FORM B
ADDITIONAL DUTY REQUEST FORM FOR PHYSICIAN ASSISTANTS

Physician Assistants must be within the scope of practice of their Primary Supervising Physician. Additional duties are medical tasks, which are not customarily learned during PA training, and are to be performed outside the physical presence of a supervising physician. Each additional duty to be performed above and beyond those duties described in your basic job description must have PRIOR APPROVAL by the Georgia Composite Medical Board. Please complete ONE FORM FOR EACH ADDITIONAL DUTY REQUESTED; submitting as many forms as necessary. You MAY NOT perform these duties until the Medical Board has notified you that your request for additional duties has been approved.

Physician Assistant Name _____License #_____

SPECIFIC DUTY REQUESTED (ONLY ONE (1) DUTY PER FORM):
_____

1. Number of times performed under direct supervision: _____
2. Length of time performed (days, weeks, months): _____
3. Has PA had prior Board Approval for this Additional Duty under another Primary Supervising MD? ___YES ___NO
4. If applicable, number of times performed under prior supervising physician: _____
5. If the duties being requested were performed in a previous practice not associated with your current practice, did you contact the prior supervising physician to verify that the PA was competent and proficient in the duties being requested? ___YES ____NO
6. Is PA ACLS Certified? _____YES _____NO If yes, submit copy of card with this form
7. Certification that the Physician Assistant is competent to perform the duty requested as shown by your personal observation **(i.e. coursework at conference or PA post-graduate training; CME, training by equipment manufacturer, other training methods and case log of duties performed under direct supervision of physician)**:
   _____
   _____
8. Statement attesting the Physician Assistants ability to recognize and manage complications:
   _____
   _____
   _____
9. IF REQUEST FOR SEDATION MUST IDENTIFY SETTING IN WHICH SEDATION WILL BE ADMINISTERED: (check all that apply)
   1. _____ Hospital
   2. _____ Hospital Owned Surgery Center (Accredited or Certified by Joint Commission, Accreditation Association for Ambulatory Care, the American Association for Accreditation of Ambulatory Surgery Facilities, or Centers for Medicare and Medicaid services.)
   3. _____ Ambulatory Surgery Center (ASC)
   4. _____ Medical Office
   5. _____ Medi Spa

_____ _____ _____
Sponsoring Physician's Typed Name Sponsoring Physician's Specialty License Number

_____ _____
Sponsoring Physician's Signature Date

_____
Address City State Zip Code

Sponsoring Physician: LIST CURRENT BOARD CERTIFICATIONS**:**_____

Physician Assistant Typed Name Physician Assistant Signature