Physician Assistant

Notice of Intent to Practice

(formerly Practice Setting Description)

MINNESOTA BOARD OF MEDICAL PRACTICE
University Park Plaza • 2829 University Avenue SE, Suite 500
Minneapolis, Minnesota 55414-3246
612-617-2130 or www.bmp.state.mn.us
Hearing Impaired-Minnesota Relay Service
Metro Area 297-5353
Outside Metro Area 1-800-627-3529

Month	Day	Year

Instructions

1. This form must be completed and submitted to the Board prior to beginning practice as a PA. Individuals who practice without submitting a Notice shall be subject to disciplinary action unless care is provided during disaster or emergency.
2. Complete all parts of the application. Incomplete Notices will not be accepted. Type or print for clarity.
3. The address and phone number listed is public information.
4. Physicians may only delegate prescribing authority to the extent of their own authority. PAs should review the physician's license status by searching their Professional Profile on the Board's website.
5. A supervising physician shall not supervise more than five full-time equivalent PAs simultaneously without the approval of the Board except when responding to disaster situations under Minn. Stat. 147A.23.
6. A new Notice must be submitted to the Board when there is a change in primary supervising physician or place of employment. A Notice is required for each place of employment.
7. A revised and updated Notice must be submitted when significant changes (e.g. change in delegated prescribing authority) are made by the physician-PA team. Evidence of review of the Notice of Intent to Practice and Delegation Agreement must be provided to the Board on the renewal form to ensure current practice is reflected.

Identification

Physician Assistant's Name (first,middle,last) _____

Business Address_____City, State, Zip_____

License #_____ Specialty_____DEA#_____ Phone_____ Email_____

Primary Supervising Physician(first,middle,last) _____

Business Address_____City, State, Zip_____

License #_____ Specialty_____ DEA #_____ Phone_____ Email_____

Current Delegation Agreement is on file at the following location:_____

Date expected to commence practicing_____

Does this Notice replace a previous Notice? If so, what is the name of primary supervising physician and termination date?_____

Prescribing Privileges

Supervising physicians may delegate to physician assistants who meet the criteria in Minn. Stat. §147A.18 Subd 1, the authority to prescribe, dispense and administer legend drugs, controlled substances, and medical devices. The supervising physician is responsible for determining if the PA is qualified and knowledgeable to prescribe the medications delegated. It is recommended the PA be provided with a list of medications for their use. The supervising physician may alter medications on the list at any time without board approval as long as the physician understands and determines the PA is qualified and knowledgeable in the use of these medications. The physician is ultimately responsible for the prescriptive practice of the PA.

Expiration Date of NCCPA Certification (must be current in order to prescribe) _____

Delegated Prescribing Authority (check one)

☐ No, this PA does not qualify under Chapter 147A and/or I do not wish to delegate such authority.

☐ Not yet, this PA does not currently qualify under Chapter 147A. Once this PA is NCCPA certified and has a temporary permit or license, I wish to delegate prescribing, dispensing and administering privileges.

☐ Yes, this PA qualifies under Chapter 147A PA Practice Act and I wish him/her to have prescribing, dispensing, and administering privileges.

PRACTICE SITES

Specify each practice location and indicate the type of patient care setting which best describes each practice site. Indicate the approximate percentage of time spent in each setting, and type(s) of supervision provided for each location.

Please Note: A physician assistant may be employed in more than one practice, and thus may have more than one Delegation Agreement in effect. The practice sites listed here should only include those pertinent to this specific physician-physician assistant Delegation Agreement.

Setting Codes
C = Office/Clinic
ER = Hospital Emergency Room
OO = Outpatient Other
UC = Urgent Care Center
LT = Long Term Care Facility
HO = Hospital Other
H = Hospital

Supervision Codes:
OS = On-Site
TC = Telecommunications
O = Other, please specify

PRIMARY PA PRACTICE SITE	SETTING	% OF PRACTICE	SUPERVISION	PHONE #	
STREET ADDRESS		CITY		STATE	ZIP CODE
OTHER PA PRACTICE SITE	SETTING	% OF PRACTICE	SUPERVISION	PHONE #	
STREET ADDRESS		CITY		STATE	ZIP CODE
OTHER PA PRACTICE SITE	SETTING	% OF PRACTICE	SUPERVISION	PHONE #	
STREET ADDRESS		CITY		STATE	ZIP CODE
OTHER PA PRACTICE SITE	SETTING	% OF PRACTICE	SUPERVISION	PHONE #	
STREET ADDRESS		CITY		STATE	ZIP CODE
OTHER PA PRACTICE SITE	SETTING	% OF PRACTICE	SUPERVISION	PHONE #	
STREET ADDRESS		CITY		STATE	ZIP CODE

ATTEST

A. Physician Assistant

I hereby certify that I have reviewed and understand the current laws pertaining to physician assistants and fully understand my responsibilities and that I have a physician-physician assistant Delegation Agreement in force and on file at the practice site.

PA Name (Printed) ______________________________________ PA Signature______________________________________

License # ____ Date____

B. Primary Supervising Physician

I hereby certify that I have reviewed and understand the current laws pertaining to physician assistants. I have reviewed and understand the physician-physician assistant Delegation Agreement between the physician assistant and myself. I have reviewed and agree to abide by the terms of the Notice of Intent to Practice, Delegation Agreement, and applicable state laws and rules. I agree to provide adequate supervision and to accept full medical responsibility for medical care rendered by the physician assistant named above.

Physician Name (Printed) _________________________________ Physician Signature__________________________________

License # ____ Date____