Utilization of Physician Assistant or Anesthesiologist Assistant

Provide information for the Physician(MD/DO) requesting utilization of PA/AA.

PA/AA Name: _____

Physician GA License Number: _____

Physician First Name: _____

Physician Middle Name: _____

Physician Last Name: _____

Address: _____

City: _____

State: _____

Zip Code: _____

Business Phone: _____

Specialty: _____

***If specialty is Pain Management, please refer to pain management rules and regulations for additional requirements REQUIRED to practice.

Type of Primary Practice Setting (clinic, hospital, ER/Urgent care, Telemedicine, etc):

_____

Telemedicine Practice: Yes_____ No_____ If you checked "yes":

Please provide the physical address in which the PA will be using to provide Telemedicine services.

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