STATE OF WEST VIRGINIA
West Virginia Board of Medicine
101 Dee Drive, Suite 103
Charleston, West Virginia 25311
Telephone: (304) 558-2921
Website: www.wvbom.wv.gov

PHYSICIAN ASSISTANT/SUPERVISING PHYSICIAN PRACTICE AGREEMENT GUIDELINES

Prior to practicing as a Physician Assistant, you must file a Practice Agreement with the Board, and receive written authorization to practice under your proposed agreement.

Requirements:

1. All applicants must hold an active license under this Board to practice as a Physician Assistant in the State of West Virginia; or has submitted a complete application for licensure that is currently pending Board approval and/or temporary approval.

2. A nonrefundable fee of $100.00 is to be submitted with each Practice Agreement payable to the West Virginia Board of Medicine. The Board accepts credit card payments, money orders, and business, personal, or cashier's checks. The Board of Medicine will not accept cash payments. Please note: Any updates and/or changes to an existing Practice Agreement will require an additional $100.00 nonrefundable fee.

3. All Practice Agreements require original signatures. Practice Agreements will not be accepted by fax or e-mail. Photocopied applications will not be accepted. If your Practice Agreement is incomplete, you will be notified by mail or e-mail notifying you of the required revisions. Incomplete Practice Agreements will delay your opportunity to receive authorization to practice by this Board. This Board will not retroactively issue an authorization date of approval.

Please note: **This agreement may be typed using a computer or printed, signed with <u>original</u> signatures where required, and mailed to the Board Office.**

This office highly suggests practitioners complete each section by typing in the provided fields. If you choose to complete this Practice Agreement by hand, please print clearly and use black or blue ink. Illegible submissions will be returned.

Prior to making a determination of authorization of a Practice Agreement, additional information and/or clarification from the Physician Assistant and/or Supervising Physician may be required.

The Board has at least fifteen (15) days to review each Practice Agreement upon receipt.

Instructions:

Page 1: Complete this page in its entirety. The name entered in Sections 3 and 6 must match the legal names on file with this Board.

Provide e-mail addresses in Sections 4 and 7 (by which the individual parties may be contacted directly).

Page 2: Complete this page in its entirety.

Section 8: Provide information for all practice locations and practice settings where the Physician Assistant will practice 20% or more of the time pursuant to this practice agreement (only list practice locations and practice settings in West Virginia under the jurisdiction of this Board). Practice Setting Description would specify the work setting. A few examples would include physician office, clinic, outpatient clinic, urgent care, hospital, surgical center, emergency room, school-based health center, nursing home, etc.

Section 9: Provide a description of the supervising physicians scope of practice and list the supervising physicians primary specialty and if applicable, a secondary specialty.

Page 3-5: Must be completed by the Supervising Physician.

Section 10: Check all that apply.

Section 10(a): Complete this section in its entirety. The Physician Assistant Evaluation must describe some level of onsite/in person interaction and oversight with the Physician Assistant. The Supervising Physician must describe the processes and/or protocols of how he/she will review the Physician Assistant's practice. Descriptions of processes and/or protocols may include how often chart reviews will be conducted including the frequency of the reviews, overview of the Physician Assistant's activities to ensure that Supervising Physician's directions are being implemented, etc.

Section 11: Complete each applicable section to what Delegated Medical Acts the Supervising Physician intends to delegate to the Physician Assistant within this agreement.

11(A): By checking this box the Supervising Physician is delegating all of the core duties as specified in W. Va. Code R. §11-1B-9 (the Legislative Rule can be found on the Boards website, by clicking on the "Rules" link under Laws and Rules, and clicking on the second link "Series 1B (Emergency Amended Rule)."

11(C): If delegating this Medical Act the Supervising Physician must indicate (1) types of chronic care conditions the Physician Assistant will treat and (2) in what situations will the patient see the Supervising Physician for evaluation.

11(D): If delegating this Medical Act the Supervising Physician must provide a description of any medical care that would be performed in an emergency situation that would allow the Physician Assistant to provide medical care that may occur outside of the Physician Assistant's stated practice setting(s). This Medical Act does not relate to the Physician Assistant's normal practice in a controlled practice/facility setting.

11 (E (1)): Advanced duties for Hospital and Ambulatory Surgical Facilities listed in Appendix A is a reference list noting those duties that have previously been approved in

the past for this setting type. This list can be used as a reference when considering the submission for advanced duties in such setting.

11 (E (2)): Advanced duties for Office Based settings are duties, which may be reviewed by Board staff for approval. If a Physician Assistant has not previously been approved by this Board for the advanced duty, the Physician Assistant must submit a procedure log with the Practice Agreement and/or a training certificate of the requested advanced duty. The procedure log must demonstrate that the Physician Assistant has successfully performed the requested procedure on at ten (10) occasions under the direction of the supervising physician. The procedure log needs to include a description of the procedure and the date the procedure was performed. Please omit any identifying patient information by using whiteout or a black magic marker. The procedure log must be signed with original signatures by the Physician Assistant and the Supervising Physician. The Supervising Physician must indicate in the Practice Agreement that the Physician Assistant can perform the advanced duty under the appropriate level of supervision that is identified in the Practice Agreement.

Section 12: If the Supervising Physician intends to delegate prescriptive authority the Physician Assistant must comply with W. Va. Code R. §11-1B-12, and understand the requirements and prescribing limitations.

Appendixes:

Appendix A: This is a reference list compiled by the Physician Assistant Committee of Advanced Duties that have been approved in the past. This list will be updated as new requests are approved by the Committee. This document is located with the Practice Agreement links on the Boards website. If a Practice Agreement contains any Advanced Duty not found on this list, the advanced duties will be presented to the Board at its next regularly scheduled meeting. In such instances the Board staff may issue the Physician Assistant authorization to practice pursuant to all portions of the practice agreement that does not require Board review.

Appendix B: This form is for the designation of an Alternate Supervising Physician by the Supervising Physician. In order to designate an Alternate Supervising Physician the alternate form must be submitted with the Practice Agreement or for Practice Agreements already authorized the alternate form can be submitted at any time. Board staff will send a confirmation e-mail notification to the Supervising Physician, Alternate Supervising Physician, and Physician Assistant. 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. Please send all e-mail correspondence to our Physician Assistant Licensure Analyst at Ryan.P.Moore@wv.gov . The notification needs to include all parties involved and an effective deletion date. Once this correspondence is received all parties involved will receive a confirmation e-mail of receipt. There is no fee for the addition, deletion, and/or change of an Alternate Supervising Physician

Additional Forms:

a. **Notification of Termination of a Practice Agreement**:

This form is to be used when an authorized Practice Agreement between the Physician Assistant and the Supervising Physician terminates. Please keep in mind that if a Practice Agreement terminates with the Supervising Physician then any designated Alternate Supervising Physician(s) delegated in that particular Practice Agreement would also end. This form must be completed in its entirety along with original signatures before any change becomes effective. Faxed and e-mailed termination forms will not be accepted.

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Physician Assistant/ Supervising Physician Practice Agreement

Physician Assistant Information: Type or Print Legibly			
1. West Virginia License # (if applicable)**:**		**2. NCCPA Certification #:**	**Expiration:**
3. Identifying Information:			
Last Name:	**First Name:**	**Middle Name:**	
4. Mailing Address and Contact Information:			
Street Address 1:			
Street Address 2:			
City:	**State:**	**Zip:**	**County:**
Home #:		**Cell #:**	
E-mail Address:			
Preferred Method of Contact:			
Physician Information: Type or Print Legibly			
5. West Virginia License #:			
6. Identifying Information:			
Last Name:	**First Name:**	**Middle Name:**	
7. Mailing Address and Contact Information:			
Street Address 1:			
Street Address 2:			
City:	**State:**	**Zip:**	**County:**
Home #:		**Cell #:**	
E-mail Address:			
Preferred Method of Contact:			

8. Location(s) and Practice Setting(s):

Facility/Practice Name: **Department** (if applicable)**:**

Physical Address 1:

Physical Address 2:

City:	**State:**	**Zip:**	**County:**

Telephone #: **Extension #:**

Practice Setting Description:

Facility/Practice Name: **Department** (if applicable)**:**

Physical Address 1:

Physical Address 2:

City:	**State:**	**Zip:**	**County:**

Telephone #: **Extension #:**

Practice Setting Description:

Facility/Practice Name: **Department** (if applicable):

Physical Address 1:

Physical Address 2:

City:	**State:**	**Zip:**	**County:**

Telephone #: **Extension #:**

Practice Setting Description:

Facility/Practice Name: **Department** (if applicable):

Physical Address 1:

Physical Address 2:

City:	**State:**	**Zip:**	**County:**

Telephone #: **Extension #:**

Practice Setting Description:

Facility/Practice Name: **Department** (if applicable)**:**

Physical Address 1:

Physical Address 2:

City:	**State:**	**Zip:**	**County:**

Telephone #: **Extension #:**

Practice Setting Description:

9. Scope of Practice: Please describe the scope of the supervising physician.

Primary Specialty:	**Secondary Specialty**:

10. Supervision: Which of the following best describes the continuous physician supervision mechanisms to be utilized in your practice? Please check all that apply.

- ☐ On-Site/In Person
- ☐ Written Instructions
- ☐ Electronic Communications
- ☐ Alternate Supervising Physician (Please complete Appendix B)
- ☐ Monthly On-Site/In Person Meetings for Physician Assistants who have been practicing for less than one year

10(a). Physician Assistant Evaluation: Please 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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11. Delegated Medical Acts: Please check all that apply and provide the additional necessary information.

