



**LIST ALL SUPERVISING PHYSICIAN(S) TO BE APPROVED:** Complete the following for each PRACTICE SITE. (Use additional sheets if necessary.)

<b>Primary Supervising Physician's Name:</b>		License Number:	
Specialty:	Number of physician assistants being supervised (including this applicant):		
Name of Practice Site(s):			
Address of Practice Site(s):			
City:		State:	Zip:
Primary Supervisors Phone Number:		Primary supervisors email:	
Percent of Direct Supervision:		Number of hours working per week:	
<b>Substitute Supervising Physician's Name:</b>		License Number:	
Specialty:			
<b>Substitute Supervising Physician's Name:</b>		License Number:	
Specialty:			
<b>Substitute Supervising Physician's Name:</b>		License Number:	
Specialty:			

<b>Primary Supervising Physician's Name:</b>		License Number:	
Specialty:	Number of physician assistants being supervised (including this applicant):		
Name of Practice Site(s):			
Address of Practice Site(s):			
City:		State:	Zip:
Primary Supervisors Phone Number:		Primary supervisors email:	
Percent of Direct Supervision:		Number of hours working per week:	
<b>Substitute Supervising Physician's Name:</b>		License Number:	
Specialty:			
<b>Substitute Supervising Physician's Name:</b>		License Number:	
Specialty:			
<b>Substitute Supervising Physician's Name:</b>		License Number:	
Specialty:			

<b>Primary Supervising Physician's Name:</b>		License Number:	
Specialty:	Number of physician assistants being supervised (including this applicant):		
Name of Practice Site(s):			
Address of Practice Site(s):			
City:		State:	Zip:
Primary Supervisors Phone Number:		Primary supervisors email:	
Percent of Direct Supervision:		Number of hours working per week:	
<b>Substitute Supervising Physician's Name:</b>		License Number:	
Specialty:			
<b>Substitute Supervising Physician's Name:</b>		License Number:	
Specialty:			
<b>Substitute Supervising Physician's Name:</b>		License Number:	
Specialty:			

**SUMMARY OF SUPERVISING PHYSICIAN: This page must be completed with all primary and substitute supervising physicians for all locations where you are working.** Use additional sheets if necessary.

**Supervising Physician's Name:**  
 Primary  Substitute  Current/Remaining

**AFFIDAVIT FOR SUPERVISING PHYSICIAN(S)** *(Use additional sheets if necessary.)*

I declare under penalty of perjury as follows:

1. I certify as a Supervising Physician, I have reviewed the types of supervision with the Physician Assistant.
2. I certify as a Supervising Physician, I have reviewed the frequency and mechanism of chart review with the Physician Assistant including the cosigning of all medical chart records of Schedule 2 or Schedule 3 prescriptions.
3. I certify as a Supervising Physician, I have reviewed the prescribing and administering of controlled substances including the cosigning of all medical chart records of Schedule 2 or Schedule 3 prescriptions with the Physician Assistant.
4. I certify as a Supervising Physician, I have reviewed my Scope of practice including my specialty with the Physician Assistant.
5. I certify as a Supervising Physician, I have reviewed the proper emergency procedures with the Physician Assistant.
6. I certify as a Supervising Physician, I have reviewed any additional considerations relating to the practice with the Physician Assistant.
7. I certify as a Supervising Physician, I have completed a “Delegation of Services Agreement” with the Physician Assistant.
8. I certify as a Supervising Physician, a copy of the Delegation of Services Agreement is on file at each of my Utah practice sites and is available to DOPL upon request.

**Signatures of all primary supervisors to be approved:**

Primary Supervising Physician Name: Primary Supervising Physician Signature:	Date:
Primary Supervising Physician Name: Primary Supervising Physician Signature:	Date:
Primary Supervising Physician Name: Primary Supervising Physician Signature:	Date:
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Primary Supervising Physician Name: Primary Supervising Physician Signature:	Date:

**AFFIDAVIT FOR THE PHYSICIAN ASSISTANT**

I declare under penalty of perjury as follows:

1. I certify as a Physician Assistant, I have reviewed the types of supervision with the Supervising Physician.
2. I certify as a Physician Assistant, I have reviewed the frequency and mechanism of chart review with the Supervising Physician including the cosigning of all medical chart records of Schedule 2 or Schedule 3 prescriptions
3. I certify as a Physician Assistant, I have reviewed the prescribing and administering of controlled substances including the cosigning of all medical chart records of Schedule 2 or Schedule 3 prescriptions with the Supervising Physician.
4. I certify as a Physician Assistant, I have reviewed my Scope of practice including my specialty with the Supervising Physician.
5. I certify as a Physician Assistant, I have reviewed the proper emergency procedures with the Supervising Physician.
6. I certify as a Physician Assistant, I have reviewed any additional considerations relating to the practice with the Supervising Physician.
7. I certify as a Physician Assistant, I have completed a “Delegation of Services Agreement” with the Supervising Physician.
8. I certify as a Physician Assistant, a copy of the Delegation of Services Agreement is on file at each of my Utah practice sites and is available to DOPL upon request.

PA Applicant Name: PA Applicant Signature:	Date:
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**NOTE: It is “unlawful conduct” under the Physician Assistant Practice Act to practice as a Physician Assistant if you are not under the supervision of a supervising Physician or substitute supervising Physician.**



# PHYSICIAN ASSISTANT NOTIFICATION OF CHANGE

## Application Instructions and Information

<b>Mandatory Attachment Check List</b> ( <i>Applications with incomplete attachments will not be considered and may be denied.</i> )	
<input type="checkbox"/>	Fill out Personal information section.
<input type="checkbox"/>	List all physicians to be removed as Supervisors or statement all current physicians will remain as supervisors.
<input type="checkbox"/>	List <b>ALL</b> physicians to remain or be added
<input type="checkbox"/>	Obtain <b>ALL PRIMARY</b> supervisors signatures, dates, and personally sign and date form
<input type="checkbox"/>	<b>Not practicing in Utah:</b> Fill in form on page 5, sign, and date.

1. **Social Security Number:** Your social security number is classified as a private record under the Utah Government Records Access and Management Act. If an SSN is not provided, the application is incomplete and may be denied.
2. **Address of Record:** The address you provide on this application will be your address of record. You are responsible to directly notify DOPL of any change to your address of record.
3. **Laws and Rules:** You are required to understand Utah laws and rules pertaining to your practice. The following laws and rules are available on the Internet at [www.dopl.utah.gov](http://www.dopl.utah.gov):
4. **Controlled Substance License:** You must hold a Utah controlled substance license **AND** a federal DEA registration to administer, possess, or prescribe a controlled substance in your practice in Utah.
5. **DEA Registration:** For DEA registration information, contact the Drug Enforcement Administration, Salt Lake District Office, 348 East South Temple, Salt Lake City, UT 84088. Telephone (801) 524-4389.
6. **Acceptable Forms of Payment:** Licensure fees can be paid by check or money order, made payable to "DOPL." Cash and debit/credit cards (*American Express, MasterCard, and Visa*) are also accepted in person at DOPL's main office – but not over the telephone.
7. **Mail Complete Application to:**

*By U.S. Mail*

Division of Occupational & Professional Licensing  
P.O. Box 146741  
Salt Lake City, Utah 84114-6741

*By Delivery or Express Mail*

Division of Occupational & Professional Licensing  
160 E 300 S, 1<sup>st</sup> Floor Lobby  
Salt Lake City, UT 84111-2305
8. **Telephone Numbers:** (801) 530-6628  
(866) 275-3675 – Toll-free in Utah