PHYSICIAN ASSISTANT ALTERNATE SUPERVISING PHYSICIAN APPLICATION

Mail completed application to:
State Medical Board of Ohio
ATTN: Physician Assistant Program Administrator
30 E. Broad St., 3rd Floor
Columbus, Ohio 43215

ALTERNATE SUPERVISING PHYSICIAN APPLICATION INSTRUCTIONS

This application is to be completed by a physician(s) who will act as an alternate supervising physician during periods in which the supervising physician will be unable to provide supervision in accordance with Section 4730.21, Ohio Revised Code. *There is no fee for this application.*

ALTERNATE SUPERVISING PHYSICIAN AFFADAVIT

I (we) have carefully and fully reviewed the Physician Supervisory Plan as approved by the State Medical Board and hereby agree to act as an alternate supervising physician to the physician assistant(s) supervised

by_____ / _____.
(Name of supervising physician) physician assistant supervision agreement number

Alternate Supervising Physician 1 (if applicable)		
_____ *Name of Alternate Physician (Please print):*		
_____ *Signature of Alternate Physician:*		
Ohio License Number:		
Office Address:		
City:	*State:*	*Zip Code:*
Office Phone Number: *( )*		

Alternate Supervising Physician 2 (if applicable)		
_____ *Name of Alternate Physician (Please print):*		
_____ *Signature of Alternate Physician:*		
Ohio License Number:		
Office Address:		
City:	*State:*	*Zip Code:*
Office Phone Number: *( )*		