

Physician Assistant

Primary Collaborative Physician

Name (Please Print) _____

Name (Please Print) _____

Address _____

Address _____

City, State, Zip _____

City, State, Zip _____

License No. _____ PA: Is this a change of address?: _____

License No. _____

Work Phone _____

Work Phone _____

Home Phone _____

Email Address _____

Email Address _____

Alternate Physician

Alternate Physician

Name _____

Name _____

Address _____

Address _____

License No. _____ Wk Phone _____

License No. _____ Wk Phone _____

Alternate Signature _____

Alternate Signature _____

(Attach addendum form 08-4226 (i) with additional alternates if needed.)

PRACTICE INFORMATION

Specific Location: _____ Remote: No Yes-see back of form
Practice at any location not specified in this plan is not authorized.

Effective Date of Plan (Beginning Date of Employment)*: _____

(*Plan must be filed with the board **NO LATER THAN 14 days** from this date.)

Prescriptive Authority (Doctor to check boxes for authority to be granted.)

- 12 AAC 40.450 (c) Prescribe, order, administer, and dispense schedules II, III, IV, and V drugs
- 12 AAC 40.450 (d) PA's prescriptive authority does not exceed physician's prescriptive authority
- 12 AAC 40.450 (e) May procure controlled substance supplies
- 12 AAC 40.450 (f) Prescribe, order, dispense, administer non-controlled drugs

Requirements of Law The physician assistant will work only within the agreed scope of practice with the primary physician
All parties to this plan agree to comply with the provisions of all statutes and regulations relating to the physician assistant's practice of medicine in Alaska.

Signature, Physician Assistant _____ Date _____

Signature, Primary Collaborating Physician _____ Date _____

NOTARY
SUBSCRIBED AND SWORN before me, a Notary Public in and for the state of Alaska, this _____ day of _____, _____.

NOTARY
SUBSCRIBED AND SWORN before me, a Notary Public in and for the state of Alaska, this _____ day of _____, _____.

Notary Public _____
My commission expires _____

Notary Public _____
My commission expires _____

(Notary Seal)

(Notary Seal)

**** Incomplete Plans Will Be Returned and Not Processed ****

INSTRUCTIONS - Collaborative Plan

*** * INCOMPLETE PLANS WILL BE RETURNED AND NOT PROCESSED * ***

- 1 **Complete all parts of the plan** – print legibly or type. Incomplete plans will not be accepted.
- 2 If it is not already on file with the board, attach a copy of the physician assistant's current NCCPA certificate.
It is your responsibility to insure that current and valid documents are on file with the board.
- 3 If it is not already on file with the board, attach a copy of the physician assistant's valid DEA registration.
It is your responsibility to insure that current and valid documents are on file with the board.
- 4 Attach a copy of the physician's valid DEA registration.
- 5 Attach a detailed curriculum vitae for the PA, if applicable, for remote site practice.
- 6 Include a check payable to the state of Alaska in the amount of \$150 if a new licensee or \$100 for a physician assistant already licensed in Alaska.
- 7 Mail the completed plan **with all attachments** to the State Medical Board. Post Office Box 110806, Juneau AK 99811-0806.
Keep a complete copy for your practice records.
- 8 **It is your responsibility to insure that this document is filed in a timely manner and that it is complete when filed.**

Received by Division:	
Receipt No.	Amount

PHYSICIAN ASSISTANT: _____ **PHYSICIAN:** _____

REMOTE SITE: Location of physician assistant's practice is more than 30 miles by road from physician's primary office.

Physician Assistants with less than two years of full-time clinical experience:

- Must work 160 hours in direct patient care under the direct and immediate supervision of the primary collaborating physician or an alternate.
 - The first 40 hours must be completed before going to the remote site practice; the remaining 120 hrs must be completed within 90 days of going to the remote site practice.
- _____ Hours of supervision will commence as soon as this plan is approved and prior to practicing at the remote site. The completed Verification of Hours of Supervision form will be sent to the State Medical Board immediately upon completion of the required hours.
[Physician: Initial this statement if applicable.]

- OR -

Physician assistants with more than two years of full-time clinical experience:

- Must attach a detailed curriculum vitae which describes the education, skills, and experience sufficient to meet the needs and demands of the remote site practice.

Upon my careful review, as primary collaborating physician, it is my opinion that the previous experience of the physician assistant documented in the attached curriculum vitae has adequately prepared and qualified this individual to work at the remote site practice location identified in this plan.

Primary Collaborating Physician Signature _____

IMPORTANT REGULATIONS (See Booklet for Complete Regulations Language)

- A PERFORMANCE AND ASSESSMENT OF PRACTICE** **[12 AAC 40.430]**
It is understood by the physician and the physician assistant that a periodic method of assessment is or will be established which will include the physician's evaluation of physician assistant's work performance which means evaluation of medical care and clinic management. Please refer to the full regulation for the frequency of assessments required. It is further understood that documentation of such periodic assessments may be audited by the State of Alaska at any time.
- B COMMUNICATIONS WITH SENSORY-IMPAIRED PATIENTS** **[12 AAC 40.980(A)(4)]**
A method is or will be devised whereby a physician assistant's level of education and professional training are communicated to patients who may be blind, deaf, or otherwise impaired.
- C IDENTIFICATION OF PHYSICIAN ASSISTANT** **[12 AAC 40.460]**
It is understood that the physician assistant will wear on his/her clothing a nameplate identifying them as a "Physician Assistant-Certified" and shall display a sign at the place of employment which posts current state licensure and that documents of the Physician Assistant's education and plan of collaboration are available for inspection.
- D PRESCRIPTIVE AUTHORITY** **[12 AAC 40.450]**
Prescribing Schedules II, III, IV, and V **[12 AAC 40.450(c)]**
The physician assistant named in this plan may, with a valid DEA registration, write a prescription for a schedule II, III, IV, or V controlled substance medication with primary collaboration physician's approval.
Prescribing Authority May Not Exceed Physician's Authority **[12 AAC 40.450(d)]**
The PA's prescriptive authority may not exceed that of the collaborating physician's prescriptive authority.
Obtaining Controlled Substance Supplies **[12 AAC 40.450(e)]**
The physician assistant named in this plan may use the physician assistant's own DEA registration number to request, receive, order, or procure controlled substance supplies from a pharmaceutical distributor, warehouse, or other entity only with primary collaboration physician's approval.
Prescribe, Order, Administer, or Dispense Non-Controlled Medications **[12 AAC 40.450(f)]**
The physician assistant named in this plan may prescribe, order, administer, or dispense a medication that is not a controlled substance only with primary collaboration physician's approval.