



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/COLLABORATING PHYSICIAN PRACTICE AGREEMENT GUIDELINES AND INSTRUCTIONS

A physician assistant (“PA”) licensed by this Board must have an authorized practice agreement in place to collaborate with a medical doctor or a podiatric physician. When making practice plans, please expect the practice agreement review process to take at least fifteen days after the Board’s receipt of a completed practice agreement. The authorization process may be delayed if a proposed practice agreement must be returned for additional information and/or clarification. Authorizations are not issued retroactively for any reason. **DO NOT COMMENCE PRACTICE AS A PHYSICIAN ASSISTANT UNTIL YOU RECEIVE WRITTEN NOTICE THAT THE BOARD HAS AUTHORIZED YOUR PRACTICE AGREEMENT.**

To seek authorization to practice in collaboration with a MD or DPM:

1. Submit a **complete and legible** proposed practice agreement on the form provided with **all required documentation**. All practice agreements require **original signatures**. For this reason, practice agreements are not accepted by fax or e-mail.

and

2. Enclose a nonrefundable **\$100** practice agreement fee with each proposed practice agreement. The Board accepts credit card payments, money orders, and business, personal, or cashier’s checks. The Board of Medicine **will not accept cash payments**. Any updates and/or changes to an existing practice agreement will require the submission of the \$100.00 nonrefundable fee.

Instructions: Complete this application in its entirety.

Page 1:

The names provided and entered in Sections 2 and 5 must match the legal names on file with this Board.

The Board will use e-mail to contact the PA and collaborating physician regarding the proposed practice agreement. Please provide complete and accurate contact information, including current e-mail addresses.

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Section 7: Provide information for every West Virginia practice location and practice setting where the PA will or may practice pursuant to the delegation set forth in this practice agreement. “Practice Setting Descriptions” include: office; clinic; outpatient clinic; urgent care; hospital; surgical center; emergency room; school-based health center; and nursing home.

Page 3-5:

These pages should be completed by the collaborating physician and signed by both parties to the agreement.

Section 8: Please describe the collaborating physician's scope of practice. A collaborating physician may only delegate those medical acts which are within his or her scope of practice and customary to his or her practice. A physician assistant may not perform any services which his or her collaborating physician is not qualified or, in a hospital setting, credentialed to perform. List the collaborating physician's primary specialty in the space provided. If applicable, a secondary specialty may also be included.

Section 9: Please select all applicable categories of collaboration.

Section 10: The "Physician Assistant Evaluation" narrative should describe some level of periodic on-site/in-person interaction and oversight of the PA by the collaborating physician. The collaborating physician must also describe the processes and/or protocols of how he/she will review the PA's practice, including a description of how often chart reviews will be conducted and what other methods the collaborating physician will use to maintain oversight of the PA's practice.

Section 11: Identify all categories of medical acts to be delegated pursuant to the proposed practice agreement. **If a category is not selected, the collaborating physician has elected not to delegate that category of medical acts.**

If the practice agreement contemplates the delegation of advanced duties, please ensure that the appropriate section is completed and all required documentation is provided.

11.E.1. Advanced duties **in a hospital or ambulatory surgical facility** require the submission of credentialing and privileges documentation from the facility for both the collaborating physician and the PA.

11.E.2 Advanced duties in **any other practice setting** generally require the submission of a procedure log. If a Physician Assistant has not previously been approved by this Board for the requested advanced duty, the PA must submit a procedure log with the practice agreement and/or a training certificate related to the requested advanced duty. Procedure logs must demonstrate that the PA has successfully performed the requested procedure on at least ten (10) occasions under the personal direction of the collaborating 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.** The procedure log must include original signatures of the PA and the collaborating physician. The collaborating physician must indicate in the practice agreement that the PA can perform the advanced duty, and specify the level of collaboration required. For a list of advanced duties which have previously been approved by the Board, please review Appendix A.

Beginning October 20, 2017, to delegate the advanced duty of Medication Assisted Treatment (MAT), please review the MAT Additional Instructions.

