SUPERVISING PHYSICIAN AND WORK SETTING INFORMATION FOR TEMPORARY CERTIFICATE HOLDERS AND LICENSEES

Complete all sections of this form and submit it to the Board within 30 days of beginning employment if you are:

1. adding an initial or additional supervising physician;
2. replacing your current supervising physician;
3. terminating a supervising physician; or
4. changing your work setting information.

Section I: PHYSICIAN ASSISTANT INFORMATION

<table>
<thead>
<tr>
<th>Name:</th>
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<tr>
<th>Address:</th>
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<tbody>
<tr>
<td>Number</td>
<td>Street</td>
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Section II: SUPERVISING PHYSICIAN INFORMATION

If you are changing only your work setting information, please check “No change in supervising physician” and move to the next section

_____ No change in supervising physician

*Please fill out Work Setting Information in Section III

_____ Adding initial supervising physician:

Initial Supervising Physician: ____________________________________________________

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<tr>
<th>Last</th>
<th>First</th>
<th>MI</th>
<th>License #</th>
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Effective Date: ____________________________________________

*Please fill out Work Setting Information in Section III
_____ Adding additional supervising physician:

New Supervising Physician: ____________________________________________________

Last First MI License #

Effective Date: ______________________________

*Please fill out Work Setting Information in Section III

_____ Replacing supervising physician:

Previous Supervising Physician: ________________________________________________

Last First MI License #

New Supervising Physician: ____________________________________________________

Last First MI License #

Effective Date: ______________________________

*Please fill out Work Setting Information in Section III

_____ Terminating supervising physician:

Physician Name: _____________________________________________________________

Last First MI License #

Effective Date: ______________________________

TO BE COMPLETED BY SUPERVISING PHYSICIAN:

List all physician assistants currently under your supervision (attach additional pages as needed):

Name: _____________________________________________ Lic. Number: _________________

Name: _____________________________________________ Lic. Number: _________________

Name: _____________________________________________ Lic. Number: _________________

If you answer YES to any of the questions below, please submit a separate sheet with a detailed explanation.

Have you [the supervising physician] been disciplined [as defined by the Board of Registration in Medicine regulations] by any government authority, hospital or health care facility or professional medical association [international, national or local] within the past ten years from the date of this application?

_____ Yes  _____ No

Within the last ten years from the date of this application, have you ever had staff privileges, employment or appointment in a hospital or health care institution denied, suspended or revoked?

_____ Yes  _____ No

Within the last ten years from the date of this application, have you ever resigned from a medical staff in lieu of disciplinary action or has any quality assurance committee suggested any form of corrective action concerning your practice?

_____ Yes  _____ No

I understand that, notwithstanding any other provisions of law, a physician assistant may perform medical services when such services are rendered under my supervision. Such supervision shall be in conformance with Board regulations at 263 CMR 5.04 and 5.05.

__________________________
Signature of Supervising Physician

__________________________
Date
Section III: WORK SETTING INFORMATION

Effective Date: ________________________________________________________________

Name of Supervising Physician Associated with Work Setting: ___________________________

Name of Facility or Office: ________________________________________________________

Address: _______________________________________________________________________

Type Facility: Office ( ) Clinic ( ) HMO ( ) Hospital ( ) Other: __________________________

Type Employment: Full time ( ) Part time ( )

List names of Massachusetts’ hospitals at which you will practice or be affiliated with in this work setting:
_____________________________________________________________________________
_____________________________________________________________________________

Check all areas of practice that apply to this setting:

___ Primary Care  ___ Administration  ___ Emergency Medicine
___ General Surgery  ___ Internal medicine  ___ Occupational health
___ Geriatric medicine  ___ Education  ___ Clinical research
___ Obstetrics/Gyn.  ___ Pediatrics/Adolescents
___ Other (specify) ____________________________________________________________

Send this form within 30 days of beginning employment or any change in your supervising physician or work setting to: MA Board of Registration of Physician Assistants, 239 Causeway Street, Suite 500 5th Floor, Boston, MA 02114. Make a copy for your records. The Board is not able to provide copies of submitted forms. You will not receive confirmation of receipt by the board.