Reset Form

APPLICATION FOR CHANGE OR ADDITION OF SUPERVISING PHYSICIAN FOR PHYSICIAN ASSISTANTS

State Form 42907 (R8 / 8-16)
Approved by State Board of Accounts, 2016

PHYSICIAN ASSISTANT COMMITTEE
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 234-2060
E-mail: pla3@pla.IN.gov
www.pla.IN.gov

INSTRUCTIONS:
1. *The fee for this application is $50.00, payable to the Indiana Professional Licensing Agency, in accordance with 844 IAC 2.2-2-8.*
2. *All fees are non-refundable and non-transferable.*
3. *Please refer to the instructions on our website, www.pla.in.gov, for the licensing requirements.*

* This agency is requesting disclosure of your Social Security Number in accordance with IC 4-1-8-1; disclosure is mandatory and this record cannot be processed without it.

FOR OFFICE USE ONLY

Date received (*month, day, year*)	Amount of fee received	Receipt number

License number issued	Date of issuance (*month, day, year*)

DO NOT WRITE ABOVE THIS LINE

TO BE COMPLETED BY THE PHYSICIAN ASSISTANT (*Please print clearly in ink.*)

Name (*last, first, middle*)			Physician Assistant license number

Address (*number and street or rural route*)		

City	State	ZIP code

Social Security number *	Date of birth (*month, day, year*)	E-mail address	Telephone number (*daytime*)
			( )

Are you applying for a change of supervising physician?	Are you adding a supervising physician?
☐ Yes ☐ No	☐ Yes ☐ No

Name of supervising physician prior to completion of this application

Name of new supervising physician	Date of discontinuation of supervision of physician (*month, day, year*)

Office address of new supervising physician (*number and street, city, state, and ZIP code*)

Specific reason for discontinuation of supervision:

Do you currently have prescriptive authority?	Are you applying for prescriptive authority under this physician?
☐ Yes ☐ No	☐ Yes ☐ No

Name(s) of additional supervising physician *(indicate all)*

Office address of additional supervising physician (*number and street, city, state, and ZIP code*)

I hereby swear or affirm under the penalties of perjury, that the statements made in this application are true, complete and correct.

Signature of Physician Assistant	Date (*month, day, year*)

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize, request and direct any person, firm, officer, corporation, association, organization or institution to release to the Professional Licensing Agency, any files, documents, records or other information pertaining to the undersigned requested by the Agency, or any of its authorized representatives in connection with processing my application for licensure as a Physician Assistant.

I hereby release the aforementioned persons, firms, officers, corporations, associations, organizations and institutions from any liability with regard to such inspection or furnishing of any such information.

I further authorize the Professional Licensing Agency to disclose to the aforementioned organizations, persons and institutions any information which is material to my application, and I hereby specifically release the Agency and the Committee from any and all liability in connection with such disclosures.

A photostatic copy of this authorization has the same force as the original.

AFFIRMATION

I hereby swear or affirm that I have read the above statements and agree to same.

Signature of Physician Assistant	Date (*month, day, year*)

SUPERVISING PHYSICIAN'S STATEMENT

Name of supervising physician (*last, first, middle*)		License number
Residence address (*number and street or rural route, city, state, and ZIP code*)		
Address of practice (*number and street or rural route, city, state, and ZIP code*)		
Residence telephone number ( )	Office telephone number ( )	E-mail address
Specialty	Board certification	

SUPERVISORY AGREEMENT FOR THE PHYSICIAN ASSISTANT

INSTRUCTIONS: ON AN ATTACHED SHEET, give a description of the exact privileges and tasks the physician assistant shall be performing under the physician's supervision. In addition, please give a detailed description of the process maintained for evaluation of the physician assistant's performance. THIS SUPERVISORY AGREEMENT MUST BE ON COMPANY LETTERHEAD, INCLUDING FACILITY ADDRESS AND TELEPHONE NUMBER, BE SPECIFIC TO THE APPLICANT, AND BE SIGNED BY BOTH THE PHYSICIAN AND THE PHYSICIAN ASSISTANT.

LIMIT ON PHYSICIAN ASSISTANT SUPERVISION

As a supervising physician, I understand that I may supervise no more than four (4) physician assistants at any one given time. Please indicate below the names and certificate numbers of all physician assistants you are currently supervising, if any. Use a separate sheet if necessary.

NAME OF PHYSICIAN ASSISTANT	LICENSE NUMBER

CERTIFICATION OF SUPERVISION

Please indicate by signing your name below that the physician assistant named in this application will be under your continuous supervision in accordance with IC 25-27.5-6, IC 25-27.5-2-14 and 844 IAC 2.2, and that you shall review records of patient encounters maintained by the physician assistant as required by IC 25-27.5-6-1.

AFFIRMATION

I hereby swear or affirm that I have read the above statements and agree to same.

Signature of supervising physician	Date (*month, day, year*)