

SUPERVISION DATA FORM

**IMPORTANT: THIS FORM MUST BE UPDATED BY THE PHYSICIAN ASSISTANT
AS A CONDITION OF PRACTICE**

Pursuant to s.458.347(7)(e) and s.459.022(7(d)), Florida Statutes, upon employment, a licensed Physician Assistant (PA) must notify the department in writing within 30 days after such employment **and after any subsequent changes in supervision**. Only physicians with a clear, active license may supervise a PA.

PHYSICIAN ASSISTANT DATA:

FL License #: PA <hr/>	Employment Start Date:
Prescribing # if applicable:	
Name: (Please print)	
Current Mailing Address:	
Home telephone #:	
E-mail Address: (Optional)	
Practice Location Name & Address:	
Practice telephone #:	
Satellite Location Name & Address:	
Satellite telephone #:	

PLEASE INDICATE BELOW THE REASON (S) FOR SUBMITTING THIS FORM:

Adding <input type="checkbox"/>	Deleting <input type="checkbox"/>	Primary Supervising Physician
Adding <input type="checkbox"/>	Deleting <input type="checkbox"/>	Alternate Supervising Physician
Adding <input type="checkbox"/>	Deleting <input type="checkbox"/>	Primary Practice Location
Adding <input type="checkbox"/>	Deleting <input type="checkbox"/>	Satellite Location(s)

SUPERVISING PHYSICIAN(S) DATA

(This page may be copied as necessary)

Pursuant to s.458.347(7)(e) and s.459.022(7(d)), Florida Statutes, upon employment, a licensed Physician Assistant (PA) must notify the department in writing within 30 days after such employment **or after any subsequent changes in the supervising physician(s)**. Only physicians with a clear, active license may supervise a PA.

**ADDING SUPERVISING PHYSICIAN(S)
TO BE COMPLETED BY THE PHYSICIAN ASSISTANT**

Name and License number of Supervising Physician(s) PLEASE PRINT	Specialty of Supervising Physician	Signature of Supervising Physician	Beginning Date of Supervision	Physician Assistant's initials
_____ ME or DO #				
_____ ME or DO #				
_____ ME or DO #				
_____ ME or DO #				
_____ ME or DO #				
_____ ME or DO #				

ATTENTION: The Physician Assistant is required to initial each named supervising physician in the boxes provided and mark through all blank spaces with an X.

All 3 pages of the Supervision Data Form must be submitted (**excluding sample page**)

Pursuant to s.458.347(7)(e) and s.459.022(7(d)), Florida Statutes, upon employment a licensed Physician Assistant (PA) must notify the department in writing within 30 days after such employment **and after any subsequent changes in supervision.** Only physicians with a clear, active license may supervise a PA.

**DELETING SUPERVISING PHYSICIAN(S)
TO BE COMPLETED BY THE PHYSICIAN ASSISTANT**

Name and License number of Supervising Physician(s) you are deleting. PLEASE PRINT	Effective Date	Physician Assistant's initials

ME or DO #		

ME or DO #		

ME or DO #		

ME or DO #		

DELETION OF PRACTICE / SATELLITE LOCATION(S)

ADDRESS OF LOCATION BEING DELETED	DELETION DATE

I affirm that these statements are true and correct and recognize that providing false information shall result in disciplinary action against my license or criminal penalties pursuant to §.456.072, 458.327, 458.331, 459.013, 459.015, 775.083, 775.084, F.S.

Signature of Physician Assistant _____

Date _____

Please submit the original and one copy of this form fully completed to the address below. The copy will be acknowledged, stamped with approval date by the Council office and returned to the physician assistant.

SAMPLE OF COMPLETED FORM

ADDING SUPERVISING PHYSICIAN(S)				
Name and License number of Supervising Physician(s) <small>PLEASE PRINT</small>	Specialty of Supervising Physician	Signature of Supervising Physician	Beginning Date of Supervision	Physician Assistant's initials
John Smith, M.D. <hr/> ME or DO # ME12345	Internal Medicine	<i>John Smith</i>	01/01/2006	
<hr/> ME or DO # X	X	X	X	X
DELETING SUPERVISING PHYSICIAN(S)				
Name and License number of Supervising Physician(s) you are deleting. <small>PLEASE PRINT</small>	Effective Date	Physician Assistant's initials		
Jane Doe, M.D. <hr/> ME or DO # ME54321	01/01/2006	<i>H.D.</i>		
<hr/> ME or DO # X	X	X		
DELETION OF PRACTICE / SATELLITE LOCATION(S)				
ADDRESS OF LOCATION BEING DELETED	EFFECTIVE DATE			
Hospital Medical Center, 123 University Blvd. Suite 101, Miami Florida 33123	01/01/2006			
REMINDER: FAILURE TO PROVIDE UPDATED LICENSURE INFORMATION WITHIN 30 DAYS OF THE OCCURRENCE SHALL RESULT IN DISCIPLINARY ACTION AGAINST YOUR LICENSE.				