

**PHYSICIAN ASSISTANT
FORM C INSTRUCTIONS**

RETURN TO: MAINE BOARD OF LICENSURE IN MEDICINE
137 STATE HOUSE STATION
AUGUSTA, ME 04333-0137
TEL: (207) 287-3601 FAX: (207) 287-6590

Please refer to Chapter 2 of the Board's Rules, which are available upon request by contacting the Board, or at http://www.docboard.org/me/me_home.htm

A Physician Assistant (PA) practicing under delegation must hold a valid license and a **Certificate of Registration, which documents the supervision relationship**, as described in Chapter 2, Section 2, B of the Board's Rules.

- A. **Initial Registration:** Before beginning employment, each PA who is newly licensed or who has inactive status must be registered with a Primary Supervising Physician by filing a Form C registration with the Maine Board of Licensure in Medicine.
- B. **Primary Supervising Physician Change:** Each PA has **14 days** in which to notify the Board upon changing Primary Supervising Physicians or adding a Primary Supervising Physician. Effective January 1, 1998, a **\$100 late registration fee** will be assessed if the Form C registration is not filed within 14 days of beginning employment. Both the Physician Assistant and Primary Supervising Physician must sign the form. The PA is responsible to notify the Board when the supervising relationship ends.
- C. **Organized Health Care Delivery System:** An Organized Health Care Delivery system may certify that the PA is an employee or principal of the system and may name the Primary Supervising Physician by submitting a completed Form C registration.
- D. **Secondary Supervision:** In the temporary absence of the Primary Supervising Physician, the responsibility of the supervising of the named PA must be transferred to another licensed physician. The secondary supervisor must designate in writing in the written Plan of Supervision his/her willingness to accept the responsibility and liability for the performance of the named PA.
- E. **Termination:** You may use this form to notify the Board when the Primary Supervising Physician relationship has terminated. Please use a separate page if more space is needed. State the date of and reason for the termination and return the Board-issued Certificate Of Registration after it has been signed by the Primary Supervising Physician.

FORM C: REGISTRATION OF PHYSICIAN ASSISTANT SUPERVISORY RELATIONSHIP

To ensure that the physician you plan to work with has been approved by the Board to serve as a Primary Supervising Physician, call the Board at 287-3782 prior to the start date of your working relationship.

PLEASE PRINT OR TYPE ALL INFORMATION CLEARLY

Physician Assistant

Maine License No.

Primary Supervising Physician

Maine M.D. License No.

Name/Address of Practice Setting:

Practice Type (Please circle one):

Individual
Group
Organized Health Care Delivery System

Tel: _____

Please check the appropriate box:

Fee

- | | | |
|--------------------------|--|------|
| <input type="checkbox"/> | First time registration with a Primary Supervising Physician
(The first time registration is valid only upon approval by the Board.) | \$50 |
| <input type="checkbox"/> | Change of Primary Supervising Physician relationship.
(Please refer to page 1, paragraph E, Termination.) | \$50 |
| <input type="checkbox"/> | Registration of multiple work site.
(e.g. Per Diem work or moonlighting work.) | \$50 |
| <input type="checkbox"/> | Renewal of Primary Supervising Physician relationship. File with license renewal. | \$50 |
| <input type="checkbox"/> | Renewal of multiple Primary Supervising Physician relationships.
(Fee is per registration - not to exceed \$250 per registration period.) | \$50 |
| <input type="checkbox"/> | Renewal of Primary Supervising Physician relationship within 1 year of initial registration of relationship. File with license renewal. | \$25 |

Termination of the Primary Supervising Physician relationship:

Name of Primary Supervising Physician: _____

Effective Date: _____

Reason for termination: _____

FORM C, Page 2
ATTESTATIONS

PHYSICIAN ASSISTANT

I have read, fully understand, and accept the responsibilities and liability of a Physician Assistant as described in 32 M.R.S.A. § 3270-A and § 3270-B and in the current Chapter 2 of the Rules of the Board of Licensure in Medicine. I affirm that a written Plan of Supervision addressing the technical requirements of supervision as set forth in Chapter 2, Section 6 of the Rules has been prepared and is available for inspection at the above named practice setting. I agree to notify the Board of Licensure in Medicine in writing no later than 14 days after the effective date of any change to or addition of a Primary Supervising Physician.

I hereby certify that to the best of my knowledge and belief the statements made in this application are true and correct.

Signature, Physician Assistant

Date

Name Printed

PRIMARY SUPERVISING PHYSICIAN

I have read, fully understand, and accept the responsibilities and liability for the supervision of a Physician Assistant as described in 32 M.R.S.A. § 3270-A and § 3270-B and in the current Chapter 2 of the Rules of the Board of Licensure in Medicine. I affirm that a written Plan of Supervision addressing the technical requirements of supervision as set forth in Chapter 2, Section 5 of the Rules has been prepared and is available for inspection at the above named practice setting.

I hereby certify that to the best of my knowledge and belief the statements made in this application are true and correct.

Signature, Primary Supervising Physician

Date

ORGANIZED HEALTH CARE DELIVERY SYSTEM CERTIFICATION

The Physician Assistant named on this application is employed by or is a principal in

_____ an Organized Health Care Delivery System as defined in Board Rule Chapter 3, Section 1, G.

_____, M.D., has been approved by the Board and will be the Primary Supervising Physician for the Physician Assistant employed by this system. The named Physician Assistant will receive all appropriate supervision as described in 32 M.R.S.A. § 3270-A and § 3270-B and in the current Chapter 2 of the Rules of the Board of Licensure in Medicine. The written Plan of Supervision is available at the practice setting.

_____ M.D.
Signature

Date

Name Printed

Title

January 28, 2009