

## PHYSICIAN ASSISTANT SUPERVISION AGREEMENT APPLICATION

**\* For Practice Outside of a Health Care Facility Only \***

Mail application to:  
State Medical Board of Ohio  
30 East Broad Street, 3rd Floor  
Columbus, Ohio 43215

Supervising Physician Contact Information		
Supervising Physician Name (Last, First, Middle):		
Supervising Physician License Number:		
Official Mailing Address:		
City:	State:	ZIP Code:
Contact Person:	Phone:	
Email:		

Practice Location Information		
Practice Name:		
Address:		
City:	State:	ZIP Code:
Contact Person:	Phone:	
Email:		

**Supervisory Agreement Terms (Please Complete Questions A-D)**

(A) The responsibilities to be fulfilled by the physician in supervising the physician assistant:

(B) The responsibilities to be fulfilled by the physician assistant when performing services under the physician's supervision:

(C) Any limitations on the responsibilities to be fulfilled by the physician assistant:

(D) The circumstances under which the physician assistant is required to refer a patient to the supervising physician:

### Alternate Supervising Physician (If Applicable)

Alternate Supervising Physician Name (Last, First, Middle):

Alternate Supervising Physician License Number:

Business Mailing Address:

City:

State:

ZIP Code:

Contact Person:

Phone:

Email:

Supervising Physician Signature:

Date:

### Affidavit of Supervising Physician

**The above statements are complete and accurate to the best of my knowledge. I have read and understand Chapter 4730 of the Ohio Revised Code and the rules and regulations set forth by the State Medical Board of Ohio regarding Physician Assistants and that as a Supervising Physician I assume legal liability for the services provided by the Physician Assistant(s) that are under my supervision.**

**I acknowledge that before initiating supervision of one or more physician assistants, a physician shall enter into a supervision agreement with each physician assistant who will be supervised. A supervision agreement shall be kept in the records maintained by the supervising physician who entered into the agreement and the board may review the supervision agreement at any time for compliance.**

**I further agree that I will supervise any Physician Assistant(s) named in this application in accordance with the terms outlined in this application.**

Supervising Physician Signature:

Date:

**Physician Assistant Signature Sheet**

**I (we) have read and agree to abide by the terms listed in this application and to practice under the supervision of the supervising physician named below.**

Supervising Physician Name:

Physician Assistant Name:	License Number:
Signature:	Date:

Physician Assistant Name:	License Number:
Signature:	Date:

Physician Assistant Name:	License Number:
Signature:	Date:

Physician Assistant Name:	License Number:
Signature:	Date:

Physician Assistant Name:	License Number:
Signature:	Date:

Physician Assistant Name:	License Number:
Signature:	Date: