DEPARTMENT OF HEALTH
Council on Physician Assistants
4052 Bald Cypress Way, BIN #C03
Tallahassee, FL 32399-3253
(850) 245-4131

MQA_PhysicianAssistant@doh.state.fl.us

INSTRUCTIONS FOR COMPLETING THE APPLICATION FOR CHANGES TO THE PRESCRIBING LICENSE

No fee required

A new application is required for any change (adding or deleting) of employment location, specialty area of practice or supervising physician(s). If an authorized supervising physician leaves an employment setting approved for the physician assistant, the physician assistant will no longer be eligible to prescribe with that physician.

A supervisory physician may delegate to a fully licensed physician assistant the authority to prescribe any medication used in the supervisory physician's practice, pursuant to Sections 458.347(4)(e), and 459.022(4)(e), Florida Statutes, and that is not listed in Rule Sections 64B8-30.008 and 64B15-6.0038, F.A.C. and is not listed in Chapter 893, F.S. and in accordance with rule sections 64B8-30.003, and 64B15-6.003 F.A.C. A "fully licensed Physician Assistant" is defined as a physician assistant who has successfully passed the NCCPA examination or other examination approved by the Board of Medicine and has been issued a license, other than a temporary license, as authorized under Sections 458.347 and 459.022, Florida Statutes.

An applicant for licensure as a prescribing physician assistant shall, together with the supervising physician, jointly file an application for licensure on a form provided by the Council. Only physicians with an active Florida license, that is not on probation, are eligible to be supervisors for prescribing physician assistants as authorized by Rules 64B8-30.003(4) and 64B15-6.003(3), F.A.C. Multiple physicians may be listed on the same application form provided that all supervising physicians practice in the same specialty area and in the same practice setting.

CHANGES WITHIN A PREVIOUSLY APPROVED EMPLOYMENT SETTING OR SPECIALTY AREA OF PRACTICE

Part A of the application must be fully completed and signed by the physician assistant. A separate application form is required for each distinct specialty area of practice, as well as separate employment settings. Satellite offices within the same practice are not considered separate employment settings.

Part B of the application must be fully completed and signed by the supervisory physician. A separate application form is required for each distinct specialty area of practice, as well as separate employment settings. Satellite offices within the same practice are not considered separate employment settings.

The application must be legibly printed or typed and all signatures must be original. All parts of the application may be duplicated in sufficient numbers to allow for completion.

Once the proper documentation to support a change to a prescribing application has been received in the board office, an approval letter will be sent to the physician assistant. A physician assistant may not prescribe under a new physician until that physician has been approved.

A new supervising physician may be added to an existing employment setting by submitting **Part B** of the prescribing application.

SUPERVISION DATA FORM:

If the physician listed on **Part B** is not currently listed as your supervising physician you must submit a Supervision Data Form in addition to the application. A Supervision Data Form can be printed from the physician assistant website at http://www.flboardofmedicine.gov/licensing/physician-assistant-licensure/.
Upon any change in employment or supervision, each physician assistant shall notify the Department on the Supervision Data Form approved by the Council and Boards within 30 days of such change pursuant to Rule 64B8-30.004 or 64B15-6.0031, F.A.C.

Upon any change in employment status the licensed physician assistant's prescribing privileges shall immediately be stayed until such time as a new written agreement is entered into pursuant to Rule 64B8-30.007 or 64B15-6.0037, F.A.C. and a new form is filed with the Department.

PRESCRIBING LICENSE RENEWAL:

The prescribing license is renewed biennially and is included with the physician assistant license renewal fee.

SUBMITTING THE APPLICATION:

The application may be submitted by mail or electronically by fax at: (850) 412-1285 or by email at: MQA_PhysicianAssistant@doh.state.fl.us

MAILING ADDRESS:

Department of Health
Council on Physician Assistants
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APPLICATION FOR CHANGES TO LICENSURE AS A PRESCRIBING PHYSICIAN ASSISTANT NO FEE REQUIRED

PART A
TO BE COMPLETED BY THE PHYSICIAN ASSISTANT:

FL PA License **#:**	**PA**			
Name: (Please Print)				
	First	Middle Name	Last	
Mailing Address:				
	Number and Street Name			
	City		State	Zip
Email Address (optional)				
Primary Practice Location:				
	Number and Street Name			
	City		State	Zip
Office Telephone #:				
Satellite Location:				
	Number and Street Name			
	City		State	Zip
Office Telephone #:				

Specialty area for this application:

Print the physician's name, license number and specialty area of practice you are deleting.

DELETION OF PRESCRIBING SUPERVISING PHYSICIAN(S)		
Physician's name:	License Number:	Specialty Area of Practice:

DELETION OF ALL PRACTICE LOCATION(S) (PLEASE PRINT)

STATEMENT OF PHYSICIAN ASSISTANT:

I, _____ hereby declare that I have
(Please Print)
been delegated by my supervising physician(s) named herein, the authority to prescribe, pursuant to a written agreement, any medication used in my supervising physician's practice pursuant to sections 458.347(4)(e) and 459.022(4)(e), Florida Statutes, that are not listed in Chapter 893, Florida Statutes and in accordance with formulary rule sections 64B8-30.008 and 64B15-6.0038, Florida Administrative Code.

I further state that I have completed at least three (3) classroom hours in prescriptive practice conducted by an accredited program approved by the Board of Medicine, which course covers the limitations, responsibilities, and privileges involved in prescribing medicinal drugs.

These statements herein are true and accurate to the best of my knowledge.

Signature of Physician Assistant: Date Signed:

PART B
TO BE COMPLETED BY THE SUPERVISING PHYSICIAN:

This page may be duplicated in sufficient numbers to allow for completion by each supervising physician

Physician's Name: Please print			
	First	Middle	Last

Physician's Florida Medical License Number:	Physician's Specialty Area of Practice:

Physician's Practice Location:			
	Number Street Name		
	City	State	Zip
Office Telephone #:	Business Phone:		
Physician's Satellite Location:			
	Number Street Name		
	City	State	Zip
Office Telephone #:	Business Phone:		

I, _____, state that I have delegated to
(Print Name of Physician)

_____, Florida PA license #: PA_____
(Print Name of Physician Assistant)
the authority to prescribe, pursuant to a written agreement on file at our practice location, any medication used in my practice if such medication is not listed in Section 893, F.S. and in accordance with the formulary rule sections 64B8-30.008 and 64B15-6.0038, F.A.C. I further acknowledge that the Physician Assistant named herein is fully licensed under, and complies with the provisions of Sections 458.347(4)(e) and 459.022(4)(e), Florida Statutes, and the rules promulgated thereunder. I have knowledge that the Physician Assistant named herein has completed the three-hour prescriptive practice course which covers the limitations, responsibilities, and privileges involved in prescribing medicinal drugs.

The statements herein are true and accurate to the best of my knowledge.

_____

Signature of Supervising Physician: Date Signed: