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 (pages 10 & 11 of the Supervising Physician Application) is required to request additional scope of medical services and procedures only if the training has already been completed (*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.

***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) 764-2601.

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 when the physician assistant is at a separate location than the practice address of the primary supervising physician 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.

Kentucky Board of Medical Licensure
Hurstbourne Office Park
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222
Telephone: (502) 429-7150
www.kbml.ky.gov

The Supervising Application fee for the Supervising Physician Application is $100.00. 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. Please send your application fee to the Board immediately upon submission of your application. **Please note that your application will not be processed until we receive your application fee.**

Please complete the following information:

_____
Last Name, First Name, and Middle Initial

_____
Email Address | Home Phone | Alternate #

_____
Mailing Address

_____
City | State | Zip

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: _____
_____
Credit Card Number:
☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Expiration Date
☐☐ ☐☐
(MM/YY)

Security Code
☐☐☐

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

Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, KY 40222

Application for Physician to Supervise Physician Assistant

This application is to be completed by the supervising physician and all contact information must be that of the supervising physician. KBML inquiries in regard to this application will be directed to the supervising physician at the contact information provided. Inquiries from the supervising physician to the KBML may be directed to the physician assistant licensing coordinator at (502) 764-2601.

This form is available in a "pdf" format, with fillable fields, on the KBML's website, http://www.kbml.ky.gov/ah/pa.htm Once completed, it must be printed, signed and returned to the KBML. Original signatures are required. Incomplete applications will be returned.

Person to contact with phone number and email for Board questions: _____

1. Name of physician assistant: _____ KY License No. _____

2. Name of supervising MD/DO*: _____ KY License No. _____

3. Primary practice address of MD/DO: _____

** If your primary practice address is not within the Commonwealth of Kentucky, you must request a waiver by attaching a letter describing the nature and extent of your practice in Kentucky. (KRS 311.854(2)(b)) Applications without a necessary waiver request, will be deemed incomplete.*

_____
(Street, City, State, Zip)

4. Telephone No. _____ E-mail address: _____

5. Is your KY medical/osteopathic license active and in good standing? ____ Yes ____ No

6. If applicable, please list name(s) of physician assistants for whom you have previously applied to supervise:

_____
_____
_____

7. Supervising physician professional affiliations (e.g., American boards, Board eligibility, medical societies, hospital affiliations):

_____
_____
_____

8. Describe the specialty/nature of your medical/osteopathic practice: _____
_____
_____

Name of Physician Assistant: _____ Supervising Physician Name: _____

9. Describe the scope of services and procedures to be delegated by you to the physician assistant. (Note: (1) you may only delegate services and procedures which are within your normal scope of practice and (2) services and procedures to be performed must be limited to those for which the physician assistant has been trained in an approved program.): _____

_____

_____

_____

10. How is the physician assistant employed? (check one): __ Full-time (by you) __ Part-time (by you)
___ Employed by healthcare system/facility ___ Other: _____

11. Levels of supervision that apply: ___ Direct ___ On-Site ___ *Off-Site (*letterhead required)
**see question #13

***(See cover sheet for definitions of levels of supervision)**

12. Outline the specific parameters for review of countersignatures (what is the agreement you have with the physician assistant with regards to reviewing of charts):

_____

_____

13. If separate from your primary practice address listed on this application, list all locations in which the physician assistant will practice under your supervision if so, a letter on letterhead must include the following per statute: **311.860 Services performed in location separate from supervising physician --Nonseparate location -- Definition and exceptions**. (2) A supervising physician who uses the services of a physician assistant in an office or clinic separate from the physician's primary office shall submit for board approval a specific written request that describes the services to be provided by the physician assistant in the separate office or clinic, the distance between the primary office and the separate location, and the means and availability of direct communication at all times with the supervising physician.
(**Note**: you must have privileges to practice in each location listed.) _____

_____

_____

_____

Name of Physician Assistant: _____ Supervising Physician Name: _____

14. Submitted with this application are the following: (Please check what is included with application)

___ Supervising Physician Application Fee and Fee Form

___ Affidavit of Supervising Physician (Non-Emergency Department)

or

___ Affidavit of Supervising Physician (Emergency Department)

___ Affidavit of Physician Assistant

Attestation

By submitting this application and signing below, I understand and agree that any false or misleading statements provided in conjunction with this application to supervise a physician assistant and/or my failure to abide by the attestations contained in the supporting affidavit may result in discipline, including up to revocation, against my license to practice medicine or osteopathy in the Commonwealth of Kentucky.

Date: _____ Signature: _____

Printed Name: _____

KY License No.: _____

***** Original signatures required *****

Return original to KBML/Faxes will not be accepted

Name of Physician Assistant: _____ **Supervising Physician Name: _____**

Affidavit of Supervising Physician
(Non-Emergency Department)

I, _____, M.D./D.O., hereby certify that I am the person named in the application to supervise _____, PA-C, and being duly cautioned and sworn, I hereby affirm under oath as follows:

1) I have read and understand the definition of "supervision" set forth in KRS 311.840(6) and I agree that I will oversee and accept responsibility for the medical services rendered by the physician assistant.

2) I understand and agree that the physician assistant is my agent and I have authorized the physician assistant to act on my behalf, and subject to my control, to the extent described in the application. (KRS 311.858(2))

3) I understand that the physician assistant may not practice independently (KRS 311.858(9)) and to that end:
    a. I understand and agree that the physician assistant shall not submit direct billing for medical services and procedures. (KRS 311.858(6))
    b. I understand and agree that the physician assistant shall only perform services in offices, clinics, hospitals, or other licensed health care facilities where I am also authorized to practice. (KRS 311.858(8) and 311.860)
    c. I understand and agree that the scope of medical services and procedures to be performed by the physician assistant shall be limited to those described in the application and shall not exceed the normal scope of my own practice. (KRS 311.850(1)(j) and 311.854(2)(c))

4) I understand and agree that I shall not allow the physician assistant to dispense controlled substances. (KRS 311.856(2))

5) I understand and agree that I shall review and countersign a sufficient number of overall medical notes written by the physician assistant to ensure quality of care provided by the physician assistant. (KRS 311.856(11))

6) I understand and agree that I shall reevaluate the reliability, accountability and professional knowledge of the physician assistant every two (2) years and in order to recommend approval or disapproval of licensure renewal to the Board. (KRS 311.856(12))

7) I understand and agree that I shall notify the Board within three (3) business days if I cease to supervise or employ the physician assistant, or I have reason to believe in good faith that the physician assistant has violated any statute or regulation governing physician assistants. (KRS 311.858(13))

Name of Physician Assistant: _____ Supervising Physicians Name: _____

8) I understand and agree that any false or misleading statements provided in conjunction with the application to supervise the physician assistant and/or my failure to abide by the attestations contained herein may be grounds for discipline, including up to revocation, against my license to practice medicine or osteopathy in the Commonwealth of Kentucky. (KRS 311.595(1), (9) and/or (10))

Further, the Affiant sayeth naught.

Signature: _____

Printed Name: _____

License No.: _____

STATE OF KENTUCKY)
) ss
COUNTY OF _____)

Subscribed and sworn to before me by the Affiant, _____ M.D./D.O., this ___ day of _____, 202___. My commission expires on _____.

_____
NOTARY PUBLIC, STATE AT LARGE

ID #: _____

***** Original signatures required *****

Return original to KBML/Faxes will not be accepted

Name of Physician Assistant: _____ Supervising Physician Name: _____

Affidavit of Supervising Physician (Emergency Department)

Note: This affidavit is to be completed only by physicians applying to supervise physician assistants within an emergency department. These departments are typically governed by an incorporated entity, such as a healthcare system or hospital, and the physician assistants are typically employed by those entities. In such circumstances, the supervising physician typically does not have control over the practice schedule, environment or policies and procedures. If in doubt as to whether this affidavit applies to you, please contact the KBML's physician assistant licensing coordinator at (502) 429-7932.

I, _____, M.D./D.O., hereby certify that I am the person named in the application to supervise _____, PA-C, and being duly cautioned and sworn, I hereby affirm under oath as follows:

1) I have read and understand the definition of "supervision" set forth in KRS 311.840(6) and I agree that I will oversee and accept responsibility for the medical services rendered by the physician assistant.

2) I understand and agree that the physician assistant is my agent and I have authorized the physician assistant to act on my behalf, and subject to my control, to the extent described in the application. (KRS 311.858(2))

3) I understand and agree that the scope of medical services and procedures to be performed by the physician assistant under my supervision shall be limited to those described in the application and shall not exceed the normal scope of practice within the emergency department. (KRS 311.850(1)(j) and 311.854(2)(c))

4) Due to non-physician oversight of the emergency department and the variations in work schedules and multiple practice locations inherent to the practice of emergency medicine within incorporated health systems (e.g., Baptist Health, Norton Healthcare, St. Elizabeth, and university systems), I shall direct the physician assistant to abide by the following protocol for collaboration and clinician guidance:
    a. The physician assistant may initiate evaluation and treatment in an emergency situation without specific approval. (KRS 311.858(3))
    b. When the physician assistant and I are practicing in the same location and at the same time, I shall be responsible for providing the first line of support for the physician assistant. However, if I am unavailable (e.g., due to the focused management of a patient) and the physician assistant needs immediate support, the physician assistant shall contact another on-site physician in the emergency department or the on-call medical director for the emergency department.
    c. When/if I am absent, the physician assistant shall collaborate with and seek guidance from other on-site physicians in the emergency department or the on-call medical director for the emergency department. If an on-site physician(s) and the on-call medical director are unavailable and physician assistant needs immediate support, the physician assistant shall contact me by phone.

