

# CLOSEOUT DATES FOR DELEGATION AGREEMENTS 2010

## DEADLINE DATES

December 18, 2009  
January 22, 2010  
February 20, 2010  
March 19, 2010  
April 23, 2010  
May 21, 2010  
June 25, 2010  
July 23, 2010  
August 20, 2010  
September 24, 2010  
October 22, 2010  
November 19, 2010  
**December 17, 2010**

## PAAC MEETING DATES

January 6, 2010  
February 3, 2010  
March 3, 2010  
April 7, 2010  
May 5, 2010  
June 2, 2010  
July 7, 2010  
August 4, 2010  
September 1, 2010  
October 6, 2010  
November 3, 2010  
December 1, 2010  
**January 5, 2011**

## BOARD MEETING DATES

January 27, 2010  
February 24, 2010  
March 24, 2010  
April 28, 2010  
May 26, 2010  
June 23, 2010  
July 28, 2010  
August 25, 2010  
September 22, 2010  
October 27, 2010  
November 17, 2010  
December 15, 2010  
**January 26, 2011**

### Deadline Dates

The Maryland Board of Physicians must receive delegation agreements on the published deadline date to be considered for Board approval.

### PAAC Meeting

The first review of the delegation agreements is conducted by the PHYSICIAN ASSISTANT ADVISORY COMMITTEE "PAAC" and then recommended to the Board for approval.

### Board Meeting Dates

Delegation agreements recommended for approval will be presented to Board on the listed date.

#### **Reminders:**

1. Review your delegation agreement for completion of all sections. BOTH Physician Assistants and Primary Supervising Physicians should keep a copy of the delegation agreement for their records **PRIOR** to mailing. **If you request a copy of the delegation after it was mailed, it may take up to 30 days to receive the copy.**
2. The approval letter will be mailed to the supervising physician and the physician assistant. **PLEASE REVIEW FOR ACCURACY.**
3. If a supervising physician delegates the prescribing of **controlled dangerous substances** to a physician assistant. The physician assistant must – obtain a Maryland Controlled Dangerous Substance (MCDS) license from the Maryland Division of Drug Control. After obtaining a MCDS license, the physician assistant must register with the Drug Enforcement Administration (DEA).  
  
To obtain an application packet for a MCDS license, please contact the Maryland Division of Drug Control at 410-764-2890. Applications for CDS should be submitted after the delegation agreement has been **Board approved**.  
  
To register with the DEA: Call 1-800-882-9539 OR visit their website at <http://www.usdoj.gov/dea>, click DEA resources for physicians/registrants, THEN REGISTER.
4. **Termination of Employment: THE SUPERVISING PHYSICIAN/EMPLOYER MUST COMPLETE THIS REPORT.** ALL terminations must be reported to the Board within ten (10) days of the termination of employment, EXCEPT in cases of quality care. These must be reported within five (5) days of the termination of employment.

# MARYLAND BOARD OF PHYSICIANS

P.O. Box 37217

Baltimore, MD 21297

## GENERAL INSTRUCTIONS FOR COMPLETING THE PHYSICIAN ASSISTANT DELEGATION AGREEMENT

1. **Fee: \$200.00 per delegation agreement.** All checks or money orders should be payable to: **Maryland Board of Physicians** and mailed with the delegation agreement to the above address. (There is no charge for adding alternate supervising physicians, adding additional core duties or adding advanced duties to an existing delegation agreement.) **Applications sent to another Board address, other than the one above, or walked into the Board may be delayed by at least one week.**
2. **Application:** Supervising Physicians and Physician Assistants **must** complete the relevant pages of the delegation agreement.
  - a. Supervising Physicians and Physician Assistants requesting a temporary practice letter, complete pages 1 - 7 and Appendix A.
  - b. Supervising Physicians and Physician Assistants not requesting a temporary practice letter, complete pages 1-7.**Submitting illegible or incomplete applications or applications without a fee will delay the process.**
3. **Temporary Practice Letter:** Physician Assistants/Supervising Physicians may be eligible for a temporary practice letter if they meet certain criteria. If eligible, complete Appendix A. (See **page iii** of the General Instructions.)
4. **Request for Approval to Perform Advanced Duties:** Advanced duties are duties that require additional training and education beyond which a physician assistant receives through their accredited physician assistant educational program. If you are requesting approval to perform advanced duties, you must meet certain education and training criteria and provide supporting documentation. Please:
  - a. Complete Section 5 (page 3 of 7);
  - b. Review the instructions in Appendix B1;
  - c. Complete Appendix B2 only if the physician assistant meets the education and training criteria; **and**
  - d. Provide the required supporting documentation.
5. **Prescriptive Authority:** If the supervising physician intends to delegate prescriptive authority to the physician assistant, complete Section 8. Supervising physicians may delegate prescriptive authority to certified physician assistants who meet certain criteria. A supervising physician may not delegate prescriptive authority to a physician assistant who holds only a temporary certificate issued by the Maryland Board of Physicians;
6. **Attestations:** Supervising physicians must read and complete the attestations on **Page 5**.
7. **Attestations, Affirmation and Release:** Supervising physicians and physician assistants must read and complete **Page 6**.
8. **Alternate Supervising Physicians:** Complete **Page 7** only if the primary supervising physician is designating an alternate(s) supervising physician in a practice setting other than a hospital, correctional facility, penal institution or local public health facility. Primary supervising physicians, physician assistants and alternate supervising physicians must complete and sign the form.

