## APPLICATION PROCESS FOR SECONDARY SITE APPROVAL

Enclosed is the application to request approval for a physician assistant to provide services at a secondary site without the personal presence of a supervising physician.

A supervising physician must be present at least 20% of the time when the physician assistant is providing medical services. (The minimum time together can be less than 20% if approved by the Board upon showing of good cause.) When secondary sites are involved, the time the supervising physician and physician assistant are together at any site can be used to meet the 20% requirement.

The additional requirements for secondary site approval include:

1. The physician assistant holds a permanent license.
2. The physician assistant has practiced in Nebraska for at least 25 hours a week for a period of six weeks under the supervision of physician who is approved to supervise the physician assistant and who is requesting approval for the physician assistant to practice at the secondary site. The six-week time requirement may be shortened if approved by the Board upon showing of good cause.
3. The supervising physician must make site visits to the secondary site at a minimum of one-half day per month. Site visits may be less if approved by the Board upon showing of good cause.
4. The supervising physician, as a method of regular reporting, must review 100% of the charts of the patients seen by the physician assistant. A systematic documentation of these reviews must be established and maintained by the supervising physician.
5. The supervising physician must maintain and make available to the Department upon request all documentation of supervision of physician assistant activities.

If your application requires Board approval, it will be presented to the Physician Assistant Committee and the Board of Medicine and Surgery at their next scheduled meetings if received in an acceptable timeframe to be added to the meeting agendas. Applications that require Board approval can take 30 to 90 days to process.

A physician assistant **may not** begin practice at a secondary site without the personal presence of a supervising physician until approval has been obtained and you have been notified of the same.

If you have questions, you may contact the Department at (402) 471-2118.

**No Fee Required**

**State of Nebraska**
**Department of Health and Human Services**
**Regulation and Licensure**
**Credentialing Division**
**301 Centennial Mall South**
**PO Box 94986**
**Lincoln, NE 68509-4986 Φ (402) 471-2118**

# APPLICATION FOR SECONDARY SITE APPROVAL:

Request for Approval for a Physician Assistant to Provide Services at a Secondary Site without the Personal Presence of a Supervising Physician

| | | | | |
|---|---|---|---|---|
| 1. | Name of Supervising Physician: | | | |
| | Physician's License Number: | | | |
| 2. | Name of Physician Assistant: | | | |
| | Physician Assistant's License Number: | | | |
| 3. | Physician's Primary Practice Site: | Name: | | |
| | | Street Address/PO Box: | | |
| | | City: | State: | Zip: |
| | | Telephone: | | |
| 4. | Secondary Site: | Name: | | |
| | | Street Address/PO Box: | | |
| | | City: | State: | Zip: |
| | | Telephone: | | |

| 5. | WEEKLY PRACTICE SCHEDULE - List the office hours for the primary and secondary locations. List specific times when supervising physician named in Section 1 (above) will be present at each location. List specific times when physician assistant named in Section 2 (above) will be present at each location. Provide total hours for each provider at each site. You may attach to this application additional information regarding the practice schedules. | | | | | |
|---|---|---|---|---|---|---|
| | | Office Hours | | Physician Present | | PA Present | |
| | | Primary | Secondary | Primary | Secondary | Primary | Secondary |
| | Monday | | | | | | |
| | Tuesday | | | | | | |
| | Wednesday | | | | | | |
| | Thursday | | | | | | |
| | Friday | | | | | | |
| | Saturday | | | | | | |
| | Sunday | | | | | | |
| | Total | | | | | | |

| | | |
|---|---|---|
| 6. | Will the supervising physician (and/or designated backup physician when acting as the supervising physician) be present at the secondary site one-half day per month during the time that the practice is open? **Answer Yes or No** | |
| 7. | Will the supervising physician (and/or designated backup physician, when acting as the supervising physician) be together 20% of the time at any site when the physician assistant is performing medical services? **Answer Yes or No** | |

If you answered "no" to question 6 and/or question 7, your application must be approved by the Board of Medicine. If you will not be present at the secondary site one-half day per month and/or will not be present 20% of the time when the PA is providing services, describe the following: (Attach additional sheet if necessary.)

| | |
|---|---|
| a | Proposed practice site: |
| b | Percentage of time supervising physician will be present when PA is providing services: |
| c | Number of years of experience of the physician: |
| d | Number of years of experience of the physician assistant: |
| e | Number of years of experience the supervising physician has supervising physician assistants: |

| | | |
|---|---|---|
| f | Any previous knowledge the supervising physician has had with the physician assistant's patient care in the community: | |
| g | Does the site serve a state or federally designated shortage or underserved area? | |
| h | General level of patient complexity: | |
| i | Other pertinent information: | |
| 8. | Will the supervising physician (and/or designated backup physician, when acting as the supervising physician) review 100% of the charts of the patients seen by the physician assistant? **Answer Yes or No** | |

AFFIDAVIT

I, _____ swear or affirm that the statements on this application are true
(name of supervising physician)
and complete.

_____
Signature of Supervising Physician

Signed before me this _____ day of _____, _____.

(Seal) _____
Signature of Notary Public

My commission Expires: _____

I, _____ swear or affirm that the statements on this application are true
(name of physician assistant)
and complete.

_____
Signature of Physician Assistant

Signed before me this _____ day of _____, _____.

(Seal) _____
Signature of Notary Public

My commission Expires: _____