance.

_____________________________________ _____________________________________

Supervising Physician Name *Idaho License Number*

_____________________________________ _____________________________________

Supervising Physician Signature *Date of Signature*

IDAHO STATE BOARD OF MEDICINE COVID-19 RESPONSE
MODIFIED DELEGATION OF SERVICES FORM

(TEMPORARY SUPERVISING PHYSICIAN ROSTER OF PHYSICIAN ASSISTANTS SUPERVISED FOR COVID-19 RESPONSE)

SUPERVISING PHYSICIAN NAME: _________________________ ID License #________________________

By signing this form, the Supervising Physician accepts responsibility for the medical acts and patient services of the Physician Assistant during this time of COVID-19. This form is to be used temporarily to allow supervising physician to supervise additional physician assistants and for the supervision of such performance as described in the attached Attestation of Supervising Physician.

PHYSICIAN ASSISTANT NAME	PA LICENSE NUMBER	DATE
PHYSICIAN ASSISTANT NAME	PA LICENSE NUMBER	DATE
PHYSICIAN ASSISTANT NAME	PA LICENSE NUMBER	DATE
PHYSICIAN ASSISTANT NAME	PA LICENSE NUMBER	DATE
PHYSICIAN ASSISTANT NAME	PA LICENSE NUMBER	DATE
PHYSICIAN ASSISTANT NAME	PA LICENSE NUMBER	DATE
PHYSICIAN ASSISTANT NAME	PA LICENSE NUMBER	DATE
PHYSICIAN ASSISTANT NAME	PA LICENSE NUMBER	DATE
PHYSICIAN ASSISTANT NAME	PA LICENSE NUMBER	DATE
PHYSICIAN ASSISTANT NAME	PA LICENSE NUMBER	DATE