I intend to delegate the following medical acts:

- ☐ A) Core Duties (as specified in W. Va. Code R. §11-1B-9)
- ☐ B) Pronouncement of Death
- ☐ C) Chronic Care: Please describe under what conditions patients being treated regularly for a life-threatening, chronic, degenerative, or disabling condition shall be seen by the supervising physician.

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- ☐ D) Description of Emergency Care: Please provide a description of any medical care the physician assistant will provide in an emergency outside of their stated practice setting (please refer to the Practice Agreement instructions for examples).

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- ☐ E) 1) Advanced Duties in a Medical Specialty (please refer to Appendix A for examples as necessary):

  1) For advanced duties performed at a hospital or ambulatory surgical facility please submit the following:

     a. A copy of the approved delineation of duties from the governing board of the health care facility stating the physician assistant has been approved;

     b. Certification that the supervising physician and physician assistant are credentialed by the hospital or ambulatory facility; and

     c. A description of the advanced duties and the education, training, and experience that qualifies the physician assistant to perform these duties. (continue on page 4)

11. E) 1) Continued

☐ E) 2) For advanced duties performed in all other practice locations please submit the following:

a. Documentation of the specialized education, training, and experience received by the physician assistant in order to perform the advanced duties (experience may consist of logs of 10, that includes the procedure performed, procedure date, and signed by the supervising physician and physician assistant); and

b. A description of the advanced duties to be delegated and the level of supervision to be utilized when such advanced duties are performed (i.e. general, direct, or personal supervision).

Attestation of the Supervising Physician Regarding Delegated Duties

As the supervising physician, I hereby attest that all of the medical acts which may be delegated to the physician assistant pursuant to this Practice Agreement, are within my scope of practice, and that all such medical acts are appropriate to the physician assistant's education, training, and level of competence.

Supervising Physician (Print or type legibly)

Supervising Physician (Original Signature) Date

Attestation of the Physician Assistant Regarding Delegated Duties

I agree that if authorized by the Board, I will practice as a physician assistant within the authority delegated to me pursuant to this Practice Agreement.

Physician Assistant (Print or type legibly)

Physician Assistant (Original Signature) Date

Prescribing Limitations for Physician Assistants

1) Physician Assistants may not prescribe: any Schedule I or II Controlled Substances of the Uniform Controlled Substances Act; Clozapine; Antineoplastics and Chemotherapeutic agents used in the active treatment of cancer; Radio-Pharmaceuticals; Radiographic Contrast Materials; or General Anesthetics.

2) Physician Assistants may prescribe Schedule III Controlled Substances, but no greater than a non-refillable 72-hour supply.

3) Physician Assistants may prescribe Schedule IV or V Controlled Substances, but for no more than 90 dosage units or a 30-day supply, whichever is less, and the prescription may not authorize a refill.

4) Physician Assistants may generally prescribe prescription drugs which are not excluded or otherwise limited hereinabove for up to 6 months, and physician assistants may prescribe up to an annual supply of any drug, other than a controlled substance, for the treatment of a chronic condition (other than chronic pain management) as defined by the Board's legislative rules governing the practice of physician assistants.

12. Delegation of Prescribing and Ordering Authority

I intend to delegate to this physician assistant the:

- ☐ prescribing of medications
- ☐ ordering of medications and/or medical equipment
- ☐ administering and/or dispensing of medications

The delegation of all such activities must comply with the limitations set forth in the West Virginia Board of Medicine's Physician Assistant Formulary.

Please describe the prescription review and/or order countersigning protocols you intend to follow.

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Attestation of the Supervising Physician and Physician Assistant for the Delegation of Prescriptive Authority.

As the supervising physician and physician assistant submitting this Practice Agreement, we hereby attest that:

1) All prescribing activities of the physician assistant shall comply with applicable state and federal law governing the practice of physician assistants;

2) All medical records and charts shall contain a notation of any prescriptions written by the physician assistant;

3) All prescriptions written by the physician assistant pursuant to this delegation of authority shall legibly include on the prescription form, whether it be a paper or electronic script: (1) the physician assistant's name; and (2) the supervising physician's name, business address, and business telephone number; and

4) We understand the eligibility criteria for the delegation of prescriptive authority to physician assistants, and have reviewed documentation which establishes that this physician assistant has successfully completed each of the requirements set forth by this Board to prescribe, and is eligible for the delegation of prescriptive authority.

_____
Supervising Physician (Print legibly)

_____ _____
Supervising Physician (Original Signature) Date

_____
Physician Assistant (Print legibly)

_____ _____
Physician Assistant (Original Signature) Date