



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)
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BACK-UP SUPERVISING PHYSICIAN INFORMATION

Back-up Supervising Physician's Name	Medical License Number
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Complete Practice or Office Address (PO Box or Street, City, State, Zip Code)			
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Office Telephone Number	Office Fax Number	Home Telephone Number	Mobile Telephone #
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E-mail Address	Specialty	Board Certified? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Type or Scope of Practice

Services Rendered

Area or Geographic Range of Practice

Type of Facility <input type="checkbox"/> Private Practice <input type="checkbox"/> Clinic <input type="checkbox"/> Hospital <input type="checkbox"/> Other _____
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PRIMARY SUPERVISING PHYSICIAN(S) INFORMATION

Primary Supervising Physician	Medical License Number
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Complete Practice or Office Address (PO Box or Street, City, State, Zip Code)

PHYSICIAN ASSISTANTS CURRENTLY UNDER YOUR SUPERVISION

Name of Physician Assistant currently under your supervision	Supervising or Back-up Supervising? <input type="checkbox"/> Supervising <input type="checkbox"/> Back-up	P.A. AR License Number
Name of Physician Assistant currently under your supervision	Supervising or Back-up Supervising? <input type="checkbox"/> Supervising <input type="checkbox"/> Back-up	P.A. AR License Number
Name of Physician Assistant currently under your supervision	Supervising or Back-up Supervising? <input type="checkbox"/> Supervising <input type="checkbox"/> Back-up	P.A. AR License Number

Supervising Physician's Signature

Date Signed

Back-up Supervising Physician's Signature

Date Signed



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Documents submitted by email must be sent in PDF format to support@armedicalboard.org

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 and agree to abide by the parameters contained therein. 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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