Minutes

The Physician Assistant Advisory Committee of the Oklahoma Board of Medical Licensure and Supervision met on April 14, 2016, in accordance with the Open Meeting Act. The meeting was held at the office of the Board, 101 NE 51st Street, Oklahoma City, Oklahoma. Advance notice of this regularly scheduled meeting was transmitted to the Oklahoma Secretary of State on October 1, 2015 and posted on the Board's website on April 12, 2016. The notice and agenda were posted in prominent public view on the front doors of the Oklahoma Board of Medical Licensure and Supervision building located at 101 NE 51st Street, Oklahoma City, Oklahoma on April 12, 2016, at 4:00 p.m.

Members present were:
- Don Flinn, PA, Acting Chair
- Gerald Wootan, DO
- Anthony Sharp, MHS, PA-C
- Lindsey Gillispie, PA
- Shannon Ijams, MPAS, PA-C - OU-Tulsa, Program Director
- Todd Doran, EdD, PA-C – OUHSC-OKC, Program Director
- Dan McNeill, PhD, PA-C – OCU, Program Director

Members absent were:
- Charles Womack, MD, Chair
- Riaz Sirajuddin, MD
- Dennis Carter, DO

Others present included:
- Lyle R. Kelsey, Executive Director
- Reji T. Varghese, Deputy Executive Director
- Barbara J. Smith, Executive Secretary
- Teresa Mitchell, Director of Licensing
- Kenna Shaw, Licensing Administrative Technician
- Tiffany Wythe, AAG, Committee Advisory

Having noted a quorum, Don Flinn called the meeting to order at 3:01 p.m. Mr. Flinn agreed to serve as Chair for this meeting due to an unforeseen scheduling conflict of Charles Womack, MD, Committee Chairman.

After Committee review, Mr. Doran moved to approve the Minutes of January 7, 2016 as written. Ms. Gillispie seconded the motion and the vote was unanimous in the affirmative.

**STEPHANIE MARTINDALE** appeared in support of her incomplete application for reinstatement of Physician Assistant licensure. Ms. Martindale stated she last practiced in May of 2013 and her license lapsed in 2015 while she stayed home with her children. She is not
currently certified through the National Commission on Certification of Physician Assistants ("NCCPA"), but has plans to renew her certification in the summer of 2016. Ms. Martindale stated she will have to show proof of continuing medical education hours in order to become recertified. She took the Physician Assistant National Recertifying Examination ("PANRE") five or six years ago and has not yet applied to sit for the recertification exam because she believes she is current. Applicant has no continuing medical education hours for 2016, but has twenty (20) hours for 2014 and twenty (20) hours for 2015. Her current practice plans are to work part-time for Integris Health in its Employee Health Department. Mr. Doran moved to deny this application pending completion of the file and Applicant demonstrating that she is current on continuing medical education hours and becoming recertified through NCCPA. Ms. Gillispie seconded the motion. The Committee discussed that an applicant does not need to be nationally certified in order to be eligible for licensure reinstatement. It was further discussed that Applicant’s license expired in March of 2015 and she has over fifteen (15) years of PA experience including working at Johns Hopkins in critical care. The vote on Mr. Doran’s motion is recorded below:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Don Flinn, PA:</td>
<td>No</td>
</tr>
<tr>
<td>Gerald Wootan, DO:</td>
<td>No</td>
</tr>
<tr>
<td>Anthony Sharp, MHS, PA-C:</td>
<td>No</td>
</tr>
<tr>
<td>Lindsey Gillispie, PA:</td>
<td>No</td>
</tr>
<tr>
<td>Shannon Ijams, MPAS, PA-C:</td>
<td>No</td>
</tr>
<tr>
<td>Todd Doran, EdD, PA-C:</td>
<td>Yes</td>
</tr>
<tr>
<td>Dan McNeill, PhD, PA-C:</td>
<td>No</td>
</tr>
</tbody>
</table>

The motion failed.

