CHANGE NOTIFICATION FORM

Physician Assistant Name _____

Mailing Address _____

_____

_____

Email Address _____

Is this a mailing address change? ☐ Yes ☐ No **PA License Number** _____

Idaho code (IDAPA 22.01.03.037.02.g) requires physician assistants to notify the Board of Medicine of a change or addition of a supervising or alternate supervising physician within **two weeks**. Failure to do so is grounds for disciplinary action.

Please complete all sections of all forms in the Practice Change Application, sign and return to the Board of Medicine **prior** to practice.

I am ☐ **changing** ☐ **adding practice sites and supervising physicians.**

My new primary supervising physician is: _____

My new alternate supervising physician(s) is/are: _____

_____

My new practice location is: _____

_____

Type of practice: _____

Other Changes:

☐ The practice site listed above will be on a part time basis in addition to my primary practice.

☐ I am deleting the following supervising physician(s) or practice site(s): _____

_____

I hereby notify the Idaho State Board of Medicine of the following changes in my supervision and/or practice. Attached to this form are the Delegation of Services Agreement forms (Form 6, Pages 1-4 *or* Form 6, Pages 1-6), with a copy kept on file at each of my practice locations and the address of the primary supervising physician. Also attached, is the Supervising Physician registration form (Form 1) with the fee, *if applicable*.

Submitted by: _____
(Please type or print name)

Signature: _____ **Effective date:** _____

GENERAL CHECKLIST FOR PHYSICIAN ASSISTANT PRACTICE CHANGE FORMS

** Questions? E-mail jodi.adcock@bom.idaho.gov **

Change Notification Form: Complete and sign. A letter to the Board regarding practice change may be submitted in lieu of this form.

Supervising Physician Registration (Form1): Fill in the top section. This form is required from your supervising physician(s). Supervising physician registration fee needs to accompany this form only if primary supervising physician is **NOT** already registered. The primary supervising physician should designate at least one alternate supervising physician to oversee the physician assistant during the supervising physician's temporary absence. **All** physicians supervising need to complete this form.

Delegation of Services Agreement (Form 6, Pages 1-4 [standard] *or* Form 6, Pages 1-6 [specialized procedures]): Fill in the top section. The Delegation of Services Agreement is a written document mutually agreed upon and signed and dated by the physician assistant and **ALL** supervising physician(s) that lists the physician assistant's training, experience and education and defines the working relationship and delegation of duties between the supervising physician(s) and physician assistant as specified by Board rule. A Delegation of Services Agreement is to be maintained at **each** practice site, at the address of record of the supervising physician **and** the Board of Medicine. Be specific on filling these forms out, this is your job description.

FAXED or emailed documents can be accepted. FAX# (208) 327-7005.

SUPERVISING PHYSICIAN FORM

The Supervising Physician must designate one alternate supervising physician to oversee the physician assistant during the supervising physician's temporary absence. Please complete and return form to the Idaho State Board of Medicine, PO Box 83720, Boise, ID 83720-0058; Express Mail: 1755 Westgate Dr. Suite 140, Boise, ID 83704. FAX: (208) 327-7005.

Date Received	Fee/Current	Approved By	Effective date

Physician Assistant Name _____

PA License No.

SUPERVISING PHYSICIAN

Name _____

Last First Initial

Address _____

Street Telephone

_____

City State Zip Code Idaho License

I certify that I have read the Rules of the Board of Medicine for Registration of Supervising and Directing Physicians

Signature _____

Date of Signature _____

Initial registration fee for primary supervising physician is $50.00.

ALTERNATE SUPERVISING PHYSICIAN

Name _____

Last First Initial

Address _____

Street Telephone

_____

City State Zip Code Idaho License

I certify that I have read the Rules of the Board of Medicine for Registration of Supervising and Directing Physicians

Signature _____

Date of Signature _____

No fee required for registration of alternate supervising physician.

DELEGATION OF SERVICES AGREEMENT

DELEGATION OF SERVICES AGREEMENT

A Delegation of Services Agreement is to be maintained at each practice site, at the address of record of the supervising physician and at the Board of Medicine. The Delegation of Services Agreement is a written document mutually agreed upon and signed and dated the physician assistant and supervising physician that lists the physician assistant's training, experience and education and defines the working relationship and delegation of duties between the supervising physician and the physician assistant as specified by Board rule. The Board of Medicine will review the written Delegation of Services Agreement and may review job descriptions, policy statements, or other documents that define the responsibilities of the physician assistant in the practice setting, and may require such changes as needed to achieve compliance with these rules, and to safeguard the public.

The following must be legible. Use additional sheets if necessary. SUBMIT YOUR DELEGATION OF SERVICES AGREEMENT TO THE BOARD WITH YOUR APPLICATION FOR LICENSURE AND WITH ANY CHANGE IN PRACTICE OR SUPERVISION.

Physician Assistant Name:_____

Supervising Physician Name:_____

Alternate Supervising Physician(s) Name(s):_____

_____

PRACTICE SITE(S):

1. Name of Facility:_____

   Address:_____

   _____

2. Name of Facility:_____

   Address:_____

   _____

THE FOLLOWING ARE CORE COMPETENCY MEDICAL AND SURGICAL SERVICES APPROVED FOR ALL IDAHO LICENSED PHYSICIAN ASSISTANTS. The supervising physician may request Board review and approval of specialized procedures not listed in the core competencies by completing Form 6 Page 5.

- Administer medications
- Perform anoscopy
- Apply/remove casts & splints
- Assist in surgery
- Perform bladder catheterization
- Perform Advanced Cardiac Life Support
- Perform CLIA waived lab procedures
- Consult with and referral to appropriate health care resources
- Perform diathermy/ultrasound
- Perform fulguration/cryotherapy of superficial lesions
- Aspirate ganglion cysts
- Incision & drainage of abscesses
- Remove ingrown toenails
- Perform non-ablative laser procedures
- Aspirate and inject small and large joints
- Repair and manage lacerations
- Administer local anesthesia including digital block
- Manage simple fractures excluding reductions
- Insert and remove nasogastric tube
- Order durable medical equipment
- Perform pulmonary function test
- Excision/biopsy of skin or subcutaneous lesions including punch biopsy
- Remove superficial foreign object
- Treat thrombosed hemorrhoids
- Perform venipuncture
- Manage wound care to include irrigation and debridement
- Assist with laser surgery and phototherapy
- Routine gynecological care including pelvic exams, Pap smears, insertion and removal of IUDs

DELEGATION OF SERVICES AGREEMENT

ACTIVITY AND LOCATION

Please list the specific activities and patient services which will be performed by the physician assistant and the specific locations and facilities in which the physician assistant will function.

DIRECTION AND CONTROL

Please describe the methods to be used to ensure responsible direction and control of the activities of the physician assistant including an on-site visit at least monthly, regularly scheduled conferences between the supervising physician and the physician assistant, and availability of the supervising physician to the physician assistant in person or by telephone at this practice site.

DELEGATION OF SERVICES AGREEMENT

PRESCRIPTION AUTHORITHY

A physician assistant who wished to apply for prescription writing authority shall submit an application for such purpose to the Board of Medicine.

The drug categories or specific legend drugs and controlled drugs, Schedule II through V that may be prescribed shall be consistent with the regular prescriptive practice of the supervising physician.

Graduate physician assistants shall not be entitled to issue any prescriptions.

CONTROLLED SUBSTANCE PRESCRIBING PRACTICE:

☐ I will not be prescribing any controlled substances.
☐ I will be prescribing schedules III through V controlled substances.
☐ I will be prescribing controlled substances, schedules II through V.

LEGEND DRUG PRESCRIBING PRACTICE:

☐ I will only be prescribing legend drugs that are within the general scope of family practice. **(Do not list medications)**

☐ In addition, other than controlled substances, I will be prescribing drugs that are **outside** of the general scope of family practice but that are consistent with the regular prescriptive practice of my supervising physician. I have listed those drugs below.

_____

_____

_____

_____

_____

Note: ***The physician assistant with approved prescriptive authority from the Board of Medicine for Schedule II through V drugs must obtain registration from the Federal Drug Enforcement Administration and the Idaho Board of Pharmacy. Forms and a link to the DEA may be accessed on the Board of Pharmacy's website at bop.idaho.gov.***

MEDICAL SERVICES REVIEW

Please describe the procedures or protocols for periodic review of a representative sample of records and a periodic review of the medical services being provided by the physician assistant. This review shall also include an evaluation of adherence to the Delegation of Services Agreement.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Note: ***Graduate physician assistants are required to have a weekly record review by their supervising physician.***

DELEGATION OF SERVICES AGREEMENT

EMERGENCY PROCEDURES and PROCEDURES FOR ADDRESSING SITUATIONS OUTSIDE THE SCOPE OF PRACTICE OF THE PHYSICIAN ASSISTANT

1) Please describe the procedures and protocols for the availability of the supervising physician to the physician assistant in person or by telephone and procedures for providing physician backup to the physician assistant in an emergency situation at this practice site(s).

2) Please describe the procedures or protocols for addressing situations that may arise that fall outside the scope of practice of the physician assistant at this practice site(s).

Physician Assistant Name	*Physician Assistant Signature*	*Date*
Supervising Physician Name	*Supervising Physician Signature*	*Date*
Atl. Supervising Physician Name	*Alt. Supervising Physician Signature*	*Date*
Atl. Supervising Physician Name	*Alt. Supervising Physician Signature*	*Date*
Atl. Supervising Physician Name	*Alt. Supervising Physician Signature*	*Date*
Atl. Supervising Physician Name	*Alt. Supervising Physician Signature*	*Date*

DELEGATION OF SERVICES AGREEMENT

SPECIALIZED PROCEDURES REQUEST FORM

For the Use of the Board
Approved: Date:

Physician Assistant Name:

All specialized procedures must be reviewed and approved by the Board before the physician assistant may provide the specialized procedures. Documentation of the physician assistant's education, training, and experience to perform the specialized procedures listed below must be included. The supervising physician must also provide his affidavit attesting to the physician assistant's qualifications and clinical abilities to perform the identified specific procedures.

