



ARKANSAS STATE MEDICAL BOARD

2100 Riverfront Drive, Little Rock, Arkansas 72202 (501) 296-1802 FAX: (501) 296-1805

www.armedicalboard.org

PHYSICIAN ASSISTANT BACK-UP SUPERVISING PHYSICIAN APPLICATION

1. Physician Assistant's Name: _____

2. Back-up Physician's Name: _____ License #: _____

3. Back-up Physician's Address: _____

4. Back-up Physician's Phone Numbers: Office: _____ Home: _____ Fax: _____

5. Back-up Physician's Medical School, Address and Date of Graduation: _____

6. Back-up Physician's Specialty: _____ Board Certified? ___ Yes ___ No

7. Type or Scope of Practice of Back-up Physician: _____
 - (a) Services Rendered: _____

 - (b) Area or Geographic Range of Back-up Physician: _____

 - (c) Type of Facility: Office _____ Clinic _____ Hospital _____ Other _____

8. Name, Address and License Number of Primary Supervising Physician:

9. List any Physician Assistants you currently provide supervision to. Include the PA's name and license number with designation of your supervision, i.e., Supervising Physician or Backup Supervising Physician:

(Date)

(Signature of Supervising Physician)

(Date)

(Signature of Backup Physician)

STATE OF _____
COUNTY OF _____

SUBSCRIBED AND SWORN To before me, a Notary Public, this _____ day
of _____, 20_____.

(Commission Expires)

(Signature of Notary Public)

NOTARY
SEAL

The following must be included when submitting this application:

- 1. Signed Rules and Regulation Affidavit**
- 2. Signed Backup Supervising Physician Scope of Practice Statement**
- 3. Signed protocol**

Failure to submit the above required items together will result in a delay of the application process

_____ **FOR USE BY OFFICE ONLY** _____

Application Received: _____

Date Approved: _____



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ARKANSAS RULES AND REGULATIONS AFFIDAVIT

I, _____ on this date, _____
(Type or Print Name of Back-up Physician)

do affirm that I have read the Physician Assistant Act, Arkansas Code 17-95-101, *et seq.*, Medical Practices Act and the Rules and Regulations of the Arkansas State Medical Board. I understand that I take full responsibility for the actions of _____ while he/she is under my supervision.

(Type or Print Name of Physician Assistant)

Signed: _____
(Back-up Physician Signature)

Date: _____

**THIS IS A REQUIREMENT FOR LICENSURE. YOU MUST COMPLETE THIS FORM AND RETURN IT TO:
ARKANSAS STATE MEDICAL BOARD
2100 RIVERFRONT DRIVE
LITTLE ROCK, AR 72202-1435**



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BACKUP SUPERVISING PHYSICIAN SCOPE OF PRACTICE STATEMENT

Regulation 24(5)(D) states:

The supervising physician and back-up supervising physician must be skilled and trained in the same scope of practice as the tasks that have been assigned to and will be performed by the physician assistant that they supervise.

I have reviewed the protocol of this Physician Assistant. My scope of practice and/or training is similar to the Supervising Physician and I feel that I can supervise this PA in the absence of the Supervising Physician.

Signed: _____
(Backup Physician Signature)

Printed Name: _____

Date: _____

Name of Physician Assistant: _____

THIS IS A REQUIREMENT FOR APPROVAL. YOU MUST COMPLETE THIS FORM AND RETURN IT TO:

Arkansas State Medical Board
Attn: Physician Assistant Licensing
2100 Riverfront Drive
Little Rock, AR 72202

(Facility Letterhead)
(Today's Date)

In compliance with statute 17-105-101, a copy of this agreement will be kept on file at all Arkansas practice sites and with the Arkansas State Medical Board. This agreement will go into effect (list date here). It will be updated as necessary to reflect changes in the practice.

Physician Assistant Protocol and Delegation of Services Agreement for (Name of PA)

Name of Facility
Address of Facility
Phone Number of Facility
Fax Number of Facility

List all locations PA will work

Supervising Physician: _____ **License #:** _____

***Backup Supervising Physician:** _____ **License #:** _____

*Add additional lines as needed

Services to be performed by physician assistant in the medical practice of the above referenced physicians: (be specific in your list as indicated in the example below)

- obtain chief complaint
- obtain history
- perform physical
- order lab tests
- develop problem list
- formulate and institute care plan
- patient education
- patient follow-up
- hospital rounds
- other types of services (must be specified)

**List ONLY the Services and Procedures
that you actually perform**

Procedures to be performed by physician assistant in the medical practice of the above referenced physicians: (be specific in your list as indicated in the example below)

- start IVs
- venipunctures
- suture simple wounds (no tendon, vascular, nerve injuries)
- medication injections (specify by classes of drugs and location to be administered)
- application of splints
- incision and drainage of superficial abscesses such as infected sebaceous cysts
- nasogastric tube placement
- placement of urinary catheter
- wound debridement and dressing changes
- anoscopy
- pap smears
- other types of services (must be specified, i.e., joint injections (elbow, knee...))

Procedures requiring onsite physician supervision: (be specific in your list)

Medications to be prescribed by the physician assistant (pending DEA and ASMB approval, be specific in your list as indicated in the example below)

- All non-controlled medications with the following exceptions:
 - Chemotherapeutic agents
 - Immunosuppressive agents with the exception of steroids
 - Thrombolytic agents
- Controlled medications within Schedules III, IV, V

Type and Frequency of Supervision by the Supervising Physician:

The physician assistant’s delegated scope of practice has the following restrictions: activities in which diagnosis, treatment or management exceeds PA’s level of competence, training or skill or is outside the scope of the physician’s level.

The supervising physician or his back-up supervising physician will be onsite or available at all times to the physician assistant. One of these physicians will be within a driving radius of 60 minutes of the physician’s assistant and would always be available via phone.

The physician assistant will not practice if the supervising physician or the back-up supervising physician is physically absent or not physically available within 60 minutes.

Process of Evaluation by Supervising Physician and Back-up Supervising Physician:

- 100% review and countersign the documentation of all physician assistant patient encounters within the first 120 days of employment
- Following the first 120 days of employment, the supervising physician will review and countersign a minimum of 10% (*or more as specified in the protocol*) of all physician assistant patient encounters in the clinic setting
- 100% review and countersign of all inpatient physician assistant encounters in compliance with the bylaws and rules and regulations of (*name of facility*)
- 100% review of all procedures performed by the physician assistant within the first 120 days of employment

Local ambulance service will be used to transport medical emergencies when supervising or back-up supervising physician is not on site. Progress notes written by the physician assistant for patients who require hospital admission or transfer to the emergency department of the local hospital will be counter signed by the supervising physician within 24 hours.

The physician assistant may be allowed to make hospital rounds at (*Name of Facility*).

Printed Name of PA: _____

Signature of PA: _____ *Date:* _____

Printed Name of Supervising Physician: _____

Signature of Supervising Physician: _____ *Date:* _____

**Printed Name of Back Up Supervising Physician:* _____

Signature of Supervising Physician: _____ *Date:* _____

**(Please add appropriate signatures lines for additional back up supervising physicians)*

Signature of Arkansas State Medical Board:

PA Chairman

Date

Board Seal

