

GENERAL INFORMATION FOR SUPERVISION AGREEMENTS

In order to practice as a Physician Assistant (PA) in Montana the PA must have on file with Board in accordance to MCA: 37-20-301, a supervision agreement. The following outlines general information for a supervision agreement for new applicants to the State of Montana, a new supervising physician and PA practice relationship or a change in supervising physician.

- A. Application Fee:** \$25.00 for new Supervision Agreement with Physician Assistant License application;
- B. Supervising Physician** is defined as a medical doctor or doctor of osteopathy licensed by the Board who agrees to a supervision agreement and duties and delegation agreement.
- C. Qualification of Supervising Physician:**
 - a. possess a current, active Montana license
 - b. exercises supervision over the physician assistant in accordance with the rules adopted by the Board
 - c. retains professional and legal responsibility for the care and treatment of patients by the physician assistant
- D. Qualifications for Physician Assistant** must have a current active Montana PA license.

MONTANA BOARD OF MEDICAL EXAMINERS
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E-MAIL dlibsmed@mt.gov WEBSITE: www.medicalboard.mt.gov

PLEASE TYPE OR PRINT IN INK.

(Please allow 10 days for processing from the date that the Board has a completed application. Non-routine applications requiring interviews may take longer depending on the applicant and supervising physician's schedule.)

Application for Supervision Agreement:

PHYSICIAN ASSISTANT INFORMATION:

1. FULL NAME: _____
Last First Middle

2. BUSINESS NAME: _____

3. BUSINESS ADDRESS: _____
Street or PO Box # City and State Zip

4. HOME ADDRESS: _____
Street or PO Box # City and State Zip

PREFERRED MAILING ADDRESS: Business Home E-MAIL ADDRESS: _____

5. TELEPHONE: (____) _____ (____) _____ (____) _____
Business Home Fax

6. SOCIAL SECURITY NUMBER: _____ LICENSE NUMBER: _____

7. DEA REG. # _____ START DATE: _____

SUPERVISING PHYSICIAN INFORMATION:

1. FULL NAME: _____
Last First Middle

2. BUSINESS NAME: _____

3. BUSINESS ADDRESS: _____
Street or PO Box # City and State Zip

4. HOME ADDRESS: _____
Street or PO Box # City and State Zip

PREFERRED MAILING ADDRESS: Business Home E-MAIL ADDRESS: _____

5. TELEPHONE: (____) _____ (____) _____ (____) _____
Business Home Fax

6. SOCIAL SECURITY NUMBER: _____ LICENSE NUMBER: _____

7. DEA REG. # _____ START DATE: _____

Requirements for use of a Physician Assistant:

A physician, office, firm, state institution or professional service corporation may not employ or make use of the services of a physician assistant in the practice of medicine unless the physician assistant is supervised by a physician licensed in the State of Montana, possesses a current active Montana PA license and has completed and submitted this Supervision Agreement application form with fee to the Board.

Scope of Practice:

A physician assistant may diagnosis, examine and treat human conditions, ailments, diseases, injuries or infirmities either physical or mental by any means, method, device or instrumentalities authorized by the supervising physician. The above named supervising physician and physician assistant shall execute a duties and delegation agreement constituting a contract that defines the physician assistants professional relationship with the supervising physician and the limitations on the physician assistant's practice under the supervision of the supervising physician. The duties and delegation agreement must be kept current by amendment or substitution to reflect changes in the duties of each party occurring over time. ***(All physician assistants must have a duties and delegation agreement on file prior to commencing practice.)***

Supervision:

A physician assistant is considered the agent of the supervising physician with regard to all duties delegated to the physician assistant. The supervising physician is professionally and legally responsible for the care and treatment of a patient by a physician assistant. The onsite or direct supervision of a physician assistant by the supervising physician is not required if the supervising physician has provided a means of communication between the supervising physician and the physician assistant or has identified a "back-up" supervising physician in the event of the primary supervising physician's absence.

"Back-up" supervision for periods of absence:

When the supervising physician is unavailable by means of communication the following will apply:

The supervising physician will provide for a "back-up" supervising physician(s) to supervise the above listed PA when the supervising physician is unavailable. A list of the "back-up" supervising physician(s) must be on file with the duties and delegation agreement, kept current and available upon request by the Board. ***(Important Note: Having a "back-up" supervising physician doesn't relieve the supervising physician listed in this agreement of the professional and legal responsibilities for the care and treatment of patients by the PA listed above.)*** OR

The physician assistant will cease to practice when the supervising physician is unavailable.

Chart Review:

The Board of Medical Examiners has recently amended its rule regarding Physician review of PA charts as follows. *(NOTE: this is an unofficial version of the rule. The official version can be found only at the Montana Secretary of State's website: <http://mtrules.org>. The updated version of this rule may not be immediately available at that website.)*

24.156.1623 CHART REVIEW

(1) Chart review for a physician assistant having less than one year of full-time practice experience from the date of initial licensure must be 20 percent for the first six months of practice, and then may be reduced to 10 percent for the next six months, on a monthly basis, for each supervision agreement.

(2) After twelve months, further chart review shall occur. The amount of chart review shall be at the discretion of the physician assistant and the supervising physician to determine in a duties and delegation agreement.

AFFIDAVITS AND SIGNATURES

I hereby declare under penalty of perjury the information included in my supervision agreement application to be true and complete to the best of my knowledge. In signing this application, I am aware that a false statement or evasive answer to any question or request for information may lead to a denial of my application or grounds for subsequent disciplinary action imposed on my licensure. I further affirm that I have read and accepted the licensing statutes and pursuant to my profession, including supervision agreement and duties and delegation agreement, and hereby certify that I will abide by all statutes and rules of the Board of Medical Examiners that pertain to my licensure. I acknowledge and understand that I may not practice medicine independently pursuant to 37-20-104(2) and 37-20-301, MCA.

Physician Assistant:

(Print Name)

(Signature)

(Date)

PRIMARY SUPERVISING PHYSICIAN AFFIRMATION

I affirm that I have read and understand the current Board of Medical Examiners statutes and rules, including those pertaining to physician assistant, supervision agreements and duties and delegation and my responsibilities as supervising physician. I acknowledge and agree pursuant to 37-20-101, 37-20-301, 37-20-403, MCA to exercise appropriate supervision over the above named PA in accordance with all statutes and rules of the Board of Medical Examiners. I acknowledge and agree that I will retain professional and legal responsibility for the care and treatment of patients by the above named PA. I understand that duties and responsibilities may be delegated, or restrictions imposed, at my discretion, including additional limitations on prescribing and dispensing of drugs above those granted by the Board, pursuant to 37-20-404, MCA, and will be reflected in the duties and delegation agreement.

Supervising Physician:

(Printed name)

(Signature)

(Date)