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)

SUPERVISING PHYSICIAN INFORMATION

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	Cellular 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 _____

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 UNDERSTAND AND AGREE THAT I MAY HAVE SUPERVISING AUTHORITY OVER MULTIPLE PHYSICIAN ASSISTANTS, HOWEVER I WILL ONLY PROVIDE DIRECT SUPERVISION FOR THREE (3) PHYSICIAN ASSISTANTS AT A SITE AT A TIME.

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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