State Medical Board of Ohio
Physician Assistant Supervision Agreement Instructions

Read all instructions prior to completing and submitting this application

What is a Physician Assistant Supervision Agreement?

It is an agreement that constitutes a working relationship between a physician assistant and a supervising physician. *Note: A supervising physician assumes legal liability for the services provided by the physician assistant under their supervision.*

Who is required to complete a Physician Assistant Supervision Agreement?

This application must be completed by every physician who wishes to supervise a physician assistant regardless of whether that physician assistant will be utilized in an office setting or a health care facility. *Note: If you have a Physician Assistant Supervision Agreement previously approved by the Board you do not need to complete this application.*

Do I need to complete this application to add additional Physician Assistants to a previously approved Supervision Agreement?

No, you need to complete an Addendum to the Physician Assistant Supervision Agreement in order to add additional Physician Assistants.

How will I know that a supervision agreement has been approved?

Once a supervision agreement is approved by the Board the supervision agreement number will appear on the Board's website at MED.OHIO.GOV.

Verification via the website constitutes notification of approval of a supervision agreement.

What is a Physician Supervisory Plan?

It describes the services the physician assistant will provide under your supervision while in an office setting. Ohio Revised Code Section 4730.09 (which appears on the next page) lists the services that are included in a standard Physician Supervisory Plan.

Do you need to submit a Physician Supervisory Plan in addition to the Supervision Agreement?

Yes, if the Physician Assistant, while under your supervision, will be working in an office setting at any time;

No, if the Physician Assistant, while under your supervision, will be working solely in either a hospital registered by the Ohio Dept. of Health or a health care facility licensed by the Ohio Dept. of Health under 3702.30, Ohio Revised Code.
Visit www.odh.ohio.gov/odhPrograms/io/hospreg/hosp1.aspx to obtain the hospital registration information.

Ohio Revised Code Section 3702.30 (A)(4) health care facilities that are licensed with the Ohio Dept. of Health include:

(a) An ambulatory surgical facility;
(b) A freestanding dialysis center;
(c) A freestanding inpatient rehabilitation facility;
(d) A freestanding birthing center;
(e) A freestanding radiation therapy center;
(f) A freestanding or mobile diagnostic imaging center.

What is a Quality Assurance System?

Any supervising physician who oversees a physician assistant must establish a quality assurance system which shall include the following components:

(1) the routine review of selected patient record entries made by the physician assistant; and
(2) the routine review of selected medical orders issued by the physician assistant, and
(3) the discussion of complex cases; and
(4) the discussion of new medical developments relevant to the practice of the physician assistant.

Instructions:

- Complete the attached Physician Assistant Supervision Agreement in its entirety. *An application will not be processed unless all information has been submitted.*
- Each physician assistant to be supervised under this agreement is required to sign, date and include his/her Ohio certificate to practice number (Ohio license). *(Name stamps, copies and faxes are not acceptable)*.
- A separate application for each supervising physician must be completed.
- List a contact person and the credential mail address where all mailings regarding this application are to be sent. *Applications submitted without this information will not be processed until we have received the required contact information*.
- You must enclose a check or money order made ***payable to the State Medical Board of Ohio in the amount of $25.00*** for each application. Fees submitted are neither refundable nor transferable. Applications submitted without the fee will not be processed until the fee is received.

PHYSICIAN ASSISTANT
SUPERVISION AGREEMENT APPLICATION

Application fee: $25.00; check or money order made payable to:
State Medical Board of Ohio

Mail completed application and fee to:
State Medical Board of Ohio
ATTN: Physician Assistant Program Administrator
30 East Broad Street, 3rd Floor
Columbus, Ohio 43215-6127

SUPERVISING PHYSICIAN INFORMATION

Supervising Physician Name (last, first, middle):			
Supervising Physician Ohio License Number:			
Practice Name:			
Practice Address:			
City:	*County:*	*State:*	*Zip Code:*
Office Phone Number: ( )		*Office Fax Number:* ( )	

The Credential mail address is the address where all mailings will be sent regarding this application. This section must be completed.