Name of Physician Assistant: _____ Supervising Physicians Name: _____

1) To the best of my knowledge, the credentialing facility has
   a. authorized the physician assistant to practice within the emergency department. (KRS 311.858(8))
   b. will not allow the physician assistant to submit direct billing for medical services and procedures. (KRS 311.858(6))
   c. will not allow the physician assistant to dispense controlled substances. (KRS 311.856(2))

2) I understand and agree that I shall review and countersign a sufficient number of overall medical notes written by the physician assistant to ensure quality of care provided by the physician assistant and in accordance with the policies and procedures of the credentialing facility. (KRS 311.856(11))

3) I understand and agree that I shall reevaluate the reliability, accountability and professional knowledge of the physician assistant every two (2) years and in order to recommend approval or disapproval of licensure renewal to the Board. (KRS 311.856(12))

4) I understand and agree that I shall notify the Board within three (3) business days if I cease to supervise the physician assistant or I have reason to believe in good faith that the physician assistant has violated any statute or regulation governing physician assistants. (KRS 311.858(13))

5) I understand and agree that any false or misleading statements provided in conjunction with the application to supervise the physician assistant and/or my failure to abide by the attestations contained herein may be grounds for discipline, including up to revocation, against my license to practice medicine or osteopathy in the Commonwealth of Kentucky. (KRS 311.595(1), (9) and/or (10))

Further, the Affiant sayeth naught.

Signature: _____
Printed Name: _____
License No.: _____

STATE OF KENTUCKY)
) ss
COUNTY OF _____)

Subscribed and sworn to before me by the Affiant, _____ M.D./D.O., this ___ day of _____, 202___. My commission expires on _____.

_____
NOTARY PUBLIC, STATE AT LARGE
ID #: _____

**** Original signatures required *** Return original to KBML/Faxes will not be accepted**

Name of Physician Assistant: _____ Name of Supervising Physician: _____

Affidavit of Physician Assistant

I, _____, P.A.-C, being duly cautioned and sworn, hereby affirm under oath as follows:

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 jurisdiction?
   ____ 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 privileges?
   ____ Yes ____ No

4) Are you currently suffering from any condition (including any physical or mental condition or alcohol/chemical dependency or abuse) for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice as a physician assistant in a competent, ethical and professional manner?
   ____ Yes ____ No

5) I understand and agree that I am the agent of the above-named supervising physician and I am authorized to act on his/her behalf, and subject to his/her control, to the extent described in the application. (KRS 311.858(2))

6) I understand that I may not practice independently (KRS 311.858(9)) and to that end:
   a. I understand and agree that the I shall not submit direct billing for medical services and procedures. (KRS 311.858(6))
   b. I understand and agree that I shall only perform services in offices, clinics, hospitals, or other licensed health care facilities where my supervising physician is also authorized to practice. (KRS 311.858(8) and 311.860)
   c. I understand and agree that the scope of medical services and procedures to be performed by me shall be limited to those described in the application and shall not exceed the normal scope of my supervising physician's practice. (KRS 311.850(1)(j) and 311.854(2)(c))

7) I understand and agree that I shall not dispense controlled substances. (KRS 311.856(2))

Name of Physician Assistant: _____ **Name of Supervising Physician:** _____

8) I understand and agree that I shall notify the Board within three (3) business days if my supervising physician should cease to supervise or employ me for any reason. (KRS 311.858(13))

9) I understand and agree that any false or misleading statements provided in conjunction with the application for licensure, including my failure to abide by the attestations contained herein in support of the supervising physician's application to supervise a physician assistant, may be grounds for discipline, including up to revocation, against my license to practice as a physician assistant in the Commonwealth of Kentucky. (KRS 311.850(1)(a), (h), (j), and (s))

Further, the Affiant sayeth naught.

Signature: _____

Printed Name: _____

PA License No.: _____

STATE OF KENTUCKY)
) ss
COUNTY OF _____)

Subscribed and sworn to before me by the Affiant, _____ P.A.-C., this ___ day of _____, 202___. My commission expires on _____.

_____
NOTARY PUBLIC, STATE AT LARGE

ID #: _____

***** Original signatures required *****
Return original to KBML/Faxes will not be accepted

Kentucky Board of Medical Licensure

310 Whittington Parkway, #1B
Louisville, KY 40222
(502) 429-7150
www.kbml.ky.gov

Supplemental Application Scope of Practice of Physician Assistant

***On the job training needs to be completed prior to submitting.

1. Name of Supervising Physician: _____
   (First) (Middle) (Last)
2. Supervising Physician 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.
   _____
   _____
   _____
7. 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) _____
    _____
12. Has this additional delegated scope of medical services and procedures been approved by an accredited facility duly constituted medical staff? ☐ Yes ☐ No

Name of Physician Assistant: _____ **Supervising Physician Name: _____**

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: _____

Definitions of Levels of Supervision

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 when the physician assistant is at a **separate location** than the practice address of the primary supervising physician 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.

THE SUPPLEMENATAL SCOPE APPLICATION SHOULD ONLY BE SUBMITTED WHEN THE PHYSICIAN ASSISTANT HAS COMPLETED ON THE JOB TRAINING FOR SUCH DUITES.

The following are **EXAMPLES** of 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