



## Agent Acknowledgment for Practice Agreement

**NOTE: Does Not Apply to SPO**

Revised 09/14/2016

An agent must sign this agent agreement to acknowledge understanding and acceptance of supervisory responsibilities prior to serving as an agent for any practice agreement under which the agent will be supervising a physician assistant. This signed acknowledgment must be attached to the practice agreement and retained at the primary practice location. (Please do not submit this form to the Board.)

**Please type or print legibly**

This acknowledgment applies to the standing practice agreement between:

**Supervising Physician:** \_\_\_\_\_

and

**Physician Assistant:** \_\_\_\_\_

By signing below, I acknowledge that I am qualified to supervise as designated in the practice agreement and competent to perform the duties delegated to the physician assistant under my supervision.

**Agent Name:** \_\_\_\_\_

**Agent Oregon License Number:** \_\_\_\_\_

**Effective Date** of agent supervision (mm/dd/yy): \_\_\_\_\_

**Agent Signature:** \_\_\_\_\_