

**OREGON MEDICAL BOARD**

1500 SW 1<sup>st</sup> Ave, Suite 620 • Portland, OR 97201  
 (971) 673-2700 or (877) 254-6263 (toll free in Oregon)  
 Web site address: [www.oregon.gov/omb](http://www.oregon.gov/omb)

Filing Deadline:	Temporary Approval Date: _____
Next Board Meeting Date:	Board Approval Date: _____

## REVISION TO THE BOARD APPROVED PRACTICE DESCRIPTION Request for Schedule II prescribing privilege

*Requesting party must submit proof of Physician Assistant's current NCCPA certification with this request.*

<b>Physician Assistant Name:</b>			<b>Oregon PA license #</b>
<b>PA's PRIMARY Practice Address (for this practice only)</b> <b>Practice Name:</b>			<b>Business Phone #</b>
<b>Street:</b>	<b>City:</b>	<b>State / Zip Code:</b>	<b>Practice Specialty:</b>
<b>Supervising Physician's Name:</b>			<b>Oregon License #</b>
			<input type="checkbox"/> MD <input type="checkbox"/> DO
<b>PRIMARY Practice Address:</b>			
<b>City:</b>	<b>State:</b>	<b>Zip Code:</b>	<b>County:</b>

### SCHEDULE II – V PRESCRIPTION PRIVILEGE

*A physician assistant may issue written or oral prescriptions for medications, including Schedule II - V, which the supervising physician has determined the physician assistant is qualified to prescribe commensurate with the practice description and approved by the Board if the physician assistant has met the requirements of OAR 847-050-0041 (2) (3). For authorization to issue prescriptions for Schedules II through V controlled substances, the prescribing physician assistant must be registered with the Federal Drug Enforcement Administration (DEA).*

**I am requesting the Board to grant my physician assistant Schedule II prescribing privilege; he/she qualifies under ORS 677.545 (6). Attached is a copy of my PA's current NCCPA certification. I am requesting no further revision to my PA's current practice description. This request is a revision to his/her current Board approved practice description, and fulfills the requirement of Senate Bill 647 to accompany the application for Schedule II prescription privileges with the practice description of my physician assistant.**

I understand that I am fully responsible for the actions of the physician assistant I supervise, even at such times as my agents are supervising the physician assistant's functions. I further understand that I am responsible for informing the designated agents of their responsibilities under Oregon law in the supervision of the physician assistant.

**Name of Supervising Physician (Print or Type):** \_\_\_\_\_

**Signature of Supervising Physician:** \_\_\_\_\_ **Date:** \_\_\_\_\_