APA-1
Revised 4/2018

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? NO

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 to the 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 action relate to or affect in any manner any litigation which the agency is a party to concerning the subject matter of the proposed rule? NO

****
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 [signature]

Date: 6/20/18

APA-2

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/appendix

SUBSTANCE OF PROPOSED ACTION: Amend for online completion

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: Carla H. Kruger, Office of the 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 Aug. 3, 2018. Persons wishing to obtain copies of the text of this rule and submit data, views, or comments or arguments orally should contact Carla H. Kruger, 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, the intended action is available at the Board's web site, www.albme.org.

FINAL DATE FOR COMMENT AND COMPLETION OF NOTICE: Aug. 3, 2018

CONTACT PERSON AT AGENCY: Carla H. Kruger

Amy T. Dorminey, Board Secretary

~~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

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

Physician:

~~Supervising Physician Name in Full~~
~~AL Medical License Number~~

~~Medical Specialty~~
~~Board Certified: YES NO~~
~~Board Eligible YES NO~~

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

Supervising Physician Name in Full
AL Medical License Number
Medical Specialty
Board Certified
Board Eligible

Practice Address
Country
Street
Apt/Suite
City
State
Zip
Telephone Number

~~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.~~

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**, Supplemental Certificate must be submitted.~~

You answered No, a Supplemental Certificate must be submitted

Physician Assistant:

~~Physician Assistant Name in Full~~ ~~AL P. A. License Number~~

~~Is the P. A. **currently** certified or registered to any other primary certifying physician? **If the answer is YES,** provide the physician name, practice address, and the number of hours per week with each primary supervising physician.~~

Physician Assistant Name in Full
AL PA License Number

Covering Physicians
Would you like to add covering physicians to this registration agreement?

P. A./Physician Supervisory Agreement Core Duties and Scope of Practice

1. The P. A. may work in any setting consistent with the supervising physician's scope of practice and are customary to the Supervising Physician's scope of practice and are customary to the practice of the Physician. The P. A. scope of practice shall be defined as those functions and procedures for which the P. A. is qualified by formal education, clinical training, area of certification and experience.
2. The following skills and functions are the core duties which may be performed by the P. A.

a. Arrange inpatient hospital admissions, transfers, and discharges in accordance with established guidelines/standards developed within the practice of the supervising physician and P. A.; perform rounds and record appropriate patient progress notes; compile detailed narrative and case summaries; complete forms pertinent to patients' medical records.

b. Perform detailed and accurate health histories, review patient records, develop comprehensive medical status reports, and order laboratory, radiological, therapeutic and diagnostic studies or treatment appropriate for the complaint, age, race, sex and physical condition of the patient.

c. Perform comprehensive physical exams and assessments. Formulate medical diagnoses, including the interpretation and evaluation of patient data to determine patient management and treatment, including the institution of therapy and ordering of medical devices or referral of patients to appropriate care facilities and/or agencies and other resources of the community or other physicians.

d. Prescribe legend drugs authorized by the supervising physician and included on the formulary approved by the guidelines established by the Alabama Board of Medical Examiners for P. A.s.

e. Institute emergency measures and emergency treatment or appropriate stabilization measures in situations such as cardiac arrest, shock, hemorrhage, convulsions, poisoning and emergency obstetric delivery where indicated.

f. Provide instructions, education and guidance regarding healthcare and healthcare promotion to patients, family and caregivers.

g. Skills and functions that are taught in usual and standard PA academic education and do not require additional training or course documentation. The supervising physician and PA may document and validate that the PA has received education, training and competency to perform the core duty or skill.

h. The Board of Medical Examiners recognizes the following as examples of usual and customary core duties and skills that a Physician Assistant can perform, including, but not limited to, the following:

(1) Perform the following example procedures/skills:
(a) Surgical Assisting
(b) Wound debridement, suturing and care of superficial wounds.
(c) Skin biopsies (facial biopsies are to be requested).
(d) Insert and removal of drains (excluding paracentesis, thoracentesis, thoracostomy tube insertion, ventriculostomy insertion, and placement of any percutaneous drain into a body cavity).
(e) Suturing-single layer closure of the face.
(f) Vein or artery cut-down for access.
(g) Vein harvesting.
(h) Surgical wound 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.
(i) Removal of superficial foreign body of the eyeball.
(j) Incision and drainage of superficial skin infections or abscesses.
(k) PICC line placement
(l) Tracheostomy tube change
(m) Thoracostomy tube removal
(n) Enteric tube exchange
(o) Groshong catheter removal
(p) Infusaport (portacath) removal
(q) Post pyloric feeding tube placement
(r) Removal of pacing wires
(s) Intubation
(t) Escharotomy
(u) Cardiac stress test monitoring.

