Kentucky Board of Medical Licensure

310 Whittington Parkway, Suite 1B, Louisville, KY 40222
502/429-7150, www.kbml.ky.gov

Addendums for Physician Assistant Licensure

Submission of these addendums is required along with your online application for physician assistant licensure. These addendums must be completed and mailed to the Board at the above address. Deadline dates for review by the Physician Assistant Advisory Committee, and subsequently the Board, are located on the Physician Assistant page (under the "Allied Health" tab on the home page) of the KBML website. **Please retain a copy of the completed application for your records. Future requests for a copy of your application will necessitate an Open Records Request to the Board's legal department.**

1. FORM 1 – Release and Waiver of Rights, **signed and notarized**. You are required to attach on this form an original passport-size photograph. All photos must be on photo quality paper (copies are not accepted).

2. FORM 2 – National Commission on Certification of Physician Assistants (NCCPA) Waiver: sign in to your account at www.nccpa.net to request release of your score. KY statute requires you to pass the PANCE examination within three **(3)** attempts.

3. FORM 3 – Verification of Licensure – **follow the instructions that each state requires for a licensure verification to any state in which you currently hold or have ever held a Physician Assistant certification/license.** Disregard if not applicable.

4. FORM 4 – Certification of Training – **complete and mail to the institution at which you completed your physician assistant program. Do not send transcript(s).**

5. Pediatric Abusive Head Trauma education documentation requirement (see information sheet).

6. Pursuant to current statute, you must provide proof of completion of a Kentucky Cabinet for Health Services approved HIV/AIDS Education Course (1.5 hrs) to this office. You can access a course online at www.netce.com The course number is 98903.

7. Background Check Requirement: See instruction sheet below for KSP/FBI new procedure as of 12/9/2020.

8. TYPED Application from KY licensed primary supervising physician **and** alternate supervising physician agreement form for Non Emergency Room setting. NOTE: THE SUPERVISING PHYSICIAN APPLICATION PDF IS ON THE PHYSICIAN ASSISTANT PAGE OF THE WEBSITE (http://www.kbml.ky.gov/ah/pa.htm). IT CONTAINS FILLABLE FIELDS; HOWEVER, ORIGINAL SIGNATURES ARE REQUIRED. THE COPY INCLUDED IN APPLICATION ADDENDUMS IS FOR YOUR REFERENCE ONLY.

9. $100 application fee from the primary supervising physician. Please attach payment form or include check with the supervising physician application. Payment must accompany this application.

10. Please make any changes/corrections to your mailing and/or practice addresses (if necessary) at: http://www.kbml.ky.gov/Address/.

11. If you need to begin working prior to Board approval, you may request a temporary license (request form is included in your application addendums). All application materials, including the supervising physician application, must be complete before your request for temporary licensure will be reviewed. Absent any complicating factors, the average application processing time is approximately three to four weeks.

12. Your application status is available on our website (log in with the user name and password you created). Please note that your application, if not completed, will expire one year from date you paid your application fee and all files will be purged two years from date of receipt.

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APPLICATION ADDENDUMS FOR PHYSICIAN ASSISTANTS

This documentation is part of the Physician Assistant application and must be completed. Your application is not considered COMPLETE until these documents are submitted to the Kentucky Board of Medical Licensure.

Name:_____ Social Security Number:_____

1. Physician Assistant Educational Training:

   Program and Location Dates (From - To)

   _____

   Course of Study: _____

2. Was the above program accredited by the Accreditation Review Commission on Education For Physician Assistants?
   YES ☐ NO ☐

3. National Commission on Certification of Physician Assistants (specifically # of attempts to pass PANCE Exam):

   Certificate # _____ Issue Date _____ Expiration _____ # of Attempts to Pass _____

4. In what states or provinces have you applied for or been granted certification/licensure as a Physician Assistant? If more than two, attach separate listing. If license not issued, so state.

   (a) _____
   (State Board) (License #) (Date Issued)

   (b) _____
   (State Board) (License #) (Date Issued)

5. EMPLOYMENT HISTORY -Beginning with the most recent, attach additional sheets if necessary to include all PA employment

   Dates: From - To _____ Position Held _____

   Name of Supervising Physician _____

   Business Address _____

   Type of Practice _____ Phone _____

   List Duties Performed in Practice _____

   _____

I Attest That:

A. I will not perform job duties and scope of medical services and procedures that have not been delegated to me by my supervising physician.
B. I will not prescribe or dispense controlled substances.
C. I will inform all patients I come in contact with of my status as a physician assistant.
D. I will wear identification that clearly states that I am a physician assistant.

