

Minutes

The Physician Assistant Advisory Committee of the Oklahoma Board of Medical Licensure and Supervision met on January 19, 2017, 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 November 1, 2016 and posted on the Board's website on January 18, 2017. 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 January 18, 2017, at 9:45 a.m.

Members present were:

Don Flinn, PA-C, Chair
Charles Womack, MD
Anthony Sharp, MHS, PA-C
Lindsey Gillispie, PA-C
*Shannon Ijams, MPAS, PA-C - OU-Tulsa, Program Director
Dan McNeill, PhD, PA-C – OCU, Program Director
*Todd Doran, EdD, PA-C – OUHSC-OKC, Program Director

Members absent were:

Louis Cox, MD
Scott Williams, DO
Dennis Carter, DO

Others present included:

Lyle R. Kelsey, Executive Director
Reji Varghese, Deputy Director
Barbara J. Smith, Executive Secretary
Teresa Mitchell, Director of Licensing
Kenna Shaw, Administrative Technician
Sherrie Gallagher, Administrative Technician
Lisa Cullen, Administrative Technician
Tiffany Wythe, AAG, Committee Advisor

Having noted a quorum, Mr. Flinn called the meeting to order at 3:02 p.m.

*Todd Doran stepped out of the meeting.

Following Committee review, Ms. Gillispie moved to approve the minutes of October 13, 2016 as written. Dr. Womack seconded the motion and the vote was unanimous in the affirmative.

Following Committee discussion, Mr. McNeill moved to nominate Don Flinn to fill the position of chair pursuant to *Title 59 Okla. Stat. §519.3.C*. Dr. Womack seconded the motion and the vote was unanimous in the affirmative.

*Todd Doran re-joined the meeting

Next, Barbara Smith, Executive Secretary, presented an update on recent appointments to the committee. Charles Womack, MD, and Lindsey Gillispie, PA-C, were re-appointed to serve another term on the committee with their new terms set to expire on January 12, 2022. Scott Williams, DO, was appointed by the Board of Osteopathic Examiners to fill the seat previously held by Gerald Wootan, DO. Dr. Williams' term is set to expire on January 6, 2022.

The Committee then reviewed Applications for Licensure. Mr. McNeill moved to recommend approval of the following complete applications for licensure. Ms. Gillispie seconded the motion and the vote was unanimous in the affirmative.

ANGE, JETTA DAWN
BRAUN, TIMOTHY RYAN
BREWER, BRENT JASON
COX, ROBERT
CURRY, DON TROY
DOLLARHIDE, RACHEL
ELDRIDGE, ALLISON SPENCE
FORT, HAYLEY MAE
GOLLAHALLI, TONYA LYNETTE
HENDLEY, REBECCA ELIZABETH
HILL, LAUREN RENEE
HUYNH, TUAN-PHAT
JACKSON, JESSICA ELISE
KADAVY, NATHAN CARL
KNOEPFEL, MICHELLE LYNN
LEE, ANNDEE NICOLE
LONG, LESLIE TAYLOR
LOVELESS, REBECCA ANNE
MARTIN, DUSTIN SCOTT
MASSIE, NICOLE MARIE
MATHERLY, WADE REED
MCLAUGHLIN, BRIANA
NGUYEN, HOAI TIEN

NUSSBAUM, RYAN
OSBORN, BRITTNEY NICOLE
PHAM, UYEN KIM
POTTER, KARON KELLY
PUGH, BRITTNEY MAY
RIEBEL, KELSEY
ROCKWOOD, JAMES
RUGER, AARON DAVID
SCHMITZ, MICHELLE ANN
SILVA, STEPHANIE
SIX, AMANDA SUE
SPROTT, KELLEIGH DEEANN
STEARNS, SHAYNIEL
STORM, MEREDITH LEE
STUTZMAN, TIFFANY
THOMAS, ANGIE RACHEL
THOMAS, ZAKARI WILLIAM
TOFT, LAUREN ASHLEIGH
VINNEDGE, DANIELLE LEAH
WARD, JOSEPH DANIEL II
WEST, AMBER NICOLE
WOOD, NEILEE

