

Simple Application Checklist

For Adding or Changing a Primary Supervising Physician for a PA or AA in Georgia

FOR ALL OF THESE FORMS, EITHER UPLOAD TO EGOV OR EMAIL TOGETHER AT: gcmb.paandaa@dch.ga.gov. PLEASE DO NOT PHYSICALLY MAIL DOCUMENTS.

Applicant Must Submit:

1. Add/Change Supervising Physician Application
2. Basic Job Description:
 - Form E (Anesthesiologist Assistant) OR Form F (Physician Assistant)
 - Supervising physician should list all alternate supervising physicians, if applicable.

Optional Forms Based on Your Circumstances:

- Form B (Request for Additional Duties)
- Form H (Separation Notification Form)
- Form J (Specific Power of Attorney)

FOR ADDITIONAL INFORMATION PLEASE SCROLL DOWN

- **FORM E (AA)/ Form F (PA)**
 - **Basic Job Description E:** Use this form for Anesthesiologist Assistants
 - **Basic Job Description F:** Use this form for Physician Assistants
 - All signatures can be DocuSign and/or electronic signatures.
 - The form **must be signed and dated by the PA/AA** (Indicate "pending" for the PA/AA license ID# blank line).
 - The form **must also be signed and dated by the supervising physician** (with a GA ID#).
 - **Alternates:**
 - You can list alternates on the form.
 - All alternate signatures must include full name, signature, and date (no blank lines).
 - Use as many pages of the Basic Job Description E/F as needed for listing alternates.
 - **AC1 Form has been Retired:** Do not complete the AC1 form; it will not be accepted.
 - **How do I add Alternate Physicians after I am licensed?**

- Go to the GCMB website, look up your current license, and print your approved Basic Job Description with the Supervising Physician in which you need to add alternates to.
 - Add alternates by completing a **new** page #3 of Form E or Form F (Basic Job Description)
 - Email your approved Basic Job Description and New page #3 of Form E or Form F with the addition of new alternates. Title the email subject "Repost Basic Job Description to Add Alternates."
 - **Supervising Physician Name:** The supervising physician's name **must match** the name on the Utilization Form.
 - **Upload Instructions:** You can upload the form to your account as a PDF, naming it "FORM E" or "FORM F."
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CIRCUMSTANTIAL FORMS

Form B (Request for Additional Duties)

- Additional duties are medical tasks, which are not customarily learned during PA training, and are to be performed outside of the physical presence of a supervising physician. Each additional duty to be performed above and beyond the duties described in the Basic Job Description must have PRIOR APPROVAL by the GCMB.
- Complete ONE FORM for each additional duty requested.
- Provide current ACLS/BLS certification
- Provide a **case log that includes at least 10 cases**. Case log should include: Date of service, Procedure name, Patient ID # or Initials, Supervising Preceptor signature, Outcome (favorable/unfavorable), Complications (i.e. if unfavorable, what happened?)
- For moderate sedation request, include sedation setting (i.e Hospital, Surgery Center, Medical Office, Medi Spa)

Form J – (Specific Power of Attorney) Requirements:

- Authorizes your designee to make inquiries to the Board regarding your application.
- Must be submitted with the Initial Application.
- Include the applicant's full name.
- List names and contact information for all designated agents.
- Applicant's signature and date required.
- Notarize the form with a seal, signature, and date.
- The form expires upon license grant, application denial, or written revocation.

Form H (Separation Notification Form)

- **Physician Assistant Statement:**
 - Notice to the Georgia Composite Medical Board that Doctor [Physician's Full Name] is no longer a primary supervising physician.
 - Effective date: [Month/Day/Year]
 - Physician's license number
 - Physician Assistant's name and license number

- Physician Assistant's signature and date signed
- **Physician's Statement:**
 - Notice to the Georgia Composite Medical Board that [Physician Assistant's Full Name] is no longer under supervision.
 - Effective date: [Month/Day/Year]
 - Physician's signature and date signed