

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE & SUPERVISION  
P. O. BOX 18256, OKLAHOMA CITY, OK 73154-0256  
(405) 962-1400  
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APPLICATION TO PRACTICE AS A PHYSICIAN ASSISTANT

(Please print or type. Use additional sheets if necessary.)

NAME OF PHYSICIAN ASSISTANT: \_\_\_\_\_ License No. \_\_\_\_\_

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

THE ABOVE NAMED PHYSICIAN ASSISTANT WILL BEGIN PRACTICE UNDER MY SUPERVISION ON \_\_\_/\_\_\_/\_\_\_\_. (NOTE: PRACTICE CANNOT BEGIN UNTIL RECEIPT OF BOARD APPROVAL) WE AGREE TO ABIDE BY THE RULES OF THE BOARD OF MEDICAL LICENSURE AND SUPERVISION. WE CERTIFY THAT THE PHYSICIAN ASSISTANT HAS PRIOR TRAINING IN AND IS KNOWLEDGEABLE OF THE INDICATIONS, CONTRAINDICATIONS, SIDE EFFECTS AND INTERACTIONS OF ALL MEDICATIONS HE/SHE SHALL TRANSMIT PRESCRIPTIONS FOR AND ORDER ON BEHALF OF THE SUPERVISING PHYSICIAN.

AS A SUPERVISING PHYSICIAN, YOU ARE RESPONSIBLE FOR THE HEALTH CARE SERVICES PROVIDED BY YOUR PA. YOU ARE ALSO RESPONSIBLE FOR PROVIDING PROPER SUPERVISION OF YOUR PA IN ACCORDANCE WITH THE PHYSICIAN ASSISTANT PRACTICE ACT AND REGULATIONS. YOU MUST GIVE PROMPT NOTICE TO THE BOARD AT THE TIME YOUR SUPERVISORY RELATIONSHIP ENDS. DISCIPLINARY ACTION MAY BE TAKEN AGAINST YOUR MEDICAL LICENSE FOR FAILURE TO PROPERLY SUPERVISE YOUR PHYSICIAN ASSISTANT.

NAME OF SUPERVISING PHYSICIAN: \_\_\_\_\_

Physician's Primary Practice Location: \_\_\_\_\_  
Street

\_\_\_\_\_(\_\_\_\_\_)\_\_\_\_\_  
City State Zip Code Telephone Number

Specialty: \_\_\_\_\_ License Number: \_\_\_\_\_

Physician/Physician Assistant Practice Setting (i.e. hospital, clinic, etc.) and address:

\_\_\_\_\_  
Facility Street

\_\_\_\_\_(\_\_\_\_\_)\_\_\_\_\_  
City State Zip Code Telephone Number

Additional Practice Locations: \_\_\_\_\_

\_\_\_\_\_

Description of the Scope of Practice of the Supervising Physician: \_\_\_\_\_

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Description of how the Physician Assistant will be utilized P.A.: \_\_\_\_\_

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Description of methods of supervising the P.A.: \_\_\_\_\_

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Is this a remote patient care setting (Title 59 O.S., Section 519.2)? (YES) (NO) If YES, please describe the times the supervising physician will be on site to supervise the physician assistant, the methods used to supervise the physician assistant when not on site, and the distance from and relationship to the supervising physician's primary practice site: \_\_\_\_\_

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By signing below, I acknowledge that I have received and read a copy of Subchapter 9 (Guidelines for the Utilization of Physician Assistants) and understand the extent of my responsibilities as a supervising physician. By applying for approval to supervise this PA, I represent to the Oklahoma State Board of Medical Licensure and Supervision that I have the necessary authority in this practice setting to assure compliance with the provisions of the Physician Assistant Practice Act and Regulations regardless of whether the Physician Assistant is actually employed or engaged by me.

