VOLUNTEER TEMPORARY PRACTICE AGREEMENT FORM

THE FOLLOWING FORM IS REQUIRED WHEN APPLYING FOR TEMPORARY PRACTICE AGREEMENT AS A PHYSICIAN ASSISTANT (INCLUDING ANESTHESIA ASSISTANT) IN THE STATE OF GEORGIA.

This application is intended for Utilization of a Physician Assistant in Clinics for Financially Disadvantaged Patients

Clinics/organizations serving financially disadvantaged patients must separately notify the Board of their intent to utilize physician assistants as volunteers.

- 1. Physician assistants may only work within the scope of practice of the physician supervising them at that clinic.
- 2. A physician may not exceed the number of physician assistants he is legally allowed to supervise.
- 3. Temporary practice agreements are valid:
 - a. For a maximum period of two years;
 - b. Only while the supervising physician and physician assistant have current Georgia licenses, in good standing.
- 4. If the organization has more than one site, a separate application must be filed for each clinic site.

Volunteer Temporary Practice Agreement

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PHYSICIAN INFORMATION: - PRINT LEGIBLY

PHYSICIAN NAME:		MD/DO (CIRCLE ONE)	
PHYSICIAN SPECIALTY:		LICENSE NUMBER:	
BUSINESS ADDRESS:			
CITY	STATE		ZIP CODE
BUSINESS PHONE:			
EMAIL ADDRESS:			
Physician Signature		Date	
PHYSICIAN ASSISTANT INFOR	MATION: - PRIN	<u>r legibly</u>	
PHYSICIAN ASSISTANT NAME:	·	I	LICENSE NUMBER:_
BUSINESS ADDRESS:			
CITY	STATE		ZIP CODE
BUSINESS PHONE:			
EMAIL ADDRESS:			
Physician Assistant Signature		Date	