



## Physician Assistant Compliance 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 \_\_\_

\* 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 physician assistant's two-year cycle (a) at least 50 hours of Category I CME required  
2-Year Period: \_\_\_\_\_ to \_\_\_\_\_ Documentation available for inspection: Yes \_\_\_ No \_\_\_

List Category I CME \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

OR;

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

Yes \_\_\_ No \_\_\_ [Section .0216 (c)]

Controlled substance prescribing CME (two category I hours during the PA's two-year CME cycle) if the PA prescribes any controlled substances: Yes \_\_\_ No \_\_\_ N/A \_\_\_ [Section .0216 (b)]

**Effective 7/1/17**

**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: \_\_\_/\_\_\_/\_\_\_

**Revision Date: 11/15/2023**



## Physician Assistant Site Visit Investigative Interview Form (Optional)

### Practice Information:

Date of Intent to Practice (Approval): \_\_\_\_\_ Date PA began practicing at site: \_\_\_/\_\_\_/\_\_\_

PA's Home Address: \_\_\_\_\_

Home Phone/cell #: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_

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

Number of patients PA sees per day: Avg: \_\_\_\_\_ Max: \_\_\_\_\_ Min: \_\_\_\_\_

Hospital privileges: Yes \_\_\_\_\_ No \_\_\_\_\_ Hospital(s): \_\_\_\_\_

Alternate Practice Sites/Schedule: \_\_\_\_\_

Owner of practice? \_\_\_\_\_

Does PA have any ownership interest in the practice? Yes \_\_\_\_\_ No \_\_\_\_\_

(If yes, see explanation in "Comment" section below)

List other mid-level practitioner(s) working at same practice site (specify if NP or PA): \_\_\_\_\_

Other states where PA is currently licensed: \_\_\_\_\_

### Prescriptive Authority: [Section .0212]

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 \_\_\_

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 as part of the review? Yes \_\_\_\_\_ No \_\_\_\_\_ Number of charts: \_\_\_\_\_

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

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

If charts were cross-checked with prescriptions, did documentation of rx's comply with Rule .0212 (6)? Yes \_\_\_\_\_ No\* \_\_\_\_\_

(\*If No, see explanation in "Comment" section below)

