Covering Physician Agreement

To: Alabama Board of Medical Examiners

As a covering (back-up) physician providing supervision for Physician Assistant_____,

P. A., by signing this document, I hereby affirm that:

1. I am familiar with the current rules regarding Physician Assistants;

2. I am familiar with the job description filed by_____,M.D./D.O.

(primary sponsoring physician), and_____, P. A., RA#_____;

3. I will be accountable for adequately supervising the medical care rendered pursuant to the job description; and

4. I will approve the drug type, dosage, quantity and number of refills of legend drugs which the assistant is authorized to prescribe in the job description.

When the primary supervising physician is not immediately available to respond to patient medical needs, the physician assistant is not authorized to perform any act or render any treatments unless another qualified physician **is immediately available to supervise the physician assistant** and has previously filed with the Board this letter stating that he or she assumes all responsibility for the actions of the physician assistant during the temporary absence of the primary supervising physician.

I will assume all responsibility for the actions of the assistant during the temporary absence of the primary supervising physician.

Medical specialty of covering physician _____

Print Physician name _____ License # _____

Physician signature _____ Date _____

Covering physician's telephone number _____ Fax _____

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.