



# 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 PROVISIONAL CERTIFICATE TO PRESCRIBE**

### **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 regarding their application as the Board deems necessary.

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

UPON COMPLETION OF YOUR PROVISIONAL PERIOD YOU WILL NEED TO COMPLETE AN APPLICATION FOR A FULL CERTIFICATE TO PRESCRIBE. All applications are available on our website at [www.med.ohio.gov](http://www.med.ohio.gov) under the Physician Assistant area.

### **Section 1: Applicant Information**

Fill out the information requested in section 1 in its entirety. *An application will not be processed unless all information has been submitted.*

### **Section 2: Verification of Educational Background information**

For verification of your Physician Assistant education as required by Section 4730.46, O.R.C., submit one of the following types of evidence:

- a) A transcript for your Master's Degree or higher that was obtained from an ARC-PA accredited program. Those documents not in English must be translated; **OR:**
- b) If you do not hold a Master's Degree or higher obtained from an ARC-PA accredited program, submit a transcript for a degree other than a Master's or higher from an ARC-PA accredited program **and** transcript for a Master's or higher degree in a course of study with **clinical relevance** to the practice of Physician Assistant that was obtained from a program accredited by a regional or specialized and professional accrediting agency recognized by the council for higher education accreditation. Those documents not in English must be translated.

### **Section 3: Verification of Pharmacology instruction : EVERYONE MUST COMPLETE THIS SECTION**

Fill in each course provider name, date taken and the number of contact hours received from this provider, including courses taken as part of your Master's Program. Enclose documentation of pharmacology course completion in the form of a university/college transcript; showing completion of an ARC-PA accredited program and/or a copy of certificate(s) from approved continuing education providers. This coursework shall be deemed approved by the board if it is approved for category I CME credit by the AAPA or an institution or organization accredited to provide CME by the ACCME. These courses must have been taken within the 3 year period immediately preceding this application. These documents must demonstrate how you have met the requirements for pharmacology instruction as delineated below:

**Section 3: Verification of Pharmacology instruction continued:**

- a) a minimum of thirty contact hours of training in pharmacology that includes pharmacokinetic principles and clinical application and the use of drugs and therapeutic devices in prevention of illness and maintenance of health, as required by Section 4730.46(C)(3)(a), O.R. C.; and:
- b) a minimum of twenty contact hours of clinical training in pharmacology; as required by Section 4730.46(C)(3) (b), O.R.C. Form C must be completed by the physician who is able to verify this training and sent directly to the Board; and:
- c) a minimum of fifteen contact hours including training in the fiscal and ethical implications of prescribing drugs and therapeutic devices and training in the state and federal laws that apply to the authority to prescribe, as required by Section 4730.46(C)(3)(c), O.R.C.

**Section 4: Affidavit and Release of Applicant**

The Affidavit and Release of Applicant must be signed and notarized.

**Form A: Affidavit of Primary Supervising Physician for Provisional Prescribing period**

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 4730.45 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 B: Verification of 20 Hours of Clinical Pharmacology Experience**

Section **4730.46(C)(3)(b)** of the Ohio Revised Code, (O.R.C.), requires that a Physician Assistant complete a minimum of twenty contact hours in clinical pharmacology in order to be eligible to participate in a provisional period of physician-delegated prescriptive authority. This form must be completed by the physician that is able to verify these twenty hours of clinical pharmacology and returned directly to the Board.



**PHYSICIAN ASSISTANT  
PROVISIONAL CERTIFICATE TO PRESCRIBE  
APPLICATION**

**Application fee: \$100.00; check or money order made payable to:  
Treasurer, State of Ohio**

*Mail completed application and fee to:  
State Medical Board of Ohio  
30 East Broad Street, 3<sup>rd</sup> Floor  
Columbus, Ohio 43215*

**SECTION 1 - APPLICANT INFORMATION**

**(Your Social Security Number is required to facilitate reporting to the Healthcare Integrity & Protection Databank (42 U.S.C. § 1320a-7e(b), 5 U.S.C. §522a, and 45 C.F.R. pt. 61) and for accurate identification under Ohio child support laws (§ 2301.373, O.R.C).)**

Name of Applicant (last, first, MI):

Certificate to Practice Number:

Social Security Number:

***Please indicate below if you want your home or business address to be used as your primary mailing address.***

Use my Home Address as the mailing address

Use my Business Address as the mailing address

Home Address:

City:

County:

State:

Zip Code:

Phone Number:

( )

Email Address:

Primary Business Address:

City:

County:

State:

Zip Code:

Office Phone Number:

( )

Office Fax Number:

( )

**SECTION 2 - EDUCATIONAL BACKGROUND**

Name of Institution:

Address of Institution:

City:

State, Zip Code:

Degree Received (Please Provide Transcript):

Date Received:

Name of Institution:

Address of Institution:

City:

State, Zip Code:

Degree Received (Please Provide Transcript):

Date Received:

**SECTION 3 – PHARMACOLOGY INSTRUCTION**

**Fill in each course provider name, date taken and the number of accredited contact hours received from this provider, including courses taken as part of your Masters program.**

**Enclose documentation of have completed pharmacology coursework not longer than three years prior to the date of this application. Acceptable documentation includes (1) a college/university transcript showing completion of an ARC-PA accredited program, and/or (2) a copy of certificate(s) evidencing the completion of continuing education approved for category I CME credit by AAPA or an institution or organization accredited to provide CME by the ACCME. For pharmacokinetic training, acceptable documentation also includes a copy of certificate(s) evidencing the completion of continuing education approved as an advanced instructional program in pharmacology by the Ohio Board of Nursing. Acceptable documentation of completion of 20 contact hours of clinical training includes the submission of a completed Form C.**

Course Provider:		
Course Name:		Number of Contact Hours:
Course Dates:	Start Date (Month/Day/Year):	Course End Date (Month/Day/Year):

Course Provider:		
Course Name:		Number of Contact Hours:
Course Dates:	Start Date (Month/Day/Year):	Course End Date (Month/Day/Year):

Course Provider:		
Course Name:		Number of Contact Hours:
Course Dates:	Start Date (Month/Day/Year):	Course End Date (Month/Day/Year):

Course Provider:		
Course Name:		Number of Contact Hours:
Course Dates:	Start Date (Month/Day/Year):	Course End Date (Month/Day/Year):

Course Provider:		
Course Name:		Number of Contact Hours:
Course Dates:	Start Date (Month/Day/Year):	Course End Date (Month/Day/Year):

**SECTION 4-AFFIDAVIT AND RELEASE OF APPLICANT  
COMPLETE AND SIGN THIS FORM IN THE PRESENCE OF A NOTARY PUBLIC**

I, \_\_\_\_\_, hereby certify under oath that I am the person named in this application for a provisional Physician Assistant Certificate to Prescribe in the State of Ohio; that all statements I have or shall make with respect thereto are true, that I am the original and lawful possessor and person named in the various forms and credentials furnished or to be furnished to this Board with respect to my application; and that all documents, forms, or copies thereof furnished or to be furnished with respect to my application are strictly true in every respect.

I acknowledge that I have read the instructions for all applicants and I have answered all questions in compliance with these instructions. I understand that the fee I submitted is not refundable or transferable.

I further state that by filing this application for a provisional Physician Assistant Certificate to Prescribe in the State of Ohio, I hereby authorize and consent to have an investigation made as to my moral character, professional reputation and fitness for registration as a Physician Assistant. I agree to give any further information which may be required in reference to my past record. I understand that I will not receive a copy of any reports or know their contents and I further understand that the contents of any investigative report will be privileged.

I further understand that failure to complete this application as requested by the Board within six months can be considered as abandonment of any request for a provisional Certificate to Prescribe and that any fee I submitted is not refundable or transferable.

I authorize and request every person, hospital, clinic, governmental agency (local, state, federal or foreign), court, association, institution, or law enforcement agency having control of any documents, records and other information pertaining to me to furnish to the State Medical Board of Ohio any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the State Medical Board of Ohio or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application, subsequent licensure or practice thereunder.

