

Kentucky Board of Medical Licensure

310 Whittington Parkway, #1B

Louisville, KY 40222

502/429-7150

www.kbml.ky.gov

MEMORANDUM

TO: Physician Requesting Supervising Physician Privileges

FROM: Carolyn L. Reed, Physician Assistant Coordinator

RE: Application to Supervise a Physician Assistant

Attached is an initial application to supervise a physician assistant in the Commonwealth of Kentucky as well as a supplemental application to supervise a physician assistant. The supplemental application is required to request additional scope of medical services and procedures not acquired through an approved physician assistant training program.

Please note that only completed applications will be considered by the Kentucky Board of Medical Licensure's Physician Assistant Advisory Committee. Incomplete applications will be returned to the applicant. If a question does not apply to you **do not leave the field blank, please specify N/A**. The fee for approval to supervise a physician assistant is \$100.00.

The Committee meets quarterly to review applications and make recommendations to the Kentucky Board of Medical Licensure for final approval. Should you wish to begin employing the physician assistant prior to the Board meeting, there are provisions for temporary licensure for supervising the new physician assistant applicant and, tentative approval for supervising the licensed physician assistant. Please note that temporary licensure or tentative approval must be granted prior to the physician assistant providing services under your supervision. The review process for approval takes approximately two to three weeks. The deadline for consideration of an application for the Physician Assistant Advisory Committee is listed on our website www.kbml.ky.gov under the Allied Health Section.

Should you have any questions regarding the above, please contact me at (502) 429-7150 extension 228.

Definitions of Levels of Supervision

It is necessary to indicate on the application the level(s) by which you will be supervising a physician assistant.

Direct Supervision: This means the supervising physician is actually in sight of the physician assistant when the physician assistant is performing the function requiring direct supervision. Although the physician may be performing some other task at the time, the supervising physician may immediately provide direction or assume the performance of the task if difficulties arise. This does not require that the physician is watching “over the shoulder” of the physician assistant as would be required during the training period to ensure that the physician assistant is competent to perform the task.

On-site supervision: Requires the physical presence of the supervising physician in the same location (i.e. the physician’s office suite) as the physician assistant, but does not require the physical presence in the same room.

Off-site supervision: The supervising physician must be continuously available for direct communication with the physician assistant and must be in a location that, under normal conditions, is not more than 30 minutes travel time from the physician assistant’s location.

New graduates please refer to KRS 311.860.

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ALL APPLICATIONS MUST BE TYPED & ALL FIELDS COMPLETE

PLEASE TYPE N/A IF APPROPRIATE

Initial Application for Physician to Supervise Physician Assistant
“This Application is in Compliance with the American Disabilities Act”

Please provide person to contact & phone number for Board questions: _____

1. Name of Supervising Physician: _____
(First) (Middle) (Last)

2. Office Address: _____
(Street Address)

(City) (State) (Zipcode)

3. Telephone: (Office) _____ 4. Type of Practice: _____

5. Kentucky Medical License Number: _____ Expiration Date: _____

6. Professional background including membership in medical societies, American Boards, Board eligibility, and or other professional organizations:

7. List hospital staff positions: _____

8. Have you filed application to supervise a physician assistant before? If your answer is YES, list the names of the physician assistants on whom applications to supervise have been previously submitted. Yes No

9. The names and address of one or more physicians who will serve as a supervisor for the physician assistant named in this application in the temporary absence of the supervising physician. Pursuant to 311.854, Sec 2[c], enclose a copy of the alternate agreement to supervise.

Name	Address	KY License Number	Specialty
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

10. Name of physician assistant: _____ KY License Number: _____

(First) (Middle) (Last)

11. Briefly describe the nature of your medical practice: _____

(Page 2 - Initial Application For Physician To Supervise Physician Assistant)

12. Briefly describe the physician assistant job duties and scope of medical services and procedures that are being delegated by you and that are also within the physician assistants scope of practice acquired in their approved training program. Only job duties which are to be performed are those which are defined in the scope of practice. Job duties may not exceed your scope of practice. The supervising physician may delegate services and procedures to the physician assistant that are within the supervising physicians scope of practice. When being supervised by the alternate physician the physician assistant can perform only job duties within the scope of practice of the alternate physician. *(To request additional scope of medical services and procedures not acquired through an approved training program, please submit the **supplemental application form**)*

13. Check all levels of supervision that apply: **Direct Supervision** **On-Site Supervision** **Off- Site Supervision**
(See attachment for definitions of levels of supervision.) A physician assistant shall not practice medicine or osteopathy in a separate location from the supervising physician unless the physician assistant has eighteen months of continuous experience in a non-separate location. The Board may modify or waive the requirement.

14. Will the physician assistant be employed full-time or part-time? _____
If part-time, please give an estimate of how many hours. _____

15. Describe the means by which you will maintain a line of communication with the physician assistant when not at the same location: _____

16. List all locations of your practice in which the physician assistant will be utilized: (Include all offices, clinics, hospitals, nursing homes, etc.) Use a separate sheet, if necessary:

17. I maintain a practice primarily within the State of Kentucky: Yes No

18. Is the physician assistant currently employed by another supervising physician? If your answer is YES, list names of all other supervising physicians and the approximate hours the physician assistant works with that supervising physician.

19. Is your Kentucky medical license current and in good standing with the KY Board of Medical Licensure? Yes No

20. I Attest That:

- A. All job duties and scope of medical services and procedures delegated to the physician assistant are within my scope of practice.
- B. All job duties and scope of medical services and procedures delegated to the physician assistant are appropriate for which the physician assistant has been trained in an approved training program.
- C. I accept responsibility for any care given by the named physician assistant.
- D. I maintain a system to assure that the physician assistant is not practicing beyond the scope of my practice.

(Page 3 - Initial Application For Physician To Supervise Physician Assistant)

- E. I will sign all records rendered by named physician assistant in a timely manner as certification that the physician assistant performed the services as delegated.
- F. I will re-evaluate the reliability, accountability, and professional knowledge of named physician assistant two years after the physician assistant's original licensure in the state of Kentucky, and every two years thereafter; and based on the re-evaluation recommend or disapprove re-licensure to the Board.
- G. I will notify the Board within three business days if I cease to supervise or employ the named physician assistant.

Affidavit of Applicant

I, _____ hereby state that I have made an adequate investigation and am of the opinion that the aforementioned physician assistant is possessed of good moral character and is both mentally and physically able to perform as a physician assistant with competence. I further state that as supervising physician, I will exercise control and supervision of the named physician assistant in accordance with the rules of the Kentucky Board of Medical Licensure and retain professional responsibility for the care and treatment of patients he/she sees as directed by me.

State of Kentucky

County _____

I, _____ hereby certify under oath that I am the person named in this application to supervise a physician assistant in the Commonwealth of Kentucky; that all statements I have made therein are true and the physician assistant will function under my supervision and responsibility.

Physician's Signature

Subscribed and sworn to before me by the above named applicant on this _____ day of _____, 20____.
This application consists of 3 pages.

Seal of Notary

Signature of Notary

My Commission expires: _____

Name of physician assistant: _____

Name of supervising physician: _____

Affidavit of Physician Assistant

The physician assistant whom you will be supervising **will be required** to complete this page. This form needs to be returned with the "Initial Application to Supervise Physician Assistant."

1) Since your last employer, have you been convicted of a felony or misdemeanor by any State or Federal court?

Yes No

2) Are any criminal charges presently pending against you in any of those courts?

Yes No

3) Has any hospital, hospital medical staff, or any other health care facility revoked, suspended, restricted, limited, reprimanded, placed on probation, or otherwise disciplined your staff privileges?

Yes No

4) Have you in the past been treated for any medical or psychiatric condition which might impair your ability to continue to practice as a physician assistant?

Yes No

5) Since your last employer have you suffered from or been treated for drug or alcohol abuse and/or dependency?

Yes No

Physician Assistant's Signature

Date

Sworn to and subscribed before me by the above named applicant on this ____ day of _____, 20 ____.

Seal

Signature of Notary Public

My Commission expires: _____

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Alternate Supervising Physician Agreement

RE: _____
Name of Physician Assistant & License # Name of Primary Supervising Physician & License #

Facility (if applicable) _____

In Compliance with Kentucky State Statute 311.854 Section 2 (c), I agree to serve as an alternate supervising physician for the above mentioned physician assistant in connection with patients under my care. I further understand that this regulation stipulates I can only supervise two physician assistants at one time. When the alternate physician is supervising the physician assistant, the physician assistant can only perform job duties within the scope of practice of the alternate physician. **(The alternate supervising physician, must be a physician other than the primary supervising physician.)**

<u>Physician (s) Name</u>	<u>License Number</u>	<u>Signature</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I've read the above, and agree that these physicians will be alternate supervising physicians in my absence.

Signature of Primary Supervising Physician

Sworn to and subscribed before me by the above name applicant on this _____ day of _____ 20 ____.

Notary

My Commission Expires _____

FAXES WILL NOT BE ACCEPTED

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Supplemental Application Scope of Practice of Physician Assistant

1. Name of Supervising Physician: _____
(First) (Middle) (Last)

2. Kentucky License Number: _____ Expiration Date: _____

3. Office Address: _____

4. Telephone (Office) _____ Office Fax _____

5. Name of Physician Assistant _____ KY License Number _____

6. Describe the physician assistant's additional scope of medical services and procedures not described in the initial application or previously submitted supplemental applications that are being delegated by you. _____

Describe the training and education that prepared the physician assistant for this additional delegated scope of medical services and procedures requested. (Information submitted for an accredited facility regarding this scope of practice can be submitted to fulfill this item.) _____

8. Was this training on-the-job training? Yes No

9. Was this education accredited? Yes No

10. Describe the setting in which the physician assistant will practice this additional delegated scope of medical services and procedures _____

11. Describe the level of supervision for this additional delegated scope of medical services and procedures (direct supervision, on-site supervision, off-site supervision) _____

(Page 2 - Supplemental Application Scope of Practice of Physician Assistant)

12. Has this additional delegated scope of medical services and procedures been approved by an accredited facility duly constituted medical staff? Yes No
13. Has this additional delegated scope of medical services and procedures received the blessing of your specialty society for delegation to a physician assistant? Yes No

14. I attest that:

- A. All additional delegated scope of medical services and procedures are within my scope of practice.
- B. All additional delegated scope of medical services and procedures are appropriate to the physician assistant's education, training and level of competence.
- C. I accept responsibility for any care given by the named physician assistant.

Affidavit of Applicant

I, _____ hereby state that I have made an adequate investigation and am of the opinion that the aforementioned physician assistant is possessed of good moral character and is both mentally and physically able to perform as a physician assistant with competence. I further state that as supervising physician, I will exercise control and supervision of the named physician assistant in accordance with the rules of the Kentucky Board of Medical Licensure and retain professional responsibility for the care and treatment of patients he/she sees as directed by me.

State of Kentucky County _____

I, _____ hereby certify under oath that I am the person named in this application to supervise a physician assistant in the Commonwealth of Kentucky; that all statements I have made therein are true and the physician assistant will function under my supervision and responsibility.

Physician's Signature

Subscribed and sworn to before me by the above named applicant on this _____ day _____, 20____.
This application consists of 2 pages.

Seal of Notary

Signature of Notary

My Commission expires: _____