

OKLAHOMA STATE BOARD OF
MEDICAL LICENSURE AND SUPERVISION
PO BOX 18256, OKLAHOMA CITY, OK 73154
(405) 962-1400

ALTERNATE SUPERVISING PHYSICIAN

EACH ALTERNATE SUPERVISING PHYSICIAN MUST COMPLETE AND SIGN ONE OF THESE FORMS. YOU MAY DUPLICATE THIS FORM AS NECESSARY. THE ALTERNATE SUPERVISING PHYSICIAN'S SPECIALTY AND SCOPE OF PRACTICE MUST BE THE SAME AS OR REASONABLY SIMILAR TO THE PRIMARY SUPERVISING PHYSICIAN'S SPECIALTY AND SCOPE OF PRACTICE.

IF NO ALTERNATE SUPERVISING PHYSICIAN IS DESIGNATED, THE PHYSICIAN ASSISTANT AND SUPERVISING PHYSICIAN MUST SIGN THE STATEMENT AT THE BOTTOM OF THIS PAGE.

Date (mm/dd/yy): _____

I, _____ License # _____ of _____, _____
Name of Alternate Supervising Physician (City) (State)

AGREE TO PROVIDE ALTERNATE SUPERVISION FOR _____
(Name of Physician Assistant)

PA Lic. # _____ IN THE ABSENCE OF _____
(Name of Primary Supervising Physician)

License # _____. I certify that my specialty is _____ and that my scope of practice is the same as or reasonably similar to the primary supervising physician's scope of practice.

Signature of Alternate Supervising Physician

Signature of Primary Supervising Physician

Signature of Physician Assistant

SUBSCRIBED AND SWORN TO BEFORE ME THIS _____ DAY OF _____, _____.

(SEAL)

Notary Public

MY COMMISSION EXPIRES (mm/dd/yy): _____

COMMISSION NUMBER: _____

IF NO ALTERNATE SUPERVISING PHYSICIAN IS DESIGNATED, WE CERTIFY THAT THE PHYSICIAN ASSISTANT WILL NOT PRACTICE IN THE ABSENCE OF NOR INDEPENDENTLY OF THE PRIMARY SUPERVISING PHYSICIAN.

Signature of the Physician Assistant

Signature of the Primary Supervising Physician

SUBSCRIBED AND SWORN TO BEFORE ME THIS _____ DAY OF _____, _____.

SEAL

Notary Public

MY COMMISSION EXPIRES (mm/dd/yy): _____

COMMISSION NUMBER: _____