ARKANSAS STATE MEDICAL BOARD

1401 W. Capitol Avenue, Suite 340, Little Rock, AR 72201
Phone (501) 296-1802 www.armedicalboard.org
***Original documents must be sent by mail to the address above ***

PHYSICIAN ASSISTANT SUPERVISION FORM

All practicing Physician Assistants are required to submit a Supervision Form signed and dated by both the Physician Assistant and the Supervising Physician. It is the responsibility of the Physician Assistant to have the Supervision Form filed with the Arkansas State Medical Board AND a signed Delegation Agreement on-site (at each practice location) PRIOR to starting work.

17-105-111. Notification of intent to practice.

(a) Prior to initiating practice, a physician assistant licensed in this state must submit on forms approved by the Arkansas State Medical Board notification of such an intent. The notification shall include:
(1) The name, business address, e-mail address, and telephone number of the supervising physician; and
(2) The name, business address, and telephone number of the physician assistant.

(b) A physician assistant shall notify the board of any changes or additions in supervising physicians within ten (10) calendar days.

☐ Adding **new** Primary Supervisor ☐ Adding **new** Back-up Supervisor

☐ Removing_____ Date Supervision Ended _____
(Name and License # of Supervising Physician)

☐ **CHECK OR MONEY ORDER MADE PAYABLE TO "ASMB" IN THE AMOUNT OF $50.00 MUST BE INCLUDED WHEN SUBMITTING A REQUEST FOR A NEW PRIMARY SUPERVISING PHYSICIAN. (This is for Supervising Physician changes ONLY)**

****** Not sending the application and fee together will result in a delay of the application process ******

PHYSICIAN ASSISTANT:

I certify that I have read and understand my responsibility to work in Arkansas only under the supervision of an ASMB approved AR licensed Physician. If my supervisor changes, it is my responsibility to provide the Board with an updated Supervision Form PRIOR to starting work. I agree to abide by the provisions of the Arkansas Medical Practices Acts and Regulations.

Name of Physician Assistant	*Business Address (#, Street, City, Zip and phone number)*	
Physician Assistant's AR License #	*Personal E-mail Address*	*Date Supervision to begin*
Physician Assistant's Signature		*Signature Date*

DO NOT WRITE IN THIS SPACE – FOR OFFICE USE ONLY

FEE RECEIVED $_____ FEE RECEIVED DATE: _____

****** NEW** SUPERVISING PHYSICIAN ****

Have the Supervising Physician and the PA 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: _____

***** A copy of the Delegation Agreement must be submitted with this application if this is a new supervision request *****

ALL SUPERVISING/BACK-UP SUPERVISING PHYSICIAN(S):

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 ONE (1) 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 THIS PHYSICIAN ASSISTANT WHILE HE/SHE IS UNDER MY SUPERVISION.

Rule 24(7)(D) states:
The supervising physician and back-up supervising physician must be skilled and trained in a similar scope of practice as the tasks that have been assigned to and will be performed by the Physician Assistant that they supervise.

SUPERVISING PHYSICIAN: I have reviewed and approve the Delegation Agreement of this Physician Assistant and I attest that my scope of practice and/or training is similar to the Back-up Supervising Physician(s).

☐ REQUESTING SCHEDULE II HYDROCODONE COMBINATION PRODUCT (ONLY) and/or BIOLOGIC AUTHORITY_____**(SP INITIALS)**

***** In order to request this authority, a copy of the Delegation Agreement must be submitted with this application. Biologic authority requires review of the Delegation Agreement and approval by the full Board. *****

BACK-UP SUPERVISING PHYSICIAN: I have reviewed and approve the Delegation Agreement of this Physician Assistant and I attest that my scope of practice and/or training is similar to the Supervising Physician. I feel that I can supervise this Physician Assistant in the absence of the Supervising Physician.

*Name of Supervising **or** Back-up Supervising Physician*	*Business Address (#, Street, City, Zip and phone number)*
*Supervising **or** Back-up Supervising Physician's AR License #*	*Type/Scope of Practice* / *Specialty*
Personal E-mail Address	*Telephone #*
*Supervising **or** Back-up Supervising Signature*	*Signature Date*

SIGNATURE OF SUPERVISING OR BACK-UP SUPERVISING PHYSICIAN MUST BE NOTARIZED

STAMP /SEAL

***COUNTY OF*_____, STATE OF ARKANSAS**

Sworn to and subscribed before me this_____day of_____, 20_____.

_____ **My Commission Expires:** _____

Notary Public