



## WYOMING BOARD OF MEDICINE

### INSTRUCTIONS FOR CHANGES OR ADDITIONS IN SUPERVISION

This Change in Supervision application should be used by the physician assistant who holds an unencumbered and current license in Wyoming when physician supervision changes.

Current NCCPA certification is required for any changes in supervision. Please submit a copy of your current NCCPA certificate.

A \$100.00 application fee is required when a physician assistant changes employment or secures additional employment under new supervision. The fee is **not** applicable when changing or adding primary supervisors within the same clinic.

**The following items must be submitted to the Board office for approval:**

- a. Change form
- b. Legible copy of current NCCPA certificate
- c. Supervising Application Form
- d. \$100.00 fee, if applicable

***Failure to submit any of the aforementioned items (a-d), will delay the approval process until the appropriate items are received. FAXED DOCUMENTS ARE NOT ACCEPTABLE.***

**Submit your application directly to:**

Wyoming Board of Medicine  
130 Hobbs Avenue, Suite A  
Cheyenne, WY 82002



**WYOMING BOARD OF MEDICINE**  
**PHYSICIAN ASSISTANT APPLICATION**  
**REQUESTING CHANGE OR ADDITION IN**  
**SUPERVISING PHYSICIAN**

I, \_\_\_\_\_ hereby apply to the Wyoming Board  
(PA Name and license number)  
of Medicine for a change/addition in supervising physician(s).

1. I am requesting to (please check one, a or b):

a. \_\_\_\_\_ **add:** \_\_\_\_\_ **Primary** Supervising Physician(s)  
\_\_\_\_\_ **Back-Up** Supervising Physician(s)

**OR**

b. \_\_\_\_\_ **change:** \_\_\_\_\_ **Primary** Supervising Physician(s)  
\_\_\_\_\_ **Back-Up** Supervising Physician(s)

2. Physician Name: \_\_\_\_\_  
(Last) (First) (MI) (WY License #)

3. Practice Address(where physician will be supervising you):

\_\_\_\_\_  
(Clinic/Hospital Name) (Street)

\_\_\_\_\_  
(City) (State) (Zip) (Phone)

**PLEASE CHECK ONE OF THE FOLLOWING:**

\_\_\_ I am requesting to **add** an additional supervising physician in the same practice setting - **No Fee**

\_\_\_ I am requesting to **change** supervision to a different supervising physician in the same practice - **No Fee**

\_\_\_ Change in employer and supervising physician (therefore removing my current primary supervising physician(s) as supervisor(s) - **\$100.00 fee**

\_\_\_ Additional Employment under new supervising physician(s) - **\$100.00 fee**

*Please read the following affidavit carefully and sign in the presence of a notary public.*

**AFFIDAVIT OF PHYSICIAN ASSISTANT**

I, \_\_\_\_\_, being first duly sworn, depose and say:

1. I am competent to make this oath and I hold license # \_\_\_\_\_ authorizing me to practice in the State of Wyoming.
2. I have recently read and understand the Wyoming Medical Practice Act, W.S. 33-26-101 et. Seq. and the regulations promulgated by the Wyoming Board of Medicine pertaining to physician assistants.
3. I understand the responsibilities involved with practicing as a physician assistant including, but not limited to, the principle of maintaining the same scope of practice as my supervising physician/s.
4. I understand that I must work within my delegated scope of duties, that a back up supervising physician, within the same scope of practice, must be utilized when primary supervision is not available. I understand that I cannot practice if physician supervision is not available.
5. I acknowledge that the Advisory Council/Board may deny this application or impose limitations upon the distance between the supervising physician's place of practice and any clinic at which I am practicing depending upon the facts and circumstances presented in this change request.
6. I acknowledge that the Advisory Council/Board may restrict or condition the scope of practice depending on the facts and circumstances presented by this change request.
7. I acknowledge and agree that if the Board opens a disciplinary investigation I will cooperate with, and if requested, appear at an informal interview.

\_\_\_\_\_  
Physician Assistant Signature

\_\_\_\_\_  
Date

STATE OF \_\_\_\_\_

COUNTY OF \_\_\_\_\_

The foregoing Affidavit was sworn to and acknowledged before me by:

this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_.

Witness my hand and seal.

\_\_\_\_\_  
Notary Public