Reset Form

APPLICATION FOR PRESCRIPTIVE AUTHORITY FOR A PHYSICIAN ASSISTANT

State Form 53314 (R9 / 8-16)

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. *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 prescriptive authority issued (*month, day, year*)

PHYSICIAN ASSISTANT INFORMATION

Name (*last, first, middle*)		
Mailing address *(number and street or rural route, city, state, and ZIP code)*		
Social Security number *	Date of birth *(month, day, year)*	Physician assistant license number
E-mail address	Telephone number ( )	Are you also applying for a Controlled Substances Registration? ☐ Yes ☐ No

SUPERVISING PHYSICIAN INFORMATION

Name of supervising physician	License number
Location of practice *(number and street or rural route, city, state, and ZIP code)*	
Date began employment with current supervising physician *(month, day, year)*	

PHYSICIAN ASSISTANT DIPLOMA GRANTED BY:

Full name of school *(do not abbreviate)*	Date of graduation *(month, day, year)*

NCCPA CERTIFICATE

NCCPA Certificate number	Date granted *(month, day, year)*	Date of expiration *(month, day, year)*

If your answer is "Yes" to any of questions 1 through 10, explain fully in a sworn affidavit, including all related details, and provide copies of all relevant arrest or court documents. Describe the event including the location, date and disposition. Falsification of any of the following is grounds for permanent revocation of the license or permit issued pursuant to this application.

1. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit you hold or have held in any state or country?	☐ Yes ☐ No
2. Have you ever surrendered or been denied a license, certificate, registration or permit to practice as a health care professional regulated in any state or country?	☐ Yes ☐ No
3. Do you have any condition or impairment *(including a history of alcohol or substance abuse)* that currently interferes, or if left untreated may interfere, with your ability to practice in a competent and professional manner?	☐ Yes ☐ No
4. *Except for minor violations of traffic laws resulting in fines, and arrests or convictions that have been expunged by a court,*	
(1) have you ever been arrested;	☐ Yes ☐ No
(2) have you ever entered into a prosecutorial diversion or deferment agreement regarding any offense, misdemeanor, or felony in any state;	☐ Yes ☐ No
(3) have you ever been convicted of any offense, misdemeanor, or felony in any state;	☐ Yes ☐ No
(4) have you ever pled guilty to any offense, misdemeanor, or felony in any state; or	☐ Yes ☐ No
(5) have you ever pled *nolo contendre* to any offense, misdemeanor, or felony in any state?	☐ Yes ☐ No
5. Have you ever been the subject of an investigation by an authority regulating your profession?	☐ Yes ☐ No
6. Have you ever had a malpractice judgment against you or settled any malpractice action?	☐ Yes ☐ No
7. Have you ever surrendered your DEA registration at any time or had any limitations placed on your DEA registration?	☐ Yes ☐ No
8. Have you ever been terminated or disciplined by your employer while practicing as a physician assistant or resigned in lieu of discipline?	☐ Yes ☐ No
9. Have you ever been excluded from being a Medicare / Medicaid provider?	☐ Yes ☐ No
10. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges revoked, suspended or subjected to any restrictions, probation or other type of discipline or limitations?	☐ Yes ☐ No
11. Have you practiced as a Physician Assistant in the last three (3) years?	☐ Yes ☐ No

APPLICATION AFFIRMATION

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

Signature of applicant	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 supervising physician.

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 Physician Assistant Committee from any and all liability in connection with such disclosures.

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

AFFIRMATION

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

Signature of applicant	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 detailed 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 address, telephone number, and fax number), BE PERSON SPECIFIC, AND BE SIGNED BY BOTH THE PHYSICIAN ASSISTANT AND THE SUPERVISING PHYSICIAN, AND COMPLY WITH IC 25-27.5.

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.

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