Utilization of Physician Assistant or Anesthesiologist Assistant

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

PA/AA Name: _____ PA/AA GA License Number: _____

Physician First Name: _____ Physician GA License Number: _____

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: _____

*** If Hospital, ER/Urgent care, Correctional Facility: Yes____ No_____ (MUST indicate at least one (1) alternate on the Basic Job Description Form E/F)

*** If Telemedicine Practice: Yes____ No____ (MUST list Out-of-State Practice address)
If you checked "yes"- Please provide the physical address in which the PA will be using to provide Telemedicine services.

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*** If Free Clinic Practice: Yes_____ No____ (MUST include copy of 501(3)(c) document)
If you checked "yes"- Please provide the physical address in which the PA will be using to provide the Free-Clinic Practice.

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