Credential Mail Address:		
City:	*State:*	*Zip Code:*
Contact Person:	*Office Phone Number:* ( )	*Office Fax Number:* ( )

PHYSICIAN ASSISTANT SITE LOCATIONS

Will the Physician Assistants be utilized ***solely* in a hospital registered with the Ohio Department of Health or a healthcare facility licensed by the Ohio Department of Health under Section 3702.30, Ohio Revised Code?**

❑ Yes: (No physician assistant supervisory plan needed)

❑ No: (Physician Supervisory Plan *required*)

❑ Both: (Physician Supervisory Plan *required for office based services*)

Submit a list of all locations in which the Physician Assistants will be utilized on the form provided on the following page. Note: A SUPERVISORY PLAN IS REQUIRED IF A PHYSICIAN ASSISTANT, WHILE UNDER YOUR SUPERVISION, WILL BE WORKING IN AN OFFICE SETTING.

PHYSICIAN ASSISTANT SITE LOCATIONS (CONTINUED)

Office Practice's

Office Practice Name:			
Practice Address:			
City:	County:	State:	Zip Code:
Office Phone Number: ( )	Office Fax Number: ( )		

Office Practice Name:			
Practice Address:			
City:	County:	State:	Zip Code:
Office Phone Number: ( )	Office Fax Number: ( )		

Office Practice Name:			
Practice Address:			
City:	County:	State:	Zip Code:
Office Phone Number : ( )	Office Fax Number : ( )		

Hospital or Health Care Facilities

Hospital or Health Care Facility Name:			Hospital/Facility Registration Number:
Facility Address:			
City:	County:	State:	Zip Code :
Office Phone Number : ( )	Office Fax Number : ( )		

Hospital or Health Care Facility Name:			Hospital/Facility Registration Number:
Facility Address:			
City:	County:	State:	Zip Code :
Office Phone Number: ( )	Office Fax Number: ( )		

Hospital or Health Care Facility Name:			Hospital/Facility Registration Number:
Facility Address:			
City:	County:	State:	Zip Code:
Office Phone Number: ( )	Office Fax Number: ( )		

AFFIDAVIT OF SUPERVISING PHYSICIAN

The above statements are complete and accurate to the best of my knowledge. I have read and understand Chapter 4730. of the Ohio Revised Code and the rules and regulations set forth by the State Medical Board of Ohio regarding Physician Assistants.

I understand that as a supervising physician I assume legal liability for the services provided by the physician assistant(s) that are under my supervision.

I further agree that I will supervise any physician assistant(s) listed in this "Physician Assistant Supervision Agreement" in accordance with Section 4730.21, Ohio Revised Code, upon approval of the State Medical Board.

Supervising Physician signature:	*Date:*

This form may be copied if additional space is needed

PHYSICIAN ASSISTANT
SUPERVISION AGREEMENT APPLICATION

PHYSICIAN ASSISTANT SIGNATURE SHEET

I (we) have read and agree to abide by the policies of the health care facility(s) listed in this application or to perform only those duties as outlined in the Physician Supervisory Plan that has been approved by the State Medical Board and was

submitted by ___________________________________
(Supervising Physician's Name)

Physician Assistant Name (Please print):	*Certificate to Practice Number:*
Physician Assistant signature:	*Date:*

Physician Assistant Name (Please print):	*Certificate to Practice Number:*
Physician Assistant signature:	*Date:*

Physician Assistant Name (Please print):	*Certificate to Practice Number:*
Physician Assistant signature:	*Date:*

Physician Assistant Name (Please print):	*Certificate to Practice Number:*
Physician Assistant signature:	*Date:*

Physician Assistant Name (Please print):	*Certificate to Practice Number:*
Physician Assistant signature:	*Date:*

Physician Assistant Name (Please print):	*Certificate to Practice Number:*
Physician Assistant signature:	*Date:*

THIS FORM MAY BE COPIED IF ADDITIONAL SPACE IS NEEDED