SPECIALIZED PROCEDURES BEING REQUESTED:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

SPECIALIZED TRAINING, EXPERIENCE AND EDUCATION OF PHYSICIAN ASSISTANT:

1. Specialized Training, Experience and Education:_____

   _____

   Date(s) of Attendance:_____

   Name of Facility:_____

   Address:_____

2. Specialized Training, Experience and Education:_____

   _____

   Date(s) of Attendance:_____

   Name of Facility:_____

   Address:_____

3. Specialized Training, Experience and Education:_____

   _____

   Date(s) of Attendance:_____

   Name of Facility:_____

   Address:_____

DELEGATION OF SERVICES AGREEMENT

The supervising physician must submit an affidavit attesting to the physician assistant's education, qualifications and clinical abilities to perform the specific specialized procedures being requested on the Specialized Procedures Request Form. **Submit the affidavit only if requesting authorization to delegate specialized procedures not listed in the Core Competencies on Form 6, page 1.**

AFFIDAVIT OF SUPERVISING PHYSICIAN

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 will be the supervising physician of _____, a physician assistant, who holds a current license issued by the Board or will obtain licensure prior to any practice as a physician assistant in Idaho.

3. I have completed the Delegation of Services Agreement with my physician assistant and have reviewed the agreement with the alternate supervising physician.

4. The Delegation of Services Agreement defines the working relationship between me and my physician assistant.

5. I attest to the qualifications and clinical abilities of _____, my physician assistant, to perform the specialized procedures listed in the Delegation of Services Agreement in accordance with IDAPA 22.01.03.030.03.

6. A copy of the agreement is on file at each of the practice sites, my address of record and at the Board of Medicine.

_____
SUPERVISING PHYSICIAN

Subscribed and sworn to before me this _____ day of _____, 20____

Signature_____

Notary Public for_____ (SEAL)

Commission Expires_____

Authorization for Release of Information

This form is to be completed by the applicant with the name(s) of any other individual(s) or entity(s), besides the applicant, that the applicant would allow this Board to discuss the status of the pending application, i.e. spouse, staff member, etc, and returned with the application. **Without this completed form, the Board may only discuss the pending status with the applicant.**

☐ I will be the only individual inquiring about the status of my application. If you are not authorizing the release of information to a third party, you will **not** need to have this form notarized, just sign and date below.

☐ I authorize the following individuals to inquire about the status of my application (see below):

_____
First Name Last Name Relationship to Applicant

_____
Name of Entity (University, Hospital, etc)

_____ _____
Telephone Number Email Address

_____
First Name Last Name Relationship to Applicant

_____
Name of Entity (University, Hospital, etc)

_____ _____
Telephone Number Email Address

I hereby authorize and direct the Idaho State Board of Medicine, employees, agents, officers, representatives, and attorneys at any time to release information regarding my filed application for an Idaho license and/or permit with the Idaho State Board of Medicine to the individuals named above.

I further authorize the Idaho State Board of Medicine, employees, agents, officers, representatives, and attorneys who have such information to consult with or discuss such information with any of the individuals named above.

Upon my knowledge and with legal consultation, I understand the nature of this Authorization for Release of Information with regard to my filed application for an Idaho license and/or permit with the Idaho State Board of Medicine.

I, and my heirs, do hereby release the Idaho State Board of Medicine, Committee on Professional Discipline of the Idaho State Board of Medicine, and its members, employees, agents, officers, representatives, and attorneys, from all liability and all claims of any nature whatsoever pertinent to the information released.

Name of Applicant: _____
(First, Middle, Last)

Signature: _____ Date: _____

State of: _____
:ss
County of: _____

On this ____ day of _____, 20____, before me, the undersigned, a Notary Public in and for said State, personally appeared _____, known or identified to me to be the person whose name is subscribed to the within instrument, and acknowledged to me that he/she executed the same.

I WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal the day and year in this certificate first above written.

_____

Notary Public for _____

Residing at: _____

My commission expires: _____

STATE OF IDAHO

BOARD OF MEDICINE

1755 Westgate Dr., Ste 140
Boise, Idaho 83704
(208) 327-7000
FAX (208) 327-7005
E-Mail info@bom.idaho.gov
Website bom.idaho.gov

Credit Card Transmittal Form
~Print Legibly~

Order Information: _____
(Description of what & who payment is for)

Name as it appears on card: _____

Billing Address: _____

City _____ State _____ Postal Code _____

Telephone Number: _____

Card Number: _____-_____-_____-_____

Type of Card ☐ MasterCard ☐ Visa

Expiration (mm/yy) _____ Authorized Charge Amount: _____

If you would like to receive a receipt of this transaction, provide your email address below.

Email Address: _____

All fields (except email) are required in order to process payment/order.