# BOARD OF MEDICINE

9960 Mayland Drive, Suite 300, Henrico, VA 23233
www.dhp.virginia.gov/medicine

Phone: (804) 367-4600    Fax (804) 527-4426
Email: medbd@dhp.virginia.gov

## PRACTICE AGREEMENT AS A PHYSICIAN ASSISTANT (PA)

**"This form is to be completed by the patient care team physician and the physician assistant."**

1. Name in Full (Please Print or Type)

| Last | First | Middle |
|---|---|---|
| | License Number<br>**0110-** | |

## Collaborating Patient Care Team Physician Practice Information

| Collaborating Physician's Name: | Phone Number |
|---|---|
| Specialty | VA License Number |
| Name of Practice | |
| Address of Practice | |

Work Setting: (check appropriate area): ☐ **Outpatient setting** ☐ **Nursing Home** ☐ **Other (specify in complete detail)** ☐ **Hospital (if employer, complete hospital information section)**

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

2. Will the PA perform medical acts when the collaborating physician is not in the office/medical facility?

☐Yes ☐No If Yes, describe situations in which this might occur and the arrangements made to ensure communication is maintained with either the collaborating physician or an alternate collaborating physician.

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

**HOSPITAL AFFILIATION**

Name of Hospital: ________________________________ Phone________________________

Address of Hospital: ______________________________________________________

Street City Zip

In what department will the P. A. collaborate with a Patient Care Team Physician?

______________________________________________________________________________

**HOSPITAL AFFILIATION**

Name of Hospital: ________________________________ Phone________________________

Address of Hospital: ______________________________________________________

Street City Zip

In what department will the P. A. collaborate with a Patient Care Team Physician?

______________________________________________________________________________

**DUTIES**

Please spell out role and function of the PA, indicating number of patients, types of illnesses, nature of treatments, special procedures, the nature of physician's availability for any direct physician involvement, and the evaluation process for the physician assistant's performance. By signing this practice agreement, the collaborating physician confirms that he shall accept the responsibilities of collaborating with PA named in this practice agreement pursuant to PA. Physician Assistants are authorized to order and interpret radiological studies; however, the application of x-rays to human beings for diagnostic or therapeutic purposes is the practice of radiological technology and requires a license issued by the Board pursuant to Virginia code section 54.1-2956.8:1

**EFFECTIVE July 1, 2019:**

The physician assistant shall retain this practice agreement for as long as the physician assistant practices medicine as part of the patient-care team, and shall make the practice agreement and evaluation process available to the Board upon request.

1. **Role and function of the PA as part of the patient care team:**

______________________________________________________________________________

______________________________________________________________________________

2. **Types of Illnesses treated by patient care team:**

______________________________________________________________________________

______________________________________________________________________________

3. **Indicate an estimated number of patients seen daily.**

______________________________________________________________________________

______________________________________________________________________________

4. **Nature of treatment:**

______________________________________________________________________________

______________________________________________________________________________

5. **Special procedures:** (See Appendix A)

6. **Nature of physician's availability for any direct physician involvement as necessary:**

______________________________________________________________________________

______________________________________________________________________________

7. **Describe the evaluation process for the physician assistant's performance.**

______________________________________________________________________________

______________________________________________________________________________

8. **When does the patient care team physician review the record of services rendered by the physician assistant?**

______________________________________________________________________________

______________________________________________________________________________

9. **Provide a detailed list of duties for the physician assistant or include an attachment.**

## PRESCRIPTIVE AUTHORITY

**⏩Request for prescriptive authority from the PA**

My signature hereto attests that I have completed a minimum of 35 hours of acceptable training in pharmacology.

**Signature of Physician Assistant** ______________________________________________

**⏩Statement of Patient Care Team Physician**

**Please check all schedules for the prescriptive authority you are requesting:**

☐ **Schedule II** ☐ **Schedule III** ☐ **Schedule IV** ☐ **Schedule V** ☐ **Schedule VI**

As the primary collaborating physician for the above named Physician Assistant, I attest to his/her competence to practice and prescribe as indicated above. I further attest that I will make periodic site visits if the physician assistant named in this practice agreement provides services at a location other than where I regularly practice.

**Signature of Collaborating Physician**______________________________________________

Print or type name ________________________________________ Date ____________________

**This form does not require prior approval of the Board of Medicine before practicing**

## Appendix A: Invasive Procedures authorized by the executed practice agreement

Please list below all minor and/or invasive procedures determined to be part of the scope of practice by the patient care team, patient care team physician, and PA based on the PA's education, training, and experience.

Hospital credentialing and privileging forms may be attached to this practice agreement to demonstrate the agreed upon procedures.

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________