Washington State Department of Health
Medical Quality Assurance Commission
PO Box 47866
Olympia, WA 98504-7866
(360) 236-4785 (A-L)
(360) 236-4784 (M-Z)

PA-C

Certified Physician Assistant

Standardized Procedures Reference/Guidelines And Practice Plan

Certified Physician Assistant Name: _____

Business Telephone Number: _____

Sponsoring Physician's Name: _____

Name of Physician Group: _____
(IF APPLICABLE)

Primary Practice Address: _____
(FOR SPONSORING PHYSICIAN) STREET ADDRESS

_____
CITY STATE ZIP CODE

Standardized Procedures Reference/Guidelines

NOTE: Guideline for physician sponsors of physician assistants and certified physician assistants: No physician who is designated as a sponsoring, supervising or alternate physician for any physician assistant shall allow that physician assistant to practice in any area of medicine or surgery that is beyond said physician's own usual scope of expertise and practice. *(WAC 246-918-140(3) states "It shall be the responsibility of the certified physician assistant and the sponsoring physician to ensure that appropriate consultation and review of work are provided.")*

Certified physician assistants may provide those services that they are competent to perform based on their education, training, and experience. The sponsoring physician(s) and the certified physician assistant shall determine which procedures may be performed and the degree of supervision under which the certified physician assistant performs the procedure.

Prescriptive Authority

Certified physician assistants may prescribe, order, administer and dispense legend drugs, including Schedule II-V controlled substances.

Practice Site: *(Mark all that apply)*

1. ____ A The PA-C will be in the same practice site as the sponsoring physician. When the PA-C is on duty, the sponsoring physician or the alternate physician(s) will be available for on-site supervision or telephone consultation at all times.

   ____ B The PA-C will be practicing in a remote site. If applicable, complete the attached Remote Site Request Form. *WAC 246-918-120(1) states: "A remote site is defined as a setting physically separate from the sponsoring or supervising physician's primary place for meeting patients or a setting where the physician is present less than twenty-five percent of the practice time of the licensee."*

2. Will the PA-C be practicing in a physician group? ☐ Yes ☐ No
   If Yes, only one sponsoring physician needs to be designated for each physician group.)

Supervision:

3. _____ *(Indicate total)* **Excluding** this applicant, how many other PA-Cs, PAs, or PASAs does the sponsoring physician sponsor? If the addition of this certified physician assistant will exceed the sponsorship or supervision of three physician assistants, provide written justification, as well as how supervision and consultation will be accomplished. *WAC 246-918-090 states: "No physician shall serve as a primary supervisor or sponsor for more than three licensees without authorization of the commission."*

Periods Of Absence:

4. Period of Absence/Vacation *(Check one.)*—This section applies to both remote and direct supervision practices. When the sponsoring physician is away from the office or practice location for any period of time, including vacation, continuing education or illness:
   - ☐ A designated alternate physician(s) will supervise the PA-C at all times in accordance with this practice description.
   - ☐ The PA-C will cease to function as such, as no alternate supervisor has been designated.

Termination:

5. We agree that if the practice plan, with any applicable attachments, is terminated, both the sponsoring physician and certified physician assistant must notify the Department of Health in writing of that termination *WAC 246-918-110 states: "Upon termination of the working relationship, the sponsoring or supervising physician and the licensee are each required to submit a letter to the commission indicating the relationship has been terminated and may summarize their observations of the working relationship. Exceptions to this requirement may be authorized by the commission or its designee."*

We, the undersigned, hereby certify under penalty of perjury under the laws of the state of Washington that the foregoing information in the practice plan, with any applicable attachment(s), is correct to the best of our knowledge and belief. We further certify that we have reviewed the current statutes, rules, and regulations of Washington State pertaining to physician assistants and the practice description and understand our duties and responsibilities as outlined in WAC 246-918. *Chapter 18.71A.050 states: "The supervising physician and physician assistant shall retain professional and personal responsibility for any act which constitutes the practice of medicine as defined in RCW 18.71.011 when performed by the physician assistant."*

PRINT NAME	SIGNATURE OF CERTIFIED PHYSICIAN ASSISTANT	DATE
PRINT NAME	SIGNATURE OF SPONSORING PHYSICIAN	DATE
PRINT NAME	SIGNATURE OF ALTERNATE PHYSICIAN (IF APPLICABLE)	DATE

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Remote Site Request Form

Complete only if the physician assistant will be utilized in a remote site.

Physician Assistant Name: _____

Business Telephone Number: _____

Will the physician assistant be utilized in more than one remote site setting? ☐ **Yes** ☐ **No**

If YES, indicate the number of remote site settings. _____ *(Complete the following information for **each** site for which the physician assistant will be utilized. Please make copies as needed.)*

Name and address of remote site: _____

_____

_____

Number of hours the supervising physician will be spending in the remote site weekly. .. _____

Number of hours the P.A. will be spending in the remote site weekly. ..... _____

Number of hours both will be present together. ..... _____

Supply a detailed plan for supervision and chart review:

Provide a brief summary of the general duties to be performed by the P.A. in the remote setting.

_____

We, the undersigned, hereby certify under penalty of perjury under the laws of the state of Washington that the foregoing information in this attachment to the practice plan is correct to the best of our knowledge and belief. We, again, further certify that we have reviewed the current statutes, rules, and regulations of Washington State pertaining to physician assistants and the practice description and understand our duties and responsibilities as outlined in WAC 246-918. *Chapter 18.71A.050 states: "The supervising physician and physician assistant shall retain professional and personal responsibility for any act which constitutes the practice of medicine as defined in RCW 18.71.011 when performed by the physician assistant."*

PRINT NAME	`SIGNATURE OF PHYSICIAN ASSISTANT	DATE
PRINT NAME	SIGNATURE OF SUPERVISING OR SPONSORING PHYSICIAN	DATE