Signature: _____ Date_____

Physician Assistant Request for Temporary License

If you need to begin working prior to Board approval, you may request a temporary license. All application materials, including the supervising physician application, must be complete before your request for temporary licensure will be reviewed. Absent any complicating factors, the average application processing time is approximately two to three weeks.

Name: _____

Supervising Physician Name: _____

Anticipated Starting Date: _____

TEMPORARY LICENSES ARE ONLY VALID FOR <u>UP TO SIX MONTHS</u>

AND CANNOT BE EXTENDED OR RENEWED

Pediatric Abusive Head Trauma
Education Documentation Requirements

In 2010, the Kentucky General Assembly passed House Bill 285. This bill requires various groups to complete a course in Pediatric Abusive Head Trauma, also known as "Shaken Baby Syndrome."

Pursuant to KRS 311.844 section (3)(d), the Board shall ensure that physician's assistant shall demonstrate completion of a one-time training course of one and one-half (1.5) hours of training covering the prevention and recognition of pediatric abusive head trauma, as defined in KRS 620.020. The one and one-half hours of continuing education required under this section shall be included in the current number of required continuing education hours.

You may want to check with the usual web-based CME providers, like TRAIN, NetCE or CME Resource. Should you choose NetCE, they have one by going to www.netce.com course number is 92404.

Send copy of **course completion certificate** to Teresa Kleinhenz at the Kentucky Board of Medical Licensure or email to Teresa.kleinhenz@ky.gov Do not send a copy of your scores or receipt – the Board must have a copy of the completion certificate.

Kentucky State Police and Federal Bureau of Investigation Criminal Background Check Requirement

Per KRS 311.565(t), all persons applying for a Kentucky Medical/Osteopathic License are required to submit proof of a Kentucky State Police (KSP) and Federal Bureau of Investigation (FBI) Criminal Background Check to the Board as a part of their application for a license to practice medicine in the Commonwealth.

NEW PROCEDURE AS OF DECEMBER 9, 2020

All applicants must pre-enroll online to schedule an appointment to have their prints taken at an IdentoGO facility (for KY residents) or at one of the nationwide enrollment centers (for residents outside of KY). You must use KBML's Service Code. Payment is made at registration. KBML will view the results online.

- Website to pre-enroll: https://uenroll.identogo.com/
- KBML's Service Code: 27GJVJ
- Cost: $51.25
- If you have questions regarding the pre-enrollment process on the IndentoGO website, please call their Customer Service number: **(844) 543-9714.**

Please note: KBML cannot provide the results of the background check to the applicant or anyone else per KRS 17.150(4). You may contact the KSP at (502) 227-8700 and complete a "Criminal History Review" for a fee of $20.

Your criminal background check is valid in our office for a period of one year (for active applications only).

Form 1

Release and Waiver of Rights Form

Name:_____ Social Security Number:_____

I, _____, hereby authorize the following individuals and entities to release all information (documented, oral or other) about me in their possession to the Kentucky Board of Medical Licensure (KBML) or its agents:

1. All hospitals or other health care facilities at which I have ever held staff privileges, whether full or limited, temporary or permanent; and all hospitals or other health care facilities at which I have ever received training.

2. All physician assistant organizations/societies, specialty boards and other related organizations with which I have been associated.

3. All supervising physicians and their associates with which I have been employed and/or associated.

4. All other state or Canadian licensure boards, federal health agencies, and federal and state drug control agencies.

5. All licensed physicians, nurses, physician assistants or other health care professionals of any state or Canadian province.

6. All schools of educational facilities at which I have ever received training as a physician assistant.

7. All attorneys who have participated in civil or criminal actions in which I am named party.

I hereby release the above-named individuals and entities from all liability for the release of information to the Board (KBML) or its agents.

I further authorize the Board (KBML) or any of its duly authorized agents, to make any investigations that they deem necessary to secure information concerning me which is relevant to the requirements of licensure. I further authorize them to release such information they may now or in the future have, concerning me to (i) any federal, state, county or local governmental entity, (ii) any hospital or other health care facility, or (iii) any other person upon a showing that the release of the information is vital to the health, safety and welfare of the general public.

I hereby make this release and waiver of rights for the purpose of allowing the Board (KBML) to carry out its duties pursuant to my request for licensure to practice as a physician assistant in the Commonwealth of Kentucky; and further, for the purpose of allowing the Board (KBML) to carry out its duties in regard to my continued licensure.

This release and waiver of rights has no expiration date and shall remain effective during my licensure in the Commonwealth of Kentucky.

_____ _____

Date Applicant

Sworn to and subscribed before me by the above named applicant on this _____day of _____, 20 ____.

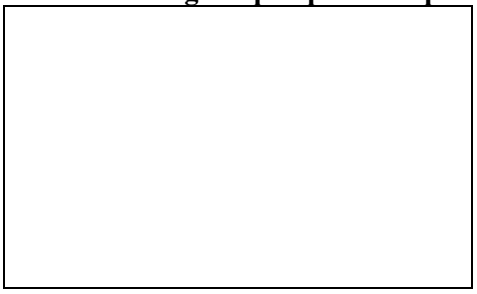
Seal

_____

Notary Public

My Commission expires:_____

Please attach original passport-size photograph.



Form 2

National Commission of Certification of Physician Assistant Score

Applicant: The best and most efficient way for PAs to request release of **exam score** is to submit the request through their own secure NCCPA account.

Sign in to your account at www.nccpa.net to request your score be sent to: Teresa Kleinhenz, PA Coordinator, Kentucky Board of Medical Licensure.

Form 3

Verification of Licensure
Physician Assistant

Please follow the guidelines for each state's requirement in regards to a licensure verification OR complete this section of the form and mail to each state board in which you are now or have been licensed. If needed, you may duplicate this form. (Disregard this form if not applicable.)

As a part of the application for licensure as a physician assistant, the Kentucky Board of Medical Licensure requires this form to be completed by each state in which I hold or have ever held licensure. I hereby authorize the release of any information in your files, favorable or otherwise to be sent directly to the Kentucky Board of Medical Licensure, 310 Whittington Parkway, Suite 1B, Louisville, KY 40222.

____, P.A.-C
Signature

____
Name

____
Address

____
License Number

• •

State of __________________ License/Registration # ________ Issue Date____________________

Full Name of License Holder: ____

Graduate of: ____

By: Endorsement/Reciprocity with ____

By: Your State Board's Written Examination ____

Is License Current? ______________________ If NO, Why? ______________________________

Has license been subject to disciplinary action by your agency? ______________________________
If YES, please attach copies of any formal orders of your agency and minutes of agency decisions.

Comments, if any ____

Signed : ____________________________________

Board Seal

Title: ____________________________________

Date: ____________________________________

Certification of Training

In applying for licensure as a Physician Assistant in the Commonwealth of Kentucky, the Kentucky Board of Medical Licensure requires this form to be completed by the training institution/school where I obtained a degree, diploma or certificate while training to be a physician assistant. My signature below is your authority to release any and all information in your files, favorable or otherwise regarding myself, directly to:

Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, KY 40222

____
Name

____

____
Address

____
Signature

• •

Certification of Training: (to be completed by the training institution/school where the physician assistant degree was conferred)

This is to certify that ____

Attended the ____

Located at ____

And was granted the degree of __________________ on ____________________________________.

____
Signature

Seal of institution

____
Title

____
Date

Kentucky Board of Medical Licensure

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Louisville, KY 40222
502/429-7150 www.kbml.ky.gov

Application to Supervise a Physician Assistant
KEEP THIS PAGE FOR FUTURE REFERENCE

THE SUPERVISING PHYSICIAN APPLICATION PDF CONTAINS FILLABLE FIELDS; HOWEVER, ORIGINAL SIGNATURES ARE REQUIRED. DO NOT SUBMIT HANDWRITTEN APPLICATIONS. The pdf can be located at: http://www.kbml.ky.gov/ah/pa.htm.

1. The Supplemental Application Scope of Practice of Physician Assistant (pages 12 & 13 of the Supervising Physician Application) is required to request additional scope of medical services and procedures only if the training has already been completed (*see Examples sheet)*.
2. The supervising physician application fee is **$100** and **must accompany the application.** If you are TRANSFERRING supervision from a physician previously approved by the Board to supervise this physician assistant to another physician within the same practice/group, the fee is $50.
3. **IMPORTANT: The Alternate Supervising Physician Agreement form must be submitted with the Supervising Physician Application if Non-Emergency Department, *Urgent Care facilities must provide the Alternate Supervising Physicians Agreement form.** Per Kentucky State Statute 311.854 Section 2 (c)(4) there must be one (1) or more physicians who agree in writing to accept responsibility for supervising the physician assistant in the absence of the supervising physician.

Incomplete applications will be returned. **Retain a copy of the completed application for your records. Future requests for a copy of your application will necessitate an Open Records Request to the Board's legal department.**

The Physician Assistant Advisory Committee meets quarterly to review applications and make recommendations to the Board for final approval (meeting dates can be located on the Physician Assistant page of the Board's website). Should you wish to begin employing the physician assistant prior to the Board meeting, there are provisions for temporary licensure for a new physician assistant applicant for Kentucky licensure; OR, tentative approval for supervising the physician assistant whose Kentucky license is active**.** Please note that temporary licensure or tentative approval must be granted prior to the physician assistant providing services under your supervision.

