

**PHYSICIAN ASSISTANT
SUPERVISION AGREEMENT APPLICATION
*For Health Care Facility Practice Only***

Mail application to:
State Medical Board of Ohio
30 East Broad Street, 3rd Floor
Columbus, Ohio 43215

Supervising Physician Contact Information		
Supervising Physician Name (Last, First, Middle):		
Supervising Physician License Number:		
Official Mailing Address:		
City:	State:	ZIP Code:
Contact Person:	Phone:	
Email:		

Health Care Facility Location Information		
"Health care facility" means any of the following: (1) A hospital registered with the department of health under section 3701.07 of the Revised Code; (2) A health care facility licensed by the department of health under section 3702.30 of the Revised Code; (3) Any other facility designated by the state medical board in rules adopted pursuant to division (B)(2) of section 4730.08 of the Revised Code.		
Facility Name:	Registration Number:	
Address:		
City:	State:	ZIP Code:
Contact Person:	Phone:	
Email:		

Health Care Facility Location Information (Continued)

"Health care facility" means any of the following: (1) A hospital registered with the department of health under section 3701.07 of the Revised Code; (2) A health care facility licensed by the department of health under section 3702.30 of the Revised Code; (3) Any other facility designated by the state medical board in rules adopted pursuant to division (B)(2) of section 4730.08 of the Revised Code.

Facility Name:		Registration Number:
Address:		
City:	State:	ZIP Code:
Contact Person:	Phone:	
Email:		

Facility Name:		Registration Number:
Address:		
City:	State:	ZIP Code:
Contact Person:	Phone:	
Email:		

Affidavit of Supervising Physician

The above statements are complete and accurate to the best of my knowledge. I have read and understand Chapter 4730 of the Ohio Revised Code and the rules and regulations set forth by the State Medical Board of Ohio regarding Physician Assistants and that as a Supervising Physician I assume legal liability for the services provided by the Physician Assistant(s) that are under my supervision.

I acknowledge that before initiating supervision of one or more physician assistants, a physician shall enter into a supervision agreement with each physician assistant who will be supervised. A supervision agreement shall be kept in the records maintained by the supervising physician who entered into the agreement and the board may review the supervision agreement at any time for compliance.

I further agree that I will supervise any Physician Assistant(s) named in this application in accordance with the policies of the Health Care Facilities listed in this application.

Supervising Physician Signature:	Date:
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Physician Assistant Signature Sheet

I (we) have read and agree to abide by the policies of the health care facility(s) listed in this application and to practice under the supervision of the supervising physician named below.

Supervising Physician Name:

Physician Assistant Name:	License Number:
Signature:	Date:

Physician Assistant Name:	License Number:
Signature:	Date:

Physician Assistant Name:	License Number:
Signature:	Date:

Physician Assistant Name:	License Number:
Signature:	Date:

Physician Assistant Name:	License Number:
Signature:	Date:

Physician Assistant Name:	License Number:
Signature:	Date: