State Medical Board of Ohio

30 E. Broad Street, 3rd Floor, Columbus, OH 43215-6127

med.ohio.gov
(614) 466-3934

APPLICATION INSTRUCTIONS FORM A
PHYSICIAN ASSISTANT PROVISIONAL CERTIFICATE TO PRESCRIBE
AFFIDAVIT OF PRIMARY SUPERVISING PHYSICIAN FOR PROVISIONAL PRESCRIBING PERIOD OF PHYSICIAN-DELEGATED PRESCRIPTIVE AUTHORITY

This form is to be completed by the supervising physician who has agreed to act as the primary supervising physician for the provisional period of physician-delegated prescriptive authority.
Section 4730., O.R.C. requires that a supervising physician of a Physician Assistant who is participating in the provisional period of physician-delegated prescriptive authority provide onsite supervision for the first 500 hours of this provisional period.

Section 1: To be completed by the Physician Assistant

The Physician Assistant who is applying for a provisional Certificate to Prescribe in the State of Ohio pursuant to Section 4730., Ohio Revised Code, must complete section 1 of this form and forward it to the supervising physician who has agreed to act as the primary supervising physician for the provisional period of physician-delegated prescriptive authority.

Section 2: To be completed by the supervising physician(s) who has agreed to act as the primary supervising physician for the provisional period of physician-delegated prescriptive authority.

This form is to be completed by the supervising physician who has agreed to act as the primary supervising physician for the provisional period of physician-delegated prescriptive authority.
Section 4730., O.R.C. requires that a supervising physician of a Physician Assistant who is participating in the provisional period of physician-delegated prescriptive authority provide onsite supervision for the first 500 hours of this provisional period.

FORM A

PRIMARY SUPERVISING PHYSICIAN APPLICATION FOR THE PROVISIONAL PERIOD OF PHYSICIAN-DELEGATED PRESCRIPTIVE AUTHORITY

Mail completed application to:
State Medical Board of Ohio
30 East Broad Street, Third Floor
Columbus, Ohio 43215

SECTION 1 - APPLICANT INFORMATION
(To be completed *by applicant* and sent to applicable physician)

Physician Assistant Full Name: _____

Certificate to Practice Number: _____

Supervision Agreement Number: _____

SECTION 2 – PRIMARY SUPERVISING PHYSICIAN AFFIDAVIT
(To be completed *by the physician* and sent directly to the Board at the above address)

Physician Name: _____ **License Number:** _____

Address: _____

City/State/Zip: _____

Phone Number: _____ **Fax Number:** _____

I have carefully and fully reviewed Chapter 4730. of the Ohio Revised Code, and agree to act as the primary supervising physician for the Physician Assistant listed above for their provisional period of physician-delegated prescriptive authority. I further agree and understand that I will verify that the Physician Assistant has had 500 hours of on-site supervision by physician(s) who hold a valid supervision agreement with this Physician Assistant and at the end of the this provisional period I will be required to complete an affidavit for this individual to obtain their certificate to prescribe.

_____

Physician Signature **Date**