

**District of Columbia
Physician Assistant Delegation Agreement Form**

This document is to be filed with the Board of Medicine. A duplicate copy is to be kept on site at the physician assistant's primary place of practice. It is to be updated as necessary, no less frequently than yearly. The Delegation Agreement must be signed by the physician assistant and the supervising physician(s).

*Use Form A2 (page 5) if there is the need to amend the Delegation Agreement through the addition or deletion of a supervising physician.

*Use Form A3 (page 6) to terminate the Delegation Agreement. (if there is a change in the physician assistant's employment or employment status)

Physician Assistant

Name _____
Last, First DC License number

Supervising Physician

Name _____
Last, First DC License number

(Add additional supervising physicians on page 3)

Location (of Practice)

1. Practice Name _____
Department _____
Address _____
Phone number _____

2. Name _____
Department _____
Address _____
Phone number _____

Delegation of Duties

The physician assistant is delegated to perform the following tasks and procedures that are within physician assistant’s education and training and the supervising physician’s scope of practice. Indicate those that are delegated to be performed in the above practice. If the physician assistant will provide patient care at sites other than the location address above please delineate.

Prescriptive Authority

Physician assistants may prescribe those drugs and devices delegated by the supervising physician. This includes non-scheduled and Schedule II-V medications. List the classes of medications the physician assistant may prescribe.

Controlled substances Yes ___ No___

Check schedules of medications:

- ___ Schedule II
- ___ Schedule III
- ___ Schedule IV
- ___ Schedule V

This delegation of prescriptive authority **DOES NOT** include the following medications:

Supervising Physician Availability

A supervising physician must be available in person or via electronic communications. Describe when and how a supervising physician is available to the physician assistant while the physician assistant is providing patient care. Describe situations when the physician assistant is caring for patients while the supervising physician is away from the site. For these situations delineate how a physician is available to supervise the physician assistant taking into account the skills and the experience of the physician assistant, and the acuity patient problems seen in the practice.

Print Name

Signature Supervising Physician

Date

DC License number

Print Name

Signature Supervising Physician

Date

DC License number

Print Name

Signature Supervising Physician

Date

DC License number

Print Name

Signature Supervising Physician

Date

DC License number

Print Name

Signature Supervising Physician

Date

DC License number

Print Name

Signature Supervising Physician

Date

DC License number

Print Name

Signature Supervising Physician

Date

DC License number

Form A 2

Supervising Physician Addendum Form

Name of Physician Assistant _____
Last, First DC License number

Additions to supervising physician list

_____ Printed Name	_____ DC License number
_____ Signature of Supervising Physician	_____ Date
_____ Printed Name	_____ DC License number
_____ Signature of Supervising Physician	_____ Date
_____ Printed Name	_____ DC License number
_____ Signature of Supervising Physician	_____ Date

Deletions to supervising physician list

_____ Printed Name	_____ DC License number
_____ Signature of Supervising Physician	_____ Date
_____ Printed Name	_____ DC License number
_____ Signature of Supervising Physician	_____ Date
_____ Printed Name	_____ DC License number
_____ Signature of Supervising Physician	_____ Date

Form A 3

Physician Assistant Delegation Agreement Termination Form

Effective Date of Termination: _____

Physician Assistant

Name _____
Last, First DC License number

Supervising Physician 1

Name _____
Last, First DC License number

Location of Practice

- 1. Practice Name _____
Department _____
Address _____
Phone number _____

- 2. Name _____
Department _____
Address _____
Phone number _____

Reason(s) for termination.

Signature:

Physician Assistant Date DC License number

Supervising Physician #1 Date DC License number