Mr. McNeill moved to recommend approval of reinstatement of Applicant’s Physician Assistant licensure pending completion of the file. Ms. Gillispie seconded the motion and the vote is recorded below.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Don Flinn, PA:</td>
<td>Yes</td>
</tr>
<tr>
<td>Gerald Wootan, DO:</td>
<td>Yes</td>
</tr>
<tr>
<td>Anthony Sharp, MHS, PA-C:</td>
<td>Yes</td>
</tr>
<tr>
<td>Lindsey Gillispie, PA:</td>
<td>Yes</td>
</tr>
<tr>
<td>Shannon Ijams, MPAS, PA-C:</td>
<td>Yes</td>
</tr>
<tr>
<td>Todd Doran, EdD, PA-C:</td>
<td>No</td>
</tr>
<tr>
<td>Dan McNeill, PhD, PA-C:</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The motion carried. The Committee encouraged Ms. Martindale to become recertified by NCCPA, but again stated it is not a requirement for reinstatement of licensure.

Next, the Committee reviewed applications for licensure. Ms. Gillispie moved to recommend approval of the following complete applications for Physician Assistant licensure. Ms. Ijams seconded the motion and the vote was unanimous in the affirmative.
During Committee review of the incomplete applications for Physician Assistant licensure, Mr. Doran stated that Applicant KEVIN EDWIN BEAVER has not passed the national exam as shown in his paperwork and further advised that Mr. Beaver was scheduled to take the national exam a second time. Mr. Doran directed Licensing Staff to follow up with the National Commission on Certification of Physician Assistants ("NCCPA") to determine why a passing score was misreported to Licensing Staff in this regard.

Further discussion was had regarding the application materials provided for EMILIA VELMA IVANS and the potential for expanded knowledge that may be had by Mr. Doran in his role as a Program Director. Ms. Wythe stated that Mr. Doran should recuse himself in this case since he may potentially be privy to information that is not available to the other Committee members. Because of this expanded knowledge, there is the potential for Program Directors to swing the vote on licensure by sharing such information with other Committee members. Mr. Lyle Kelsey, Executive Director, agreed with Ms. Wythe's opinion and stated that he believes situations such as this merit a recusal.

*Mr. Doran recused and left the meeting.

Mr. McNeill moved to recommend approval of the incomplete application for Physician Assistant licensure pending completion of the file of EMILIA VELMA IVANS. Ms. Gillispie seconded the motion and the vote was unanimous in the affirmative.

*Mr. Doran re-joined the meeting.

Mr. McNeill moved to recommend approval of the following incomplete applications for Physician Assistant licensure pending completion of the file. Ms. Ijams seconded the motion and the vote is recorded below.

<table>
<thead>
<tr>
<th>BUTLER, CHASITY JANE</th>
<th>SMITH, KENNA LEE</th>
</tr>
</thead>
<tbody>
<tr>
<td>EWER, MINDY DIANE</td>
<td>SPAHN, AMANDA LEAH</td>
</tr>
<tr>
<td>FELL, JULIA KATHLEEN</td>
<td>WITMER, RACHEL</td>
</tr>
<tr>
<td>KING, ANGELA NICOLE</td>
<td>YARBOROUGH, ERIN C</td>
</tr>
<tr>
<td>PARKER, CAROLINE KEHR</td>
<td>MARR, DREW J.</td>
</tr>
<tr>
<td>SALIBA, MEGHAN ELISE</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ARCHER-COOPER, ELIZABETH JANE</th>
<th>HARPER, KELLY R</th>
</tr>
</thead>
<tbody>
<tr>
<td>BEAVER, KEVIN EDWIN</td>
<td>LUMPKIN, JOSHUA</td>
</tr>
<tr>
<td>CALDWELL, AMANDA</td>
<td>MCGORDON, SHAINA LINELL</td>
</tr>
<tr>
<td>DARGAN, PATRICK</td>
<td>MCGOWEN, AUDREY GRACE</td>
</tr>
<tr>
<td>DAU, KY M</td>
<td>OLIVO, KRISTY MARIE</td>
</tr>
<tr>
<td>FELARCA, CHRISTINA M</td>
<td>SHERRY, ALEX SCOTT</td>
</tr>
<tr>
<td>GARCIA, EDUARDO</td>
<td>TRAN, VY A</td>
</tr>
<tr>
<td>GREEN, AMBRE JAMARRA</td>
<td></td>
</tr>
</tbody>
</table>
Don Flinn, PA:    Yes
Gerald Wootan, DO:   Yes
Anthony Sharp, MHS, PA-C:  Yes
Lindsey Gillispie, PA:    Yes
Shannon Ijams, MPAS, PA-C:  Yes
Todd Doran, EdD, PA-C:    Abstain
Dan McNeill, PhD, PA-C:    Yes

