To: Alabama Board of Medical Examiners

QACSC Covering Physician Agreement

As a covering (back-up) physician providing supervision for Physician Assistant __ _____ by signing this document, I hereby affirm that (1) I am familiar with the current rules regarding physician assistants and their ability to prescribe controlled substances (2) that I am familiar with the Approved Formulary for Qualified Alabama Controlled Substance Certificate pursuant to RA# _____ (3) that I have a current and unrestricted Alabama Controlled Substance Certificate #___ _____and (4) that I will be accountable for adequately supervising the physician assistant's controlled substance prescribing.

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

Telephone number _____ Fax number _____

Relationship with primary supervising physician: (check one below)

Partnership ____ Professional group _____Medical Professional Corporation _____

Physician Practice Foundation _____Physician sharing call _____.

Medical Specialty of Covering Physician _____

_____/_____/_____/_____

Print Physician Name License Number Date Physician Signature

Print Form