Physician Assistant Evaluation Survey

As delineated in Section (11) of the Kentucky Licensed Physician Assistant Statutes and Regulations, 311.856, all supervising physicians must analyze/evaluate every two (2) years the physician assistant’s reliability, accountability, fund of medical knowledge, and recommend approval or disapproval of re-licensure to the Board. The **primary** supervising physician must complete this form.

Name of **Primary** Supervising Physician: ______________________________________________

Name of Physician Assistant: _____________________________________________________

KY License Number: _______________ Dates of employment: ______________________

**This section must be completed or the form will be returned.** In the space below, please provide the Board with an updated summary of the physician assistant’s duties within the practice and reliability and accountability with respect to specific duties:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

If you answer “No” to the following questions, please attach a written explanation.

1. Does the physician assistant function effectively within the guidelines of your scope of practice and specialty?
   - Yes □  No □

2. Does the physician assistant function within the guidelines set forth in the Kentucky Statutes and Regulations for Licensed Physician Assistants referenced above?
   - Yes □  No □

3. Based on the physician assistant’s performance while under your supervision, would you recommend the renewal of his/her licensure in the Commonwealth of Kentucky?
   - Yes □  No □

4. Please list any other physicians who have participated in this evaluation of the physician assistant’s performance. __________________________________________

I, ________________________________________________, am currently functioning as the **primary** supervising physician for the physician assistant named above and state that the information submitted in this critical survey is true and correct to the best of my knowledge.

Signature of **Primary** Physician: ___________________________ Date: ___________