PHYSICIAN ASSISTANT SITE VISIT 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 ____
  Supervising MD’s name & telephone number [.0212 (5) (c)]? 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: ___/___/____

s:sitevisit.pa.doc Revision Date: 3/22/17