



State Medical Board of Ohio

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

(614) 466-3934
med.ohio.gov

APPLICATION INSTRUCTIONS FOR A PHYSICIAN ASSISTANT CERTIFICATE TO PRESCRIBE

Section 4730.44 of the Ohio Revised Code allows for a Physician Assistant to apply for a Certificate to Prescribe via three different routes. In order to receive a Certificate to Prescribe the attached application must be completed and sent to the Board with the appropriate fee.

General Instructions

Once the form has been completed, it is to be returned directly to the State Medical Board of Ohio at the address on the form with a check or money order made payable to Treasurer, State of Ohio in the amount of \$100.00.

Application processing time is 10-12 weeks. Please be advised that all information submitted will be thoroughly investigated and individuals will be contacted in writing regarding their application as the Board deems necessary.

Once the application is approved by the Board, a Certificate to Prescribe will be issued. Verification of this certificate must be done on our website at www.med.ohio.gov under the licensee profile and status option.

Section 1: To be completed by the Physician Assistant

The Physician Assistant must complete Section 1 of this form and forward it to the appropriate verifying body/or approved supervising physician. There are three ways to obtain a certificate to prescribe, indicate which route you are eligible for and sign the application.

Section 2: To be completed by the supervising physician that agreed to act as the primary supervising physician for this applicant during the provisional period of physician-delegated prescriptive authority

If you were granted a provisional certificate to prescribe and you have completed the provisional period of prescriptive authority, the primary supervising physician who supervised the provisional period of physician-delegated prescriptive authority for this applicant must complete Section 2 of this form certifying that the applicant has completed the required number of hours under the appropriate levels of supervision as required by Section 4730.45 of the Ohio Revised Code. This must at a minimum include 1000 hours of supervision, the first 500 hours must be on-site supervision, and last for no less than a 6 month period as required by Rule 4730-2-04(C) of the Ohio Administrative Code.

Please note that only the physician who completed Form A of your provisional certificate to prescribe application must complete Section 2 of this application. If you worked in a setting where you were prescribing for more than one physician, the physician who completed Form A of your provisional certificate to prescribe application must be willing to accept and testify to the prescribing that you have done under the supervision of other physicians.

Section 3: To be completed by state licensing agency from the state in which you hold or have held prescribing abilities.

If you hold or have held valid prescribing authority in another state or the United States government to prescribe therapeutic devices and drugs, including at least some controlled substances, you must complete Section 3 of the application. Send a copy of the verification form to all states and/or the United States government agencies to be completed and sent back to the State Medical Board of Ohio. You must also submit an original transcript showing that you have obtained a Master's or higher degree that was issued by a program accredited by the Accreditation Review Commission on Education for the Physician Assistant or a predecessor or successor organization recognized by the board.

Section 4: To be completed by branch of the military, the state national guard unit or the Department of Veterans Affairs that can verify that you have held prescribing abilities while practicing as a Physician Assistant for 3 consecutive years.

If your certificate to practice was granted by having experience practicing as a Physician Assistant for at least three consecutive years while on active duty in any of the armed forces of the United States or the national guard of any state, including experience attained while practicing as a Physician Assistant at a health care facility or clinic operated by the United States Department of Veterans Affairs, and you were authorized to prescribe drugs and therapeutic devices, including at least some controlled substances while practicing as a Physician Assistant, then you will need to complete Section 4 of this application and forward it to the appropriate governmental body to be verified and returned to the State Medical Board of Ohio.



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Physician Assistant Certificate to Prescribe Application

Application fee: \$100; Check or money order made payable to: Treasurer, State of Ohio

Mail completed form and application fee to:

State Medical Board of Ohio
30 East Broad Street, 3rd Floor
Columbus, Ohio 43215

Section 1: Applicant Information

Physician Assistant Full Name:

Certificate to Practice Number:

Provisional Certificate Number, if applicable:

Current address:

City:

State:

ZIP Code:

Please check the appropriate box:

I have successfully completed the provisional period of physician delegated prescriptive authority, under the supervision of the physician listed in Section 2 below, pursuant to Section 4730.45 of the Ohio Revised Code. Proceed to Section 2 of the application and have your supervising physician who signed FORM A of your provisional period complete Section 2.

I hold a Master's or higher degree obtained from a program accredited by the Accreditation Review Commission on Education for the Physician Assistant, and have held valid authority issued by the another state or the United States government to prescribe therapeutic devices and drugs, including at least some controlled substances. Proceed to Section 3 of the application.

I received a certificate to practice by meeting the educational and military experience requirements specified in division (C)(3) of Section 4730.11 of the Revised Code, and have been authorized to prescribe drugs and therapeutic devices while practicing as a Physician Assistant in the U.S. Armed Forces, State National Guard, or health care facility or clinic operated by the U.S. Department of Veterans Affairs. Proceed to Section 4 of the application.

Physician Assistant Signature:

Date:

Section 2: Verification of Provisional Period of Physician-Delegated Prescriptive Authority

(To be completed by the supervising physician and sent directly to the Board at the address above.)