## GENERAL INSTRUCTIONS CONTINUED

9. **Controlled Dangerous Substance Certificate:** To obtain a Maryland Controlled Dangerous Substance application contact:

**DHMH-Division of Drug Control**

4201 Patterson Avenue  
Baltimore, MD 21215  
(410) 764-2890

- \* The processing of this application will take approximately 2-3 weeks.
  - \* **CDS applications should be submitted after the delegation agreement is approved by the Maryland Board of Physicians.**
10. **Drug Enforcement Administration License:** To obtain an application for registration with the DEA, call 1-800-882-9539 or visit their website at <http://www.usdoj.gov/dea>, **click *DEA Resources, For Physician/Registrants, then Registration.***

**Questions and concerns regarding Controlled Dangerous Substance and Drug Enforcement Agency applications should be directed to the appropriate agency and not to the Maryland Board of Physicians.**

11. **STATUTE AND REGULATIONS:** The statute (Health Occupations Article, Title 15, Annotated Code of Maryland) and the Code of Maryland Regulations (COMAR) 10.32.03 may be obtained by accessing the Board's website at [www.mbp.state.md.us](http://www.mbp.state.md.us). Click on "Physician Assistants," then "Laws and Regulations"
12. **DELEGATION AGREEMENTS** and other applications pertaining to physician assistants can be found at [www.mbp.state.md.us](http://www.mbp.state.md.us). Click on "Download Forms," click "Allied Health Forms," then click on the application(s) of your choice.

Questions may be directed to either Ms. K. Noel Spindler at 410-764-4768/ [nspindler@dhhm.state.md.us](mailto:nspindler@dhhm.state.md.us) or Ms. Gwendolyn Joyner at 410-764-4781/ [gjoyner@dhhm.state.md.us](mailto:gjoyner@dhhm.state.md.us). Your questions may also be answered by going to the Board's website at [www.mbp.state.md.us](http://www.mbp.state.md.us). Click on "Physician Assistants".

### IMPORTANT

- A. **KEEP A COPY OF THE DELEGATION AGREEMENT FOR YOUR RECORDS AND FOR FUTURE REFERENCE.**
- B. **IF ONE CHECK IS SUBMITTED FOR MULTIPLE PHYSICIAN ASSISTANTS, PLEASE:**
- \* **SPECIFY THE NAME(S) OF THE PHYSICIAN ASSISTANT(S) ON THE CHECK OR ON A SEPARATE SHEET OF PAPER ATTACHED TO THE CHECK WITH THE CORRECT FEE FOR EACH PHYSICIAN ASSISTANT.**
- C. **TERMINATION NOTICES MUST BE FILED WITH THE MARYLAND BOARD OF PHYSICIANS REGARDLESS OF THE REASON FOR THE TERMINATION. A TERMINATION OF EMPLOYMENT FORM IS PROVIDED AT THE END OF THIS APPLICATION. (See Appendix C)**
- D. **FAILURE TO NOTIFY THE BOARD WITHIN 60 DAYS OF A NAME CHANGE OR CHANGE OF ADDRESS MAY RESULT IN A \$100 FINE. (COMAR 10.32.03.09C)**

## GENERAL INSTRUCTIONS CONTINUED

A new law went into effect on October 1, 2006. This new law, Senate Bill 818, will allow some physician assistants to practice, under certain conditions, without waiting for a formal Board approval. If the supervising physician and the physician assistant meet these conditions, Board staff will issue a temporary practice letter that will be effective until the next Board meeting. If the Board approves the delegation agreement, Board staff will send a Board approval letter to the physician assistant and the supervising physician. If the Board does not approve the delegation agreement, then Board staff will notify the supervising physician and the physician assistant that the physician assistant must cease practicing until the Board approves the delegation agreement.

