

PHYSICIAN ASSISTANT SITE VISIT FORM

{In accordance with Subchapter 32S-Physician Assistant Regulations 21 NCAC 32S.0201-.0223}

GENERAL INFORMATION:

Physician Assistant's Name: _____ Date of Visit: _____
Date PA notified of visit: __/__/__ Start Time: _____ End Time: _____
Location of Audit/Interview: _____
Work Address: _____ Work Phone #: _____
_____ Ext. #: _____

MANDATORY NOTIFICATION OF INTENT TO PRACTICE:

[Section .0203]

Date PA submitted notification of Intent to Practice: __/__/__
(Verified by investigator prior to conducting site visit: date verified: __/__/__)

IDENTIFICATION REQUIREMENTS: [Section .0210 & .0218(a)(2)]

GS 90-640 is referenced in .0210; pertinent wording of this statute is as follows, "When providing health care to a patient, a health care practitioner shall wear a badge or other form of identification displaying in readily visible type the individual's name and the license, certification, or registration held by the practitioner. The badge or other form of identification is not required to be worn if the patient is being seen in the health care practitioner's office and, the name and license of the practitioner can be readily determined by the patient from a posted license, a sign in the office, a brochure provided to patients, or otherwise."

License Number #: [Section .0210] _____
Annual Registration Certificate: [Section .0204 & .0210] Available for inspection: Yes ___ No ___
Appropriate name tag: Yes ___ No ___ (.0218(a)(2) allows abbreviations, "PA or "PA-C")
Other methods of identification at practice site(s): _____

PRESCRIPTIVE AUTHORITY: [Section .0212]

Dispensing (other than samples) from site(s): Yes ___ No ___
If yes, Pharmacy Permit #: _____ Available for Inspection: Yes ___ No ___
Consulting Pharmacist's name and license #: _____

Prescription Blank* attached: Yes ___ No ___ Required to include the following:

PA's name, address & practice telephone number [.0212 (5) (a)]? Yes ___ No ___
PA's license and DEA #'s [.0212 (5) (b)]? Yes ___ No ___
Supervising MD's name & telephone number [.0212 (5) (c)]? Yes ___ No ___

* Some large institutions have prescription pads with the practitioners' names listed but without each practitioner's license and DEA numbers typed on them. In this situation, the PA should provide a copy of a prior prescription that he or she has written.

Written instructions for prescribing drugs and written policy for periodic review: Yes ___ No ___
[.0212 (2) & .0213 (d)]

SUPERVISORY/SCOPE OF PRACTICE STATEMENT: [Section .0213]

Signed Statement of Supervisory Arrangements: Yes ___ No ___
(Required to be available for inspection [Sections .0201 (9) & .0213 (b) & (c)])

QUALITY IMPROVEMENT PROCESS: [Section .0213]

Documentation of Quality Improvement meetings (signed/dated by PA & PSP): Yes _____ No _____
(Required to be available for inspection [Section .0213 (d)])

(Meetings are required monthly for first 6 months in new practice arrangement; thereafter are required no less than every 6 months)[Section .0213 (d)]

Dates of most recent Quality Improvement Meetings:

Date: _____ Clinical problems discussed: _____
Date: _____ Clinical problems discussed: _____
Date: _____ Clinical problems discussed: _____

SUPERVISING PHYSICIAN AND RESPONSIBILITIES OF PRIMARY SUPERVISING PHYSICIANS IN REGARD TO BACK-UP SUPERVISING PHYSICIANS: [Section .0214 & .0215]

Primary Supervising Physician ("PSP"): _____

Back-up Supervising Physician(s): _____

Back-up Supervising Physician(s) list available for inspection: [Section .0215 (b)] Yes _____ No _____

CONTINUING MEDICAL EDUCATION: [Section .0216]

CME during previous 2 year period[a]: (100 hours of which 50 hrs of Category I are required)

2-Year Period: _____ to _____ Documentation available for inspection: Yes _____ No _____

List Category 1 _____
CME _____

OR;

Certification with the National Commission on Certification of Physician Assistants (NCCPA)

Yes _____ No _____ [Section .0216 (b)]

CONCLUSIONS:

Compliance Issues summarized (in PA's presence): _____

If yes, date PA to provide documentation to demonstrate compliance with rules: ____/____/____

PSP advised of site check and compliance issues (if any): Yes _____ No _____ Date: ____/____/____

Re-visit recommended: Yes _____ No _____

NCMB Representative Signature: _____ Date: ____/____/____

Physician Assistant Signature: _____ Date: ____/____/____

Primary Supervising Physician Signature: _____ Date: ____/____/____