Section 12: This section governs the delegation of prescriptive authority. The collaborating physician must provide details of the proposed delegation, and both parties must execute the required attestation. If this is the PA's first request for the delegation of prescriptive related privileges, the PA must submit evidence of completion of a Board approved three (3) hour continuing education course on drug diversion training and best practice prescribing of controlled substances.

USE APPENDIX B TO DESIGNATE ALTERNATE COLLABORATING PHYSICIANS.



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Physician Assistant/Collaborating Physician Practice Agreement

Type or Print Legibly

1. Physician Assistant Information:			
WV License # (if applicable):			
2. Physician Assistant Identifying Information:			
First Name:	Middle Name:	Last Name:	Suffix:
3. Mailing Address and Contact Information:			
Street Address 1:			
Street Address 2:			
City:	State:	Zip:	County:
Home #:		Cell #:	
E-Mail:			
4. Physician Information:			
WV License #:			
5. Physician Identifying Information:			
First Name:	Middle Name:	Last Name:	Suffix:
6. Mailing Address and Contact Information:			
Street Address 1:			
Street Address 2:			
City:	State:	Zip:	County:
Home #:		Cell #:	
E-Mail:			

7. Location(s) and Practice Setting(s):			
1.) Facility/Practice Name:		Department (if applicable):	
Physical Address 1:			
Physical Address 2:			
City:	State:	Zip:	County:
Phone #:		Extension:	
Practice Setting Description:			
2.) Facility/Practice Name:		Department (if applicable):	
Physical Address 1:			
Physical Address 2:			
City:	State:	Zip:	County:
Phone #:		Extension:	
Practice Setting Description:			
3.) Facility/Practice Name:		Department (if applicable):	
Physical Address 1:			
Physical Address 2:			
City:	State:	Zip:	County:
Phone #:		Extension:	
Practice Setting Description:			
4.) Facility/Practice Name:		Department (if applicable):	
Physical Address 1:			
Physical Address 2:			
City:	State:	Zip:	County:
Phone #:		Extension:	
Practice Setting Description:			
5.) Facility/Practice Name:		Department (if applicable):	
Physical Address 1:			
Physical Address 2:			
City:	State:	Zip:	County:
Phone #:		Extension:	
Practice Setting Description:			

COPY THIS PAGE IF YOU PRACTICE AT MORE THAN FIVE LOCATIONS

8. Scope of Practice: Please describe the scope of the collaborating physician.

Primary Specialty:	Secondary Specialty (if applicable):
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9. Collaboration: Which of the following best describes the continuous physician/PA collaboration mechanisms to be utilized in your practice: Please check all that apply.

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

10. Physician Assistant Evaluation: Please describe the process by which the collaborating physician will personally review the physician assistant’s practice, appropriate to the practice setting and consistent with current standards of acceptable medical practice. (Minimum required frequency of review is quarterly. Please list either the number of, or the percentage of, charts to be reviewed.)

11. Delegated Medical Acts:

In addition to Core Duties and Signature Authority (as specified in W. Va. Code R. §11-1B-9), I intend to delegate the following medical acts:

- A) Pronouncement of Death
- B) Completion of Death Certifications §11-1B-9.5.b (To delegate this responsibility, the collaborating physician must ensure the PA has been appropriately trained.)
- C) Chronic Care, with the understanding that a patient being treated regularly for a life-threatening, chronic, degenerative, or disabling condition shall be seen by the collaborating physician as frequently as the patient’s condition requires.
- D) Emergency Care: The physician assistant is delegated authority to act within his or her education, training and experience in an emergency situation where inaction or the absence of care would be detrimental to patient and/or public safety.
- E) 1 For advanced duties in a hospital and/or ambulatory surgical facility please submit the following:
 - a. A copy of each of the approved delineation of duties from the governing board of the health care facility stating the collaborating physician and physician assistant have been approved; and
 - b. Certification the collaborating physician and physician assistant are credentialed by the hospital or ambulatory facility.

In the space below, please describe the education, training and experience that qualifies the physician assistant to perform these duties.