### QUALIFICATIONS FOR A TEMPORARY PRACTICE LETTER

1. A physician assistant may request a temporary practice letter if the following conditions are met:
  - a. The Board previously approved a delegation agreement for the physician assistant with the same scope of practice as currently requested in the proposed delegation agreement; **AND**
  - b. The Board previously approved a delegation agreement for the supervising physician to supervise one or more physician assistants in the proposed practice setting for the same scope of practice as currently requested in the proposed delegation agreement.
2. A physician assistant who is requesting a temporary practice letter must:
  - a. Indicate on the delegation agreement that a temporary practice letter is requested;
  - b. Include the name of the physician, the name of the physician assistant, and the date of the delegation agreement that satisfies the requirements of paragraph (1)(a); **AND**
  - c. Include the name of the physician, the name of the physician assistant, and the date of the delegation agreement that satisfies the requirements of paragraph (1)(b).
3. If the requirements are met, Board staff will issue a temporary practice letter which entitles the physician assistant to work in accordance with the proposed delegation agreement until:
  - a. Staff notifies the physician assistant and supervising physician that the proposed delegation agreement has been denied by the Committee or the Board; **OR**
  - b. Staff notifies the physician assistant and supervising physician that the proposed delegation agreement has been approved by the Board.

The following physician assistants and supervising physicians **WILL NOT** qualify for a temporary practice letter:

A supervising physician who has never been approved by the Board to supervise a physician assistant.

A physician assistant who has never been approved by the Board to practice.

MARYLAND BOARD OF PHYSICIANS

P.O. Box #37217  
Baltimore, Maryland 21297

<b>FOR BANK USE ONLY</b>	
DATE:	____ / ____ / 200 ____
CHECK NUMBER:	_____
AMT PAID: \$	_____
NAME CODE:	_____
APPID:	53

Fee: \$200

**Physician Assistant/Supervising Physician Delegation Agreement**

**INSTRUCTIONS: Physician Assistant: PUT AN X IN THE APPROPRIATE BOX(ES), THEN COMPLETE THE APPLICATION.**

A. Delegation Agreement with Temporary Practice Letter. Complete Appendix A.

B. Delegation agreement without Temporary Practice Letter.

**1. PHYSICIAN ASSISTANT INFORMATION (TYPE OR PRINT LEGIBLY)**

**A. Maryland Certification Number:** \_\_\_\_\_ **NCCPA Certificate Number:** \_\_\_\_\_

**B. Name:** \_\_\_\_\_  
Last, Generational indicator (Sr., Jr., etc.)                      First                      Middle                      Maiden

**C. Mailing Address:** \_\_\_\_\_  
Street Number and Name    Apt No. or P.O. Box

\_\_\_\_\_

City    State    Zip Code

**D. Contact Information:**

Home: (    ) \_\_\_\_\_ Pager/Cell: (    ) \_\_\_\_\_

Work: (    ) \_\_\_\_\_ ext. \_\_\_\_\_ Fax: (    ) \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

**E. Name of professional school and date of graduation from accredited Physician Assistant Educational Program.**

\_\_\_\_\_  
Name of Professional School

\_\_\_\_\_  
Date of Graduation

**PLEASE ANSWER "YES" OR "NO" TO QUESTIONS F AND G**

**F.** Have you passed the PANCE, PANRE OR PATHWAY II within the last two years? \_\_\_\_\_ **YES** \_\_\_\_\_ **NO**. If "**YES**," provide date of exam \_\_\_\_\_.

**G.** Have you ever been subject to any disciplinary action in any jurisdiction by any licensing or disciplinary board or an entity of the armed services? \_\_\_\_\_ **NO** \_\_\_\_\_ **YES**.

If you answered "**YES**," provide a detailed explanation and supporting documentation on a separate sheet of paper. Be sure to sign and date all documentation. (**Failure to provide an explanation or supporting documentation will delay the processing of your application.**)

**2. SUPERVISING PHYSICIAN INFORMATION (TYPE OR PRINT LEGIBLY)**

**A. Maryland License#:** \_\_\_\_\_

**B. Name:** \_\_\_\_\_  
Last (Generational indicator - Sr., Jr., etc.)      First      Middle      Maiden

**C. Mailing Address:** \_\_\_\_\_  
Street Number and Name      Apt. #  
\_\_\_\_\_  
City      State      Zip Code

**D. Telephone Numbers:**

Home (\_\_\_\_\_) \_\_\_\_\_      Pager (\_\_\_\_\_) \_\_\_\_\_

Work (\_\_\_\_\_) \_\_\_\_\_ ext. \_\_\_\_\_      Cell (\_\_\_\_\_) \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

**Please check "YES" OR "NO" to Question E.**

**E. Have you ever been subject to any disciplinary action in any jurisdiction by any licensing or disciplinary board or an entity of the armed services? \_\_\_\_\_ YES \_\_\_\_\_ NO.**

If you answered "YES," provide a detailed explanation and supporting documentation on a separate sheet of paper. Be sure to sign and date all documentation. ***(Failure to provide an explanation or supporting documentation will delay the processing of this application.)***

