

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

MQA_Physician Assistant@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. 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)(f), and 459.022(4)(f), 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 64B8-30.008(3)(a), and 64B15-6.003(2) 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(7)(b) 2, 458.347(7)(f) and 459.022(7)(e), 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 64B8.003(4) and 64B15-6.003(2), 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/SPECIALTY:

A new supervising physician may be added to an existing employment setting by submitting **part B** of the prescribing application **AND an updated Supervision Data Form (SDF) (see details below)**. The SDF alone does not authorize the Physician Assistant the authority to prescribe under the physicians listed in that same form. Always submit **ALL** pages of the Changes to the Prescribing Application with the original signatures.

CHANGES IN EMPLOYMENT SETTING/SPECIALTY AREA OF PRACTICE:

THE APPLICANT SHALL HAVE COMPLETED:

A minimum of three-months of clinical experience in the specialty area of the supervising physician, which is defined as three continuous months of full-time practice or its equivalent, following full licensure as a Physician Assistant, within four years immediately preceding the filing of the application.

THE APPLICANT MUST SUBMIT THE FOLLOWING:

1. **Part A** of the application, which must be fully completed and signed by the Physician Assistant applicant. 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.
2. **Part B** of the application, which must be fully completed and signed by EACH supervising physician. Part B of the application may be duplicated in sufficient number to allow for completion by each supervising physician.
3. A copy of the Board-stamped Supervision Data Form reflecting all supervising physicians previously approved by the Board.
4. Applicants who completed the three months of clinical experience outside of the state of Florida must provide an original letter from their supervising physician, addressed to the Department of Health, Council on Physician Assistants, confirming the three months of clinical experience and specialty area. Additionally, the applicant must arrange to have the medical board, from the state the clinical experience was completed, to submit their physician assistant license verification to the address listed at the top of page 1.

Copies must be legibly printed or typed.

All signatures must be original.

It is acceptable, and preferred that large documents be reduced to 8.5" by 11".

If adequate space is not provided on the application form to complete the requested information, please attach additional sheets as necessary.

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.

Renewal of a prescribing license is subject to biennial renewal and shall be renewable only if the supervisory physician(s) delegate to the licensed physician assistant the authority to prescribe pursuant to Section 458.347(7)(c) and 459.022(7)(b), Florida Statutes.

MAIL THE COMPLETED APPLICATION AND SUPPORTING DOCUMENTATION TO THE ADDRESS PRINTED AT THE TOP OF PAGE ONE.



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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:

Social Security Number:		FL License #: PA	
1. Name: (Please Print)	First	Middle	Last
2. Mailing Address:	Number and Street Name		
	City	State	Zip
3. Practice Location:	Number and Street Name		
	City	State	Zip
4. Telephone:	Home:		Office:
5. Are you or have you ever been certified as a prescribing physician assistant in Florida? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please state your prescribing license and specialty area of practice.			
License #:		Specialty Area of Practice:	
6a. Specialty area for this application:			
6b. The specialty I am adding is:			

The specialty I am deleting is:			

A three-hour course approved by the Boards in prescriptive practice, which course shall cover the limitations, responsibilities, and privileges involved in prescribing medicinal drugs or evidence that you have received education comparable to the continuing education course as part of an accredited physician assistant training program. **Out-of-state prescriptive course certificates are not acceptable.**

The Board approved programs are listed below. Check the prescriptive program you completed

Florida Academy of Physician Assistants Course	
University of Florida Physician Assistant Program	
Nova Southeastern Univ. P. A. Program	
Barry University Physician Assistant Program	

A minimum of three (3) months of clinical experience within the last four years must be completed in the specialty area of practice for which this application for prescriptive privileges is being made. Three (3) months of clinical experience is defined as three continuous months of full-time practice or the equivalent, following full licensure as a physician assistant. The following information must be provided to verify the required clinical experience:

Name of Supervising Physician Providing Clinical Experience	Location at Which Clinical Experience Was Completed	Dates That Clinical Experience Was Completed	
		From:	To:
		From:	To:
		From:	To:

AFFIRMATION OF PHYSICIAN ASSISTANT:

I, _____ hereby affirm that I have been delegated by my
 (Please Print)
 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 Section 458.347(4)(f) and 459.022(4)(e), Florida Statutes, that are not listed in Chapter 893, Florida Statutes and in accordance with Rule Sections 64B8-30.008 and 64B15-6.0038, Florida Administrative Code.

I further affirm 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.

I have also completed a minimum of three-(3) months clinical experience in the specialty area of practice of my supervising physician(s) and for which I am applying for prescriptive privileges.

I hereby state that the 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

Physicians Name:			
	First	Middle	Last

Florida Physician License Number:	Physician's Specialty Area:
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Physician's Practice Location:			
	Number	Street Name	
	City	State	Zip
Telephone:	Business Phone:		

Please Designate Whether The Above Practice Address Represents a Primary Location or Satellite Office To The Practice Address Listed On Page 1.	
Satellite Office	Primary Practice/Employment Setting

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

_____ the authority to prescribe, pursuant to a written
(Please Print Name of Physician Assistant)

agreement on file at our practice location, any medication used in my practice if such medication is not listed in Section 893, Florida Statutes and in accordance with 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 a minimum of three months of clinical experience in the specialty area of my practice and has completed the three-hour prescriptive practice course which covers the limitations, responsibilities, and privileges involved in prescribing medicinal drugs.

I hereby state that the statements herein are true and accurate to the best of my knowledge.

Signature of Supervising Physician: _____

Date Signed: _____