\_\_\_\_\_  
Signature of Supervising Physician

\_\_\_\_\_  
Signature of Physician Assistant

Sworn to before me this date: \_\_\_\_\_

(SEAL)

\_\_\_\_\_  
Notary Public

Commission Number: \_\_\_\_\_

My commission expires: \_\_\_\_\_

## **SUBCHAPTER 9. GUIDELINES FOR THE UTILIZATION OF PHYSICIAN ASSISTANTS**

### Section

- 435:15-9-1. General responsibilities and obligations
- 435:15-9-2. Supervision
- 435:15-9-3. New patients
- 435:15-9-4. Setting
- 435:15-9-5. Understanding and variance from guidelines

[Source: Codified 5-26-94]

### **435:15-9-1. General responsibilities and obligations**

- (a) The physician assistant is an agent of a specific licensed physician or group of physicians. The physician assistant is licensed only to perform health care services as authorized by law under the supervision and at the direction of the responsible physician or group of physicians.
- (b) While licensure as a physician assistant under 59 O.S. 519 is the responsibility of the individual applicant, the approval to practice as a physician assistant is a joint act of the physician assistant and the responsible physician(s). This implies that each party agrees to the terms and provisions specified in the approval process.
- (c) It is recognized that there are an infinite variety of acts, tasks and functions that might be delegated to a physician assistant, and an infinite variety of settings and circumstances under which these services might be performed. The sections which follow represent an attempt by the Board to clarify its understanding of the obligations of the licensed physician and his/her physician assistant in several of the more common settings. This list is not intended to be all-inclusive but merely representative of the current thoughts and policies of the Board. These understandings are considered as having been accepted by the physician assistant and supervising physician unless otherwise described in the approval to practice.

[Source: Added at 10 Ok Reg 4377, eff 7-27-93 (emergency); Added at 11 Ok Reg 2331, eff 5-26-94; Amended at 15 Ok Reg 2022, eff 5-26-98; Amended at 16 Ok Reg 378, eff 10-6-98 (emergency); Amended at 16 Ok Reg 1214, eff 5-14-99; Amended at 19 Ok Reg 2303, eff 6-28-02]

### **435:15-9-2. Supervision**

- (a) Proper physician supervision of the physician assistant is essential. Supervision implies that the physician regularly and routinely reviews, and is involved in the health care services delivered by the physician assistant. Supervision also implies that the physician is directing the care delivered by the physician assistant. This may be done by establishing standards and protocols in advance of the care to be given, which the physician assistant will follow in delivering care; directly observing at the time the act or function is performed; or reviewing the care given through chart reviews and audits. While each type of supervision is important, the most essential aspect is that supervision is provided frequently and on an on-going basis. At the same time, it is important for the physician assistant to recognize his/her own limitations and to seek appropriate physician supervision and consultation whenever the physician assistant is unsure about a particular patient problem or treatment.
- (b) Physician supervision shall be conducted in accordance with the following standards:
  - (1) The supervising physician is responsible for the formulation or approval of all orders and protocols, whether standing orders, direct orders, or any other orders or protocols, which direct the delivery of health care services provided by a physician assistant, and periodically reviews such orders and protocols.
  - (2) The supervising physician regularly reviews the health care services provided by the physician assistant and any problems or complications encountered.
  - (3) The supervising physician is available physically or through direct telecommunications for consultation, assistance with medical emergencies or patient referral.
  - (4) The supervising physician is on-site to provide medical care to patients a minimum of one-half day per week. Additional on-site supervision may be required at the recommendation of the Committee and approved by the Board.

[Source: Added at 10 Ok Reg 4377, eff 7-27-93 (emergency); Added at 11 Ok Reg 2331, eff 5-26-94]

### **435:15-9-3. New patients**

- (a) One particular area of concern regarding physician supervision involves how to handle new patients who have not previously been seen by the supervising physician(s). In these cases, the patients are unfamiliar with and do not have an established relationship with the physician. This may lead to misunderstandings regarding the physician/physician assistant relationship and to the potential for legal problems if this relationship is not clarified.

(b) It is assumed by the Board that the physician will be actively involved in the initial care of any new patient seen in the practice. This means that, wherever possible, the physician will personally see the new patient at some point during the initial clinic visit. Where this is not possible, such as in remote patient care settings, the physician assistant shall make clear to the patient that he/she is a physician assistant and not a physician, and under whose supervision he/she is providing care. The physician assistant shall display identification on his or her person identifying him/herself as a "Physician Assistant" and shall keep his/her license available for inspection at the primary place of business. In addition, the patient shall be scheduled to see the physician at their next scheduled clinic appointment which shall conform to the following provision in law: "In patients with newly diagnosed chronic or complex illness, the physician assistant shall contact the supervising physician within forty-eight (48) hours of the physician assistant's initial examination or treatment, and schedule the patient for appropriate evaluation by the supervising physician as directed by the physician." [Title 59 O.S., Section 519.6(C)]

[Source: Added at 10 Ok Reg 4377, eff 7-27-93 (emergency); Added at 11 Ok Reg 2331, eff 5-26-94; Amended at 16 Ok Reg 378, eff 10-6-98 (emergency); Amended at 16 Ok Reg 1214, eff 5-14-99; Amended at 19 Ok Reg 2303, eff 6-28-02]

#### **435:15-9-4. Setting**

##### **(a) Office setting.**

(1) In office settings, it is assumed that the physician and the physician assistant function in the same clinical setting and that the physician is available to supervise and consult with the physician assistant about any matter in question, a point in the patient's history, an abnormal physical finding, etc. It is further assumed that the physician assistant immediately notifies the supervising physician of any medical emergency, patient complication or other patient problem encountered.

(2) It is assumed that the physician regularly and systematically checks the charts and notes of the patients seen by the physician assistant, checking for accuracy and completeness of such records, and in particular, the suitability of the plan of management. It is assumed that this type of review is conducted within 48 hours of the care being delivered. It is further assumed that the supervising physician reviews, at least on an annual basis, all existing protocols and orders governing the care given by the physician assistant. This review should be conducted on all protocols and orders for both the outpatient and inpatient settings.

(3) It is assumed that if the primary supervising physician is not available to supervise the physician assistant, another licensed physician, approved by the Board, will be available to provide such supervision. It is also assumed that there are established criteria covering those situations in which the physician must be consulted immediately, such as the patient with substernal chest pain, a child with a temperature over 104 degrees, a patient with severe abdominal pain and guarding, etc.

##### **(b) Hospital setting.**

(1) The physician assistant's functions in a hospital setting are regulated by the medical staff bylaws and regulations.

(2) The usual process is that the application for such privileges is filed by both the physician assistant and the supervising physician, reviewed for personal and professional qualifications by the credentials committee, and presented for approval to the medical staff. This process serves two purposes:

(A) Assuring the medical staff that the physician assistant meets professional and ethical standards.

(B) Publicizing the presence of the physician assistant to the medical staff and hospital administration.

(3) Initial workup of patients upon admission is often delegated to the physician assistant.

This is an appropriate function if checked and countersigned by the supervising physician on his/her next visit to the hospital, which should usually occur within 24 hours. These workups should meet the standards set for workups performed by the physician staff of the hospital. It is assumed that any abnormalities or other findings are validated by the physician, and that his/her countersignature indicates his/her agreement with the findings recorded by the physician assistant.

(4) Initial orders may be delegated to a physician assistant. These activities are very important in that they involve the function of others, such as the R.N. and L.P.N. assigned to the ward. Copies of all standing orders that the physician has delegated to the physician assistant to order on his/her behalf should be on file in the hospital and available to the nurse accepting such orders as a means of assurance that these orders are emanating from the responsible physician and that they are within the authority which the physician has delegated to the physician assistant. All orders should be checked and countersigned by the responsible physician at his/ her next visit to the hospital, which should usually occur within 24 hours.

(5) Examples of orders that a physician assistant can be authorized to issue for a patient include, but are not limited to:

(A) Status orders - indicating the condition of the patient and usually used by the hospital staff to regulate visitors, to transmit to callers, etc. (i.e. "condition fair").

(B) Activity orders - indicating the degree of restriction of position or activity of the patient (i.e. "complete bed rest").

(C) Diet and fluid orders - indicating the amount and type of food and/or oral fluids (i.e. "low salt diet", "1200 calorie ADA diet", "force fluids", etc.).

(D) Test and procedure orders - indicating those tests and procedures necessary for care of the patient (i.e. "urinalysis in am", "schedule for IV urogram", etc.).

(E) Ward Observation and Measurement Orders - indicating those procedures to be carried out by hospital staff personnel (i.e. "BP twice daily", "record I & O").

(F) Medication Orders - indicating those drugs that are to be given to the patient usually by the nursing staff assigned to administer medications (i.e. "ampicillin 250 mg capsules by mouth four times daily").

