WEST VIRGINIA BOARD OF MEDICINE
101 DEE DRIVE, SUITE 103, CHARLESTON, WEST VIRGINIA 25311,
(304) 558-2921
WWW.WVBOM.WV.GOV

PHYSICIAN ASSISTANT ALTERNATE SUPERVISING PHYSICIAN PRACTICE INFORMATION

A PHYSICIAN MAY SERVE AS AN ALTERNATE SUPERVISING PHYSICIAN IF:

1. The alternating supervising physician supervises in accordance with a practice agreement approved by the Board;

2. The alternate supervising physician supervises NO MORE than five physician assistants at any one time; or in a hospital or ambulatory surgical facility setting, no more than five physician assistants per shift;

3. The period of supervision, in the absence of the supervising physician, DOES NOT exceed a period of 45 consecutive days at any one time;

4. The physician assistant performs ONLY those medical acts that:
   a. Have been delegated under the practice agreement filed with the Board; and
   b. Are within the scope of practice of the supervising physician and the alternate supervising physician;

5. The alternate supervising physician is registered with the Board on the appropriate form.

In the event of a sudden departure, incapacity, or death of a supervising physician, a designated alternate supervising physician may assume the role of the supervising physician by submitting a new delegation agreement to the Board within 15 days.

The Board must be notified within 10 days by mail or e-mail (from the physician assistant, supervising physician, or the alternate supervising physicians personal e-mail account) when an alternate relationship has dissolved.

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ALTERNATE SUPERVISING PHYSICIAN INFORMATION FOR PHYSICIAN ASSISTANTS

Instructions: Alternate supervising physicians, supervising physicians, and physician assistants must complete the information below and send this form to the above address. Please complete a separate form for each designated alternate supervising physician.

1. ALTERNATE SUPERVISING PHYSICIAN INFORMATION:	
Name of Alternate Supervising Physician:	Professional Suffix (M.D., D.P.M., or D.O.):
West Virginia License #:	Preferred Contact Method:
Cell #: Work #:	E-mail Address:

2. PHYSICIAN ASSISTANT AND PRIMARY SUPERVISING PHYSICIAN INFORMATION:	
Name of Physician Assistant:	Name of Supervising Physician:
Original Signature of Physician Assistant: _____	Original Signature of Supervising Physician: _____

3. ALTERNATE SUPERVISING PHYSICIAN SCOPE OF PRACTICE: Please describe your scope of practice.

_____

_____

_____

_____

Primary Specialty: _____ **Secondary Specialty:** _____

4. ATTESTATION

I hereby attest that I have been furnished a copy of the practice agreement for the listed physician assistant. I accept the responsibility of supervising the listed physician assistant in the absence of his or her supervising physician. My supervision of the physician assistant will comply with the terms established in the practice agreement.

_____ _____
Alternate Supervising Physician (Print Name) Date

_____
Alternate Supervising Physician (Original Signature)