I hereby release, discharge, and exonerate the State Medical Board of Ohio, its agents or representatives, and any person furnishing information, from any and all liability of every nature and kind arising out of investigation made by the State Medical Board of Ohio. I authorize the State Medical Board of Ohio to release information, material, documents, orders or the like relating to me or to this application to any other governmental agency (local, state, federal or foreign); or to any hospital, nursing home, clinic, health maintenance organization, or similar institution, or to any professional association.

I further understand that consideration of this application is based on the truth of the statements and documents made or furnished in connection with it. If any of the statements are false, I may be permanently denied licensure a provisional Physician Assistant Certificate to Prescribe in Ohio.

<i>Signature of Applicant:</i>	<i>Date:</i>
<i>Notary public signature</i>	<i>Date commission expires:</i>
<i>Sworn to and subscribed before me this _____ of _____, 20____.</i>	<i>Notary seal:</i>



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## **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

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## **APPLICATION INSTRUCTIONS FORM B PHYSICIAN ASSISTANT PROVISIONAL CERTIFICATE TO PRESCRIBE VERIFICATION OF 20 CONTACT HOURS OF CLINICAL TRAINING IN PHARMACOLOGY AS REQUIRED IN SECTION 4730.46(C)(3)(B), O.R.C.**

Section **4730.46(C)(3)(b)** of the Ohio Revised Code, (O.R.C.), requires that a Physician Assistant complete a minimum of twenty contact hours of clinical training in pharmacology in order to be eligible to participate in a provisional period of physician-delegated prescriptive authority.

### **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 must complete section 1 of this form and forward it to the supervising physician(s) that is able to verify that you have completed the twenty contact hours in clinical pharmacology in order to be eligible to participate in a provisional period of physician-delegated prescriptive authority.

### **Section 2: To be completed by the supervising physician(s) who is able to verify the completion of twenty contact hours in clinical pharmacology in order for the Physician Assistant named in this application to be eligible to participate in a provisional period of physician-delegated prescriptive authority.**

The supervising physician(s) must complete section 2 of this form attesting to the time period that this Physician Assistant completed the twenty hours of clinical training in pharmacology as required under Section 4730.46(C)(3)(b) of the Ohio Revised Code.

Once the form(s) have been completed, they are to be returned directly to the State Medical Board of Ohio at the address on the form.

**FORM B**



**PHYSICIAN ASSISTANT  
PROVISIONAL CERTIFICATE TO PRESCRIBE  
VERIFICATION OF 20 HOURS OF CLINICAL PHARMACOLOGY  
AS REQUIRED UNDER SECTION 4730.46(C)(3)(b)  
OF THE OHIO REVISED CODE.**

*Mail completed form to:  
State Medical Board of Ohio  
30 East Broad Street, 3<sup>rd</sup> Floor  
Columbus, Ohio 43215*

Section **4730.46(C)(3)(b)** of the Ohio Revised Code, (O.R.C.), requires that a Physician Assistant complete a minimum of twenty contact hours of clinical training in pharmacology in order to be eligible to participate in a provisional period of physician-delegated prescriptive authority.

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

Physician Assistant

Full Name: \_\_\_\_\_

Certificate to

Practice Number: \_\_\_\_\_

**SECTION 2 – VERIFICATION OF 20 HOURS OF CLINICAL PHARMACOLOGY PRACTICE**  
(To be completed *by the physician* and sent directly to the Board at the above address)

Physician Name: \_\_\_\_\_ License Number: \_\_\_\_\_

State of Licensure: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Provide the dates below that you supervised, witnessed or had knowledge of the above named applicant engaging in twenty hours of clinical practice of pharmacology as a Physician Assistant: (attach separate sheets if further space is needed)

**Start**  
(Month/Day/Year): \_\_\_\_\_

**End**  
(Month/Day/Year): \_\_\_\_\_

I certify that the above named Physician Assistant did obtain twenty contact hours of clinical training in pharmacology as required under 4730.46(C)(3)(b) of the Ohio Revised Code, during the dates provided above.

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_