ARKANSAS STATE MEDICAL BOARD

LICENSURE DEPARTMENT
1401 W. Capitol Ave., Suite 340, Little Rock, AR 72201
Phone (501) 296-1802 Fax (501) 296-1972 www.armedicalboard.org

PHYSICIAN ASSISTANT
BACK-UP SUPERVISING PHYSICIAN APPLICATION

1. This form is to be filled out by each prospective Back-Up Supervising Physician.
2. Type or print legibly (in dark blue or black ink). (one sided only)
3. All questions must be answered. If a question does not apply to you, please write "n/a" in the space provided.

IMPORTANT INFORMATION

THE FOLLOWING ITEMS MUST BE INCLUDED WHEN SUBMITTING THIS APPLICATION:

1. **Signed Arkansas Medical Practices Act and Rules & Regulations Affidavit**
2. **Signed Back-Up Supervising Physician Scope of Practice Statement**
3. **Protocol signed and dated by PA, Supervising Physician and Back-up Supervising Physician(s)**

Not sending these items together will result in a delay of the application process.

PHYSICIAN ASSISTANT

Physician Assistant's Name	License No. (if applicable)

BACK-UP SUPERVISING PHYSICIAN INFORMATION

Back-up Supervising Physician's Name			Medical License Number
Complete Practice or Office Address (PO Box or Street, City, State, Zip Code)			
Office Telephone Number	Office Fax Number	Home Telephone Number	Mobile Telephone #
E-mail Address		Specialty	Board Certified? ☐ Yes ☐ No
Type or Scope of Practice			
Services Rendered			
Area or Geographic Range of Practice			
Type of Facility ☐ Private Practice ☐ Clinic ☐ Hospital ☐ Other ______________________			

Back-up Supervising Physician's Signature _______________ Date Signed _______________

Physician Assistant's Signature _______________ Date Signed _______________

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ARKANSAS MEDICAL PRACTICES ACT and RULES AND REGULATIONS AFFIDAVIT

(Back-up Supervising Physician)

I AFFIRM THAT I HAVE READ THE PHYSICIAN ASSISTANT ACT, ARKANSAS CODE 17-105-101, *et seq.*, AND THE RULES AND REGULATIONS OF THE ARKANSAS STATE MEDICAL BOARD. I UNDERSTAND THAT A.C.A § 17-105-101(3) SAYS "SUPERVISION" MEANS OVERSEEING THE ACTIVITIES OF AND ACCEPTING RESPONSIBILITY FOR THE MEDICAL SERVICES RENDERED BY A PHYSICIAN ASSISTANT. I TAKE FULL RESPONSIBILITY FOR THE ACTIONS OF ____ WHILE HE/SHE IS UNDER MY SUPERVISION.

____

Back-up Supervising Physician's Full Name (First Middle Last, Suffix, Degree)

____

Back-up Supervising Physician's Signature (no rubber stamps)

____

Signature Date

COUNTY OF ______________
STATE OF ARKANSAS

Sworn to and subscribed before me this ______ day of __________, 20___.

____
Notary Public

My Commission Expires: _______________

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BACK-UP SUPERVISING PHYSICIAN SCOPE OF PRACTICE STATEMENT

Regulation 24(7)(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 Physician Assistant in the absence of the Supervising Physician.

____
Back-Up Supervising Physician's Full Name (First Middle Last, Suffix, Degree)

____
Back-Up Supervising Physician's Signature (no rubber stamps)

____
Signature Date

____
Physician Assistant's Full Name

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