

**Physician Assistant / Supervising Physician
Notification of Termination of Supervisory
Relationship**

Use this form to notify the Oregon Medical Board that the Board approved supervisory relationship between the physician and physician assistant indicated below has ended. The Board must receive notice of termination within fifteen days following termination of supervision. This form will be returned if not complete.

PHYSICIAN ASSISTANT complete the following section:

PRINT Full Name: _____ License Number: PA _____

Reason for Termination:

Termination Effective Date: _____

PA Signature: _____ Date Signed: _____

SUPERVISING PHYSICIAN complete the following section:

PRINT Full Name: _____ License Number: _____

Reason for Termination:

Termination Effective Date: _____

Physician Signature: _____ Date Signed: _____