

MARYLAND BOARD OF PHYSICIANS

P.O. Box 37217

Baltimore, MD 21297

www.mpb.state.md.us

PHYSICIAN ASSISTANT/PRIMARY SUPERVISING PHYSICIAN DELEGATION AGREEMENT FOR CORE DUTIES

All PAs must file a delegation agreement with the Board.

Dear Primary Supervising Physician and Physician Assistant:

On October 1, 2010, a new law went into effect changing the delegation agreement process. Changes include, but are not limited to, the following:

- The Board is no longer required to approve a delegation agreement before the physician assistant (PA) begins working if the delegation agreement does not include advanced duties.
- A PA may begin working after the Board receives the completed delegation agreement and acknowledges receipt of the delegation agreement. Unless otherwise specified, acknowledgements will be sent to the physician assistant and the primary supervising physician by email.

Note: Pursuant to §15-302.1(e), the Board is authorized to disapprove any delegation agreement not meeting the requirements of the law or if the Board believes that a PA is unable to perform the delegated duties safely.

- PAs with prescriptive authority may dispense starter dosages or drug samples of any drug the PAs are authorized to prescribe to their patient.
- In settings other than a hospital, correctional facility, detention center or public health facility, primary supervising physicians may supervise up to four (4) PAs at any one time.

There are no specified deadlines for filing a delegation agreement. Since there are no specified deadlines, the Board will not accept faxed copies of delegation agreements.

Please keep a copy of your delegation agreement.

The Allied Health Division
Physician Assistant Program
Board of Physicians

MARYLAND BOARD OF PHYSICIANS

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**GENERAL INSTRUCTIONS FOR COMPLETING
THE PHYSICIAN ASSISTANT/PRIMARY SUPERVISING PHYSICIAN
DELEGATION AGREEMENT**

FOR CORE DUTIES* IN ANY SETTING

To request advanced duties, please complete the Delegation Agreement Addendum for Advanced Duties

1. Fee: \$200.00 per delegation agreement. All checks or money orders should be payable to: Maryland Board of Physicians and mailed with the delegation agreement to the above address—**P.O. Box 37217, Baltimore, MD 21297** (There is no charge for adding alternate supervising physicians, adding additional core duties or adding advanced duties to an existing delegation agreement.) **Applications sent to another Board address, other than the one above, or walked into the Board may be delayed by at least one week.**

2. Application: This application consists of 7 pages. Submitting illegible or incomplete applications or applications without a fee will delay the process. **PLEASE DO NOT FAX YOUR DELEGATION AGREEMENTS TO THE BOARD. THE BOARD NOT ACCEPTING FAXED COPIES OF DELEGATION AGREEMENTS.**

3. Prescriptive Authority: Primary supervising physicians may delegate prescriptive authority to licensed physician assistants if the primary supervising physician attests that the PA has met certain criteria.

The physician assistant must obtain Maryland Controlled Dangerous Substance and Drug Enforcement Registrations before prescribing controlled dangerous substances.

To obtain an application for registration for a Maryland Controlled Dangerous Substance (CDS) permit contact:

DHMH-Division of Drug Control
4201 Patterson Avenue
Baltimore, MD 21215
(410) 764-2890
<http://www.dhmh.state.md.us/drugcont/>

The processing of this application may take 2-3 weeks. CDS applications should be submitted after the delegation agreement is approved by the Maryland Board of Physicians.

To obtain an application for registration with the DEA, call 1-800-882-9539 or visit their website at http://www.deadiversion.usdoj.gov/drugreg/reg_apps/onlineforms_new.htm

Questions and concerns regarding Controlled Dangerous Substance and Drug Enforcement Agency applications should be directed to the appropriate agency and not to the Maryland Board of Physicians.

4. Dispensing Drug Samples and Starter Dosages: Physician Assistants who are delegated the authority to prescribe may dispense a starter dosage or dispense drug samples of any drug the physician assistant is authorized to prescribe to a patient of the PA if: (1) The starter dosage or drug sample complies with the labeling requirements of Health Occupations Article §12-505; (2) No charge is made for the starter dosage; (3) The starter dosage does not exceed a 72 hour supply; (4) The Physician Assistant enters an appropriate record in the patient's medical record; and (5) The Physician Assistant complies with the requirements under Title 12 and 14 of Health Occupations and applicable Federal law and regulations.

