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: __/__/___

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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 rxs comply with Rule .0212 (6)? Yes _____ No* _____
(*If No, see explanation in "Comment" section below)

Supervision: *[Section .0213]*
PSP on site at all times: Yes _____ No _____
Frequency of face-to-face, one-on-one contact with PSP (check one):
___ Daily ___Weekly ___ Bi-Monthly ___Monthly ___Other: _____

Frequency of other direct communications with PSP (check one):
___ Daily ___Weekly ___Bi-Monthly ___Monthly ___Other: _____

Frequency of any contact with any of the Backup Supervising Physician(s) on record (check one):
___ Daily ___Weekly ___ Bi-Monthly ___Monthly ___Other: _____

Date/time of most recent contact with PSP or Backup Supervising Physician: _____

Quality Improvement Process:
Copy of QI documentation obtained: Yes _____ No _____

Comments: _____

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