

Supervising Physician Approval for Physician Assistant to Perform Fluoroscopic Procedures

I, _____ certify that I am the supervising physician for
(Physician name)
_____, at _____ and
(Physician Assistant name) (Name of Healthcare Facility)

that he/she has met the required didactic and clinical training as required at 105 CMR 120.405(K)(3) to perform the following fluoroscopic procedures:

A written practice agreement between me and the physician assistant as set forth in the regulations of the Board of Registration in Medicine at 243 CMR 2.08(6)(a)(2)(b) and the Board of Registration of Physician Assistants in 263 CMR 5.08(1)(c)(2) is attached.

(Name and Title of Supervising Physician)

(Signature of Supervising Physician and Date)