The motion carried.

Mr. McNeill moved to recommend approval of the complete application of **CRYSTAL JONES HENSLEY** for reinstatement of Physician Assistant licensure. Ms. Gillispie seconded the motion and the vote was unanimous in the affirmative.

Mr. McNeill moved to recommend approval of the Physician Assistant Transfer List (PA7). Dr. Wootan seconded the motion and the vote is recorded below.

<table>
<thead>
<tr>
<th>Name</th>
<th>Vote</th>
</tr>
</thead>
<tbody>
<tr>
<td>Don Flinn, PA:</td>
<td>Yes</td>
</tr>
<tr>
<td>Gerald Wootan, DO:</td>
<td>Yes</td>
</tr>
<tr>
<td>Anthony Sharp, MHS, PA-C:</td>
<td>Yes</td>
</tr>
<tr>
<td>Lindsey Gillispie, PA:</td>
<td>Yes</td>
</tr>
<tr>
<td>Shannon Ijams, MPAS, PA-C:</td>
<td>Abstain</td>
</tr>
<tr>
<td>Todd Doran, EdD, PA-C:</td>
<td>Yes</td>
</tr>
<tr>
<td>Dan McNeill, PhD, PA-C:</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The motion carried.  *(See Attachment #1)*

Dr. Wootan moved to recommend approval of the Physician Assistant Additional Position List (PA1). Ms. Gillispie seconded the motion and the vote was unanimous in the affirmative.  *(See Attachment #2)*

Next, the Committee heard from Mr. Reji Varghese and Mr. Todd Doran regarding potential revisions to the current Form 5 as it pertains to telemedicine. Upon review, Ms. Wythe objected to rule language contained therein as it was not the current rule, but the proposed rule. Ms. Wythe stated that until the rule is actually changed, the rule as currently stated needs to be presented. Ms. Wythe wanted to make it clear that what is contained on the form as 435:15-9-2-(b)(3) is not current rule language. Mr. Varghese stated that eventually Form 5 will be available for electronic submission. He also hopes to remove the notary requirement and be able to track percentages of Form 5 supervisions. Mr. Varghese stated he is working with Jason Seay, Assistant Attorney General, to review the revised Form 5 from a legal standpoint. The Committee thanked Executive Staff and the I.T. Department for their work on the form. Ms. Gillispie moved to approve the revised Form 5 with Ms. Wythe's
recommended corrections. Mr. McNeill seconded the motion and the vote was unanimous in the affirmative. *(See Attachment #3)*

