



**ALABAMA STATE BOARD OF MEDICAL EXAMINERS**

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**Supervised Practice Quality Assurance Plan**

**PA Name:**

**Supervising Physician:**

**SPECIALTY:**

**QUALITY ASSURANCE (540-x-7-.23):** The mechanism for quality assurance shall be as follows: Specify a plan for quality assurance management with defined quality outcome measures for evaluation of the clinical practice of the physician assistant and include review of a meaningful sample of medical records plus all adverse outcomes. The term “medical records” includes, but is not limited to, electronic medical records. Documentation of quality assurance review shall be readily retrievable, identify records that were selected for review, include a summary of findings conclusions, and, if indicated, recommendations for change.

<b>List Patient Diagnosis Group (s)</b> to be monitored (high-risk, problem-prone, or low-volume groups only)	<b>Sample Size</b> (percentage or number of charts to be reviewed)	<b>Frequency of Review</b> (Weekly, Monthly, Quarterly)	<b>Designated Personnel</b> (Individual who will compile data)
Adverse Outcomes	100 %	Immediately	Physician and PA

**Each Quality Assurance/Adverse Outcome document review will include the following:**

1. Identified medical records, based on problem-prone, high-risk patient population
2. Summary of the Quality Assurance findings and conclusions presented to PA and supervising physician
3. Recommendations for change, if indicated
4. Comment section, if indicated
5. Date of review, and signature of PA and supervising physician

**The completed quality assurance reviews are to remain on file at the practice site.**

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.

\_\_\_\_\_  
 Print Name

\_\_\_\_\_  
 Signature of Supervising Physician

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Print Name

\_\_\_\_\_  
 Signature of Physician Assistant

\_\_\_\_\_  
 Date