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. 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.

B. 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

C. Qualifications for Physician Assistant must have a current active Montana PA license.

D. Supervision Relationship Education:

A supervision physician or physician assistant who is new to supervision relationships in Montana will also be required to submit a certificate of completion for the board-approved online education for physicians and physician assistants in supervision relationships. One can access the education and assessment here: https://dlitraining.mt.gov/login/index.php You will find instructions for setting up/logging into the course on the board website, here.

Upon passage of the quiz please submit the certificate of completion in one of the following ways:

- email to dlibsdmed@mt.gov
- mail to Board of Medical Examiners, PO Box 200513, Helena, MT 59620-0513
- upload to your online application

MONTANA BOARD OF MEDICAL EXAMINERS
PO Box 200513
(301 S PARK, 4TH FLOOR - Delivery)
Helena, Montana 59620-0513
(406) 444-6880 FAX (406) 841-2305
E-MAIL dlibsdmed@mt.gov **WEBSITE:** www.medicalboard.mt.gov

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. DEA Registration # _____ LICENSE NUMBER: _____

SUPERVISION 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. DEA REG. # _____ LICENSE NUMBER: _____

SUPERVISION START DATE: _____

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 statues 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 statues 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)