(6) A glance at (b)(5) of this section reveals the enormous range of orders that may be necessary for the diagnosis and treatment of the patient in the hospital setting. Some are "routine" and could be delegated with very little supervision. Others might need very close supervision. The

Board believes that a responsible physician might consider protocols of a "blanket type" covering those types of orders which would require less supervision. These might include orders of type (A), (B), (C), and (D) of (b)(5) of this section. Orders of type (E) of (b)(5) of this section might require more specification, but still may be of the blanket type. Medication orders from the list of drugs on the Oklahoma Physician Assistant Drug Formulary, Subchapter 11 of this Chapter, should also be included under the protocol.

(7) The protocol described in (6) of this subsection might take the form described in Appendix A of this Chapter.

(8) The protocol as listed in 435:15-9-4(b)(7) should cover the majority of those orders of a routine or "housekeeping" variety which are necessary for the efficient operation of a unit and for patient comfort, yet carrying little risk in case of error. Still other protocols could be written for specific clinical conditions that are frequently handled by the individual physician/physician assistant team. These protocols could be in the form of standard "sets" of orders for a given clinical diagnosis, such as a patient with an acute appendicitis, uncomplicated myocardial infarction, etc.

(9) There are also orders that must be written in an emergency to cover those rare but urgent situations arising in any hospital environment. These can never be adequately covered in a protocol, and the only advice which can be given is that the patient's interests must take precedence, and the physician assistant and other hospital personnel involved must work out each solution ad hoc. In all such cases, the physician must be contacted immediately and must personally take over the care of the patient as soon as possible.

(10) The physician assistant working in the hospital setting might be delegated any of a wide variety of procedures to be performed on patients under the care of the responsible physician. The delegation of these procedures implies that the physician is satisfied that the physician assistant has the requisite skill, and that the physician agrees with the technique and the safeguards under which the procedure is performed. The physician must not delegate tasks in which he/she is not capable of judging the quality of the skill and technique employed by the physician assistant.

(11) The physician assistant is often delegated the task of writing/dictating the discharge summary on patients under the care of the responsible physician. All such summaries should be carefully read and countersigned by the physician. The physician is reminded that this function is not only an excellent opportunity to review the case, but can also serve as an important review of the physician assistant's role in the hospital setting.

### (c) **Emergency room setting.**

(1) The physician assistant may utilize the emergency room in the course of assisting the physician in the care of patients. For example, a patient may call when the office is closed and, for convenience, the emergency room may be the place of meeting. Such occasional or incidental use is not considered as different from settings listed in (a) and (b) of this section. It is assumed that the activities will be supervised by the responsible physician and that the physician assistant has associate staff privileges to utilize the emergency room for such activities.

(2) The physician assistant may also be employed to work in an emergency room as a primary responsibility. There is ample documentation that a physician assistant can be very effectively and responsibly employed in this setting, but this should be carefully regulated by the facility.

(3) There are special problems in working as a physician assistant in the emergency room setting. The first is the fact that emergencies of a wide variety of severity may enter at any time, including multiple person disasters. Second, the patients are usually transient, with no previous relationship with the physician. They also usually come because of an unscheduled or unexpected illness or injury, and are more prone to be upset and/or hostile. These factors make the emergency room a frequent source of misunderstanding and litigation.

(4) The physician assistant in the emergency room setting must be clearly identified. When the physician assistant is working along side his/her supervising physician, the same understandings are assumed to exist as in the office setting. See 435:15-9-4(a).

(5) The Board is not opposed to the proper and responsible "semiautonomous" utilization of a physician assistant in emergency rooms. There are many small hospitals with such small medical staffs that full-time physician coverage in the emergency room is not possible. In these locations, the utilization of a well-trained physician assistant for

such coverage is justified toward the provision of good emergency services, just as the provision of well-trained emergency medical technicians has been an improvement over non-trained ambulance drivers.

(6) If this is the case, then the physician assistant should be the best-trained person possible, preferably with advanced training in emergency medicine (i.e. ACLS certification). The community should be well prepared by a public notice stressing the nature of the physician assistant's training and his/her relationship to area physicians. The physician coverage should be clearly specified and the responsibility clearly accepted by area physicians.

**(d) Nursing home and/or extended care facility.**

(1) The nursing home or similar long-term care facility shares some of the problems of the hospital, but has the advantage that there is less turnover of patients and the problems. Such facilities are suitable for the utilization of a physician assistant, either on a full-time or part-time basis, under proper physician supervision.

(2) As in the hospital setting, (b) of this section, the initial workup of newly admitted patients is often delegated to a physician assistant. If this is the case, these workups should meet the standards set for workups performed by a physician. It is assumed that all abnormalities are validated by the responsible physician at his/her next visit indicating agreement with the findings as recorded by the physician assistant.

