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). **Note**: Backup supervising physicians are not mandatory. If used however, a record of backup supervisors must be kept. **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

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

(2)_____ _____
Signature of primary supervising physician Date

(3)_____ _____
Signature of physician assistant Date

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

(2)_____ _____
Signature of primary supervising physician Date

(3)_____ _____
Signature of physician assistant Date