

OREGON MEDICAL BOARD

1500 SW 1st Ave, Suite 620 • Portland, OR 97201
 (971) 673-2700 or (877) 254-6263 (toll free in Oregon)
 Web: www.oregon.gov/OMB

Temporary approval date: _____	Board approval date: _____
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REVISION TO THE BOARD APPROVED PRACTICE DESCRIPTION

This form will be returned if it is not typed. Faxes/Copies will not be accepted.

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

I AM REQUESTING THE FOLLOWING ADDITIONAL MEDICAL AND SURGICAL SERVICES TO BE ADDED TO THE PRACTICE DESCRIPTION OF THE ABOVE PA

List procedures requesting. Please do not use abbreviations. Submit the frequency that these procedures have been performed by the physician and the PA as well as documentation of the PA's training and experience.	NUMBER PERFORMED IN PAST 12 MONTHS	SELECT LEVEL OF SUPERVISION REQUESTED
	PA: Physician:	<input type="checkbox"/> Personal <input type="checkbox"/> Direct <input type="checkbox"/> General
	PA: Physician:	<input type="checkbox"/> Personal <input type="checkbox"/> Direct <input type="checkbox"/> General
	PA: Physician:	<input type="checkbox"/> Personal <input type="checkbox"/> Direct <input type="checkbox"/> General
	PA: Physician:	<input type="checkbox"/> Personal <input type="checkbox"/> Direct <input type="checkbox"/> General
	PA: Physician:	<input type="checkbox"/> Personal <input type="checkbox"/> Direct <input type="checkbox"/> General
	PA: Physician:	<input type="checkbox"/> Personal <input type="checkbox"/> Direct <input type="checkbox"/> General

Supervising physician sign here to attest that this PA is competent to perform these procedures at the level of supervision you have requested:

Signature of Supervising Physician: _____ **Date:** _____

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