(3) The writing of orders and the performance of procedures should be subject to the same rules and restrictions described for the hospital setting in (b) of this section.

**(e) Remote patient care settings.**

(1) In an effort to address the shortage of available health care services in rural and inner city areas, the Legislature has authorized the use of physician assistants in practice settings remote from their supervising physicians. These settings, if supervised properly, will assist in expanding health care to areas of Oklahoma previously underserved by existing resources. However, they do require special consideration and constant interaction by both the physician assistant and the physician to assure that good quality medical care is delivered.

(2) It is recognized in remote patient care settings that the physician and the physician assistant are geographically separated during a majority of the time that the physician assistant is delivering patient care. However, the Board assumes that the physician and physician assistant are in frequent contact by telephone or other means of telecommunication whenever the remote site is delivering care to patients, and not just at times when a problem or question arises. The Board further assumes that the physician and physician assistant have practiced together a sufficient period of time to establish a close working relationship in order for the physician assistant to fully understand the physician's standards of care and requirements for consultation on any patient problem seen in the facility.

(3) Remote patient care settings also require an advanced level of knowledge and skills on the part of the physician assistant. This additional knowledge and skill must be documented to the Board in the approval to practice and should include experience in delivering a comprehensive range of care in a non-remote practice setting as well as additional training in emergency medicine procedures.

(4) The supervising physician must also recognize his/her additional role and responsibilities in utilizing a physician assistant in a remote patient care setting. The physician must always be immediately and easily available for consultation on patient problems and willing to personally see any patient upon request from the physician assistant. Further, the physician must exercise close and careful review of the care being delivered in such sites with frequent review of patient protocols, orders and chart entries.

(5) Finally, the Board requires that all remote patient care settings shall have, in writing and signed by the physician, policies which govern the delivery of care of most common illness/injuries likely to be seen in these settings. These policies shall include the historical and physical exam findings, laboratory and other diagnostic test findings, and the plan of treatment and follow-up necessary for each of the conditions defined. The Board further assumes that any patient problem seen in these facilities which is not covered by an existing written policy will be discussed with and the treatment plan decided by the physician at the time of the patient's visit to the facility.

**(f) Anesthesia setting.**

(1) The physician assistant may perform pre- and post-procedural assessment of patients in accordance with guidelines established by the supervising physician.

(2) Physician assistants may administer topical anesthetics, local infiltration, or digital blocks. Physician assistants may administer wrist and ankle nerve blocks under the direct supervision of the supervising physician and following approval by the credentialing committee of the facility.

(3) Physician assistants may not administer general anesthesia.

(4) Physician assistants may administer intravenous sedation analgesia as defined in the current *Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists* of the American Society of Anesthesiologists. Administration of intravenous sedation analgesia by physician assistants must be performed

under the direct supervision of the supervising physician. Specific education and training is required and must be documented and approved by the credentialing committee of the facility.

[Source: Added at 10 Ok Reg 4377, eff 7-27-93 (emergency); Added at 11 Ok Reg 2331, eff 5-26-94; Amended at 16 Ok Reg 378, eff 10-6-98 (emergency); Amended at 16 Ok Reg 1214, eff 5-14-99; Amended at 19 Ok Reg 2303, eff 6-28-02; Amended at 19 Ok Reg 2995, eff 8-19-02 (emergency); Amended at 20 Ok Reg 973, eff 5-21-03]

#### **435:15-9-5. Understanding and variance from guidelines**

(a) The Board assumes that the physician and physician assistant are in agreement with the principles contained in this subchapter, and are completely familiar with the law and rules governing the use of physician assistants. The Board also assumes that any differences from the guidelines in this subchapter are fully explained in the approval to practice on file with the Board that describes the individual practice profile requested for the physician assistant. This profile also contains specific data that will enable the Board to evaluate the degree to which the practice conforms to these assumptions.

(b) The Board also invites inquiry, if needed, for clarification of specific details. The Board reminds both the physician and physician assistant that the approval to practice is under the aegis of the licensed physician, and that the Board's ultimate recourse in case of violation of any agreements under such approval lies in the restriction or removal, after due process, of the physician's license to practice medicine and the physician assistant's license to practice as a physician assistant in Oklahoma.