Provisional Period Start Date (Month/Day/Year):

Provisional Period End Date (Month/Day/Year):

Hours of on-site supervision:

Hours of off-site supervision:

Total hours of supervision:

Supervising physician name:

Supervision agreement #:

I certify that the Physician Assistant named in Section 1 of this application has successfully completed the provisional period of physician-delegated prescriptive authority under my supervision pursuant to Chapter 4730. of the Ohio Revised Code.

Supervising physician signature:

Date:

Section 3a: Verification of Out-of-State Prescriptive Authority

Please list the state(s)/agency of the United States government in which you hold/held valid authority to prescribe drugs and therapeutic devices, including at least some controlled substances. **Complete the VERIFICATION OF PHYSICIAN ASSISTANT PRESCRIPTIVE AUTHORITY FORM and send to state(s)/ agency of the U.S. government that can provide verification.**

State/U.S. government agency	License/Certificate Number	Issuance/Employment Start Date	Expiration/Employment End Date

Section 3b: Verification ARC-PA Master's Degree

Please list all ARC-PA Master's Degrees that you have received. Submit an original transcript from each institution

Name of Institution	City and State	Degree received	Date degree conferred

Section 4: Verification of Prescriptive Authority During Military Service

Please list the branch of the United States Armed Forces, state National Guard, or health care facility or clinic operated by the United States Department of Veterans Affairs for which you hold/held valid authority to prescribe drugs and therapeutic devices, including at least some controlled substances. **Complete the VERIFICATION OF PHYSICIAN ASSISTANT PRESCRIPTIVE AUTHORITY FORM and send to the appropriate U.S. Government agency for verification.**

Armed Forces Branch or State National Guard or Veterans Affairs Facility or Clinic	Employment/Service Start Date	Employment/Service End Date



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VERIFICATION OF PHYSICIAN ASSISTANT PRESCRIPTIVE AUTHORITY FORM

Please complete and forward this form to the state(s) **OR** to the place of employment/service within the U.S. government where you hold/held valid authority to prescribe drugs and therapeutic devices, including at least some controlled substances.

Section 1: General Information (To be completed by applicant)		
Physician Assistant Full Name:		Date of Birth:
Current address:		
City:	State:	ZIP Code:
State Licensure Information (for state where prescriptive authority is being verified)		
License/Certificate #:	Issuance Date:	Expiration Date:
U.S. Government Employment/Service Information		
U.S Government Agency/Branch:		
Employment/Service Start Date (Month/Year):	Employment/Service End Date (Month/Year):	
I hereby authorize the Physician Assistant licensing authority of the state of _____ / OR the U.S. government agency/branch to furnish the information below to the State Medical Board of Ohio.		
Applicant signature		Date

Section 2: Prescriptive Authority Verification (To be completed by the appropriate licensing authority OR U.S. government employer only and mailed directly to the State Medical Board of Ohio. An application is incomplete if this information is not received by the Board.)		
Physician Assistant Full Name:		Date of Birth:
License/Certificate#:	Issuance Date:	Expiration Date:
Employment/Service Start Date (Month/Year):	Employment/Service End Date (Month/Year):	
Is the license/certificate/privilege active: <input type="checkbox"/> YES <input type="checkbox"/> NO		

<p>1. Has/was this Physician Assistant given valid authority to prescribe drugs and therapeutic devices, including at least some controlled substances?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Cannot answer under current state/federal law. If yes, please attach details.</p>
<p>2. Is the applicant currently the subject of a pending investigation by the licensing or disciplinary authority in your state OR the agency/branch of the U.S. government?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Cannot answer under current state/federal law. If yes, please attach details.</p>
<p>3. Have formal disciplinary proceedings been initiated against the applicant or applicants license/registration by the disciplinary authority in your state OR agency/branch of the U.S. government?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Cannot answer under current state/federal law. If yes, please attach details.</p>
<p>4. Has the applicant ever been warned, censured or in any other manner disciplined or has the applicant's license/certificate/privileges been revoked, suspended, or in any other manner limited by a licensing or disciplinary authority in your state OR agency/branch of the U.S. government?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Cannot answer under current state/federal law. If yes, please attach details.</p>

TO BE COMPLETED BY STATE LICENSING AUTHORITY REPRESENTATIVE ONLY	
<p>I certify that the above information accurately represents the information on file with the _____ state licensing authority for the above named applicant.</p>	
(AGENCY SEAL)	<p>Signature: _____</p> <hr/> <p>Title: _____</p> <hr/> <p>Date: _____</p>

TO BE COMPLETED BY THE U.S. GOVERNMENT REPRESENTATIVE ONLY	
<p>I certify that the above information accurately represents the information on file with (Identify agency or branch of U.S. government) _____, for the above named applicant.</p>	
<p>Signature of U.S. Government Representative: _____</p>	<p>Date: _____</p>
<p>Printed Name: _____</p>	

**RETURN COMPLETED FORM TO:
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Columbus, Ohio 43215-6127**