BACK-UP SUPERVISING PHYSICIAN (S) FORM

NAME OF PHYSICIAN ASSISTANT: _____

Please keep a copy of this form on file at all practice sites for which it applies as part of the inspectable supervisory arrangements statement described in Rule 21 NCAC 32S.0111(b). **DO NOT send this form to the NCMB**.

(1)_____ _____
Signature of back-up supervising physician Date

(2)_____ _____
Signature of primary supervising physician Date

(3)_____ _____
Signature of physician assistant Date

(1)_____ _____
Signature of back-up supervising physician Date

(2)_____ _____
Signature of primary supervising physician Date

(3)_____ _____
Signature of physician assistant Date

(1)_____ _____
Signature of back-up supervising physician Date

(2)_____ _____
Signature of primary supervising physician Date

(3)_____ _____
Signature of physician assistant Date