West Virginia Board
of Osteopathic Medicine
405 Capitol Street, Suite 402
Charleston, WV 25301

Osteopathic Physician Assistant Practice Agreement

Name of Physician Assistant	NCCPA Certification #	License #
Business Address		
City	State	Zip Code
Phone (enter 10 digit #)	Email Address	County
Home Address		
City	State	Zip Code
Home Phone (enter 10 digit #)		County
Primary Collaborating Osteopathic Physician (DO Only) (Required)		
Physician Name	Specialty	License #
Business Address		
City	State	Zip Code
Phone (enter 10 digit #)	Email Address	County
Physician Group		
Business Name		
Business Address		
City	State	Zip Code
Contact Name	Contact Phone #	
Contact Email Address	Credentialing Staff Office Phone #	

Physician's Scope of Training and Practice

Education and Training

Institution	No. Of Months Attended	Date of Graduation	Degree Obtained	Attended From	Attended To

1. Are you certified by any American Boards of Osteopathic Medical Specialties? _____

   If yes, please list the dates of certification:

   _____

2. Do you consider yourself a specialist in any particular field of medicine? _____

   If yes, please describe why you are so classified.

   _____

   _____

3. Have you ever had disciplinary action by an appropriate licensing body in any other state? ___

   If so, provide information as to the nature of action taken.

   _____

   _____

4. Do you enjoy hospital or staff privileges? _____

   If yes, list hospital(s) and date privileges granted:

   _____

   _____

5. Have you ever had your staff privileges revoked, restricted or suspended by a hospital?

   _____

If so, provide information as to the nature of the action taken.

_____

_____

6. Are you a member of a professional corporation or association, or affiliated in a group practice?____
If yes, please list other physician members of said group and whether they intend to collaborate with individual Physician Assistants as well.

_____

_____

7. Have you ever been convicted of felony? _____.

If yes, please give complete details concerning the matter.

_____

_____

Concept of Physician Assistant Utilization

1. Where do you intend to utilize the services of a Physician Assistant?

_____

2. Provide name, address and license number of **ALL** physicians who are willing to act as alternate collaborating physicians for this Physician Assistant in your absence. **MUST BE COMPLETED**

_____

_____

_____

_____

_____

3. How many PA's do you currently supervise? _____ (Five maximum, unless you work in an Emergency Room or other 24/7 healthcare facility)

List their names:

_____

_____

_____

_____

_____

CORE DUTIES

4.3 An Osteopathic Physician assistant should have, as a minimum, the knowledge and competency to perform the following functions and may, with appropriate collaboration, perform them (Check all Requested):

____ 4.3.a. Screen patients to determine the need for medical attention;

____ 4.3.b. Review patient records to determine health status;

____ 4.3.c. Take a patient history;

____ 4.3.d. Perform a physical examination;

____ 4.3.e. Perform development screening examinations on children;

____ 4.3.f. Record pertinent patient data;

____ 4.3.g. Make decisions regarding data gathering and appropriate management and treatment of patients being seen for the initial evaluation of a problem or the follow-up evaluation of a previously diagnosed and stabilized condition;

____ 4.3.h. Prepare patient summaries for those patients the PA has had direct patient care responsibilities;

____ 4.3.i. Initiate requests for commonly performed initial laboratory studies;

____ 4.3.j. Collect specimens for, and carry out, commonly performed blood, urine and stool analyses and cultures;

____ 4.3.k. Identify normal and abnormal findings in patient history and physical examination and in commonly performed laboratory studies;

____ 4.3.l. Initiate appropriate evaluation and emergency management for emergency situations; for example, cardiac arrest, respiratory distress, injuries, burns, and hemorrhage;

____ 4.3.m. Provide counseling and instruction for common patient questions;

____ 4.3.n. Execute documents at the direction of and for the collaborating physician;

____ 4.3.o. Assist in surgery;

____ 4.3.p. Perform clinical procedures such as, but not limited to, the following:

____ 4.3.p.1. Venipuncture;

____ 4.3.p.2. Electrocardiogram;

____ 4.3.p.3. Care and suturing of minor lacerations, with injection of local anesthesia;

____ 4.3.p.4. Casting and splinting;

____ 4.3.p.5. Control of external hemorrhage;

____ 4.3.p.6. Application of dressings and bandages;

____ 4.3.p.7. Removal of superficial foreign bodies;

____ 4.3.p.8. Cardiopulmonary resuscitation;

____ 4.3.p.9. Audiometry screening;

____ 4.3.p.10. Visual screening;

____ 4.3.p.11. Carry out aseptic and isolation techniques;

____ 4.3.p.12. Assist physician under personal collaboration in a manner by which to learn and become proficient in new procedures;

____ 4.3.p.13. Pronounce death and complete death certificates after completing training;

____ 4.3.p.14. Sign orders for life sustaining treatment;

____ 4.3.p.15. Complete orders for scope of treatment;

____ 4.3.p.16. Sign Do Not Resuscitate forms;

____ 4.3.p.17. Complete disability medical evaluations for persons in support of hunting or fishing permits;

___ 4.3.p.18. Complete utility company forms requiring maintenance of utilities regardless of ability to pay;

____ Other (Complete Additional Privilege Form)

ADVANCED DUTIES REQUEST FORM

****MUST HAVE BOARD APPROVAL PRIOR TO PRACTICE****	
Additional Privileges	Pursuant to 24-2-9.2, the physician assistant may perform the following additional tasks as delegated by the collaborating physician: _____ Description of Task _____ Collaborating Physician Signature _____ Description of Task _____ Collaborating Physician Signature Please attach additional pages as necessary. Provide proof of training/experience for above – Requested Privileges or Hospital Approved Privilege List: _____ _____ _____ _____

WV SURVEY ON PRACTICE DEMOGRAPHICS

Practice Sites	**# of hours in a week PA spends at each setting**
Primary Care Clinic	
Specialty Care Clinic	
Mental Health Facility	
Chemical Dependency Settings	
Home Visit	
Hospital	
Correctional Facility	
Ambulatory Surgical Center	
Adult Family Home Visits	
Nursing Home/Rehabilitation	
Free Standing Urgent Care Clinics	
Emergency Rooms	
Retail Clinics	
Medical Spas	
Hospice Care	
Occupational Medicine	
Other – Please describe	

Other Current Practice Plans:

List by name all the physicians with which this PA has a current practice agreement.

_____ _____

_____ _____

Termination:

If this practice agreement is terminated, the physician assistant must notify the Board in writing of that termination within 10 days of termination. See §24-2-11.13.

Send notification to:

WV Board of Osteopathic Medicine
405 Capitol Street, Suite 402
Charleston, WV 25301

Email: wvbdosteo@wv.gov

Fax: (304) 558-6096

We hereby certify under penalty of perjury under the laws of the State of West Virginia that the foregoing information in this practice agreement is correct to the best of our knowledge and belief. We further certify we have reviewed the current rules and regulations of the WV Board of Osteopathic Medicine pertaining to osteopathic physician assistants and this practice description and understand our roles and responsibilities.

_____ _____
Signature of Osteopathic Physician Assistant Date

_____ _____
Signature of Collaborative Osteopathic Physician Date

_____ _____
Signature of Board Member Date

DELEGATION OF PRESCRIPTIVE AUTHORITY

I intend to delegate to this physician assistant the following:

____ Prescribe

____ Administer

____ Dispense (PA's may only dispense/administer controlled substances after securing a CSL (Controlled Substance License) from the Board, securing a DEA and registering as a prescriber with the WV Board of Pharmacy)

____ Order (DME)

Delegate by Checking the Box	Medications	Please identify any additional limitations or restrictions to the quantities or frequency of prescribing for each delegated class of medication. If you do not have any additional restrictions, please write "none."
	Schedule III (30-Day With No Refills) (Suboxone/buprenorphine requires MAT delegation)	
	Schedule IV	
	Schedule V	
	Non-Controlled Prescription Medications	

ATTESTATIONS OF COLLABORATING PHYSICIAN & PHYSICIAN ASSISTANT

We hereby attest to the following:

1) All prescribing activities of the physician assistant shall comply with applicable state and federal law governing the practice of physician assistants;

2) All medical records and charts shall contain a notation of any prescription written by the physician assistant as well as the plan for continued evaluation of effectiveness of any controlled substances at the initial issuance of the prescription;

3) All prescriptions, including electronic prescriptions, written by the physician assistant will include the PA's name, professional designation, practice location, telephone number, signature, license number issued by the Board, the collaborating physician's name, business address and business telephone number, and any other information required by state and federal law; and

4) We understand the eligibility criteria for the delegation of prescriptive authority to physician assistants, and have reviewed documentation which establishes that this physician assistant has successfully completed each of the requirements set forth by this Board to prescribe, and is eligible for the delegation of prescriptive authority.

_____ _____

Signature of Osteopathic Physician Assistant Date

_____ _____

Signature of Collaborative Osteopathic Physician Date

_____ _____

Signature of Board Member Date