Kentucky Board of Medical Licensure

310 Whittington Parkway, Suite 1B
Louisville, KY 40222
502/429-7150 www.kbml.ky.gov

Application to Supervise a Physician Assistant
KEEP THIS PAGE FOR FUTURE REFERENCE

THE SUPERVISING PHYSICIAN APPLICATION PDF CONTAINS FILLABLE FIELDS; HOWEVER, ORIGINAL SIGNATURES ARE REQUIRED. DO NOT SUBMIT HANDWRITTEN APPLICATIONS. The pdf can be located at: http://www.kbml.ky.gov/ah/pa.htm.

1. The Supplemental Application Scope of Practice of Physician Assistant (the last 2 pages of the Supervising Physician Application) is required to request additional scope of medical services and procedures (*see Examples sheet).*
2. The supervising physician application fee is **$100** and **must accompany the application.** If you are TRANSFERRING supervision from a physician previously approved by the Board to supervise this physician assistant to another physician within the same practice/group, the fee is $50.
3. **IMPORTANT: The Alternate Supervising Physician Agreement form must be submitted with the Supervising Physician Application.** Per Kentucky State Statute 311.854 Section 2 (c)(4) there must be one (1) or more physicians who agree in writing to accept responsibility for supervising the physician assistant in the absence of the supervising physician.

Incomplete applications will be returned. **Retain a copy of the completed application for your records. Future requests for a copy of your application will necessitate an Open Records Request to the Board's legal department.**

The Physician Assistant Advisory Committee meets quarterly to review applications and make recommendations to the Board for final approval (meeting dates can be located on the Physician Assistant page of the Board's website). Should you wish to begin employing the physician assistant prior to the Board meeting, there are provisions for temporary licensure for a new physician assistant applicant for Kentucky licensure; OR, tentative approval for supervising the physician assistant whose Kentucky license is active**.** Please note that temporary licensure or tentative approval must be granted prior to the physician assistant providing services under your supervision.

Should you have any questions regarding the above, please contact Teresa Kleinhenz at (502) 429-7932.

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 by means of the line of communication specified by the primary supervising physician on his/her *Application for Physician to Supervise Physician Assistant* filed with the Kentucky Board of Medical Licensure.

Matthew G. Bevin
Governor

Preston P Nunnelley, MD
President

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The Supervising Application fee for the Supervising Physician Application is $100. You may pay the required fee by check, money order, or credit card. Make your check or money order payable to the Kentucky Board of Medical Licensure or KBML. Payment must accompany the submission of the application.

Please complete the following information:

_____

Payment of this fee is for the application to supervise (name of physician assistant)

_____

Submitted by (name of supervising physician)

Payment Type:

Check ☐
Check No. _____
Amount: _____

Money Order ☐
Money Order No. _____
Amount: _____

Credit Card ☐
Credit Card Type (i.e. Visa, Mastercard, etc.): _____
Amount: _____
Credit Card Holder Name: _____
Billing Address: _____
_____
Email Address of Card Holder: _____
Phone Number of Card Holder:_____

Credit Card Number:

☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Expiration Date

☐☐ ☐☐ (MM/YY)

Security Code

☐☐☐

This form will be destroyed upon the processing of your payment.

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Application for Physician to Supervise Physician Assistant

THE SUPERVISING PHYSICIAN APPLICATION PDF IS ON THE PHYSICIAN ASSISTANT PAGE OF THE WEBSITE (http://www.kbml.ky.gov/ah/pa.htm). IT CONTAINS FILLABLE FIELDS; HOWEVER, ORIGINAL SIGNATURES ARE REQUIRED. INCOMPLETE APPLICATIONS WILL BE RETURNED.

Person to contact & phone number for Board questions: _____

1. Name of physician assistant: KY License Number (if applicable): _____

_____
(First) (Middle) (Last)

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

3. Kentucky Medical License Number: _____ 4. Specialty: _____

5. Office Address: _____
(Street Address)
_____
(City) (State) (Zip code)

6. Telephone: (Office) _____ Email (office)_____

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

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

9. Supervising Physician professional background (including American Boards, Board eligibility, medical societies, and/or hospital affiliations):

_____

_____

10. **Pursuant to Kentucky State Statute 311.854, Sec 2[c], I have included the required Alternate Supervising Physician Agreement** ☐ Yes ☐ No (the application will be returned by the Board)

11. Describe the nature of your medical practice: _____

_____

12. Describe the physician assistant job duties and scope of medical services/procedures that are being delegated by you and are also within the physician assistant's scope of practice acquired in their approved training program. The supervising physician may delegate services/procedures to the physician assistant that are within the supervising physician's scope of practice. **When being supervised by an 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 cover sheet for definitions of levels of supervision.)

14. Please outline the specific parameters for review of countersignatures:_____

_____

15. Will the physician assistant be employed full-time or part-time? _____

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

_____

17. List all locations of your practice in which the physician assistant will be utilized: (Include all offices, clinics, hospitals, nursing homes, etc.)

_____

_____

18. **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.
E. I will review and countersign a sufficient number of overall notes written by the physician assistant to ensure quality of care provided by the physician assistant in accordance with the parameters for review of countersignatures set forth in question #14.
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

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

_____
Signature of Notary Public

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.

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 again 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 named physician assistant in connection with patients under my care. (The alternate supervising physician must be a physician other than the primary supervising physician.)

Physician (s) Name	KY License Number	Signature
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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 named applicant on this _____ day of _____ 20 ___.

_____
Signature of Notary Public

My Commission Expires _____.

FAXES WILL NOT BE ACCEPTED

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Supplemental Application Scope of Practice of Physician Assistant

1. Name of Physician Assistant _____ KY License Number_____

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

3. Kentucky License Number: _____ Specialty: _____

4. Office Address: _____

_____

5. Telephone (Office) _____ Email (office)_____

6. Additional duties/procedures requested for the physician assistant requiring additional training or certification).

_____

_____

_____

7. Provide description of the training and/or certification which qualifies the physician assistant to perform each additional duty or procedure named in the question above. Prior experience in performing the procedure(s) must be quantitative. (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. Location(s) in which the physician assistant will practice this additional delegated scope of medical services and procedures.

_____

_____

11. Check all levels of supervision that apply: ☐ **Direct Supervision** ☐ **On-Site Supervision** ☐ **Off- Site Supervision**

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 approval/endorsement 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 Public

My Commission expires: _____

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The following are EXAMPLES of duties/procedures that require the submission of the Supplemental Scope of Practice Application. **These are examples only and are not intended to be a comprehensive list.**

- Arterial line placement
- Biopsies
- Bone marrow aspirates
- Bronchoscopy
- Cardiac stress testing
- Central venous line placement
- Chemotherapy administration
- Chest tube insertions/placement
- Colposcopy
- Cosmetic laser procedures for hair removal, vein & vascular lesions, scars, wrinkles
- Epidural or spinal catheters
- Facial filler injections and laser skin treatments
- Gastric band adjustments
- Intubation
- Large & small joint injections, trigger point injections, peripheral nerve blocks
- Lumbar punctures
- Myelograms
- Nerve block injections
- OB/GYN ultrasound
- Opthalmology: Yag laser capsulotomy
- Stem cell infusion
- Swan Ganz catheter placement
- Tilt table testing
- Ultrasound bed studies