*Core duties mean medical acts that are included in the standard curricula of accredited physician assistant education programs.

5. Attestations: Primary supervising physicians please sign the attestations on Page 4.

6. Attestations and Release: Primary supervising physicians and physician assistants please complete and sign Page 5.

7. Alternate Supervising Physicians: Please complete Page 6 only if the primary supervising physician is designating an alternate supervising physician in a practice setting other than a hospital, correctional facility, detention center or local public health facility.

8. Information for Physician Assistant: For information about physician assistants, including applications, the statute (Health Occupations Article, §15-101, et seq) and regulations (COMAR 10.32.03), please go to the Board's website at www.mpb.state.md.us.

Questions about the delegation agreements may be directed to Gwendolyn Joyner, Allied Health Analyst, at 410-764-4781/ gjoyner@dhmh.state.md.us or Ellen Douglas Smith, Chief, Allied Health at 410-764-2477/ edsmith@dhmh.state.md.us. Your questions may also be answered by going to the Board's website at <http://www.mbp.state.md.us>

IMPORTANT

- A. KEEP A COPY OF THE DELEGATION AGREEMENT.
- B. THE BOARD DOES NOT ACCEPT FAXED DELEGATION AGREEMENTS.
- C. IF ONE CHECK IS SUBMITTED FOR MULTIPLE PHYSICIAN ASSISTANTS, PLEASE:
 - SPECIFY THE NAME(S) OF THE PHYSICIAN ASSISTANT(S) ON THE CHECK OR ON A SEPARATE SHEET OF PAPER ATTACHED TO THE CHECK WITH THE CORRECT FEE FOR EACH PHYSICIAN ASSISTANT.
- D. TERMINATION NOTICES MUST BE FILED WITH THE MARYLAND BOARD OF PHYSICIANS REGARDLESS OF THE REASON FOR THE TERMINATION. A TERMINATION OF EMPLOYMENT FORM IS PROVIDED AT THE END OF THIS APPLICATION.
- E. FAILURE TO NOTIFY THE BOARD WITHIN 60 DAYS OF A NAME CHANGE OR CHANGE OF ADDRESS MAY RESULT IN A \$100 FINE. PLEASE GO TO THE BOARD'S WEBSITE TO OBTAIN A NAME CHANGE OR ADDRESS CHANGE FORM. YOU MAY ALSO UPDATE YOUR ADDRESS ONLINE. GO TO THE BOARD'S WEBSITE AT www.mbp.state.md.us AND CLICK ON PRACTITIONER PROFILES.

MARYLAND BOARD OF PHYSICIANS
P.O. BOX 37217
BALTIMORE, MD 21297
www.mbp.state.md.us

FOR BANK USE ONLY
Date _____
Check Number _____
Amt Paid _____
Name Code _____
App ID: 53

Fee: \$200

**PHYSICIAN ASSISTANT/PRIMARY SUPERVISING PHYSICIAN
DELEGATION AGREEMENT FOR CORE DUTIES**

PHYSICIAN ASSISTANT INFORMATION: TYPE OR PRINT LEGIBLY		
1. Maryland License #:	2. NCCPA Certification #:	
3. IDENTIFYING INFORMATION:		
Last Name, (Suffix, Jr., III):	First Name:	
Middle Name/Initial:	Maiden Name:	
4. MAILING ADDRESS:		
Street Address 1:		
Street Address 2:		
City:	State:	Zip code:
5. CONTACT INFORMATION: (Unless otherwise specified, your notification letter will be sent to your email address. Please be sure the email address you provide is valid.)		
Home #:	Work #:	
Pager #:	Cell #:	
Fax #:	Email address:	
6. PLEASE ANSWER "YES" OR "NO" TO THE FOLLOWING QUESTION:		
<p>Have you ever been subject to any disciplinary action in any jurisdiction by any licensing or disciplinary board or an entity of the armed services?</p> <p style="text-align: center;"> <input type="checkbox"/> Yes <input type="checkbox"/> No </p> <p>If you answered "YES," provide a signed and dated detailed explanation on a separate sheet of paper and supporting documentation. (Failure to provide an explanation or supporting documentation will delay the processing of this application.)</p>		
For Board Use Only: Approval Date: _____		

PRIMARY SUPERVISING PHYSICIAN INFORMATION: TYPE OR PRINT LEGIBLY

7. Maryland License #:

8. IDENTIFYING INFORMATION:

Last Name (Suffix, Jr., III) **First Name:**

Middle Name/Initial: **Maiden Name:**

9. MAILING ADDRESS:

Street Address 1:

Street Address 2:

City: **State:** **Zip code:**

10. CONTACT INFORMATION: *(Notification letters will be sent to your email address. Please provide a valid email address.)*

Home #: **Work #:**

Pager #: **Cell#:**

Fax #: **Email Address:**

11. PLEASE ANSWER “YES” OR “NO” TO THE FOLLOWING QUESTION:

Have you ever been subject to any disciplinary action in any jurisdiction by any licensing or disciplinary board or an entity of the armed services?

Yes No

If you answered “YES,” provide a signed and dated detailed explanation on a separate sheet of paper and supporting documentation. (Failure to provide an explanation or supporting documentation will delay the processing of this application.)

12. PRACTICE SETTING: Describe the setting(s) in which the physician assistant will practice:

- Hospital Public Health Facility Ambulatory Surgical Facility Nursing Home HMO
- Private Practice Urgent Care Center Detention Center/ Correctional Facility
- Other _____

13. LOCATION(S): For additional locations, please use a separate sheet of paper.

Facility/Practice Name:

Department:

Address:

City: **State:** **Zip code:**

Contact Name: **Telephone #:**

Facility/Practice Name:

Department:

Address:

City: **State:** **Zip code:**

Contact Name: **Telephone #:**

20. I ATTEST THAT:

- a. **FOR PRIMARY SUPERVISING PHYSICIANS IN ANY SETTING.** The Physician Assistant will practice only within the scope of practice of the primary supervising physician or a designated alternate supervising physician. I, as the primary supervising physician, assume responsibility for maintaining and enforcing mechanisms that assure this requirement is met on a continuous basis.
- b. **FOR PRIMARY SUPERVISING PHYSICIANS IN A SETTING OTHER THAN A HOSPITAL/CORRECTIONAL FACILITY/DETENTION CENTER OR PUBLIC HEALTH FACILITY.** I will not delegate medical acts under a delegation agreement to more than **four** physician assistants at any one time. When acting as an alternate supervising physician, I will not supervise more than four physician assistants at any one time.
- c. All medical acts to be delegated to the physician assistant are within my scope of practice or the scope of practice of a designated alternate supervising physician and are appropriate to the physician assistant's education, training, and level of competence.
- d. I accept responsibility for any care given by the named physician assistant.
- e. I will utilize the mechanisms of continuous supervision described on in this delegation agreement.
- f. I will respond in a timely manner when contacted by the physician assistant.

21. OTHER INFORMATION: H.O. Section 15-302(b)(10)

- a. I understand that repealing the requirement for supervising physicians to review and co-sign medical charts does not relieve me of the responsibility for any and all medical acts the physician assistant performs.
- b. I understand that completing this agreement in bad faith, completing a false or misleading agreement, or the failure to perform the supervision provided in the agreement, constitutes unprofessional conduct in violation of Health Occupations Article Section 14-404(a)(3), Annotated Code of Maryland.
- c. In non-emergent situations, the policy of my practice is to notify patients in advance (ideally at the time of scheduling), if a physician assistant will be the treating practitioner.
- d. The policy of my practice is that either the physician assistant or I discuss the nature and purpose of the proposed treatment or procedure; the risks and benefits of not receiving or undergoing the treatment or procedure; alternative treatments and procedures; and risks or benefits of alternative treatments or procedures with all patients.
- e. I will report to the Board, within 5 days:
 - Any termination for any reason, including quality of care issues; or
 - Any limitation, reduction or change of the terms of employment of Physician Assistant for any reasons that might be grounds for discipline under Health Occupations Article, §15-314.

Primary Supervising Physician (Print legibly)

Primary Supervising Physician (Signature)

Date

**22. ATTESTATIONS FOR THE DELEGATION OF PRESCRIPTIVE AUTHORITY:
For Primary Supervising Physicians and Physician Assistants**

I, as the primary supervising physician named in this delegation agreement intend to delegate prescriptive authority to: _____ . I attest that the Physician Assistant has:
Name of Physician Assistant

- Passed the NCCPA Exam within the previous 2 years and the date of passage was _____; **OR**
mm/dd/yyyy
- Successfully completed 8 Category I hours of pharmacology education within the previous 2 years; **AND**
- Has a Bachelor's degree or its equivalent (120 credit hours); **OR**
- Has successfully completed 2 years of work experience as a physician assistant.

I also attest that:

- a. All prescribing activities of the physician assistant will comply with all federal and state laws governing the prescribing of medications, including controlled dangerous substances.
- b. Medical charts or records will contain a notation of any prescriptions written by the physician assistant.
- c. All prescriptions written by the physician assistant will include the physician assistant's name, the primary supervising physician's name, business address, and business telephone number legibly written or printed.
- d. I, as the Primary Supervising Physician, shall notify the Board within 5 business days if the physician assistant's delegation to prescribe has been restricted or revoked.
- e. I have read and am thoroughly familiar with Health Occupations Article Title 15, Annotated Code of Maryland and Code of Maryland Regulations (COMAR) 10.32.03 which govern physician assistants and the requirements and responsibilities of the primary supervising physician. (http://www.mbp.state.md.us/pages/phys_assi_laws.html)

23. RELEASE

I agree that the Maryland Board of Physicians (the Board) and the Physician Assistant Advisory Committee may request any information necessary to process my delegation agreement from any person or agency, including but not limited to former and current employers, government agencies, the National Practitioners Data Bank, the Healthcare Integrity and Protection Data Bank, hospitals and other licensing bodies, and I agree that any person or agency may release to the Board the information requested. I also agree to sign any subsequent releases for information that may be requested by the Board.

24. AFFIRMATION

I solemnly affirm under penalties of perjury, that the contents of the foregoing document are true to the best of my knowledge, information and belief.

Primary Supervising Physician (print)

Primary Supervising Physician (Signature)

Date

Physician Assistant (print)

Physician Assistant (Signature)

Date

**ALTERNATE SUPERVISING PHYSICIAN
DESIGNATION INFORMATION**

A PHYSICIAN MAY SUPERVISE AS AN ALTERNATE SUPERVISING PHYSICIAN IF:

1. The alternating supervising physician supervises in accordance with a delegation agreement approved by the Board;
2. The alternate supervising physician supervises **NO MORE** than four physician assistants at any one time, except in a hospital, correctional facility, detention center, or public health facility;
3. The period of supervision, in the absence of the primary supervising physician, **DOES NOT** exceed the lesser of:
 - a. The period of time specified in the delegation agreement; or
 - b. A period of 45 consecutive days at any one time; and
4. The physician assistant performs **ONLY** those medical acts that;
 - a. Have been delegated under the delegation agreement filed with the Board; and
 - b. Are within the scope of practice of the primary supervising physician or the alternate supervising physician.

Hospitals, Correctional Facilities, Detention Centers, or Public Health facilities

The primary supervising physician may designate alternate supervising physicians by:

1. Keeping an ongoing list of all approved alternate supervising physicians on file at all practice sites;
2. Including each alternate supervising physician's scope of practice; and
3. Having each alternate supervising physician sign and date the list.
4. Providing the list on request in writing, during business hours, to representatives of the Board or the Office of Health Care Quality.

The list must be kept up-to-date with additions and terminations of alternate supervising physicians.

