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 FOR PRACTICE IN ALL PRACTICE SETTINGS EXCEPT HOSPITALS

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 for all non-hospital practice settings. **Hospital based practice requires the submission of a Practice Notification. Please contact the Board if you have questions regarding your practice location.** 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 FROM THE BOARD THAT YOU ARE AUTHORIZED TO PRACTICE.**

To seek authorization to practice in collaboration in non-hospital settings 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 email.

   and

2. Enclose a nonrefundable **$100** Practice Agreement fee with each proposed Practice Agreement. The Board accepts 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 a new Practice Agreement and 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 email to contact the PA and collaborating physician regarding the proposed Practice Agreement. Please provide complete and accurate contact information, including current email addresses.

Page 2:

Section 7: Provide information for every West Virginia practice location and non-hospital 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; ambulatory surgical center; school-based health center; and nursing home. Please check the appropriate response regarding whether or not your practice at this location will involve the provision of healthcare to patients via telemedicine technologies.

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 an ambulatory surgical center, 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 an 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 non-hospital 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.

To delegate the advanced duty of Medication Assisted Treatment (MAT), please review the MAT Additional Instructions, which are available on the Board's website.

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 #:**	
Email:			
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 #:**	
Email:			

7. Location(s) and Practice Setting(s):
For each location/setting please indicate whether or not you will be practicing via telemedicine at this site by checking the appropriate box.

1.) Facility/Practice Name:			
Physical Address 1:			
Physical Address 2:			
City:	**State:**	**Zip:**	**County:**
Phone #:		**Extension:**	
Practice Setting Description:		**Telemedicine at this site:** **____ Yes** **____ No**	
2.) Facility/Practice Name:			
Physical Address 1:			
Physical Address 2:			
City:	**State:**	**Zip:**	**County:**
Phone #:		**Extension:**	
Practice Setting Description:		**Telemedicine at this site:** **____ Yes** **____ No**	
3.) Facility/Practice Name:			
Physical Address 1:			
Physical Address 2:			
City:	**State:**	**Zip:**	**County:**
Phone #:		**Extension:**	
Practice Setting Description:		**Telemedicine at this site:** **____ Yes** **____ No**	
4.) Facility/Practice Name:			
Physical Address 1:			
Physical Address 2:			
City:	**State:**	**Zip:**	**County:**
Phone #:		**Extension:**	
Practice Setting Description:		**Telemedicine at this site:** **____ Yes** **____ No**	
5.) Facility/Practice Name:			
Physical Address 1:			
Physical Address 2:			
City:	**State:**	**Zip:**	**County:**
Phone #:		**Extension:**	
Practice Setting Description:		**Telemedicine at this site:** **____ Yes** **____ No**	

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):**

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 an 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 ambulatory facility.

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

☐ E) 2 For advanced duties in all other non-hospital locations, please submit 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 include the procedure performed, the procedure date and the signature of the collaborating physician and PA. Please refer to Appendix A for examples of advanced duties.

For the delegation of Medication Assisted Treatment (MAT), please refer to the Additional Instructions for the Delegation of MAT.

In the space below, please provide a description of the advanced duties to be delegated and the level of collaboration to be utilized when such duties are performed (i.e. general, on-site, or personal collaboration).

Attestation of the Collaborating Physician Regarding Delegated Duties

As the collaborating 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. I will appropriately evaluate the practice of the physician assistant at regular intervals.

Collaborating Physician's name

Collaborating Physician's 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's name

Physician Assistant's 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; Radio-Pharmaceuticals; or General Anesthetics.
2) Physician assistants may prescribe Schedule III Controlled Substances, but no greater than a non-refillable 30-day supply.
3) Physician assistants may generally prescribe Schedule IV or V Controlled Substances, pursuant to the restrictions imposed by the collaborating physician in section 12 below.
4) Physician assistants may generally prescribe prescription drugs which are not excluded or otherwise limited hereinabove for 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 Prescriptive Authority

If this is a PA's first request for the delegation of prescriptive authority in WV, the PA must submit evidence of completion of a Board approved 3-hour course on drug diversion training and best practice prescribing of controlled substances.

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 ***(PA's may only dispense controlled substances after registering with the Board as a controlled substance dispensing practitioner pursuant to 11 CSR5.)***

This delegation includes the following classes of medications:

Check the box to delegate:	Medications	Please identify any additional limitations or restrictions to the quantities or frequency of prescribing for each delegated class of medications. If you do not have any additional restrictions, please write "none".
	Schedule III * (30-day no refills)	
	Schedule IV	
	Schedule V	
	Non-controlled prescription medications	

***Prescribing of Suboxone/buprenorphine requires delegation of MAT.**

Attestation of the Collaborating Physician and Physician Assistant for the Delegation of Prescriptive Authority

As the collaborating 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, including electronic prescriptions, written by the physician assistant will include the physician assistant's name, professional designation, practice location, telephone number, signature, license number issued by the Board, the collaborating physician's name, business address and business telephone number, and any other information required by state and federal law; 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.

_____ _____

Collaborating Physician's signature Date

_____ _____

Physician Assistant's signature Date