

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.

Physician Assistant Application for Prescription Privileges (Form 7): This form must be notarized and filled out by the physician assistant and primary supervising physician. Please note the frequency must be filled out on this form, ex: weekly, monthly, or bi-weekly.

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

PRESCRIPTION AUTHORITY

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.

ROTATING ON-CALL ALTERNATE SUPERVISING PHYSICIANS

NAME OF FACILITY: _____

PHYSICIAN NAME

SIGNATURE

DATE

PHYSICIAN ASSISTANT APPLICATION FOR PRESCRIPTION PRIVILEGES

Please complete and return this form directly to the Idaho Board of Medicine, PO Box 83720, Boise ID 83720-0058. Express Mail: 1755 Westgate Drive, #140, Boise, ID 83704; Fax: (208) 327-7005. Please provide all required documentation.

Applicant's Name: _____
(Please print or type)

SUPERVISING PHYSICIAN AFFIDAVIT

I, _____, Supervising Physician for the above named physician assistant, do hereby request that the prescribing privileges, in accordance to IDAPA 22.01.03, Section 042, Para. 1-5 be authorized for

Physician Assistant Name _____

I further submit that the prescriptions issued by the physician assistant will be reviewed on a _____ basis and shall not exceed those categories described in 22.01.03, Section 042, Para. 01.

Signature – Supervising Physician

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

Signature _____

(SEAL)

Notary Public for _____

Commission Expires _____

I hereby request prescription privileges as allowed by IDAPA 22.01.03, Section 042, Para. 1-5 of the Rules for Physician Assistants. I further submit that I have complied with all requirements as listed in IDAPA 22.01.03, Section 042, Para. 1-5. (Attach certified copies of pharmacology courses/training, if it is not reflected in the transcripts.)

Signature –Physician Assistant

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

Signature _____

(SEAL)

Notary Public for _____

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
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Name of Entity (University, Hospital, etc)

Telephone Number	Email Address
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First Name	Last Name	Relationship to Applicant
------------	-----------	---------------------------

Name of Entity (University, Hospital, etc)

Telephone Number	Email Address
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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.