



ADDENDUM TO THE PHYSICIAN ASSISTANT SUPERVISION AGREEMENT APPLICATION

Mail completed application to:
State Medical Board of Ohio
ATTN: Physician Assistant Program Administrator
77 South High Street, 17th Floor
Columbus, Ohio 43215

APPLICATION INSTRUCTIONS

Complete this form if you have an existing Physician Assistant Supervision Agreement and want to add additional Physician Assistants to the Agreement. ***There is no fee for this application.***

PHYSICIAN ASSISTANT SIGNATURE SHEET

I (we) have read and agree to perform only those duties as outlined in the Physician Supervisory Plan, submitted by the undersigned Supervising Physician and as approved by the State Medical Board or the policies of the health care facility listed in the original application.

Physician Assistant Name (Please print):

Certificate to Practice Number:

Physician Assistant signature:

Date:

Physician Assistant Name (Please print):

Certificate to Practice Number:

Physician Assistant signature:

Date:

Physician Assistant Name (Please print):

Certificate to Practice Number:

Physician Assistant signature:

Date:

Physician Assistant Name (Please print):

Certificate to Practice Number:

Physician Assistant signature:

Date:

AFFIDAVIT OF SUPERVISING PHYSICIAN

I agree that I will supervise any physician assistant(s) listed in this "Addendum to the Physician Assistant Supervision Agreement" in accordance with Section 4730.21, Ohio Revised Code, upon approval of the State Medical Board.

Supervising Physician signature *Ohio License Number*

Date

Supervision Agreement Number: