

EMPLOYMENT CONTRACT FORM

I, _____ , an applicant for
(Applicant's Name)

Licensure as a Physician Assistant, will be employed by

(Employer's Name including Department)

for the period beginning _____
(Month/Day/Year)

Signature of Physician Assistant (Date)

Signature of Supervising Physician (Date)

Print Name of Physician _____

(Must have employment contract for each office)

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
108 CHERRY STREET
BURLINGTON, VT 05401
(802) 657-4223

PRIMARY SUPERVISING PHYSICIAN APPLICATION

Please print. Incomplete applications will be returned. Attach additional sheets as needed.

Name of Supervisor _____
(Last) (First) (Middle)

Address where PA will be supervised:

(Office Name)

(Street)

(City/State) (Zip Code) (Telephone Number)

Supervisors Vermont License #: _____

Hospital(s) where you have privileges:	Hospital(s) Location	Specialty
_____	_____	_____
_____	_____	_____

What arrangements have you made for supervision when you are not available or out of town:

CERTIFICATE OF SUPERVISING PHYSICIAN

I hereby certify that, in accordance with 26 VSA, Chapter 31, I shall be legally responsible for all medical activities of (name of PA) _____, P.A. while under my supervision. I further certify that the protocol outlining the scope of practice, attached to this application, does not exceed the normal limits of my practice. I further certify that notice will be posted that a physician assistant is used, in accordance with 26 VSA, Chapter 31, Section 1741.

I further certify that I have read the statutes and Board rules governing physician assistants.

Signature of Supervising Physician: _____ Date: _____

Signature of PA: _____ Date: _____

Note: A PA who prescribes controlled drugs must obtain an ID number from DEA.
PA's DEA Number _____

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SECONDARY SUPERVISING PHYSICIAN APPLICATION

Please print. Incomplete applications will be returned. Attach additional sheets as needed.

Name of Supervisor: _____
(Last) (First) (Middle)

Address where PA will be supervised:

(Office Name)

(Street)

(City/State) (Zip Code) (Telephone Number)

Supervisors Vermont License #: _____

Hospital(s) where you have privileges: Hospital(s) Location Specialty

List all physician's assistants names and addresses you currently supervise:

CERTIFICATE OF SECONDARY SUPERVISING PHYSICIAN

I hereby certify that, in accordance with 26 VSA, Chapter 31, I shall be legally responsible for all medical activities of (name of PA) _____, P.A. only when the primary supervising physician is unavailable and only when consulted by the aforesaid Physician Assistant. I further certify that the protocol outlining the scope of practice, attached to this application, does not exceed the normal limits of my practice and that in accordance with 26 VSA, Chapter 31, Section 1741, the use of a physician assistant has been posted.

I further certify that I have read the statutes and Board rules governing physician assistants.

Signature of Secondary Supervising Physician: _____

Date: _____

Delegation agreement requirements for Physician Assistants

In order to practice, a licensed physician assistant shall have completed a delegation agreement as described in section 1735a of this title with a Vermont licensed physician signed by both the physician assistant and the supervising physician or physicians. The original shall be filed with the board and copies shall be kept on file at each of the physician assistant's practice sites. All applicants and licensees shall demonstrate that the requirements for licensure are met.

The Delegation Agreement document shall be signed by the primary supervising physician and the PA, and shall cover at least the following:

- Narrative: A description of the practice setting, patient population common to the practice and a general overview of the role of the physician assistant in that practice.
- A detailed description of the manner in which on-site and off-site physician supervision and communication will occur;
- A detailed description of the manner in which secondary supervising physicians will be utilized, and the means by which communication with them will be managed;
- A detailed description of the manner in which emergency conditions will be handled in the absence of an on-site physician, including:
 - Plans for immediate care,
 - Means of accessing emergency transport;
 - A detailed description of the physician's supervision plan for the PA's practice; and
- A detailed description of the physician's plan for retrospective review of PA charts which must at least include the following:
 - The frequency with which these reviews will be conducted;
 - The minimum number or percentage of charts that will be reviewed;
 - The method by which charts will be selected for review; and
 - The methods by which the review will be documented;
- Sites of Practice: Name, physical address and type of facility for each practice site.
- Duties: A list of the tasks and duties delegated to the PA, which shall include only activities within the supervising physician's scope of practice. The supervising physician may only delegate those tasks for which the physician assistant is qualified by education, training and experience to perform.
- Authorization To Prescribe. A PA may prescribe only those drugs that are within the scope of practice of both the PA and the primary supervising physician as documented in the Delegation Agreement. If authorized to prescribe prescription drugs and/or devices, the delegation agreement must address all of the following (if applicable): 27.3.5.1 Whether the PA is authorized to prescribe controlled substances;
 - The PA's DEA number; and
 - The specific schedules authorized.