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: ___________