

	<p>COMMONWEALTH OF VIRGINIA</p>
	<p>BOARD OF MEDICINE Department of Health Professions 9960 Mayland Drive, Suite 300 Henrico, Virginia 23233-1463</p>
	<p>(804) 367-4501 (804) 527-4426 Fax</p>

PA Name: _____ **VA License Number** _____

Date of Birth: _____ **Social Security Number** _____ - _____ - _____

Please print or type name, address, city and state of public health or community setting where you will be volunteering:

Telephone Number: (_____) _____

Are you a graduate of an accredited Physician Assistant program?

Yes (please attach a copy of diploma) No (please contact the Board)

Are you currently certified by the National Commission on the Certification of Physician Assistants?

Yes (please attach copy of NCCPA certificate) No – (please contact the Board)

Name of Supervising Physician: _____

Specialty: _____ **License Number:** _____

Signature

***Name of Alternate Supervising Physician:** _____

Specialty: _____ **License Number:** _____

Signature

**If more than one alternate supervisor, please provide the above information on a separate sheet.*

PROTOCOL OF DUTIES: Please spell out the **1)** role and function of the assistant, **2)** indicating number of patients, **3)** types of illnesses, nature of treatments, special procedures and, **4)** the nature of the physician's availability ensuring direct physician involvement. **NOTE:** Invasive procedures other than those performed under general supervision (i.e. insertion of a nasogastric tube, bladder catheter, needle, or peripheral intravenous catheter, but not a flow directed catheter, minor suturing, venipuncture, and subcutaneous, intramuscular or intravenous injection).

This license will have prescriptive authority: Yes No

Approved by the Board of Medicine _____

Date: _____

Ahladin

Request for prescriptive authority from the PA

+

This is to request prescriptive authority pursuant to 18 VAC 85-50-130, 140 and 150 and

§54.1.2952.1; under the primary supervision of Dr. _____.

MD/DO/DPM/DC

I have verified that my school _____ is on the

(School Name)

*enclosed list of accepted pre-reported pharmacology requirements.

Signature of Physician Assistant _____

*If your school of graduation is not listed on the enclosed list, please contact them and have a letter submitted to the board verifying the minimum requirement of 35 hours of pharmacology courses covered in your curriculum.

Statement From Supervising Physician:

+

I am requesting prescriptive authority for the following schedule(s):

Schedule II _____ Effective July 1, 2007
Schedule III _____
Schedule IV _____
Schedule V _____
Schedule VI _____

As the primary supervising physician for the above named Physician Assistant, I attest to his/her competency to prescribe.

Signature of Supervising Physician _____

Print or type name _____ Date _____

Please note that only complete applications will be processed. Incomplete applications will not be acted upon or returned to the licensee for completion. If you have not received a written acknowledgement of your approved prescriptive authority within two weeks after submission of your request, please call the above number for assistance.