APA-1
6/93

TRANSMITTAL SHEET FOR NOTICE OF INTENDED ACTION

Control 540 Department or Agency Alabama State Board of Medical Examiners
Rule No. 540-X-7, Appendix A
Rule Title: Application for Registration of Physician Assistant

_____ New __X__ Amend _____ Repeal _____ Adopt by Reference

Would the absence of the proposed rule significantly harm or endanger the public health, welfare, or safety?	YES
Is there a reasonable relationship between the state's police power and the protection of the public health, safety, or welfare?	YES
Is there another, less restrictive method of regulation available that could adequately protect the public?	NO
Does the proposed rule have the effect of directly or indirectly increasing the costs of any goods or services involved and, if so, to what degree?	NO
Is the increase in cost, if any, more harmful tot he public than the harm that might result from the absence of the proposed rule?	NO
Are all facets of the rulemaking process designed solely for the purpose of, and so they have, as their primary effect, the protection of the public?	YES

****

Does the proposed rule have an economic impact? NO

If the proposed rule has an economic impact, the proposed rule is required to be accompanied by a fiscal note prepared in accordance with subsection (f) of Section 41-22-23, Code of Alabama 1975.

****

Certification of Authorized Official

I certify that the attached proposed rule has been proposed in full compliance with the requirements of Chapter 22, Title 41, Code of Alabama 1975, and that it conforms to all applicable filing requirements of the Administrative Procedure Division of the Legislative Services Agency.

Signature of certifying officer _____

Date: December 14, 2017

APA-2
6/93

ALABAMA STATE BOARD
OF MEDICAL EXAMINERS

NOTICE OF INTENDED ACTION

AGENCY NAME: Alabama State Board of Medical Examiners

RULE NO. & TITLE: 540-X-7, Appendix A, Application for Registration of Physician Assistant

INTENDED ACTION: To amend the Rule.

SUBSTANCE OF PROPOSED ACTION: To amend for online form completion and to combine Appendices B and C (repeals proposed separately) into this Appendix A

TIME, PLACE, MANNER OF PRESENTING VIEWS: All interested persons may submit data, views, or arguments concerning the proposed new rule(s) and regulation(s) in writing to: Patricia E. Shaner, General Counsel, Alabama State Board of Medical Examiners, Post Office Box 946, Montgomery, Alabama 36101-0946, by mail or in person between the hours of 8:30 a.m. and 4:30 p.m., Monday through Friday, until and including February 2, 2018. Persons wishing to obtain copies of the text of this rule and submit data, views, or comments or arguments orally should contact Patricia E. Shaner, by telephone (334-242-4116) during said period in order to set up an appointment for a hearing respecting such oral data, views, or arguments. Additionally, proposed rules are posted to the Board's web site, www.albme.org.

FINAL DATE FOR COMMENT AND COMPLETION OF NOTICE: February 2, 2018

CONTACT PERSON AT AGENCY: Patricia E. Shaner

Edward H. Munson, Jr., Acting Executive Director

Under Alabama law, this document is a public record and if requested it will be provided in its entirety.

ALABAMA BOARD OF MEDICAL EXAMINERS

P.O. Box 946 / Montgomery, AL 36101-0946 / (334) 242-4116

APPLICATION FOR REGISTRATION OF PHYSICIAN ASSISTANT

PHYSICIAN TO COMPLETE:

Supervising Physician Name in Full
~~Ala.~~ AL Medical License Number
~~Date of Birth~~ _____ ~~Social Security No.~~ ___ / ___ / ___
~~Pursuant to Ala. Code § 30-3-194, it is mandatory that we request and that you provide your social security number (SSN) on this application. The uses of your SSN are limited to the purpose of administering the state child support program and intra-agency for identification purposes. If your SSN is not provided, your application is not complete, and no license will be issued.~~

Medical Specialty
Board Certified: YES NO
Board Eligible YES NO

Principal Practice Location Address
(If mailing address is different please provide ~~here~~)
Telephone Number
FAX Number

1. ~~List~~ Provide the name, practice site address and designated working hours per week of each physician assistant and/or CRNP and/or CNM **currently** registered to you. ~~Attach additional sheets if necessary.~~

2. ~~Have you ever had a physician assistant certified or registered to you by the Alabama Board of Medical Examiners?~~

~~YES _____ NO _____ **If the answer is YES**, list the names of the assistant(s) in the spaces provided.~~

_____ _____ _____

_____ _____ _____

3. Is the physician assistant for whom registration is sought employed by you or by your group, partnership or professional corporation?

YES
NO **If the answer is NO**, ~~Appendix C to Chapter 7~~ Supplemental Certificate must be submitted.

~~I hereby certify that the foregoing information is correct to the best of my knowledge, information and belief, and that I have reviewed and understand the current rules and regulations of the Alabama Board of Medical Examiners pertaining to physician assistants and understand my responsibilities.~~

~~**Date:** **Primary Supervising Physician Signature:**~~

~~In accordance with Rule 540-X-7-.21 confirmed receipt of this application will be sent by mail, unless a FAX number is provided where the confirmation can be transmitted by FAX.~~

~~A physician assistant previously approved to practice under the provisions of Chapter 7 of the Board of Medical Examiners Rules and Regulations may continue in the supervised practice with this interim supervising physician and may continue until such time as this application is approved or denied, provided the supervising physician meets the qualifications established in Rule 540-X-7-.17.~~

PHYSICIAN ASSISTANT ~~TO COMPLETE~~:

Physician Assistant Name in Full
~~Ala.~~ AL P. A. License Number
~~Date of Birth~~ _____ ~~Social Security No.~~ ___/___/___

~~1. Have you ever been certified or registered as a physician assistant by the Alabama Board of Medical Examiners?~~

~~YES~~ ____ ~~NO~~ ____ ~~If the answer is YES, list the names of the physicians in the spaces provided.~~

_____

_____

2. ~~Are you~~ Is the P. A. **currently** certified or registered to any other primary certifying physician? **If the answer is YES,** ~~in the space below give~~ provide the physician name, ~~physician~~ practice ~~location~~address, ~~*assistant's* certification or registration number,~~ and ~~*assistant's*~~ the number of hours per week ~~for~~ with each primary supervising physician. ~~(There are spaces for three separate registrations.~~

~~NAME~~ _____

~~ADDRESS~~ _____

~~REGISTRATION No.~~ _____

~~HOURS per week~~ _____

~~I hereby certify that the foregoing information is correct to the best of my knowledge, information and belief; and that I have reviewed and understand the current rules and regulations of the Alabama Board of Medical Examiners pertaining to physician assistants and understand my responsibilities.~~

~~Date:~~ _____ ~~Physician Assistant Signature:~~

I hereby certify that the foregoing information is correct to the best of my knowledge, information and belief; and that I have reviewed and understand the current rules and regulations of the Alabama Board of Medical Examiners pertaining to physician assistants and understand my responsibilities.

I understand and agree that by typing my name, I am providing an electronic signature that has the same legal effect as a written signature pursuant to Ala. Code §§ 8-1A-2 and 8-1A-7. I attest that the foregoing information has been provided by me and is true and correct to the best of my knowledge, information and belief.

~~Office Use~~ ▼	~~PLEASE NOTE & RESPOND TO THE FOLLOWING AS APPROPRIATE FOR THIS REGISTRATION REQUEST.~~
	~~FEE: Each new registration requires submission of a $100.00 fee. Please attach check payable to Alabama Board of Medical Examiners.~~
	~~JOB DESCRIPTION: Please attach a completed job description signed by the physician and the assistant.~~
	~~FORMULARY: If assistant is to be granted legend drug prescribing authority attach a completed and signed formulary.~~
	~~APPENDIX C : If assistant is employed by an entity other than the physician, the physician's group or professional corporation please include a completed Appendix C. Include a separate sheet for responses if required.~~

~~COVERING PHYSICIAN LETTERS: The absence of "covering physician" letter(s) indicates that when the primary physician is not working, the assistant is not working. (A "sample" form was included in the registration package.)~~

Under Alabama law, this document is a public record and if requested it will be provided in its entirety.

