

## PHYSICIAN ASSISTANT SITE VISIT / INTERVIEW FORM

*[In accordance with Subchapter 32S–Physician Assistant Regulations 21 NCAC 32S.0201-.0219, effective 9/1/09]*

Physician Assistant's Name: \_\_\_\_\_  
Date of Site Visit: \_\_\_\_\_ Date PA notified of visit: \_\_\_\_\_  
Start Time: \_\_\_\_\_ End Time: \_\_\_\_\_  
Location of Interview/Inspection: \_\_\_\_\_  
Home Address: \_\_\_\_\_ Home Phone #: \_\_\_\_\_  
\_\_\_\_\_ DOB: \_\_\_\_\_  
\_\_\_\_\_ Social Security #: \_\_\_\_\_

PA License Number: *[Section .0210]* \_\_\_\_\_ Available for Inspection: Yes \_\_\_\_ No \_\_\_\_

Annual Registration Certificate: *[Section .0204 & .0210]* Available for inspection: Yes \_\_\_\_ No \_\_\_\_  
Certificate #: \_\_\_\_\_

Other states currently licensed as a PA: \_\_\_\_\_

### PRACTICE INFORMATION:

Date of Approval to Practice: \_\_\_\_\_  
Work Address: \_\_\_\_\_ Work Phone #: \_\_\_\_\_  
\_\_\_\_\_ ext. #: \_\_\_\_\_  
\_\_\_\_\_

Type Practice: \_\_\_\_\_ Usual Working Hours: \_\_\_\_\_ Hours/Week: \_\_\_\_\_

Primary Supervising Physician: \_\_\_\_\_  
Back-up Supervising Physician(s): \_\_\_\_\_

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

Number of patients PA sees per day: Avg: \_\_\_\_ Max: \_\_\_\_ Min: \_\_\_\_  
Hospital privileges: Yes \_\_\_\_ No \_\_\_\_ Hospital(s): \_\_\_\_\_  
Rural health clinic: Yes \_\_\_\_ No \_\_\_\_

Schedule/Other Practice site(s) where PA sees patients in this practice arrangement in typical week:

\_\_\_\_\_  
\_\_\_\_\_

Who owns the practice? \_\_\_\_\_

Does PA have any ownership interest in the practice? (If yes, describe the ownership)

\_\_\_\_\_  
\_\_\_\_\_

List Other Extenders working at same practice site (specify if NP or PA): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

### CONTINUING MEDICAL EDUCATION: *[Section .0216]*

CME during previous 2 year period/a/: (100 hours of which 40 hrs American Academy of PA/Category I required)

2-Year Period: \_\_\_\_\_ to \_\_\_\_\_ Documentation available for inspection: Yes \_\_\_ No \_\_\_  
List CME \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PRESCRIPTIVE AUTHORITY:** [Section .0212]

Dispensing from site(s): Yes \_\_\_ No \_\_\_ Samples dispensed: Yes \_\_\_ No \_\_\_  
Controlled Substance Samples dispensed: Yes \_\_\_ No \_\_\_ \*Rx Blank attached: Yes \_\_\_ No \_\_\_  
Prescription Blank includes:

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.

DEA Privileges: Yes \_\_\_ No \_\_\_ Schedules: \_\_\_\_\_ DEA #: \_\_\_\_\_  
DEA registration certificate available for inspection: Yes \_\_\_ No \_\_\_ Exp. Date: \_\_\_\_\_

Compliant with 30-day limit for dosage units of schedules 2/2N/3/3N: [.0212(4)(b)] Yes \_\_\_ No \_\_\_

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

Prescriptions by PA on file at local pharmacies audited: Yes\* \_\_\_ No \_\_\_

\*If yes, time period considered? \_\_\_\_\_

Were controlled substances prescribed? Yes \_\_\_ No \_\_\_

Comments/Other observations: \_\_\_\_\_

Were Charts requested during the audit? Yes \_\_\_ No \_\_\_ Number of charts: \_\_\_\_\_

Documentation legible: Yes \_\_\_ No \_\_\_

Comments: \_\_\_\_\_

—

If corresponding chart entries to match prescriptions were checked, did documentation of rx's meet requirements of [.0212 (6)]: Yes \_\_\_ No\* \_\_\_

\*If No, explain discrepancies and attach documentation: \_\_\_\_\_

\_\_\_\_\_

**SUPERVISION:** [Section .0213]

Supervising Physician on site at all times: Yes \_\_\_ No \_\_\_

Frequency of face-to-face, one-on-one contact with Primary Supervising MD (check one):  
\_\_\_ Daily \_\_\_ Weekly \_\_\_ Bi-Monthly \_\_\_ Monthly \_\_\_ Other: \_\_\_\_\_

Frequency of other direct communications via telecommunication with Primary Supervising MD (check one):

\_\_\_ Daily \_\_\_ Weekly \_\_\_ Bi-Monthly \_\_\_ Monthly \_\_\_ Other: \_\_\_\_\_

Frequency of any contact with any of Backup Supervising MDs on record (check one):

\_\_\_ Daily \_\_\_ Weekly \_\_\_ Bi-Monthly \_\_\_ Monthly \_\_\_ Other: \_\_\_\_\_

Date/time of most recent contact with Primary or a Backup Supervising MD: \_\_\_\_\_

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

Documentation of Quality Improvement meetings: Yes \_\_\_\_\_ No \_\_\_\_\_  
(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: \_\_\_\_\_

Meeting documentation signed/ dated by PA & supervising MD?[Section ..0213 (d)]: Yes \_\_\_\_\_ No \_\_\_\_\_  
Copy of documentation obtained: Yes \_\_\_ No \_\_\_  
If not available for review, why not?  
\_\_\_\_\_

**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. If the identity of the individual's license, certification, or registration is commonly expressed by an abbreviation rather than by full title, that abbreviation may be used on the badge or other identification".*

Appropriate name tag: Yes \_\_\_\_\_ No \_\_\_\_\_ (.0218(a)(2) allows abbreviations, "PA or "PA-C")  
Other methods of identification at practice site(s): \_\_\_\_\_

**CONCLUSIONS:**  
Discrepancies summarized: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PA advised of discrepancies: Yes \_\_\_\_\_ No \_\_\_\_\_  
Primary Supervising MD advised of site check and discrepancies (if any): Yes \_\_\_\_\_ No \_\_\_\_\_  
Date MD notified: \_\_\_\_\_ by Meeting \_\_\_\_\_ by Phone Contact \_\_\_\_\_

If any items not available at time of inspection, submit to NCMB by (date) \_\_\_\_\_  
Return visit or site check recommended: Yes \_\_\_\_\_ No \_\_\_\_\_  
Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Investigator conducting this inspection: \_\_\_\_\_  
s:sitevisit.pa.doc **Revision Date: 11/17/09**