WYOMING BOARD OF MEDICINE

SUPERVISING PHYSICIAN APPLICATION
INSTRUCTION SHEET

The following Supervising Physician Application form is to be completed by the **Supervising Physician**

Please complete the following form in accurate detail; you may submit attachments if needed. If it is determined that the form is not filled out completely, properly or with enough detail to understand the supervising agreement, ***it will be returned for completion and will delay processing of the application.***

Instructions:

1. Complete every section on the form. Please type or print legibly.

2. Please submit one form per physician. If there is more than one supervising physician in the same practice being added, please complete the Group Supervising Application.

3. Submit this form with the appropriate fee (if applicable) and "Application Form for Change in Supervision for Physician Assistant" (to be completed by the physician assistant, if applicable). **PHOTOCOPIES AND FAXES ARE NOT ACCEPTABLE.**

4. Once the form(s) have been submitted, **please allow 10 business days for the supervising agreement to be approved by the Physician Assistant Advisory Council and Board officers**. Please note that a physician assistant is prohibited from working under a physician's supervision without the approval of the PA Council and Board officers.

Please return to:

Wyoming Board of Medicine

130 Hobbs Avenue, Suite A

Cheyenne, WY 82002

WYOMING BOARD OF MEDICINE

SUPERVISING PHYSICIAN APPLICATION

SECTION A. IDENTIFYING INFORMATION:

1. I am applying as a **Supervising Physician** for:

_____

Name of Physician Assistant

3. Physician Name:_____

(Last) (First) (MI) (Degree) WY License #

My medical specialty is_____

My primary practice area is _____

4. Practice Address (where you will be supervising the Physician Assistant):

_____

(Clinic/Hospital/Business Name) (Street)

_____

(City) (State) (Zip) (Phone)

SECTION B. EMPLOYMENT INFORMATION:

4. Do you supervise other physician assistants? _____ Yes _____ No

If yes, please list PA's name(s):

_____

_____

If you recently relocated to Wyoming have you supervised PAs in another state?

_____ Yes _____ No If yes, how many years did you act a supervising physician? _____

5. Where do you intend to utilize the physician assistant (check all that apply)?

_____Hospital _____Clinic _____Other (please specify below)

_____Office _____Nursing Home _____

_____Satellite Clinic _____Medical Spa _____

a. Define the practice setting (i.e. – Emergency room, walk-in clinic, women's health, family practice, surgery, etc.)

_____

_____

b. What is the patient population (i.e. – pediatrics, geriatrics, all ages, etc.)

_____

_____

6. Please complete the following subsections regarding your practice plan with the physician assistant. Insufficient answers will result in the return of this form to you to be completed.

a. Please discuss your chart review policy. Include how many and how often charts will be reviewed with your physician assistant and how many charts will be co-signed and how often.

_____

_____

_____

_____

b. Please discuss, if any, the call schedule the PA will have at this practice:

_____

_____

c. On a daily basis, how often will you be available to the PA for personal contact?

_____

_____

d. When you are not available in person, by what means of communication will the PA be able to reach you?

_____

e. Please discuss the duties of the PA. Include, in detail, all duties they will provide in the O.R., E.R. and/or office/clinic. Include prescribing policies, surgical procedures, injections, diagnostic tools, etc.

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7. Please list the names of the physician(s) who will be acting as the back-up supervising physician(s) for this PA (Please note, the back-up supervising physician(s) must submit a supervising form for approval):

_____

_____

AFFIDAVIT OF SUPERVISING PHYSICIAN

I, _____
M.D./D.O. being duly sworn upon my oath, hereby depose and state as follows:

1. I hold an unencumbered and current license to practice medicine 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 supervising a physician assistant including, but not limited to, the principle of maintaining the same scope of practice for both physician and PA.

4. I understand that I am responsible for all professional actions taken by the PA within his or her scope of delegated duties, that a back up supervising physician must be utilized when primary supervision is not available, and that the PA shall not work when physician supervision is not available.

5. I acknowledge that the Board may deny this application or impose limitations upon the distance between the supervising physician's place of practice and any clinic at which a PA is practicing depending upon the facts and circumstances presented by this application, the PA's work experience the nature of the practice, and other factors.

6. I acknowledge that the Board may restrict or condition the scope of practice of this physician assistant depending on the facts and circumstances presented by this application.

7. I acknowledge and agree that if the Board opens a disciplinary investigation involving either my practice or that of the physician assistant that I supervise, I will cooperate with and, if requested, appear at an informal interview.

_____ _____
Physician Signature and License Number 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