WYOMING BOARD OF MEDICINE

GROUP SUPERVISING APPLICATION

SECTION A. IDENTIFYING INFORMATION:

1. Application as Supervising Physicians for a total of ________________ physician assistants and total of ______________ physicians.

The medical specialty(ies) is/are:

____

Name(s) of Physician Assistant(s) Supervised:

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2. Supervising Physicians Names and License Numbers:

____ ________________________________

____ ________________________________

____ ________________________________

____ ________________________________

____ ________________________________

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Practice Address where Physicians will be supervising Physician Assistants:

____
(Clinic/Hospital/Business Name) (Street)

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

SECTION B. EMPLOYMENT INFORMATION:

4. Where do you intend to utilize the physician assistant?

   Hospital____ Office _____ Satellite Clinic_____ Clinic_____ Other (specify below):____

   ____

5. Please discuss, if any, the call schedule the PA(s) will have at this practice:

   ____

6. How frequently will the PA have personal contact with the physicians, and what will that contact include?

   ____

   ____

7. What means of telecommunication contact will the PA have with the physicians?

   ____

8. Define the practice setting and patient population (i.e. Emergency room, walk-in clinic, etc.).

   ____

9. 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.

   ____

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   ____

10. 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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AFFIDAVIT OF THE PRIMARY SUPERVISING PHYSICIANS

I/We, physicians, as signed below, being duly sworn upon my/our oath, hereby depose and state as follows:

1. I/We hold unencumbered and current licenses to practice medicine in the state of Wyoming
2. I /We 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/We 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 supervising physician/s and PA/s.
4. I/We understand that I/we are responsible for all professional actions taken by the PAs within their scope of delegated duties, that a supervising physician must always be utilized and that a PA shall not work when physician supervision is not available.
5. I/We 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.
6. I/We 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/We acknowledge and agree that if the Board opens a disciplinary investigation involving either my practice or that of the physician assistant/s that I supervise, I will cooperate with and, if requested, appear at an informal interview.

________________________________ Physician Signature Date	________________________________ Physician Signature Date
________________________________ Physician Signature Date	________________________________ Physician Signature Date
________________________________ Physician Signature Date	________________________________ Physician Signature Date
________________________________ Physician Signature Date	________________________________ Physician Signature Date
________________________________ Physician Signature Date	________________________________ Physician Signature Date

STATE OF ______________________

COUNTY OF ____________________

The foregoing Affidavit was sworn to and acknowledged before me by the above listed physicians on

this _____day of __________________, 20_____.

Witness my hand and seal.

____
Notary Public