The next item on the Agenda was placed at the request of Mr. McNeill, which was a discussion item regarding Oklahoma-licensed Physician Assistants ("PAs") who work at Federal facilities. Mr. McNeill asked Sheila Walker, PA, to make a presentation in this regard. Ms. Walker stated she has been employed by the Veteran's Administration since 2008. She told the Committee that PAs who work as Federal employees are required to have a license from any state and to be certified by the National Commission on Certification of Physician Assistants ("NCCPA"). The Federal Practice Act defines employment, scope of practice and documentation. Because a PA working in a Federal domain is not required to be licensed in the state in which they practice, that puts the PA outside of Oklahoma's jurisdiction. Part of the licensing process involves connecting a PA with a supervising physician which can sometimes be problematic in a Federal facility. Ms. Walker asked that consideration be made for a form modification to include a place to delineate practicing in a Federal facility. Ms. Walker also indicated that if her alternate supervising physicians are not all licensed in Oklahoma, she cannot properly complete the form as it is now. She indicated that for Oklahoma-licensed PAs who are employed in a Federal capacity, the Medical Board website shows that PA as "not active" or "not licensed." Ms. Walker stated the website is a barrier as it is indistinct if a licensee pursues credentialing. Mr. Varghese stated if the licensee holds a current license and has paid their fees, the website will say "not practicing," but it will not say "not active" or "not licensed." Mr. Kelsey stated that if an Oklahoma-licensed PA who is working in the Veteran's Administration or Indian Health Services has a violation that could impact their practice, there is a question over jurisdiction as it relates to that license. Ms. Walker stated she would like to see our website be more distinct on Federally-employed PAs who are licensed in Oklahoma. She also requested a modification on the form to delineate if a licensee is working in a Federal facility. Her final issue is the potential problem that could occur if she is an Oklahoma-licensed PA, but her supervising physician is not licensed in Oklahoma. Mr. Doran suggested that Ms. Walker work with the Committee Chairman and Executive Director in putting together language for a proposal to be reviewed at the next meeting.

Ms. Gillispie moved to adjourn the meeting. Dr. Wootan seconded the motion and the vote was unanimous in the affirmative. The meeting was adjourned at 4:17 p.m.
Physician Assistant Advisory Committee
PA7 – Transfer List

BULLARD, ROBERT LEE
ELLIOTT, ROGER ALAN
GRAVES, VALORIE JEAN
JORDAN, TERI LYNN
GROVER, NILA DEVONA
TAYLOR, MARYLN SUE
STEELE, LORI FLETCHER
LYLE, AUSTIN ALEXANDER
BENNETT, JOSEPH SINCLAIR
EVANS, MARK ANTHONY
BIVENS, ELIZABETH EDITH
STOCK, ELAINE EDITH
WALKER, ALIA MELISSA
MARLOW, TIMOTHY KEVIN
IJAMS, SHANNON DENISE
CUMMINGS, DEANNA JOHNSTON
SAFFA, TAMME MARIE
MCCOMBS, JOHN RANDALL
LABRIO, DEBORAH DENICE
BENTON, MICHAEL JON
RISLEY, AMY BETH
WHATLEY, STEPHANIE ARLENE
Peevy, Robert Earl
HILL, COLIN GEOFFREY
FARROW, DEMETRIOUS
JOHNSON, KYLE ERICK
DOHLMAN, MATTHEW BRETT
PURVINE, AMBER DAWN
AAFEDT, SARAH DAWN
WAPLES, ANGELA LYNNE
BREEDEN, CANDICE RAE
WADLEY, CORI ELENA
ACKERMAN, AUTUMN RENAE
HOFIELD, MEGAN CATHERINE
MARTIN, REX EDWARD
GORDON, RANDY PAUL
COCHRAN, KARI LYNN
PINSON, SARAH BROOKE
TIGER, BRANDY S
LAFAYE, SALLEFERN
RANDALL, CARRIE LINDA
BOLING, KIMBERLY ANNE
STACHMUS, AMBER DAWN
ROGERS, WILLIAM ARTHUR
MESSER, HALEY JOYCE
KELLEY, MARGARET PORTER
MEeks, JEFFREY ROBERT
BARNETT, PETER MICHAEL
CLORAN, SHAILYNNE ESTELLE
DUM, ERIN MICHELLE
HELMS, CHRISTINA MICHELLE
JENKINS, CHELSEA RENE
PECK, KRISTIN MARIE
RUBINSTEIN, JESSICA DAWN
PHILLIPS, WHITNEY JEANNE
STRAHORN, BRANDI LEIGH
HOLLEY, STEVIE MARIE WHITE
BOHANNON, QUINQON T
FILES, ROBERT TRACY
HALL, PATRICIA LYNN
FORD, KELLEY LEE
BLOME, KELSEY PAIGE

