

AFFIDAVIT OF PRACTICE

Complete only one of the supervision options below:

Option 1: To be completed by applicants who will be practicing in Utah upon approval of this change.

You must complete a separate form for each primary supervisor. If more than two substitute supervisors, please attach a separate sheet with the name and license number of each additional supervisor.

Applicant's Name: _____

Supervising Physician: _____ **License Number:** _____

Telephone Number: _____ **Email:** _____

Substitute Supervising Physician: _____ **License Number:** _____

Substitute Supervising Physician: _____ **License Number:** _____

Total Number of PAs supervised (including the applicant): _____ **Full-Time Equivalent:** _____

Percentage of Direct Supervision for this applicant: _____

We, the undersigned, declare under penalty of perjury we have completed a "Delegation of Services Agreement" that meets the requirements of R156-70a-501 and have reviewed the agreement with each substitute supervising physician. A copy of the agreement is on file at each of the PAs Utah practice sites and will be made available to DOPL upon request.

Signature of Applicant: _____ Date _____

Signature of Supervisor: _____ Date: _____

Option 2: To be completed by applicants who will not immediately begin practice in Utah.

I declare under penalty of perjury that I will not be practicing as a Physician Assistant in Utah at this time. If, at any future time, I choose to practice in Utah, I agree to complete and submit to DOPL a "Notification of Change" form. I understand that I must receive approval from DOPL before I begin practice with the proposed supervisor(s).

Signature of Applicant: _____ Date _____