<b>F. DESCRIBE THE SETTING(S) IN WHICH THE PHYSICIAN ASSISTANT WILL PRACTICE:</b>	
<input type="checkbox"/> Hospital	<input type="checkbox"/> Detention Center, Correctional Facility
<input type="checkbox"/> Other _____	<input type="checkbox"/> Public Health Facility

**G. LOCATION(S):**

1. Facility/Practice Name: \_\_\_\_\_  
Department \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Contact name: \_\_\_\_\_ Telephone # (\_\_\_\_\_) \_\_\_\_\_, ext. \_\_\_\_\_

2. Facility/Practice Name \_\_\_\_\_  
Department \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Contact name: \_\_\_\_\_ Telephone # (\_\_\_\_\_) \_\_\_\_\_ ext. \_\_\_\_\_

**(Include additional locations on a separate sheet of paper.)**

### 3. SCOPE OF PRACTICE

Please place an (X) in the box that corresponds with the supervising physician's scope of practice.

<input type="checkbox"/> ANE Anesthesiology	<input type="checkbox"/> NP Neurology/Psychiatry	<input type="checkbox"/> RA Radiology
<input type="checkbox"/> ACC Adult Critical Care	<input type="checkbox"/> NS Neurosurgery	<input type="checkbox"/> RO Radiation Oncology
<input type="checkbox"/> AI Allergy / Immunology	<input type="checkbox"/> OB OB/GYN	<input type="checkbox"/> SU General Surgery
<input type="checkbox"/> CA Cardiology	<input type="checkbox"/> OM Occupational Health	<input type="checkbox"/> TP Transplant Surgery
<input type="checkbox"/> CV Cardiovascular Surgery	<input type="checkbox"/> ON Oncology	<input type="checkbox"/> TS Thoracic
<input type="checkbox"/> DE Dermatology	<input type="checkbox"/> OP Ophthalmology	<input type="checkbox"/> UR Urology
<input type="checkbox"/> EM Emergency Medicine	<input type="checkbox"/> OR Orthopedics	<input type="checkbox"/> VS Vascular Surgery
<input type="checkbox"/> EN Endocrinology	<input type="checkbox"/> OTH Other _____	
<input type="checkbox"/> ENT Ear, Nose, Throat, Head and Neck	<input type="checkbox"/> PN Pain Management	
<input type="checkbox"/> FP Family Practice	<input type="checkbox"/> PA Pathology	
<input type="checkbox"/> GE Geriatric	<input type="checkbox"/> PE Pediatrics	
<input type="checkbox"/> GI Gastroenterology	<input type="checkbox"/> PCC Pediatric Critical Care	
<input type="checkbox"/> IM Internal Medicine	<input type="checkbox"/> PSU Pediatric Surgery	
<input type="checkbox"/> IN Infectious Disease	<input type="checkbox"/> PS Plastic Surgery	
<input type="checkbox"/> NT Neonatology	<input type="checkbox"/> PH Public Health & General Preventative Medicine	
<input type="checkbox"/> NE Nephrology	<input type="checkbox"/> PM Physical Medicine & Rehabilitation	
<input type="checkbox"/> NU Neurology	<input type="checkbox"/> PU Pulmonology	

**4. PHYSICIAN ASSISTANT CORE DUTIES:** Please list at least five examples of the core duties the physician assistant is to perform under the supervision of the supervising physician. Core duties **DO NOT REQUIRE** training and education beyond which physician assistant receive through their accredited Physician Assistant educational programs.

**EXAMPLES:** Conduct histories and physicals, EKG's and XRays (initial read only), interpret and evaluate patient data, issue diagnostic orders, repair lacerations, ID abscess, apply splints, record patient progress and provide instruction and guidance regarding medical matters to patients.

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**5. PHYSICIAN ASSISTANT ADVANCED DUTIES: (Check one)**

Not requesting advanced duties.

Requesting Advanced Duties. If requesting approval to perform advanced duties, carefully review the instructions in **Appendix B1** and if you meet the criteria, complete **Appendix B2** and attach to the delegation agreement.

**6. QUALITY ASSURANCE: Physician Assistant's Evaluation:** Describe the process by which the supervising physician will review the physician assistant's practice, appropriate to the practice setting and consistent with current standards of acceptable medical practice.

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**7. SUPERVISION:** Choose which of the following best describes the continuous physician supervision methods to be utilized in your practice.

**PLEASE CHECK ALL THAT APPLY.**

<input type="checkbox"/> ON SITE	<input type="checkbox"/> WRITTEN INSTRUCTIONS
<input type="checkbox"/> ELECTRONIC MEANS	<input type="checkbox"/> ALTERNATE SUPERVISING PHYSICIAN

## 8. PRESCRIPTIVE AUTHORITY

Supervising physicians may delegate the authority to prescribe controlled dangerous substances, prescriptive drugs and medical devices to **certified** physician assistants who meet certain criteria. Supervising physicians may not delegate prescriptive authority to physician assistants who hold only temporary certification.

### **SUPERVISING PHYSICIANS WHO INTEND TO DELEGATE PRESCRIPTIVE AUTHORITY, PLEASE CHECK THE BOX(ES) THAT APPLY:**

**Controlled Dangerous Substances**    **Prescription Drugs**    **Medical Devices**

In order for a supervising physician to delegate prescriptive authority to a certified physician assistant, the physician assistant **must** attach documentation of the following:

#### **(PLEASE CHECK ALL THAT APPLY)**

- I. Passage of the NCCPA Exam within the previous 2 years; Date of Passage \_\_\_\_\_; **OR**  
 II. Successful completion of 8 Category I hrs. of pharmacology education within the previous 2 years. (Attach documentation of CME. See Guidelines below)\*;

#### **AND**

- I. A Bachelor's Degree or its equivalent (120 credit hours); **OR**  
 II. 2 years of work experience as a physician assistant.

**Failure to provide the relevant documentation will delay the processing of the application.**

**If a supervising physician delegates prescriptive authority for controlled dangerous substances to a physician assistant, the physician assistant must (1) obtain a Maryland Controlled Dangerous Substance (MCDS) license from the Maryland Division of Drug Control; and (2) must register with the Drug Enforcement Administration (DEA).**

**To obtain an application packet for an MCDS license, contact the Maryland Division of Drug Control at 410-764-2890. Applications for CDS should be submitted after the delegation agreement has been approved. Pending CDS applications will not be processed.**

**To register with the DEA, call 1-800-882-9539 or visit their website at <http://www.usdoj.gov/dea>, click *DEA Resources, For Physician/Registrants, then Registration.***

**\*Category I hours** means hours of continuing medical education given in formally organized programs pertinent to the practice of physician assistant duties, accredited by the American Academy of Physician Assistants, the American Academy of Family Physicians, the Accreditation Council on Continuing Medical Education, MedChi, The Maryland State Medical Society, or equivalent certifying bodies.

Required documentation of successful completion of 8 Category I hours in pharmacology education is a certificate or other documentation of attendance which contains at least the following:

- the program title;
- the sponsor's name;
- the physician assistant's name;
- inclusive dates and location of the CME event;
- CME category designation and the number of designated or prescribed CME credit hours; **and**
- documented verification of successful completion by stamp, signature, hospital printout, or other official proof, and demonstration that the CME activity fell within the 2-year period immediately preceding submission of the delegation agreement.

The physician assistant may be required to provide the course outline, syllabus or other information in addition to the above documentation.

**ATTESTATIONS FOR SUPERVISING PHYSICIANS ONLY  
PLEASE READ, PRINT YOUR NAME, SIGN AND DATE**

**9. I ATTEST THAT:**

- a. **For Hospital and Penal Institution/Detention Center and Public Health Facility Supervising Physicians.** The Physician Assistant will practice only within the scope of practice of the primary supervising physician. The primary supervising physician assumes responsibility for maintaining and enforcing mechanisms that assure this requirement is met on a continuous basis.
- b. **For All Other Supervising Physicians.** I am a primary supervising physician in a **SETTING OTHER THAN A HOSPITAL/CORRECTIONAL FACILITY/DETENTION CENTER OR PUBLIC HEALTH FACILITY.** I will not delegate medical acts under a delegation agreement to more than two physician assistants **at any one time.** When acting as an alternate supervising physician, I will not supervise more than four physician assistants **at any one time.**
- c. All medical acts to be delegated to the physician assistant are within my scope of practice and are appropriate to the physician assistant's education, training, and level of competence.
- d. I accept responsibility for any care given by the named physician assistant.
- e. I will utilize the mechanisms of continuous supervision required by COMAR 10.32.03.06C(10) that are described on page 3 of this delegation agreement.
- f. I will respond in a timely manner when contacted by the physician assistant.