TFF/ JESS ROY, DO 3989
TFF/ JOE BASINGER, MD 21113
TFF/ ROBERT SPENCER, MD 23186
TFF/ VIRGINIA HELLER, MD 18981
TFF/ SUSAN BEESON, DO 3105
TFF/ DEmille MADoux, MD 15810
TFF/ SCOTT COLE MD, 27620
TFF/ AHMAD AGHA, MD 11766
TFF/ DAVID CAMPBELL, DO 4465
TFF/ JOHN ROOT, MD 20046
TFF/ WILLIAM WELDON, MD 18917
TFF/ CHANDINI SHARMA, MD 24955
TFF/ ROBERT NOWLIN, MD 15751
TFF/ DIANNE ADAMS, DO 5006
TFF/ L. JANELLE WHITT, DO 3610
TFF/ PAUL PLOWMAN, MD 23548
TFF/ JIMMIE MCADAMS, DO 2634
TFF/ COLE LUNDQUIST MD 30901
TFF/ LONNIE LITCHFIELD, MD 19449
TFF/ JOHN SEGUGIN, MD 19008
TFF/ KRISTOPHER AVANT, DO 4499
TFF/ DUSTIN BAYLOR, MD 24652
TFF/ ROBERT PEEVY DO 5903
TFF/ CHARLES OGLE, DO 2645
TFF/ ROBERT MITCHELL, MD 22998
TFF/ GREG FAIRLIE, DO 3850
TFF/ COLE LUNDQUIST, MD 30901
TFF/ NAEEM TAHIRKHIL, MD 19422
TFF/ KHALIL SALIBA, MD 21634
TFF/ JAMES BOND, MD 21989
TFF/ ELENA WOODSON, MD 31155
TFF/ KEVIN CONASTER DO 3562
TFF/ L. JANELLE WHITT, DO 3610
TFF/ DANIEL HARRIS, MD 23380
TFF/ BARRETT BRADT, MD 29420
TFF/ GREGORY DENNIS, DO 4513
TFF/ THOMAS OSBORNE, DO 2188
TFF/ MARX BRANDENBURG, MD 18449
TFF/ BILLY BEETS, MD 21208
TFF/ RICHARD HELTON DO, 2096
TFF/ DAVID CAMPBELL, DO 4465
TFF/ DENNIS STAGGS, DO 2212
TFF/ Darryl ROBINSON, MD 22361
TFF/ SCHUYLER STEELBERG, MD 21125
TFF/ KAAS WIERENGA, MD 26999
TFF/ BRYAN MARSH, MD 19507
TFF/ SCOTT FELTEN, MD 26083
TFF/ STEPHEN HARSHIN, MD 17845
TFF/ BRETT BRALY, MD 30393
TFF/ DAVID DYE, MD 16529
TFF/ DAVID WILSON MD 22903
TFF/ JEROME MCTAGUE, MD 30495
TFF/ ELLE ZANETAKIS, MD 16096
TFF/ SARAH-ANNE SCHUMANN, MD 28564
TFF/ ERICK VANDELL, MD 30537
TFF/ KELLY DERRICK, DO 5489
TFF/ STEVEN NUSBAUM, DO 3826
TFF/ BARBARA TULEY, MD 17220
TFF/ MARCELLA JONES, DO 5877
TFF/ RACHELLE DAVIS, DO 4241
TFF/ CAROL GAMBRILL, DO 4636
TFF/ MARCELLA JONES, DO 5877

April 14, 2016
<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>TANNER, ANITA LOUISE</td>
<td>ADDTL POS WIDWAYNE ROUSH, MD 19836</td>
</tr>
<tr>
<td>QUALS, STEVEN DALE</td>
<td>ADDTL POS W CHARLES GARriott, DO 5168</td>
</tr>
<tr>
<td>KYTLE, KAREN SUZANNE</td>
<td>ADDTL POS WI GUY PETErson, DO 4944</td>
</tr>
<tr>
<td>GRECO, AMY COHLMIA</td>
<td>ADDTL POS WJ ROBERT RADER, MD 21263</td>
</tr>
<tr>
<td>CARLTON, BRUCE SCOT</td>
<td>ADDTL POS WI JEFFREY SHUART, MD 18498</td>
</tr>
<tr>
<td>NICHOLS, CHAD LEE</td>
<td>ADDTL POS WI JOSEPH BROOME, MD 23006</td>
</tr>
<tr>
<td>ZYBACH, NIKKI SUE</td>
<td>ADDTL POS WI JEFFREY SHUART, MD 18498</td>
</tr>
<tr>
<td>PEEVY, ROBERT EARL</td>
<td>ADDTL POS WI JEFFREY SHUART, MD 18498</td>
</tr>
<tr>
<td>LAVICTOIRE, SUSAN LENORA</td>
<td>ADDTL POS W CHARLES GARriott, DO 5168</td>
</tr>
<tr>
<td>SANFORD, JAIME ANN</td>
<td>ADDTL POS WMike GonCe, MD 17330</td>
</tr>
<tr>
<td>SCALF, MICHAEL SHAWN</td>
<td>ADDTL POS W JEFFREY PORRAS MD 23554</td>
</tr>
<tr>
<td>HART, JOANNA LEE</td>
<td>ADDTL POS W CHARLES GARriott, DO 5168</td>
</tr>
<tr>
<td>HICKMAN, JEFFERY CHARLES</td>
<td>ADDTL POS WMike ONATHY WARREn, DO 2228</td>
</tr>
<tr>
<td>TENPENNY, KRISTOPHER</td>
<td>ADDTL POS W CHARLES GARriott, DO 5168</td>
</tr>
<tr>
<td>MORRIS, JANA NIKOLE</td>
<td>ADDTL POS W CHARLES GARriott, DO 5168</td>
</tr>
<tr>
<td>VERBICK, JENNIFER KRANZ</td>
<td>ADDTL POS W CHARLES GARriott, DO 5168</td>
</tr>
<tr>
<td>HELD, REAGAN LEE</td>
<td>ADDTL POS W CHARLES GARriott, DO 5168</td>
</tr>
<tr>
<td>ILIFF, SUZANNE AMANDA</td>
<td>ADDTL POS W CHARLES GARriott, DO 5168</td>
</tr>
<tr>
<td>PHAM, NGOC MINH</td>
<td>ADDTL POS W CHARLES GARriott, DO 5168</td>
</tr>
<tr>
<td>KAY, ANNA MAE MARIE</td>
<td>ADDTL POS W CHARLES GARriott, DO 5168</td>
</tr>
<tr>
<td>ARMS, TODD DAVID</td>
<td>ADDTL POS W CHARLES GARriott, DO 5168</td>
</tr>
<tr>
<td>NOEL, STEPHANIE MARIE</td>
<td>ADDTL POS W CHARLES GARriott, DO 5168</td>
</tr>
<tr>
<td>ROGERS, WILLIAM ARTHUR</td>
<td>ADDTL POS W CHARLES GARriott, DO 5168</td>
</tr>
<tr>
<td>MURRAY, NATHAN DANIEL</td>
<td>ADDTL POS W CHARLES GARriott, DO 5168</td>
</tr>
<tr>
<td>SALAMY-SULLINS, VICTORIA J</td>
<td>ADDTL POS W CHARLES GARriott, DO 5168</td>
</tr>
<tr>
<td>HANSON, RICHARD EMINNIS</td>
<td>ADDTL POS W CHARLES GARriott, DO 5168</td>
</tr>
<tr>
<td>CHAPMAN, BARBARA MICHELLE</td>
<td>ADDTL POS W CHARLES GARriott, DO 5168</td>
</tr>
<tr>
<td>STAFFORD, KELLEY KRISTEEN</td>
<td>ADDTL POS W CHARLES GARriott, DO 5168</td>
</tr>
<tr>
<td>FARMER, ASHLEY GAIL</td>
<td>ADDTL POS W CHARLES GARriott, DO 5168</td>
</tr>
<tr>
<td>BODINE, AMANDA</td>
<td>ADDTL POS W CHARLES GARriott, DO 5168</td>
</tr>
<tr>
<td>SPELLS, AARON</td>
<td>ADDTL POS W CHARLES GARriott, DO 5168</td>
</tr>
<tr>
<td>ACKLIN, LAUREN FAITH</td>
<td>ADDTL POS W CHARLES GARriott, DO 5168</td>
</tr>
<tr>
<td>ITEN, MICHAEL JEROME</td>
<td>ADDTL POS W CHARLES GARriott, DO 5168</td>
</tr>
<tr>
<td>SCHUSTER, LINDSEY</td>
<td>ADDTL POS W CHARLES GARriott, DO 5168</td>
</tr>
<tr>
<td>FITE, NATHAN WAYNE</td>
<td>ADDTL POS W CHARLES GARriott, DO 5168</td>
</tr>
<tr>
<td>BLAKEMAN, AMBER R</td>
<td>ADDTL POS W CHARLES GARriott, DO 5168</td>
</tr>
<tr>
<td>SHANAKI, SAURA CHARLENE</td>
<td>ADDTL POS W CHARLES GARriott, DO 5168</td>
</tr>
<tr>
<td>WALKER, KELLY LEA</td>
<td>ADDTL POS W CHARLES GARriott, DO 5168</td>
</tr>
<tr>
<td>BRAZIEL, JERRY</td>
<td>ADDTL POS W CHARLES GARriott, DO 5168</td>
</tr>
<tr>
<td>KING, ANGELA RENEE</td>
<td>ADDTL POS W CHARLES GARriott, DO 5168</td>
</tr>
<tr>
<td>KELLINGTON II, ROBERT WILLIAM</td>
<td>ADDTL POS W CHARLES GARriott, DO 5168</td>
</tr>
<tr>
<td>MYERS, JAYME JAE</td>
<td>ADDTL POS W CHARLES GARriott, DO 5168</td>
</tr>
<tr>
<td>JAHANGIR, FARZANA</td>
<td>ADDTL POS W CHARLES GARriott, DO 5168</td>
</tr>
<tr>
<td>GREY, LESLIE CARYN</td>
<td>ADDTL POS W CHARLES GARriott, DO 5168</td>
</tr>
<tr>
<td>QUINN, MARIANNE ELIZABETH</td>
<td>ADDTL POS W CHARLES GARriott, DO 5168</td>
</tr>
<tr>
<td>ROBBINS, HOPE MARIE</td>
<td>ADDTL POS W CHARLES GARriott, DO 5168</td>
</tr>
<tr>
<td>GREWELL, PAIGE ELIZABETH</td>
<td>ADDTL POS W CHARLES GARriott, DO 5168</td>
</tr>
<tr>
<td>CARLTON, BRUCE SCOT</td>
<td>ADDTL POS W CHARLES GARriott, DO 5168</td>
</tr>
</tbody>
</table>
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: ____________________________
__________________________________________________________
City State Zip Code Telephone Number
Specialty: ______________________ License Number: ____________

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

__________________________________________________________
City State Zip Code Telephone Number

Additional Practice Locations: __________________________________
Description of the Scope of Practice of the Supervising Physician:

Supervision setting:  ○ Onsite  ○ Onsite & Telemedicine  ○ By Telemedicine Only

Description of how the Physician Assistant will be utilized:

Description of methods and frequency of supervising the P.A.:

For PA: By signing below, I acknowledge that my scope of practice is the same as the primary supervising physician’s scope of practice.

For Physician: 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: __________________________

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 ongoing 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.

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 for 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 staff that full-time physician coverage in the emergency room is not possible. In these situations, 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.

(c) 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-. 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.