BOARD OF MEDICINE

Virginia Department of Health Professions

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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 **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
Keep on file. Only forward this form to the Board of Medicine upon request.

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.

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