**10. OTHER INFORMATION: H.O. Section 15-302(b)(9)**

- a. **I understand that the recent change in the law repealing the requirement for supervising physicians to review and co-sign medical charts does not relieve me of the responsibility for any and all medical acts the physician assistant performs.**
- b. I will provide on site supervision at all times for a physician assistant who has a temporary certification.
- c. I understand that completing this agreement in bad faith, completing a false or misleading agreement, or the failure to perform the supervision provided in the agreement, constitutes unprofessional conduct in violation of Health Occupations Article Section 14-404(a)(3), Annotated Code of Maryland.
- d. In non-emergent situations, the policy of my practice is to notify patients in advance (ideally at the time of scheduling), if a physician assistant will be the treating practitioner.
- e. The policy of my practice is that either the physician assistant or I discuss the nature and purpose of the proposed treatment or procedure; the risks and benefits of not receiving or undergoing the treatment or procedure; alternative treatments and procedures; and risks or benefits of alternative treatments or procedures with all patients.
- f. **I will report any Physician Assistant termination to the Maryland Board of Physicians within 10 days. If the reason for the termination involves a quality of care issue, I will report the termination to the Board within 5 days.**

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Supervising Physician (Print legibly)

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Supervising Physician (Signature)

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Date

**ATTESTATIONS, AFFIRMATION AND RELEASE  
FOR DELEGATION OF PRESCRIPTIVE AUTHORITY  
FOR SUPERVISING PHYSICIANS AND PHYSICIAN ASSISTANTS  
PLEASE READ, PRINT YOUR NAME, SIGN AND DATE**

**11A. I ATTEST THAT:**

1. All prescribing activities of the physician assistant will comply with all federal and state laws governing the prescribing of medications, including controlled dangerous substances.
2. Medical charts or records will contain a notation of any prescriptions written by the physician assistant.
3. All prescriptions written by the physician assistant will include the physician assistant's name, the supervising physician's name, business address, and business telephone number legibly written or printed.
4. I, as **the Supervising Physician**, shall notify the Board within 5 business days if the physician assistant's delegation to prescribe has been restricted or revoked.
5. I have read and am thoroughly familiar with Health Occupations Article Title 15, Annotated Code of Maryland and Code of Maryland Regulations (COMAR) 10.32.03 which govern physician assistants and the requirements and responsibilities of the supervising physician.
6. Under the penalty of perjury that the information supplied to the Maryland Board of Physicians is true to the best of my knowledge and belief.

**B. RELEASE:**

I agree that the Maryland Board of Physicians (the Board) and the Physician Assistant Advisory Committee may request any information necessary to process my delegation agreement from any person or agency, including but not limited to former and current employers, government agencies, the National Practitioners Data Bank, the Healthcare Integrity and Protection Data Bank, hospitals and other licensing bodies, and I agree that any person or agency may release to the Board the information requested. I also agree to sign any subsequent releases for information that may be requested by the Board.

\_\_\_\_\_  
Supervising Physician (Print legibly)

\_\_\_\_\_  
Supervising Physician (Signature)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician Assistant (Print legibly)

\_\_\_\_\_  
Physician Assistant (Signature)

\_\_\_\_\_  
Date

**In a hospital, correctional facility, penal institution, or local public health facility**, the supervising physician **may designate alternate supervising physicians by:** (1) keeping an ongoing list of all approved alternate supervising physicians on file at all practice sites; (2) including each alternate supervising physicians scope of practice; and (3) having each alternate supervising physician sign and date the list. The list **must** be kept up-to-date with additions and terminations of alternate supervising physicians.

**In all other practice settings**, an alternate supervising physician **may be designated by completing Page 7.**

**FOR SETTINGS OTHER THAN:  
HOSPITAL, CORRECTIONAL FACILITY, PENAL INSTITUTION OR PUBLIC HEALTH FACILITY**

**ALTERNATE SUPERVISING PHYSICIAN INFORMATION**

**Instructions:** Primary supervising physician and physician assistant complete Sections 12A-D. Alternate supervising physician complete Sections 12F and 12G.

**EACH ALTERNATE SUPERVISING PHYSICIAN MUST SUBMIT THIS COMPLETED FORM**

**12. A.** Name of Physician Assistant: \_\_\_\_\_

**B.** Signature of Physician Assistant: \_\_\_\_\_

**C.** Name of Primary Supervising Physician: \_\_\_\_\_

**D.** Signature of Primary Supervising Physician: \_\_\_\_\_

**E. A PHYSICIAN MAY SUPERVISE AS AN ALTERNATE SUPERVISING PHYSICIAN IF:**

- (1) The supervising physician is on vacation or takes leave;
- (2) The alternating supervising physician supervises in accordance with a delegation agreement filed with the Board;
- (3) The alternate supervising physician supervises **NO MORE** than four physician assistants **at any one time**, except in a hospital, correctional facility, detention center, or public health facility;
- (4) The period of supervision, in the absence of the primary supervising physician, **DOES NOT** exceed the lesser of:
  - (a) The period of time specified in the delegation agreement; or
  - (b) A period of 45 consecutive days at any one time; and
- (5) The physician assistant performs **ONLY** those medical acts that:
  - (a) Have been delegated under the delegation agreement filed with the Board; and
  - (b) Are within the scope of practice of the alternate supervising physician.

If the scope of practice of the alternate supervising physician, as determined by the Board, is different from that of the primary supervising physician, **a separate delegation agreement must be filed.**

**F. ALTERNATE SUPERVISING PHYSICIAN PLEASE ANSWER “YES” OR “NO”**

Have you ever been subject to public disciplinary action in any jurisdiction by any licensing or disciplinary board or an entity of the armed services? \_\_\_\_\_ **NO** \_\_\_\_\_ **YES**

If you answered “**YES**,” provide a detailed explanation and supporting documentation on a separate sheet of paper. Be sure to sign and date all documentation. ***(Failure to provide an explanation or supporting documentation will delay the processing of this application.)***

**G. AFFIRMATION**

I accept the responsibility of supervising the listed physician assistant in the absence of the listed supervising physician in accordance with COMAR 10.32.03.07D as outlined in Section E. I hereby affirm under penalty of perjury that the information supplied to the Maryland Board of Physicians is true to the best of my knowledge and belief.

\_\_\_\_\_  
Alternate Supervising Physician (Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Alternate Supervising Physician (Signature)

\_\_\_\_\_  
Maryland License Number

## TEMPORARY PRACTICE LETTER REQUEST FORM FOR PHYSICIAN ASSISTANTS AND SUPERVISING PHYSICIANS

**INSTRUCTIONS: COMPLETE THIS PAGE AND ATTACH IT TO THE DELEGATION AGREEMENT ONLY IF YOU MEET THE CRITERIA FOR A TEMPORARY PRACTICE LETTER.** A physician assistant may request a temporary practice letter if the following conditions are met: (1) The Board previously approved a delegation agreement for the physician assistant with the same scope of practice as currently requested in the proposed delegation agreement; **AND** (2) The Board previously approved a delegation agreement for the supervising physician to supervise one or more physician assistants in the proposed practice setting for the same scope of practice as currently requested in the proposed delegation agreement.

A physician assistant and supervising physician **WILL NOT** qualify for a temporary practice letter if: (1) The supervising physician has never been approved by the Board to supervise a physician assistant; (2) the physician assistant has never practiced under an approved delegation agreement.

**(TYPE OR PRINT LEGIBLY)**

A. Name of physician assistant requesting temporary practice letter: \_\_\_\_\_  
\*(Please print full legal name)

B. Name of primary supervising physician requesting temporary practice letter: \_\_\_\_\_  
\*(Please print full legal name)

C. The Board previously approved a delegation agreement with the same scope of practice for the named physician assistant on \_\_\_\_\_ with \_\_\_\_\_.  
\*Board approval date                      \*Name of primary supervising physician on previously approved DA

D. The Board previously approved a delegation agreement for the named primary supervising physician to supervise one or more physician assistants in the proposed practice setting for the same scope of practice on \_\_\_\_\_.  
\*Date of Board approval                      \*Name(s) of physician assistant: \_\_\_\_\_

**\*Required fields** - Failure to complete the required fields will delay the processing of your temporary practice letter and delegation agreement.

**INSTRUCTIONS FOR SUBMITTING REQUESTS FOR APPROVAL OF ADVANCED DUTIES**  
Review Appendix B1 and Complete Appendix B2

**A. For Physician Assistants Who: (1) Have a new or existing delegation agreement; OR (2) Have never been approved to perform the requested advanced duty/duties:**

Please provide the following documentation:

1. Letter signed by both the supervising physician and physician assistant requesting the type of procedure(s) to be performed;
2. Documentation of, including but not limited to, the following:
  - a. Description of the procedure;
  - b. Procedure logs;
  - c. Advanced education and training, including training certificates indicating training completion or a delineation of hospital privileges;
  - d. Type of supervision during proposed procedure;
  - e. Consent form(s).

**EXAMPLES OF ADVANCED DUTIES: Arterial line insertion, thoracentesis, lumbar puncture, endometrial biopsy, exercise stress testing, venous cutdown, harvesting saphenous veins, nasal fiberoptic endoscopy, laser procedures and central line insertion.**

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**B. For Physician Assistants Who: (1) Have a new or existing delegation agreement; AND (2) Have been previously approved to perform the same advanced duties in the same practice setting.**

Please provide the following documentation:

1. Letter signed by both the supervising physician and physician assistant requesting the type of procedure(s) to be performed; and
2. Verification of the Board's previous approval to perform these duties.

**Please note that if the supervising physician/physician assistant cannot supply documentation verifying the Board's previous approval to perform these duties, the supervising physician/physician assistant will be required to follow Section A.**

REQUEST FOR APPROVAL OF ADVANCED DUTIES FORM

Supervising physicians and physician assistants, please complete the applicable parts of this form. **Attach this form to your supporting documentation.**

**PART 1: Physician Assistant Information:**

Maryland Certification Number: \_\_\_\_\_

\_\_\_\_\_  
Last Name (Generation: Sr., Jr., etc.)                      First Name                      Middle Name                      Maiden Name

**PART 2: Supervising Physician Information:**

Maryland License Number: \_\_\_\_\_

\_\_\_\_\_  
Last Name (Generation: Sr., Jr., etc.)                      First Name                      Middle Name                      Maiden Name

**PART 3: Physician Assistants, please check either A or B and sign.**

\_\_\_\_\_ A. I have never been approved by the Board to perform the requested advanced duties; I have included:

1. Letter signed by both the supervising physician and physician assistant requesting the type of procedure(s) to be performed;
2. Documentation of, including but not limited to:
  - a. Description of the procedure;
  - b. Procedure logs;
  - c. Advanced education/training, including training certificates indicating training completion or a delineation of hospital privileges;
  - d. Type of supervision during procedure;
  - e. Consent forms

\_\_\_\_\_ B. I have been approved by the Board to perform the same advanced duties, in the same setting; I have included:

1. Letter signed by both the supervising physician and physician assistant requesting the type of procedure(s) to be performed; and
2. Verification of the Board's previous approval to perform these duties.

\_\_\_\_\_  
Physician Assistant (Print)                      Physician Assistant (Signature)                      Date

**Part 4: Supervising physicians, please sign read and sign below. I ATTEST THAT:**

- (a) All medical acts to be delegated to the named physician assistant are within my scope of practice and are appropriate to the physician assistant's education, training, and level of competence;
- (b) I accept responsibility for any care given by the named physician assistant.
- (c) The policy of my practice is to notify patients in advance (ideally at the time of scheduling), in non-emergent situations, that a physician assistant will be the treating practitioner.
- (d) The policy of my practice is that either the physician assistant or I, discuss the nature and purpose of the proposed treatment or procedure; the risks and benefits of of not receiving or undergoing the treatment or procedure; alternative treatments and procedures; and risks and benefits of alternative treatments and procedures.

\_\_\_\_\_  
Supervising Physician (Print)                      Supervising Physician (Signature)                      Date

**ATTACH THIS FORM TO THE DOCUMENTATION SUPPORTING THE REQUEST TO PERFORM ADVANCED DUTIES**

MARYLAND BOARD OF PHYSICIANS  
P.O. BOX 2571  
BALTIMORE, MD 21215

**INSTRUCTIONS FOR COMPLETING  
TERMINATION OF EMPLOYMENT (DELEGATION AGREEMENT) REPORT**

Health Occupations Article, §15-103, Annotated Code of Maryland and COMAR  
10.32.03.07A(2)(a)(b)(c), 10.32.03.13 and 14

The supervising physician/employer must complete this report. All terminations must be reported to the Board within ten (10) days of termination of employment, except in the case of quality care which must be reported to the Board within five (5) days of termination employment.

Please complete the following information on the Termination of Employment (Delegation Agreement) Report form.

1. Date of termination - Report must be made within 10 days of any termination of employment. If the reason for the termination is a quality of care issue, the supervising physician/employer must report it to the Board within five (5) days.
2. Physician Assistant Information - Please print full legal name and the certification number.
3. Supervising Physician Information - Please print full legal name and the license number.
4. Locations of Practice/Health Care facility - Include all locations. If more than two locations, please use another sheet of paper. Include the name of the physician assistant and supervising physician on each additional sheet of paper.
5. Reasons for termination - Including, but not limited to:
  - Voluntary resignation;
  - Termination for conduct which may be grounds for discipline, i.e, quality of care issue. (Provide documentation for reason for termination):
  - Resignation after a notice of intent to terminate. Provide the reason(s) for the intent to terminate.
6. Signature, telephone number and e-mail address - Please be sure to print and write your name. Include a telephone number where you can be reached during the day and an e-mail address, if applicable.

**DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MARYLAND BOARD OF PHYSICIANS  
P.O. BOX 2571  
BALTIMORE, MD 21215**

**TERMINATION OF EMPLOYMENT (DELEGATION AGREEMENT) REPORT**

**1. Effective Date of Termination:** \_\_\_\_\_

**2. Physician Assistant Information (Please print):**

Certification number: \_\_\_\_\_

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Last Name	First Name	Middle Name	Maiden Name
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**3. Supervising Physician Information (Please print):**

License number: \_\_\_\_\_

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Last Name	First Name	Middle Name	Maiden Name
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**4a. Location(s) of Practice/Health Care Facility:**

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Facility/Practice Name

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Street Address

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City	State	Zipcode
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**b. Location(s) of Practice/Health Care Facility:**

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Facility/Practice Name

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Street Address

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City	State	Zipcode
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