PHYSICIAN ASSISTANT JOB DESCRIPTION

Name of Physician Assistant

Name of Primary Supervising Physician

Physician's Principal Practice Location Name and Address

Telephone Number

Medical Specialty of Primary Supervising Physician

1. A Supervising Physician shall delegate only tasks and procedures to his or her Assistant which are within the Supervising Physician's scope of practice and are customary to the practice of the Physician. **However, the Physician Assistant may not perform any procedure not listed under #2 below without prior approval of the Alabama Board of Medical Examiners.** The Assistant may work in any setting that is within the scope of his or her Supervising Physician's practice. The Supervising Physician's scope of practice shall be defined for the purpose of this section as those tasks and procedures which the Supervising Physician is qualified by training or expertise to perform.
2. The following list represents the duties which may be performed by the Assistant.
   a. Perform complete, detailed and accurate histories, review patient records to develop comprehensive medical status reports, and order laboratory, radiological and diagnostic studies appropriate for complaint, age, race, sex and physical condition of the patient.
   b. Do complete physical examinations and record pertinent data in acceptable medical forms.
   c. Make medical diagnoses and institute therapy or referrals of patients to the appropriate health care facilities, agencies, other resources of the community, or other physicians.
   d. Institute emergency measures and emergency treatment or appropriate stabilization measures in situations such as cardiac arrest, shock, hemorrhage, convulsions, poisoning, and emergency obstetric delivery.
   e. Arrange hospital admissions and discharges at the direction of the Supervising Physician; perform hospital rounds and record appropriate patient progress notes; accurately and appropriately transcribe and execute specific orders at the direction of the Supervising Physician; compile detailed narrative and case summaries; complete forms pertinent to patients' medical records; issue diagnostic orders, which must be signed within specified time period as defined by hospital guidelines.
   f. Interpret and evaluate patient data to determine patient management and treatment.
   g. Provide instructions and guidance regarding medical care matters to patients.
   h. Perform or assist in the following routine laboratory medical techniques and the following routine therapeutic procedures:
      (1) The drawing of arterial, venous or peripheral blood and the routine examination of the blood.
      (2) Urinary bladder catheterization and routine urinalysis.
      (3) Nasogastric intubation and gastric lavage.
      (4) The collection of and the examination of the stool.
      (5) The collection of materials for bacteriological or viral culture.
      (6) The performance of pulmonary function tests.
      (7) Performing electrocardiograms.
      (8) Injections - subcutaneous, intramuscular, intravenous (Note: injections to any other sites, for example, joints, must be requested).
      (9) Immunizations.
      (10) Debridement, suture and care of superficial wounds.
      (11) Removal of sutures.
      (12) Administration of subcutaneous local anesthesia.
      (13) Strapping, casting and splinting of sprains and fractures.

(14) Removal of cast.
(15) Incision and drainage of superficial skin infections.

i. Perform or assist in the following surgical procedures:
(1) Pre and post-op care.
(2) Surgical assisting.
(3) Wound debridement.
(4) Incise and drain abscesses (superficial only).
(5) Biopsies (facial biopsies must be requested).
(6) Insert and remove drains (excluding paracentesis, thoracentesis, thoracostomy tube insertion, ventriculostomy insertion, and placement of any percutaneous drain into a body cavity).
(7) Suturing-single layer closure of the face.
(8) IV cutdown.
(9) Vein harvesting.
(10) Closure-may close the outermost layer of the fascia, subcutaneous tissue, dermis and epidermis on extremities; over thoracic or abdominal cavities approval to close subcutaneous, dermis and epidermis only.
(11) Intensive care.

j. Perform or assist in the following procedures:
(1) PICC line placement
(2) Tracheostomy tube change
(3) Thoracostomy tube removal
(4) Enteric tube exchange
(5) Groshong catheter removal
(6) Infusaport (portacath) removal
(7) Post pyloric feeding tube placement
(8) Removal of pacing wires
(9) Intubation
(10) Escharotomy
(11) Placement of Aspen collars

k. Provide emergency medical services in the event of declared national emergency or natural disaster in accordance with the requirements of Board Rules.

l. Additional duties requested for the Assistant (i.e. diagnostic or surgical procedures requiring additional training). Provide documentation of the training and / or certification which qualifies the Assistant to perform each additional duty / procedure which is requested. Training for the additional duty/procedure shall have been previously approved by the Board.

3. List each practice site where this Job Description will be utilized, including the practice name, address, phone number, and designated working hours per week.

4. Is there a request for the applying P. A. to practice in a remote site? Yes/No

If yes, provide a letter from the physician requesting approval to utilize the assistant at a remote site and complete the following information:

Name, address and telephone number of remote site

Number of hours the sponsoring physician will be spending in the remote site weekly

Number of hours the Assistant will spend in the remote site weekly

Number of hours both will be present together

Provide a plan describing the practice location, facilities and arrangements for appropriate

communication, consultation and review.

5. Provide a written plan for review of medical records and patient outcomes. (Example: what percentage of charts will be reviewed, who will review them, and how often that review will take place)

6. Will this P. A. be authorized to have prescriptive privileges? Yes/No

If yes, provide a completed Formulary which is a list of the legend drugs which are authorized by the Physician to be prescribed by the Assistant. The formulary approved under the Guidelines of the Board of Medical Examiners should be utilized and attached as the authorized legend drugs to be prescribed. The medication categories chosen should reflect the needs of the medical practice.

7. Will this Assistant be authorized to have prescriptive privileges to prescribe controlled substances as provided in Alabama Code Section 20-2-60, et. seq.? (Prerequisites for controlled substances prescribing by P.A.s are stated in Board Rules, Chapter 540-X-12) Yes/No

If yes, the application for a Qualified Alabama Control Substance Certificate can be found at our web site, www.albme.org.

We hereby certify under penalty of law of the State of Alabama that the information in the Physician Assistant Job Description is correct to the best of our knowledge and belief. We certify that we have reviewed the current rules of the Alabama Board of Medical Examiners pertaining to assistants to physicians and understand our responsibilities. We understand that we are equally responsible for the actions of the Assistant to the Physician.

_____ / _____ / _____

Print Name Signature of Primary Supervising Physician Date

_____ / _____ / _____

Print Name Signature of Assistant to Physician Date

This form must be printed, signed, and emailed/faxed/mailed to the Board. Email address is provided on instructions page.

Under Alabama law, this document is a public record and will be provided upon request

SUPPLEMENTAL CERTIFICATE TO APPLICATION FOR REGISTRATION AS A PHYSICIAN ASSISTANT

To: (Name and Address of Hospital or Corporate Employer)

The State Board of Medical Examiners has been presented with an application from _____, P. A., for certification as a physician assistant to _____ M.D. Information available to the Board indicates that _____, M.D., is an employee of _____ (legal entity), and that _____, Physician Assistant, is an employee of _____ (legal entity).

To assist the Board in evaluating this application, it is requested that this questionnaire be filled out and

executed by the President, Chairman, Chief Executive Officer or Chief Administrative Officer of the corporation or other legal entity that employs the physician and/or the physician assistant. These questions relate directly to the supervisory relationship contemplated by Board Rules, Chapter 540-X-7. When an additional explanation is to be provided, please attach additional information on separate pages.

1. Is the physician whose name appears above, employed by you to engage in the full-time practice of medicine? If the answer to this question is no, please provide the Board with details of the employment agreement between your corporation and the physician.

2. Does the physician whose name is stated above have the unqualified authority to terminate the employment of the physician assistant registered to him/her? If the answer to this question is no, please set out in detail the steps required to terminate the employment of the physician assistant and identify the officer or officers of the corporation authorized to make that decision.

3. Does the physician whose name is stated above, have the unqualified authority to determine the levels of compensation to be paid to the physician assistant registered to him/her? If the answer to this question is no, please set forth in detail the manner in which the compensation of the physician assistant is established and the identification of the officer or officers of the corporation who are authorized to establish, increase or reduce the compensation of the physician assistant.

4. Does the physician whose name appears above have the unqualified authority in matters relating to patient care to enforce compliance with orders and directives issued to the physician assistant? Please describe in detail the manner in which such orders and directives may be enforced.

5. Is the physician assistant whose name appears above subject to the supervision, direction or control of any officer, director, supervisor or employee of the corporation other than the physician to whom he/she is registered? If the answer to this question is yes, please explain in detail, identifying the individual exercising the supervision, direction or control and the circumstances in which such supervision, direction and control would be exercised.

6. In matters relating to patient care, is the physician assistant whose name appears above subject to the immediate supervision, direction or control of any non-physician?
If yes, explain the relationship.

7. Will the physician assistant whose name appears above be expected or required to perform any part of his ~~or~~/her duties at any time when the physician to whom he ~~or~~/she is registered is not on duty and physically present on the premises of the hospital, clinic, or facility where the physician's assistant services will be rendered? If the answer to this question is yes, please explain in detail all such circumstances.

I understand that the information submitted herein is to be used by the Board of Medical Examiners as the basis for registration of a physician assistant and that the furnishing of false or misleading information or the

future occurrence of substantial departures from or violations of the standards and procedures outlined in this response; may be considered by the Board as grounds for termination of the registration of the physician assistant.

The undersigned hereby certifies that the foregoing information is true and correct to the best of my knowledge, information and belief.

Name of the Corporation | Title of Officer Signing Certificate

Printed Name of the Officers Signing Certificate | Signature

This form may be sent to the Board via facsimile or email (see instructions)

Author: Alabama Board of Medical Examiners
Authority: Ala. Code § 34-24-303
History: Amended/Approved: November 16, 2017