THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
DEPARTMENT OF PUBLIC HEALTH
BUREAU OF HEALTH PROFESSIONS LICENSURE
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BOSTON, MA 02108
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https://www.mass.gov/orgs/bureau-of-health-professions-licensure

BOARD OF REGISTRATION OF PHYSICIAN ASSISTANTS

CHANGE IN SUPERVISING PHYSICIAN

Complete this form and submit it to the Board within 30 days if you are:

If you are reporting changes in more than one work setting, you must complete and submit a separate form for each supervising physician in each work setting.

Please check the appropriate box:

- ❒ Adding a new supervisory physician
- ❒ Replacing your current supervising physician
- ❒ Adding an additional supervising physician
- ❒ Terminating a supervising physician
- ❒ Change of Work Setting Information

Section I : Physician Assistant Information

Name : _____
Last First Middle License #

Address: _____
Number Street City/Town State Zip

Section II: Change Request Information

_____ **Adding new supervising physician:**

New Supervising Physician: _____
Last First MI License #

Facility Name:_____

Facility Type: ❒ Office ❒Clinic ❒Hospital ❒Other : _____

Employment Type: ❒ Full-Time ❒Part-Time ❒Per Diem ❒Other:_____

Address: _____
Street City State Zip

Effective Date: _____

_____ **Replacing supervising physician:**

Previous Supervising Physician: _____
Last First MI License #

Termination Date: _____

New Supervising Physician : _____

Facility Name :_____

Facility Type: ❒ Office ❒Clinic ❒Hospital ❒Other : _____

Employment Type: ❒ Full-Time ❒Part-Time ❒Per Diem ❒Other:_____

Address: _____
Street City State Zip

Effective Date: _____

_____ **Adding additional supervising physician:**

New Supervising Physician: _____
Last First MI License #

Facility Name: _____

Address: _____
Street City State Zip

Facility Type: ❒ Office ❒Clinic ❒Hospital ❒Other : _____

Employment Type: ❒ Full-Time ❒Part-Time ❒Per Diem ❒Other: _____

Effective Date: _____

_____**Terminating Supervising Physician:**

Physician Name: _____
Last First MI License #

Termination Date: _____

Clinical Setting: Please check all areas of practice that apply:

- ❒ Administration
- ❒ Adolescents
- ❒ Clinical Research
- ❒ Emergency Medicine
- ❒ Education
- ❒ Internal Medicine
- ❒ General Medicine
- ❒ General Surgery
- ❒ Occupational Health
- ❒ Pediatrics
- ❒ Primary Care
- ❒ Obstetrics/Gynecology
- ❒ Other (Please Specify) _____

Section III: To be filled out by Supervising Physician

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.

_____
Print Name

_____ _____
Signature of Supervising Physician Date

A Massachusetts Board of Registration in Medicine Physician Profile must be attached. Profiles are available online at Findmydoctor.mass.gov . Send the profile and the completed form to the Massachusetts Board of Physician Assistants at the address above. Please keep a copy of your records. You will not receive confirmation of receipt by the Board.