

DELEGATION OF SERVICES AGREEMENT

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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 by 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 office procedures & surgery
- 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

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PRESCRIPTION AUTHORITY

A physician assistant who wishes 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 www.accessidaho.org/bop.

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

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 this 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 _____