~~i.~~ j. For additional skills requested outside the core duties of the P. A. by the supervising physician (i.e. diagnostic or surgical procedures requiring additional training), the supervising physician must provide documentation of the training and / or certification which qualifies the P. A. The training for the additional duty/skill shall have been previously approved by the Board.

~~Please list each additional skill request.~~

Do you want to request approval to train for additional skills at this time?

See attached "Additional Skills Request Protocol" from the supervising physician.

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

i. Signature Authority Delegation Standard Delegation, which includes:
1. Certification of patient disability for disabled parking tags/placards.
2. Physicals for bus drivers using State of Alabama forms.
3. Authorizations for durable medical equipment.
4. Authorizations for diabetic testing supplies.
5. Authorization for diabetic shoes.
6. Within the State Medicaid system, forms for:
a. ordering medications, nutritional supplements, infant formulas,
b. referrals to medical specialist,

c. referrals for home health services,
d. referrals for physical or occupation therapy.
7. Within the Department of Mental Health, forms for:
a. physical examination,
b. certifications in residential or inpatient dwellings.

Signature Authority Delegation Optional Delegations
Please uncheck any optional delegations NOT to approve.
Absenteeism forms for employment or school purposes, including documents associated with the Federal Family and Medical Leave Act.
Home health care recertification orders.
Physicals to verify eligibility for students to participate in the Special Olympics.
Employment and pre-employment physicals for Transportation Security Agency (TSA) employees at an airport or for governmental employees such as firefighters and law enforcement officers.
Adoptive parent applications.
College or trade school physicals.
Boy Scout or Girl Scout physicals or physical required by similar organizations.
Forms excusing a potential jury member due to an illness.
Death certificates.
Forms for ambulance transport.
Forms for donor breast milk.
Required documentation allowing a diabetic to renew or obtain a driver's license.

3. List each practice site where this Job Description will be utilized and the number of hours this P. A. will be working weekly in each site. ~~Must include name, address and phone number of each site: See attached for additional information.~~

   Practice Site Address
   Name (Practice/Site Name)
   Country
   Street
   Apt/Suite
   City
   State
   Zip
   County
   Phone Number

4. Is there a request for the P. A. to practice in a remote site? ~~Yes/No~~
   ~~If yes, attach a letter from the physician requesting approval to utilize the P. A. at a remote site and complete the following information:~~
   ~~Name, address and telephone number of the remote site~~
   ~~Number of hours and at what frequency will the supervising physician will visit the remote site~~
   ~~Number of hours the P. A. will spend in the remote site weekly~~
   ~~Number of hours both will be present together~~
   ~~Provide (attach) a plan describing the practice location, facilities and arrangements for appropriate communication, consultation and review.~~

You answered Yes, Please complete the following information from the physican requesting approval to utilize the PA at a remote site.

Remote Site Address
Name (Practice/Site Name)
Country
Street
Apt/Suite
City
State
Zip
Country
Phone Number
Number of hours and at what frequency will the supervising physician will visit the remote site.
Number of hours the PA will spend in the remote site weekly
Number of hours both will be present together
Provide a plan describing the 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 perform the review, and how often the review will take place). The review should be documented and maintained at the practice location.

Who will perform the review
What percentage of charts will be reviewed
How often will the review take place
Additional Comments

6. Will this P. A. be authorized to have prescriptive privileges? ~~Yes/No~~
~~If yes, attach a completed~~ You answered Yes, complete the Formulary which is a list of the legend drugs which are authorized by the Physician to be prescribed by the P. A.. The formulary approved under the rules 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 supervising physician's medical practice.

7. Will this P. A. be authorized to have prescriptive privileges to prescribe controlled substances as allowed under 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 foregoing information in this 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

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.

Knowingly providing false information to the Alabama Board of Medical Examiners or Medical Licensure Commission of Alabama could result in disciplinary action.

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 e ____________________(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/her duties at any time when the physician to whom he/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 Officer Signing Certificate — Signature

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