Should you have any questions regarding the above, please contact Teresa Kleinhenz at (502) 429-7932.

Definitions of Levels of Supervision

It is necessary to indicate on the application the level(s) by which you will be supervising a physician assistant.

Direct Supervision: This means the supervising physician is actually in sight of the physician assistant when the physician assistant is performing the function requiring direct supervision. Although the physician may be performing some other task at the time, the supervising physician may immediately provide direction or assume the performance of the task if difficulties arise. This does not require that the physician is watching "over the shoulder" of the physician assistant as would be required during the training period to ensure that the physician assistant is competent to perform the task.

On-site supervision: Requires the physical presence of the supervising physician in the same location (i.e. the physician's office suite) as the physician assistant, but does not require the physical presence in the same room.

Off-site supervision: The supervising physician must be continuously available for direct communication with the physician assistant when the physician assistant is at a separate location than the practice address of the primary supervising physician by means of the line of communication specified by the primary supervising physician on his/her Application for Physician to Supervise Physician Assistant filed with the Kentucky Board of Medical Licensure.

Matthew G. Bevin
Governor

Preston P Nunnelley, MD
President

Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222
Telephone: (502) 429-7150
www.kbml.ky.gov

The Supervising Application fee for the Supervising Physician Application is $100. You may pay the required fee by check, money order, or credit card. Make your check or money order payable to the Kentucky Board of Medical Licensure or KBML. Payment must accompany the submission of the application.

Please complete the following information:

_____
Payment of this fee is for the application to supervise (name of physician assistant)

_____
Submitted by (name of supervising physician)

Payment Type:

Check ☐
Check No. _____
Amount: _____

Money Order ☐
Money Order No. _____
Amount: _____

Credit Card ☐
Credit Card Type (i.e. Visa, Mastercard, etc.): _____
Amount: _____
Credit Card Holder Name: _____
Billing Address: _____
_____
Email Address of Card Holder: _____
Phone Number of Card Holder: _____

Credit Card Number:
☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Expiration Date ☐☐ ☐☐ (MM/YY)

Security Code ☐☐☐

This form will be destroyed upon the processing of your payment.

Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, KY 40222

Application for Physician to Supervise Physician Assistant

This application is to be completed by the supervising physician and all contact information must be that of the supervising physician. KBML inquiries in regard to this application will be directed to the supervising physician at the contact information provided. Inquiries from the supervising physician to the KBML may be directed to the physician assistant licensing coordinator at (502) 429-7932.

This form is available in a "pdf" format, with fillable fields, on the KBML's website, http://www.kbml.ky.gov/ah/pa.htm Once completed, it must be printed, signed and returned to the KBML. Original signatures are required. Incomplete applications will be returned.

Person to contact with phone number and email for Board questions: _____

1. Name of physician assistant: _____ KY License No. _____

2. Name of supervising MD/DO*: _____ KY License No. _____

3. Primary practice address of MD/DO: _____

** If your primary practice address is not within the Commonwealth of Kentucky, you must request a waiver by attaching a letter describing the nature and extent of your practice in Kentucky. (KRS 311.854(2)(b)) Applications without a necessary waiver request, will be deemed incomplete.*

_____
(Street, City, State, Zip)

4. Telephone No. _____ E-mail address: _____

5. Is your KY medical/osteopathic license active and in good standing? ____ Yes ____ No

6. If applicable, please list name(s) of physician assistants for whom you have previously applied to supervise:

_____
_____
_____

7. Supervising physician professional affiliations (e.g., American boards, Board eligibility, medical societies, hospital affiliations):

_____
_____
_____

8. Describe the specialty/nature of your medical/osteopathic practice: _____
_____
_____

Name of Physician Assistant: _____ Supervising Physician Name: _____

9. Describe the scope of services and procedures to be delegated by you to the physician assistant. (Note: (1) you may only delegate services and procedures which are within your normal scope of practice and (2) services and procedures to be performed must be limited to those for which the physician assistant has been trained in an approved program.): _____

_____

_____

_____

10. How is the physician assistant employed? (check one): __ Full-time (by you) __ Part-time (by you)
___ Employed by healthcare system/facility ___ Other: _____

11. Levels of supervision that apply: ___ Direct ___ On-Site ___ *Off-Site (*letterhead required)

***(See cover sheet for definitions of levels of supervision)

12. Outline the specific parameters for review of countersignatures (what is the agreement you have with the physician assistant with regards to reviewing of charts):

_____

_____

13. If separate from your primary practice address listed on this application, list all locations in which the physician assistant will practice under your supervision if so, a letter on letterhead must include the following per statute: **311.860 Services performed in location separate from supervising physician --Nonseparate location -- Definition and exceptions**. (2) A supervising physician who uses the services of a physician assistant in an office or clinic separate from the physician's primary office shall submit for board approval a specific written request that describes the services to be provided by the physician assistant in the separate office or clinic, the distance between the primary office and the separate location, and the means and availability of direct communication at all times with the supervising physician.
(**Note**: you must have privileges to practice in each location listed.) _____

_____

_____

_____

Name of Physician Assistant: _____ Supervising Physician Name: _____

14. Submitted with this application are the following:

___ Supervising Physician Application Fee and Fee Form

___ Affidavit of Supervising Physician (Non-Emergency Department)

or

___ Affidavit of Supervising Physician (Emergency Department)

___ Affidavit of Physician Assistant

___ Alternate Supervising Physician Agreement (if applicable)

Attestation

By submitting this application and signing below, I understand and agree that any false or misleading statements provided in conjunction with this application to supervise a physician assistant and/or my failure to abide by the attestations contained in the supporting affidavit may result in discipline, including up to revocation, against my license to practice medicine or osteopathy in the Commonwealth of Kentucky.

Date: _____ Signature: _____

Printed Name: _____

KY License No.: _____

***** Original signatures required *****
Return original to KBML/Faxes will not be accepted

Name of Physician Assistant: _____ Supervising Physician Name: _____

Alternate Supervising Physician Agreement

Note: If the supervising physician has submitted an Affidavit of Supervising Physician (Emergency Department) this Alternate Supervising Physician Agreement is not required.

Name of physician assistant: _____ KY License No. _____

Primary supervising MD/DO: _____ KY License No. _____

Attestation of Alternative Supervising Physician(s)

In compliance with KRS 311.854 Section 2(c), I agree to serve as an alternative supervising physician for the above-named physician assistant in connection with patients under my care and/or in the absence of the primary supervising physician. In furtherance thereof, I attest as follows:

1) I have read and understand the definition of "supervision" set forth in KRS 311.840(6) and I agree that I will oversee and accept responsibility for the medical services rendered by the physician assistant when under my supervision.

2) When under my supervision, I understand and agree that the physician assistant is my agent and I have authorized the physician assistant to act on my behalf, and subject to my control, to the extent described in the primary application. (KRS 311.858(2))

3) I understand that the physician assistant may not practice independently (KRS 311.858(9)) and to that end:
    a. I understand and agree that the physician assistant shall not submit direct billing for medical services and procedures. (KRS 311.858(6))
    b. I understand and agree that the physician assistant shall only perform services in offices, clinics, hospitals, or other licensed health care facilities where I am also authorized to practice. (KRS 311.858(8) and 311.860)
    c. I understand and agree that the scope of medical services and procedures to be performed by the physician assistant shall be limited to those described in the application and shall not exceed the normal scope of my own practice. (KRS 311.850(1)(j) and 311.854(2)(c))

4) When under my supervision, I understand and agree that I shall not allow the physician assistant to dispense controlled substances. (KRS 311.856(2))

5) When under my supervision, I understand and agree that I shall review and countersign a sufficient number of overall medical notes written by the physician assistant to ensure quality of care provided by the physician assistant. (KRS 311.856(11))

Name of Physician Assistant: _____ **Supervising Physician Name:** _____

6) I understand and agree that I shall notify the Board within three (3) business days if I cease to serve as an alternate supervising physician for the physician assistant or I have reason to believe in good faith that the physician assistant has violated any statute or regulation governing physician assistants. (KRS 311.858(13))

7) I understand and agree that any false or misleading statements provided in conjunction with this agreement and/or my failure to abide by the attestations contained herein may be grounds for discipline, including up to revocation, against my license to practice medicine or osteopathy in the Commonwealth of Kentucky. (KRS 311.595(1), (9) and/or (10))

Printed MD/DO Name(s)	KY License No.	Signature & Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Attestation of Primary Supervising Physician

I have read the above and agree that the above-named physician(s) shall serve as alternative supervising physician(s) in my absence.

Date: _____ Signature: _____

Printed Name: _____

KY License No.: _____

***** Original signatures required *****

Return original to KBML/Faxes will not be accepted

Name of Physician Assistant: _____ **Supervising Physician Name: _____**

Affidavit of Supervising Physician
(Non-Emergency Department)

I, _____, M.D./D.O., hereby certify that I am the person named in the application to supervise _____, PA-C, and being duly cautioned and sworn, I hereby affirm under oath as follows:

1) I have read and understand the definition of "supervision" set forth in KRS 311.840(6) and I agree that I will oversee and accept responsibility for the medical services rendered by the physician assistant.

2) I understand and agree that the physician assistant is my agent and I have authorized the physician assistant to act on my behalf, and subject to my control, to the extent described in the application. (KRS 311.858(2))

3) I understand that the physician assistant may not practice independently (KRS 311.858(9)) and to that end:
    a. I understand and agree that the physician assistant shall not submit direct billing for medical services and procedures. (KRS 311.858(6))
    b. I understand and agree that the physician assistant shall only perform services in offices, clinics, hospitals, or other licensed health care facilities where I am also authorized to practice. (KRS 311.858(8) and 311.860)
    c. I understand and agree that the scope of medical services and procedures to be performed by the physician assistant shall be limited to those described in the application and shall not exceed the normal scope of my own practice. (KRS 311.850(1)(j) and 311.854(2)(c))

4) I understand and agree that I shall not allow the physician assistant to dispense controlled substances. (KRS 311.856(2))

5) I understand and agree that I shall review and countersign a sufficient number of overall medical notes written by the physician assistant to ensure quality of care provided by the physician assistant. (KRS 311.856(11))

6) I understand and agree that I shall reevaluate the reliability, accountability and professional knowledge of the physician assistant every two (2) years and in order to recommend approval or disapproval of licensure renewal to the Board. (KRS 311.856(12))

7) I understand and agree that I shall notify the Board within three (3) business days if I cease to supervise or employ the physician assistant, or I have reason to believe in good faith that the physician assistant has violated any statute or regulation governing physician assistants. (KRS 311.858(13))

Name of Physician Assistant: _____ Supervising Physicians Name: _____

8) I understand and agree that any false or misleading statements provided in conjunction with the application to supervise the physician assistant and/or my failure to abide by the attestations contained herein may be grounds for discipline, including up to revocation, against my license to practice medicine or osteopathy in the Commonwealth of Kentucky. (KRS 311.595(1), (9) and/or (10))

Further, the Affiant sayeth naught.

Signature: _____

Printed Name: _____

License No.: _____

STATE OF KENTUCKY)
) ss
COUNTY OF _____)

Subscribed and sworn to before me by the Affiant, _____ M.D./D.O., this ___ day of _____, 202___. My commission expires on _____.

_____
NOTARY PUBLIC, STATE AT LARGE

ID #: _____

***** Original signatures required *****
Return original to KBML/Faxes will not be accepted

Name of Physician Assistant: _____ Supervising Physician Name: _____

Affidavit of Supervising Physician (Emergency Department)

Note: This affidavit is to be completed only by physicians applying to supervise physician assistants within an emergency department. These departments are typically governed by an incorporated entity, such as a healthcare system or hospital, and the physician assistants are typically employed by those entities. In such circumstances, the supervising physician typically does not have control over the practice schedule, environment or policies and procedures. If in doubt as to whether this affidavit applies to you, please contact the KBML's physician assistant licensing coordinator at (502) 429-7932.

I, _____, M.D./D.O., hereby certify that I am the person named in the application to supervise _____, PA-C, and being duly cautioned and sworn, I hereby affirm under oath as follows:

1) I have read and understand the definition of "supervision" set forth in KRS 311.840(6) and I agree that I will oversee and accept responsibility for the medical services rendered by the physician assistant.

2) I understand and agree that the physician assistant is my agent and I have authorized the physician assistant to act on my behalf, and subject to my control, to the extent described in the application. (KRS 311.858(2))

3) I understand and agree that the scope of medical services and procedures to be performed by the physician assistant under my supervision shall be limited to those described in the application and shall not exceed the normal scope of practice within the emergency department. (KRS 311.850(1)(j) and 311.854(2)(c))

4) Due to non-physician oversight of the emergency department and the variations in work schedules and multiple practice locations inherent to the practice of emergency medicine within incorporated health systems (e.g., Baptist Health, Norton Healthcare, St. Elizabeth, and university systems), I shall direct the physician assistant to abide by the following protocol for collaboration and clinician guidance:
    a. The physician assistant may initiate evaluation and treatment in an emergency situation without specific approval. (KRS 311.858(3))
    b. When the physician assistant and I are practicing in the same location and at the same time, I shall be responsible for providing the first line of support for the physician assistant. However, if I am unavailable (e.g., due to the focused management of a patient) and the physician assistant needs immediate support, the physician assistant shall contact another on-site physician in the emergency department or the on-call medical director for the emergency department.
    c. When/if I am absent, the physician assistant shall collaborate with and seek guidance from other on-site physicians in the emergency department or the on-call medical director for the emergency department. If an on-site physician(s) and the on-call medical director are unavailable and physician assistant needs immediate support, the physician assistant shall contact me by phone.

Name of Physician Assistant: _____ Supervising Physicians Name: _____

1) To the best of my knowledge, the credentialing facility has
   a. authorized the physician assistant to practice within the emergency department. (KRS 311.858(8))
   b. will not allow the physician assistant to submit direct billing for medical services and procedures. (KRS 311.858(6))
   c. will not allow the physician assistant to dispense controlled substances. (KRS 311.856(2))

2) I understand and agree that I shall review and countersign a sufficient number of overall medical notes written by the physician assistant to ensure quality of care provided by the physician assistant and in accordance with the policies and procedures of the credentialing facility. (KRS 311.856(11))

3) I understand and agree that I shall reevaluate the reliability, accountability and professional knowledge of the physician assistant every two (2) years and in order to recommend approval or disapproval of licensure renewal to the Board. (KRS 311.856(12))

4) I understand and agree that I shall notify the Board within three (3) business days if I cease to supervise the physician assistant or I have reason to believe in good faith that the physician assistant has violated any statute or regulation governing physician assistants. (KRS 311.858(13))

5) I understand and agree that any false or misleading statements provided in conjunction with the application to supervise the physician assistant and/or my failure to abide by the attestations contained herein may be grounds for discipline, including up to revocation, against my license to practice medicine or osteopathy in the Commonwealth of Kentucky. (KRS 311.595(1), (9) and/or (10))

Further, the Affiant sayeth naught.

Signature: _____
Printed Name: _____
License No.: _____

STATE OF KENTUCKY)
) ss
COUNTY OF _____)

Subscribed and sworn to before me by the Affiant, _____ M.D./D.O., this ___ day of _____, 202___. My commission expires on _____.

_____
NOTARY PUBLIC, STATE AT LARGE
ID #: _____

**** Original signatures required *** Return original to KBML/Faxes will not be accepted**

Name of Physician Assistant: _____ Name of Supervising Physician: _____

Affidavit of Physician Assistant

I, _____, P.A.-C, being duly cautioned and sworn, hereby affirm under oath as follows:

1) Since your last employer, have you been convicted of a felony or misdemeanor by any State or Federal court?
   ____ Yes ____ No

2) Are any criminal charges presently pending against you in any jurisdiction?
   ____ Yes ____ No

3) Has any hospital, hospital medical staff, or any other health care facility revoked, suspended, restricted, limited, reprimanded, placed on probation, or otherwise disciplined your privileges?
   ____ Yes ____ No

4) Are you currently suffering from any condition (including any physical or mental condition or alcohol/chemical dependency or abuse) for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice as a physician assistant in a competent, ethical and professional manner?
   ____ Yes ____ No

5) I understand and agree that I am the agent of the above-named supervising physician and I am authorized to act on his/her behalf, and subject to his/her control, to the extent described in the application. (KRS 311.858(2))

6) I understand that I may not practice independently (KRS 311.858(9)) and to that end:
   a. I understand and agree that the I shall not submit direct billing for medical services and procedures. (KRS 311.858(6))
   b. I understand and agree that I shall only perform services in offices, clinics, hospitals, or other licensed health care facilities where my supervising physician is also authorized to practice. (KRS 311.858(8) and 311.860)
   c. I understand and agree that the scope of medical services and procedures to be performed by me shall be limited to those described in the application and shall not exceed the normal scope of my supervising physician's practice. (KRS 311.850(1)(j) and 311.854(2)(c))

7) I understand and agree that I shall not dispense controlled substances. (KRS 311.856(2))

Name of Physician Assistant: _____ Name of Supervising Physician: _____

8) I understand and agree that I shall notify the Board within three (3) business days if my supervising physician should cease to supervise or employ me for any reason. (KRS 311.858(13))

9) I understand and agree that any false or misleading statements provided in conjunction with the application for licensure, including my failure to abide by the attestations contained herein in support of the supervising physician's application to supervise a physician assistant, may be grounds for discipline, including up to revocation, against my license to practice as a physician assistant in the Commonwealth of Kentucky. (KRS 311.850(1)(a), (h), (j), and (s))

Further, the Affiant sayeth naught.

Signature: _____

Printed Name: _____

PA License No.: _____

STATE OF KENTUCKY)
) ss
COUNTY OF _____)

Subscribed and sworn to before me by the Affiant, _____ P.A.-C., this ___ day of _____, 202___. My commission expires on _____.

_____
NOTARY PUBLIC, STATE AT LARGE

ID #: _____

***** Original signatures required *****
Return original to KBML/Faxes will not be accepted

Kentucky Board of Medical Licensure

310 Whittington Parkway, #1B
Louisville, KY 40222
(502) 429-7150
www.kbml.ky.gov

Supplemental Application Scope of Practice of Physician Assistant

***On the job training needs to be completed prior to submitting.

1. Name of Supervising Physician: _____
   (First) (Middle) (Last)
2. Supervising Physician Kentucky License Number: _____ Expiration Date: _____
3. Office Address: _____
   _____
4. Telephone (Office) _____ Office Fax _____
5. Name of Physician Assistant _____ KY License Number_____
6. Describe the physician assistant's additional scope of medical services and procedures not described in the initial application or previously submitted supplemental applications that are being delegated by you.
   _____
   _____
   _____
7. Describe the training and education that prepared the physician assistant for this additional delegated scope of medical services and procedures requested. (Information submitted for an accredited facility regarding this scope of practice can be submitted to fulfill this item.) _____
   _____
   _____
   _____
8. Was this training on-the-job training? ☐ Yes ☐ No
9. Was this education accredited? ☐ Yes ☐ No
10. Describe the setting in which the physician assistant will practice this additional delegated scope of medical services and procedures _____
    _____
    _____
11. Describe the level of supervision for this additional delegated scope of medical services and procedures (direct supervision, on-site supervision, off-site supervision) _____
    _____
12. Has this additional delegated scope of medical services and procedures been approved by an accredited facility duly constituted medical staff? ☐ Yes ☐ No

Name of Physician Assistant: _____ **Supervising Physician Name: _____**

13. Has this additional delegated scope of medical services and procedures received the blessing of your specialty society for delegation to a physician assistant? ☐ Yes ☐ No

14. **I attest that:**

    A. All additional delegated scope of medical services and procedures are within my scope of practice.

    B. All additional delegated scope of medical services and procedures are appropriate to the physician assistant's education, training and level of competence.

    C. I accept responsibility for any care given by the named physician assistant.

Affidavit of Applicant

I, _____ hereby state that I have made an adequate investigation and am of the opinion that the aforementioned physician assistant is possessed of good moral character and is both mentally and physically able to perform as a physician assistant with competence. I further state that as supervising physician, I will exercise control and supervision of the named physician assistant in accordance with the rules of the Kentucky Board of Medical Licensure and retain professional responsibility for the care and treatment of patients he/she sees as directed by me.

State of Kentucky County_____

I, _____ hereby certify under oath that I am the person named in this application to supervise a physician assistant in the Commonwealth of Kentucky; that all statements I have made therein are true and the physician assistant will function under my supervision and responsibility.

_____
Physician's Signature

Subscribed and sworn to before me by the above named applicant on this _____ day _____, 20____.
This application consists of 2 pages.

Seal of Notary

_____
Signature of Notary

My Commission expires: _____

The following are EXAMPLES of procedures that require the submission of the Supplemental Scope of Practice Application. These are examples only and are not intended to be a comprehensive list.

- Arterial line placement
- Biopsies
- Bone marrow aspirates
- Bronchoscopy
- Cardiac stress testing
- Central venous line placement
- Chemotherapy administration (?)
- Chest tube insertions/placement
- Colposcopy
- Cosmetic laser procedures for hair removal, vein & vascular lesions, scars, wrinkles
- Epidural or spinal catheters
- Facial filler injections and laser skin treatments
- Gastric band adjustments
- Intubation
- Large & small joint injections, trigger point injections, peripheral nerve blocks
- Lumbar punctures
- Myelograms
- Nerve block injections
- OB/GYN ultrasound
- Opthalmology: Yag laser capsulotomy
- Stem cell infusion
- Swan Ganz catheter placement
- Tilt table testing
- Ultrasound bed studies

Definitions of Levels of Supervision

Direct Supervision: This means the supervising physician is actually in sight of the physician assistant when the physician assistant is performing the function requiring direct supervision. Although the physician may be performing some other task at the time, the supervising physician may immediately provide direction or assume the performance of the task if difficulties arise. This does not require that the physician is watching "over the shoulder" of the physician assistant as would be required during the training period to ensure that the physician assistant is competent to perform the task.

On-site supervision: Requires the physical presence of the supervising physician in the same location (i.e. the physician's office suite) as the physician assistant, but does not require the physical presence in the same room.

Off-site supervision: The supervising physician must be continuously available for direct communication with the physician assistant when the physician assistant is at a separate location than the practice address of the primary supervising physician by means of the line of communication specified by the primary supervising physician on his/her *Application for Physician to Supervise Physician Assistant* filed with the Kentucky Board of Medical Licensure.