

**FORM B
ADDITIONAL DUTY REQUEST FORM
FOR PHYSICIAN ASSISTANTS**

Physician Assistants must be within the scope of practice of the 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 per additional duty. Please use as many forms as necessary for your additional duties. You **MAY NOT** perform these duties until the Medical Board has notified you that your request for additional duties has been approved. It is helpful to submit a log of procedures of the specific duty requested.

Physician Assistant Name _____ License # _____
Last Name First Name Middle

SPECIFIC DUTY REQUESTED: _____

1. Number of times performed under direct supervision: _____
2. Length of time performed (days, weeks, months): _____
3. If applicable, number of times performed under prior supervising physician: _____
4. Are you ACLS Certified? _____YES _____NO
5. Certification from sponsoring physician that the Physician Assistant is competent to perform the duty requested as shown by 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**)

6. If the duties being requested were performed in a previous practice not associated with your current practice, did you contact the physician to verify that the PA was competent and proficient in the duties being requested?
_____YES _____NO (please circle one)
7. Statement from sponsoring physician of the Physician Assistants ability to recognize and manage complications.

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 Date

PLEASE RETURN THIS FORM TO:
GEORGIA COMPOSITE MEDICAL BOARD
2 Peachtree Street, N.W., 36th Floor
Atlanta, GA 30303
ATTN: Physician Assistant Unit