In All Other Practice Settings

A primary supervising physician may designate an alternate supervising physician by completing Page 6 of the delegation agreement.

In the event of a sudden departure, incapacity, or death of a primary supervising physician, a designated alternate supervising physician may assume the role of the primary supervising physician by submitting a new delegation agreement to the Board within 15 days.

DESIGNATED ALTERNATE SUPERVISING PHYSICIAN INFORMATION
FOR SETTINGS OTHER THAN A HOSPITAL, CORRECTIONAL FACILITY,
DETENTION CENTER, OR PUBLIC HEALTH FACILITY

Instructions: Primary supervising physicians, physician assistants and alternate supervising physicians must complete the appropriate sections.

EACH DESIGNATED ALTERNATE SUPERVISING PHYSICIAN MUST SUBMIT THIS COMPLETED FORM

25. ALTERNATE SUPERVISING PHYSICIAN INFORMATION:

Name of Alternate Supervising Physician:	Maryland License #:
Work #:	Cell #:
Pager #:	Email Address:

26. PHYSICIAN ASSISTANT AND PRIMARY SUPERVISING PHYSICIAN INFORMATION:

Name of Physician Assistant:	Name of Primary Supervising Physician:
Signature of Physician Assistant:	Signature of Primary Supervising Physician:

27. ALTERNATE SUPERVISING PHYSICIAN SCOPE OF PRACTICE: Please describe your scope of practice.

28. ALTERNATE SUPERVISING PHYSICIAN PLEASE ANSWER "YES" OR "NO"

Have you ever been subject to public disciplinary action in any jurisdiction by any licensing or disciplinary board or an entity of the armed services?

Yes No

If you answered "YES," provide a detailed explanation and supporting documentation on a separate sheet of paper. Be sure to sign and date all documentation. (Failure to provide an explanation or supporting documentation will delay the processing of this application.)

29. AFFIRMATION

I accept the responsibility of supervising the listed physician assistant in the absence of the listed primary supervising physician. I solemnly affirm under penalties of perjury, that the contents of the foregoing document are true to the best of my knowledge, information and belief.

Alternate Supervising Physician (Print)

Date

Alternate Supervising Physician (Signature)

TERMINATION OF EMPLOYMENT (DELEGATION AGREEMENT) REPORT

REPORTING REQUIREMENTS: Hospitals, related institutions, alternative health care systems, or employers are required to report to the Board any termination of employment of the physician assistant for any reason, including quality of care issues within 5 days of the termination. Hospitals, related institutions, alternative health care systems, or employers are also required to report to the Board within 5 days any limitation, reductions or other changes of employment of the change of employment that might be grounds for disciplinary actions under Health Occupations Article, §15-314.

INSTRUCTIONS: Employers/Primary Supervising Physicians, please complete the applicable information on pages 1 and 2. Unless otherwise specified, termination notifications will be emailed to the primary supervising physician and the physician assistant.

1. EFFECTIVE DATE OF TERMINATION:

2. PHYSICIAN ASSISTANT INFORMATION:

License #:

Last Name, (Suffix, Jr., III):

First Name:

Middle Name/Initial:

Maiden Name:

Email Address:

3. PRIMARY SUPERVISING PHYSICIAN INFORMATION:

License #:

Last Name, (Suffix, Jr., III):

First Name:

Middle Name/Initial:

Maiden Name:

Email Address:

4. LOCATION(S) OF PRACTICE/HEALTH CARE FACILITY:

Facility/Practice Name:

Department:

Address:

City:

State:

Zip code:

Facility/Practice Name:

Department:

Address:

City:

State:

Zip code:

5. Reason(s) for Termination: Reasons may include, but are not limited to: voluntary resignation, quality of care issue, resignation after a notice of intent to terminate. Please provide supporting documentation, if applicable.

6. Reason(s) for limitation, reductions or other changes of employment that might be grounds for disciplinary actions under Health Occupations Article, §15-314.

7. Signatures

Name of Primary Supervising Physician/Employer in Print:

Signature Primary Supervising Physician/Employer:

Telephone Number:

Date:

Email Address: