

SUPERVISION DATA FORM

IMPORTANT: THIS FORM MUST BE UPDATED BY THE PHYSICIAN ASSISTANT AS A CONDITION OF PRACTICE

Pursuant to s. 458.347(7)(e) and s. 459.022(7)(d), F.S., upon employment, a licensed physician assistant must notify the department in writing within 30 days after such employment and after any subsequent changes in supervision.

Council on Physician Assistants, 4052 Bald Cypress Way, Bin #C-03, Tallahassee, Florida 32399-3253

***** PLEASE PRINT *****

Name:

First

Middle Initial

Last

Florida Physician Assistant license number: PA _____

Print your current mailing address: _____

All current practice locations:

(1) Facility name: _____

Address #: _____ Street: _____ City: _____ State: _____ Zip Code: _____

(2) Facility name: _____

Address #: _____ Street: _____ City: _____ State: _____ Zip Code: _____

(3) Facility name: _____

Address #: _____ Street: _____ City: _____ State: _____ Zip Code: _____

(4) Facility name: _____

Address #: _____ Street: _____ City: _____ State: _____ Zip Code: _____

Make additional copies of page 1 as needed. **Return all 5 pages.** This Supervision Data Form will not be processed without the Physician Assistant's signature and date.

I am ADDING the following supervising physician(s). PLEASE PRINT

Name and license number of supervising physician(s)	Specialty of supervising physician	Beginning date of Supervision
<hr/> ME or DO license number:		

<hr/> ME or DO license number:		
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<hr/> ME or DO license number:		
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<hr/> ME or DO license number:		
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<hr/> ME or DO license number:		
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<hr/> ME or DO license number:		
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<hr/> ME or DO license number:		
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<hr/> ME or DO license number:		
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Make additional copies of page 2 as needed

I am DELETING the following supervising physician(s). PLEASE PRINT

Name and license number of supervising physician(s)	Effective date of deletion
<hr/> ME or DO license number:	

<hr/> ME or DO license number:	
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<hr/> ME or DO license number:	
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<hr/> ME or DO license number:	
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<hr/> ME or DO license number:	
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<hr/> ME or DO license number:	
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Make additional copies of page 3 as needed

I am ADDING the following practice location(s). PLEASE PRINT

(1) Facility name: _____

Address #: _____ Street: _____ City: _____ State: _____ Zip Code: _____

(2) Facility name: _____

Address #: _____ Street: _____ City: _____ State: _____ Zip Code: _____

(3) Facility name: _____

Address #: _____ Street: _____ City: _____ State: _____ Zip Code: _____

(4) Facility name: _____

Address #: _____ Street: _____ City: _____ State: _____ Zip Code: _____

(5) Facility name: _____

Address #: _____ Street: _____ City: _____ State: _____ Zip Code: _____

(6) Facility name: _____

Address #: _____ Street: _____ City: _____ State: _____ Zip Code: _____

(7) Facility name: _____

Address #: _____ Street: _____ City: _____ State: _____ Zip Code: _____

(8) Facility name: _____

Address #: _____ Street: _____ City: _____ State: _____ Zip Code: _____

Make additional copies of page 4 as needed

I am DELETING the following practice location(s). PLEASE PRINT

(1) Facility name: _____

Address #: _____ Street: _____ City: _____ State: _____ Zip Code: _____

(2) Facility name: _____

Address #: _____ Street: _____ City: _____ State: _____ Zip Code: _____

(3) Facility name: _____

Address #: _____ Street: _____ City: _____ State: _____ Zip Code: _____

(4) Facility name: _____

Address #: _____ Street: _____ City: _____ State: _____ Zip Code: _____

(5) Facility name: _____

Address #: _____ Street: _____ City: _____ State: _____ Zip Code: _____

(6) Facility name: _____

Address #: _____ Street: _____ City: _____ State: _____ Zip Code: _____

Signature of Physician Assistant

Date of signature:

Return all 5 pages. This Supervision Data Form will not be processed without the Physician Assistant's signature and date.