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