



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

- Are you adding a new supervising physician? or
- Replacing your supervising physician?

Name of former supervising physician

Date supervision ended (former supervising physician)

PHYSICIAN ASSISTANT SUPERVISING PHYSICIAN APPLICATION

1. This form is to be filled out by the prospective 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.

THE FOLLOWING ITEMS MUST BE INCLUDED WHEN SUBMITTING THIS APPLICATION:

1. Payment in the amount of \$50.00, to be paid by the Supervising Physician. Make check payable to ASMB.
2. Arkansas Medical Practices Act and Rules and Regulations Affidavit signed by the Supervising Physician.
3. Scope of Practice Statement signed by the Supervising Physician.
4. Copy of Supervising Physician's Federal DEA Registration Certificate.
5. 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 Full Name	License No. (if applicable)
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SUPERVISING PHYSICIAN INFORMATION

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

Office Telephone Number	Office Fax Number	Home Telephone Number	Cellular 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
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Area or Geographic Range of Practice

Type of Facility

Private Practice Clinic Hospital Other _____

Have the Supervising Physician and the P.A. worked together in any capacity prior to this application? Yes No

If yes, please state length of working relationship. _____

If no, please provide proposed date for the start of employment. _____

Supervising Physician's Signature

Date Signed

DO NOT WRITE IN THIS SPACE – FOR OFFICE USE ONLY

FEE RECEIVED \$ _____

FEE RECEIVED DATE: _____



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ARKANSAS MEDICAL PRACTICES ACT and RULES AND REGULATIONS AFFIDAVIT

(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.

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

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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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 Back-up Supervising Physician.

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

Supervising Physician's Signature (no rubber stamps)

Signature Date

Physician Assistant's Full Name

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