ALABAMA BOARD OF MEDICAL EXAMINERS

P.O. Box 946 / Montgomery, AL 36101-0946 / (334) 242-4116

APPLICATION FOR REGISTRATION OF PHYSICIAN ASSISTANT

PHYSICIAN TO COMPLETE:

Supervising Physician Name in Full _____ Ala. Medical License Number _____

Date of Birth _____ Social Security No. _____ Medical Specialty _____
Board Certified: | Board Eligible:

Principal Practice Location Address _____

(If mailing address is different please provide here) _____

Telephone Number: _____ FAX Number _____

1. List the name, practice site address and designated working hours per week of each physician assistant and/or CRNP and/or CNM **currently** registered to you. Attach additional sheets if necessary.

NAME: _____ _____ _____

ADDRESS _____ _____ _____

HOURS _____ _____ _____

2. Have you ever had a physician assistant certified or registered to you by the Alabama Board of Medical Examiners?
   YES _____ NO _____ **If the answer is YES**, list the names of the assistant(s) in the spaces provided.

   _____ _____ _____

   _____ _____ _____

   _____ _____ _____

3. Is the physician assistant for whom registration is sought employed by you or by your group, partnership or professional corporation?

   YES_____ NO_____ **If the answer is NO**, Appendix **C** to Chapter 7 must be submitted.
   http://www.albme.org/Documents/Forms/PAsuppcert.pdf

I hereby certify that the foregoing information is correct to the best of my knowledge, information and belief; and that I have reviewed and understand the current rules and regulations of the Alabama Board of Medical Examiners pertaining to physician assistants and understand my responsibilities.

Date: _____ **Primary Supervising Physician Signature**: _____

In accordance with Rule 540-X-7-.21 confirmed receipt of this application will be sent by mail, unless a FAX number is provided where the confirmation can be transmitted by FAX.

A physician assistant previously approved to practice under the provisions of Chapter 7 of the Board of Medical Examiners Rules may continue in the supervised practice with this interim supervising physician and may continue until such time as this application is approved or denied, provided the supervising physician meets the qualifications established in Rule 540-X-7-.17.

PHYSICIAN ASSISTANT TO COMPLETE:

Physician Assistant Name in Full _____

Ala. P. A. License Number _____ Date of Birth _____ Social Security No. _____

1. Have you ever been certified or registered as a physician assistant by the Alabama Board of Medical Examiners?

   YES _____ NO _____ **If the answer is YES**, list the names of the physicians in the spaces provided.

   _____

   _____

2. Are you **currently** certified or registered to any other primary certifying physician? **If the answer is YES,** in the space below give the physician name, physician practice location, *assistant's* certification or registration number, and *assistant's* number of hours per week for each primary supervising physician. (There are spaces for three separate registrations.

NAME _____

ADDRESS _____

REGISTRATION NO. _____

HOURS PER WEEK _____

I hereby certify that the foregoing information is correct to the best of my knowledge, information and belief; and that I have reviewed and understand the current rules and regulations of the Alabama Board of Medical Examiners pertaining to physician assistants and understand my responsibilities.

Date: _____ **Physician Assistant Signature**: _____

Office Use ▼	**PLEASE NOTE & RESPOND TO THE FOLLOWING AS APPROPRIATE FOR THIS REGISTRATION REQUEST.**
	FEE: Each new registration requires submission of a $100.00 fee. Please attach check payable to Alabama Board of Medical Examiners.
	JOB DESCRIPTION: Please attach a completed job description signed by the physician and the assistant.
	FORMULARY: If assistant is to be granted legend drug prescribing authority attach a completed and signed formulary.
	APPENDIX C , SUPPLEMENTAL CERTIFICATE: If assistant is employed by an entity **other than** the physician, the physician's group or professional corporation please include a completed Appendix C. Include a separate sheet for responses if required.
	COVERING PHYSICIAN LETTERS: The absence of "covering physician" letter(s) indicates that when the primary physician is not working, the assistant is not working. (A "sample" form was included in the registration package.)