During review of the incomplete applications for licensure, a discussion ensued regarding the file of **JACOB C. BROWN**. Upon questions posed to staff by the Committee, Reji Varghese, Deputy Director, advised that the applicant had met with Board Secretary and was subsequently evaluated by the Allied Professional Peer Assistance Program ("APPA") and that APPA had no recommendations for the applicant. Mr. Varghese told the Committee they could meet with the applicant if that would make them feel more comfortable. The Committee advised staff that, in the future, when there is someone that presents with application information similar to Mr. Brown's, they would like to see that applicant in person, even if Board Secretary clears them for licensure. Mr. Doran stated he knew the applicant as a student and he made brief comments in full support of his application for licensure. Mr. Womack moved to recommend

approval of the application of **JACOB C. BROWN** for licensure pending completion of the file. Mr. McNeill seconded the motion and the vote was unanimous in the affirmative.

Mr. McNeill moved to recommend approval of the following incomplete applications for licensure pending completion of the files. Ms. Ijams seconded the motion and the vote was unanimous in the affirmative.

DAVIS, KRISTINA LEAH
FRITZ, MARTHA BOON
HOLMAN, LAURA KATHRYN
IRBY, LAUREN
JACKSON, ANISHA NICOLE
LAURITSEN, KJETIL RODLAND
NEWSOME, DENNIS CLARK
OLSEN, KELSEY ANNE
PARK, ELIZABETH CHRISTINE
RAMEY, MORGAN BROOKE
RICE, TIRZAH REBECCA

RIDDER, LORI ANN
RITER, EMILY JEAN
SAXON, MARK DAVID
SCHAUER, KIMBERLY LOUISE
SCHUMACHER, BRITNEY
SIMKO, MELLISSA DAWN
TWO BEARS, KELSEY MARIE
VASS, ANNA BROOKE
WILLIAMS, MADISON
ZANOTTI, ANGELA LEIGH

Teresa Mitchell, Director of Licensing, advised that the file of **DANIELLE ELIZABETH WHEAT** had not been cleared for Committee review and requested that the application be tabled. Dr. Womack moved to recommend tabling the application of **DANIELLE ELIZABETH WHEAT** due to multiple deficiencies remaining in her file. Ms. Gillispie seconded the motion and the vote was unanimous in the affirmative.

Ms. Gillispie moved to recommend approval of the complete application of **DEANA MICHELLE WAGES** for reinstatement of licensure. Mr. McNeill seconded the motion and the vote was unanimous in the affirmative.

Mr. McNeill moved to recommend approval of the following incomplete applications for reinstatement of licensure pending completion of the files. Ms. Gillispie seconded the motion and the vote was unanimous in the affirmative.

BEAIRD, TERA LYNN
LUEDERS, KELLY ANN

PARSONS, DEANNA JO

Mr. Flinn announced that the documentation setting forth the Requests for Transfers, Additional Positions and Additional Alternates for Previously Approved Positions had not been timely provided and, as such, the Committee took no action on these matters.

Next, Ms. Mitchell presented proposed revisions to Forms, 5, 6, 7 and the PA Update Form. She advised that staff had combined Forms 5, 7 and the PA Update into one form. She stated this will greatly improve staff's efficiency and response time in processing. Mr. Doran stated he would like the form to show how the PA will be utilized and supervised as well as the method of supervision. Ms. Mitchell stated language regarding the "\$50.00 fee" will be placed at the top of the first page of the new form. Mr. McNeill stated the date range shown on page 1

(7-10 days) should be a flat 7 days. The Committee discussed removing the notarization block from all PA forms. Dr. Womack moved to remove the notarization block from all PA forms. Mr. McNeill seconded the motion and the vote was unanimous in the affirmative. Mr. Flinn stated the form was much improved and thanked staff for their work in this regard.

Ms. Mitchell then presented proposed revisions to Form 6 and requested input from the Committee regarding language to be provided on Form 6. Mr. Doran volunteered to work on that language and provide it to staff. The Committee recommended deleting “alternate supervising physician specialty” and making the first sentence on the first page bolder. Mr. Doran moved to accept Form 6 with the changes as recommended. Ms. Ijams seconded the motion and the vote was unanimous in the affirmative. The Committee was very appreciative of the work done by staff on the forms.

Upon further review of proposed Form 6, and following much discussion, Ms. Ijams moved to remove the last sentence on the first page of the form which reads, “If no Alternate Supervising Physician is designated, I certify that the Physician Assistant will not practice in the absence of nor independently of the Primary Supervising Physician.” Mr. Doran seconded the motion and the vote was unanimous in the affirmative.

Ms. Mitchell then gave a presentation on the processing of Form 5s that are submitted after the stated employment date. (This does not involve Form 5s that are submitted at the time of initial licensure.) Ms. Mitchell requested a Staff Directive from the Committee that if a Form 5 is received less than 30 days (1-29 days) after the employment start date listed on the form, the Licensing Department can send an email to the applicant and supervising physician confirming employment and Board Secretary can issue a temporary license (letter). If the form is received 30 days or more past the employment start date listed on the form, it will then be up to Board Secretary to determine if a temporary license (letter) is appropriate. Tiffany Wythe, Assistant Attorney General, stated she is concerned that the Committee is discussing the possibility of issuing a form of discipline (withholding a temporary license) without giving due process. She advised the Committee against such action.

Mr. Doran requested information concerning late submissions of Form 5s that is broken down into categories for Committee review for purposes of clarification. He also stated that his program instructs all of their students that there is a “zero tolerance” policy regarding proper documentation and licensure. Mr. Kelsey agreed that more work needed to be done before the next presentation to the Committee in this regard, particularly with a focus on categorizing the late submissions.

*Ms. Ijams left the meeting

*Mr. Doran left the meeting

Upon further discussion regarding the requested Staff Directive, Ms. Wythe read Title 59 Okla. Stat. 519.6 which states, in part, “No health care services may be performed by a physician assistant unless a current...[Form 5]...is on file with and approved by the State Board of Medical Licensure and Supervision.” She stated that there is no authority to waive this law.

Mr. Kelsey directed Teresa Mitchell to look at each PA case and find out how many PAs fall into the category of “late submission” and to prepare a no-tolerance and a cease and desist

letter for his review. Mr. Flinn requested that Ms. Smith place a discussion item to finalize the matter of processing late submissions of Form 5s on the April agenda.

There being no new business, Ms. Gillispie moved to adjourn. Mr. McNeill seconded the motion and the vote was unanimous in the affirmative. The time was 4:21 p.m.

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE & SUPERVISION
101 NE 51ST STREET, OKLAHOMA CITY, OK 73105
Phone: (405) 962-1400 Fax: (405) 962-1440 E-mail: licensing@okmedicalboard.org

APPLICATION TO PRACTICE AS A PHYSICIAN ASSISTANT – FORM 5

CHOOSE ONE: (Include \$50 if Additional Position or Transfer)

Initial Position

Additional Position

Transfer

NAME OF PHYSICIAN ASSISTANT: _____ License #/Application #: _____

Mailing Address: _____

The above named physician assistant will begin practice under my supervision on ____/____/____. **(NOTE: PRACTICE CANNOT BEGIN UNTIL RECEIPT OF BOARD APPROVAL. ALLOW AT LEAST 7-10 BUSINESS DAYS FOR REVIEW AND APPROVAL.)** We agree to abide by the Rules and Laws of the Oklahoma 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.

The supervising physician is responsible for the health care services provided by the Physician Assistant. The supervising physician is also responsible for providing proper supervision of the Physician Assistant in accordance with the Physician Assistant Practice Act And Regulations. The supervising physician must give prompt notice to the board at the time the supervisory relationship ends. Disciplinary action may be taken against the supervising physician's medical license for failure to properly supervise the 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:

Name of Facility Street

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: _____

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE & SUPERVISION
101 NE 51ST STREET, OKLAHOMA CITY, OK 73105
Phone: (405) 962-1400 Fax: (405) 962-1440 E-mail: licensing@okmedicalboard.org

APPLICATION TO PRACTICE AS A PHYSICIAN ASSISTANT – FORM 5

Description of methods & frequency of supervising the PA: _____

NAME OF SUPERVISING PHYSICIAN: _____ License Number: _____

I certify that I am **PRIMARY SUPERVISING PHYSICIAN** for the following Physician Assistant(s).

Name of Physician Assistant: _____ License Number: _____

Name of Physician Assistant: _____ License Number: _____

Name of Physician Assistant: _____ License Number: _____

Name of Physician Assistant: _____ License Number: _____

ALTERNATE SUPERVISING PHYSICIAN(S) **NO** **YES – COMPLETE FORM 6**

For PA: By signing below, I acknowledge that my scope of practice is the same as the primary supervising physician's scope of practice. If no Alternate Supervising Physician is designated, I certify that I will not practice in the absence of nor independently of the Primary Supervising Physician,

For Physician: By signing below, I acknowledge that I have received and read 435:15-3-13. Supervising physician; alternatives 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. If no Alternate Supervising Physician is designated, I certify that the Physician Assistant will not practice in the absence of nor independently of the Primary Supervising Physician,

Signature of Primary Supervising Physician

Signature of Physician Assistant

PAFORM #5

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE & SUPERVISION
101 NE 51ST STREET, OKLAHOMA CITY, OK 73105
Phone (405) 962-1400 Fax (405) 962-1440 e-mail: licensing@okmedicalboard.org

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: _____

PAFORM #5

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE & SUPERVISION
101 NE 51ST STREET, OKLAHOMA CITY, OK 73105
Phone (405) 962-1400 Fax (405) 962-1440 e-mail: licensing@okmedicalboard.org

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 P.A.: _____

Description of methods & frequency of supervising the Physician Assistant: _____

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 435:15-3-13. Supervising physician; alternatives 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

(SEAL)
Commission Number: _____

My commission expires: _____

PAFORM #7

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE & SUPERVISION
101 NE 51ST STREET, OKLAHOMA CITY, OK 73105
Phone (405) 962-1400 Fax (405) 962-1440 e-mail: licensing@okmedicalboard.org

NOTICE TO PHYSICIAN ASSISTANTS

IT IS MANDATORY THAT THIS DOCUMENT, PROPERLY EXECUTED, BE SUBMITTED TO THE STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION PRIOR TO APPROVAL FOR PRACTICE TEMPORARILY BY THE SECRETARY OF THE STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION.

=====

I, _____ (M.D.) (D.O.)
Name of primary Supervising Physician - Type or print

LICENSE NUMBER: _____, CERTIFY THAT I AM PRIMARY SUPERVISING PHYSICIAN FOR THE FOLLOWING PHYSICIAN ASSISTANT(S) ONLY:

I FURTHER CERTIFY THAT I AM ALTERNATE SUPERVISING PHYSICIAN FOR THE FOLLOWING PHYSICIAN ASSISTANT(S):

In accordance with OAC 435:15-3-13 (c) (1) which states, "A supervising physician shall not serve as the supervising physician for more than four (4) physician assistants practicing at any one time. (2) shall not apply to a supervising physician who is a medical director or supervising physician of a state institution, correctional facility, or hospital."
I confirm that I will not supervise more than four physician assistants at any one time.

Date Signature of Physician

PA UPDATE FORM

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE & SUPERVISION
101 NE 51ST STREET, OKLAHOMA CITY, OK 73105
Phone (405) 962-1400 Fax (405) 962-1440 e-mail: licensing@okmedicalboard.org

The \$50 Application to Practice fee must be submitted with a request for transfer or additional position.

APPLICATION FOR: TRANSFER OR ADDITIONAL POSITION

NAME: _____

LICENSE NUMBER: _____

MAILING ADDRESS: _____

PRIMARY PRACTICE ADDRESS: _____

PRIMARY PRACTICE PHONE NUMBER: _____

PRACTICE SETTING(S): (List any additional positions on back – any positions not listed will be deleted)

Primary Supervising Physician: _____

Date began: _____

Additional positions:

(1) Primary Supervising Physician: _____

Date began: _____

(2) Primary Supervising Physician: _____

Date began: _____

IF YOU ARE TRANSFERRING SUPERVISION FROM ONE PHYSICIAN TO ANOTHER, PLEASE INDICATE:

Previous Supervising Physician: _____

Date Supervision Ceased: _____

Signature of Physician Assistant: _____

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION
101 NE 51st STREET OKLAHOMA CITY OK 73105
Phone: (405) 962-1400 Fax: (405) 962-1440 email: Licensing@okmedicalboard.org

APPLICATION TO PRACTICE AS A PHYSICIAN ASSISTANT – FORM 6 – ALTERNATE SUPERVISING PHYSICIAN(S)

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.

Physician Assistant Name: _____	License #: _____
Primary Supervising Physician Name: _____	License #: _____
Primary Supervising Physician Specialty: _____	

Alternate Supervising Physician Name: _____	Alternate Supervising Physician Specialty: _____
Alternate Supervising Physician Signature: _____	License #: _____

Alternate Supervising Physician Name: _____	Alternate Supervising Physician Specialty: _____
Alternate Supervising Physician Signature: _____	License #: _____

Alternate Supervising Physician Name: _____	Alternate Supervising Physician Specialty: _____
Alternate Supervising Physician Signature: _____	License #: _____

Alternate Supervising Physician Name: _____	Alternate Supervising Physician Specialty: _____
Alternate Supervising Physician Signature: _____	License #: _____

Alternate Supervising Physician Name: _____	Alternate Supervising Physician Specialty: _____
Alternate Supervising Physician Signature: _____	License #: _____

Alternate Supervising Physician Name: _____	Alternate Supervising Physician Specialty: _____
Alternate Supervising Physician Signature: _____	License #: _____

For PA: By signing below, I acknowledge that my scope of practice is the same as the primary supervising physician's scope of practice. If no Alternate Supervising Physician is designated, I certify that I will not practice in the absence of nor independently of the Primary Supervising Physician,

For Physician: By signing below, I acknowledge that I have received and read 435:15-3-13. Supervising physician; alternatives 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. If no Alternate Supervising Physician is designated, I certify that the Physician Assistant will not practice in the absence of nor independently of the Primary Supervising Physician,

Signature of Primary Supervising Physician

Signature of Physician Assistant

PAFORM #6

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE & SUPERVISION
101 NE 51ST STREET, OKLAHOMA CITY, OK 73105
Phone (405) 962-1400 Fax (405) 962-1440 e-mail: licensing@okmedicalboard.org

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.

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

HAVE READ SUBCHAPTER 9 (GUIDELINES FOR THE UTILIZATION OF PHYSICIAN ASSISTANTS) AND 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.

By signing below, I acknowledge that I have received and read 435:15-3-13. Supervising physician; alternatives 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 Alternate Supervising Physician Signature of Primary Supervising Physician

Signature of Physician Assistant

SUBSCRIBED AND SWORN TO BEFORE ME THIS _____ DAY OF _____ 20 _____.

(SEAL)

Notary Public
COMMISSION NUMBER: _____ MY COMMISSION EXPIRES: _____

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 _____, 20 _____.

SEAL

Notary Public
COMMISSION NUMBER: _____ MY COMMISSION EXPIRES: _____