THE STATE of ALASKA

Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing

MED

FOR DIVISION USE ONLY

Alaska State Medical Board
PO Box 110806, Juneau, AK 99811
Website: *ProfessionalLicense.Alaska.Gov/StateMedicalBoard*

Physician Assistant Collaborative Plan

Important Instructions:

1. **Complete all parts of the plan** – print legibly or type. **Incomplete plans will not be accepted.**
2. Include the $125 Collaborative Plan fee with this form.
3. Attach a detailed curriculum vitae for the PA, if applicable, for remote site practice (see remote site information below).

PART I Payment of Fees

Required Fees:	☐ Collaborative Plan Fee	**$125.00**

PART II Collaborative Plan Information

Physician Assistant Name:		**Collaborating Physician Name:**	

This section is only for Physician Assistants in a remote site practice.

REMOTE SITE: Location of physician assistant's practice is more than 30 miles by road from physician's primary office.

Option 1: Physician Assistants with less than two years of full-time clinical experience:

☐ Must work 160 hours in direct patient care under the direct and immediate supervision of the primary collaborating physician or an alternate.

☐ The first 40 hours must be completed before going to the remote site practice; the remaining 120 hours must be completed within 90 days of going to the remote site practice.

I hereby certify the hours of supervision will commence as soon as this plan is approved and prior to practicing at the remote site. The completed Verification of Hours of Supervision form (#08-4892b) will be sent to the State Medical Board immediately upon completion of the required hours.

_____ **(Physician: Initial this statement if applicable.)**

- OR -

Option 2: Physician Assistants with more than two years of full-time clinical experience:

☐ Must attach a detailed curriculum vitae which describes the education, skills, and experience sufficient to meet the needs and demands of the remote site practice.

Upon my careful review, as primary collaborating physician, it is my opinion that the previous experience of the physician assistant documented in the attached curriculum vitae has adequately prepared and qualified this individual to work at the remote site practice location identified in this plan.

Primary Collaborating Physician Signature:	

IMPORTANT REGULATIONS (See Booklet for Complete Regulations Language)

PERFORMANCE AND ASSESSMENT OF PRACTICE, 12 AAC 40.430: It is understood by the physician and the physician assistant that a periodic method of assessment is or will be established which will include the physician's evaluation of physician assistant's work performance which means evaluation of medical care and clinic management. Please refer to the full regulation for the frequency of assessments required. It is further understood that documentation of such periodic assessments may be audited by the State of Alaska at any time.

COMMUNICATIONS WITH SENSORY-IMPAIRED PATIENTS, 12 AAC 40.980(A)(4): A method is or will be devised whereby a physician assistant's level of education and professional training are communicated to patients who may be blind, deaf, or otherwise impaired.

IDENTIFICATION OF PHYSICIAN ASSISTANT, 12 AAC 40.460: It is understood that the physician assistant will wear on his/her clothing a nameplate identifying them as a "Physician Assistant-Certified" and shall display a sign at the place of employment which posts current state licensure and that documents of the Physician Assistant's education and plan of collaboration are available for inspection.

PRESCRIPTIVE AUTHORITY, 12 AAC 40.450:

Prescribing Schedules II, III, IV, and V [12 AAC 40.450(c)] The physician assistant named in this plan may, with a valid DEA registration, write a prescription for a schedule II, III, IV, or V controlled substance medication with primary collaboration physician's approval.

Prescribing Authority May Not Exceed Physician's Authority, 12 AAC 40.450(d): The PA's prescriptive authority may not exceed that of the collaborating physician's prescriptive authority.

Obtaining Controlled Substance Supplies, 12 AAC 40.450(e): The physician assistant named in this plan may use the physician assistant's own DEA registration number to request, receive, order, or procure controlled substance supplies from a pharmaceutical distributor, warehouse, or other entity only with primary collaboration physician's approval.

Prescribe, Order, Administer, or Dispense Non-Controlled Medications, 12 AAC 40.450(f): The physician assistant named in this plan may prescribe, order, administer, or dispense a medication that is not a controlled substance only with primary collaboration physician's approval.

Physician Assistant

Full Name:		**License Number:**	
Address:	P.O. Box or Street / City / State / Zip		
Work Phone:		**Home Phone:**	
Email Address:			

Primary Collaborative Physician

Full Name:		**License Number:**	
Address:	P.O. Box or Street / City / State / Zip		
Work Phone:		**Home Phone:**	
Email Address:			

Alternate Physician #1

Full Name:		**License Number:**	
Address:	P.O. Box or Street / City / State / Zip		
Alternate #1 Signature:		**Work Phone:**	

(Attach addendum form #08-4892a with additional alternates if needed.)

Practice Information

Specific Location:	
Remote Site:	☐ Yes ☐ No

Effective Date of Plan

Beginning Date of Employment:	

*****PLAN MUST BE FILED WITH THE BOARD NO LATER THAN 14 DAYS FROM THIS DATE.*****

Prescriptive Authority

☐	12 AAC 40.450 (c) Prescribe, order, administer, and dispense schedule II, III, IV, and V drugs.
☐	12 AAC 40.450 (d) PA's prescriptive authority does not exceed physician's prescriptive authority. The physician must check the appropriate boxes in this section in order to grant those specific prescriptive authorities.
☐	12 AAC 40.450 (e) May procure controlled substance supplies.
☐	12 AAC 40.450 (f) Prescribe, order, dispense, administer non-controlled drugs.
☐	I do not wish to have any prescriptive authority under this plan.

Requirements of Law

The physician assistant will work only within the agreed scope of practice with the primary physician. All parties to this plan agree to comply with the provisions of all statutes and regulations relating to the physician assistant's practice of medicine in Alaska.

Signatures

Physician Assistant Printed Name:			
Physician Assistant Signature:		**Date Signed:**	
Primary Collaborating Physician Printed Name:			
Primary Collaborating Physician Signature:		**Date Signed:**	

THE STATE of ALASKA
Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing

Alaska State Medical Board
PO Box 110806, Juneau, AK 99811
Phone: (907) 465-2550
Email: *MedicalBoard@Alaska.Gov*
Website: *ProfessionalLicense.Alaska.Gov/StateMedicalBoard*

Addendum to Collaborative Plan

Physician Assistant Name:		**Primany Physician Name:**	
Collaborative Plan Number:		**Terminate Plan:**	☐ Yes ☐ No

If you have more than one alternate collaborating physician for a collaborative plan, use this form to add additional alternate collaborating physicians and attach to the plan between the PA-C and the physician shown above.

Alternate Collaborating Physician's Statement

I hereby certify that I am familiar with the statutes and regulations of the State of Alaska governing the activities and responsibilities of a collaborating physician and that I will fulfill those responsibilities in this collaborative agreement in the absence of the primary collaborating physician. In entering into this agreement as alternate collaborating physician, I accept professional or employer liability to patients of the physician assistant for whom malpractice is adjudged. I have retained a copy of this agreement for my records. I will also maintain and make available for audit by the State of Alaska any performance assessment records which are generated as a result of this collaborative agreement in my capacity as alternate collaborating physician.

1.	☐ Add	☐ Delete	☐ No Change	☐ Move to Primary
Signature:			**Date:**	
Printed Name:			**AK License Number:**	
Address:			**Phone:**	

2.	☐ Add	☐ Delete	☐ No Change	☐ Move to Primary
Signature:			**Date:**	
Printed Name:			**AK License Number:**	
Address:			**Phone:**	

3.	☐ Add	☐ Delete	☐ No Change	☐ Move to Primary
Signature:			**Date:**	
Printed Name:			**AK License Number:**	
Address:			**Phone:**	

THE STATE of ALASKA
Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing

Alaska State Medical Board
PO Box 110806, Juneau, AK 99811
Phone: (907) 465-2550
Email: *MedicalBoard@Alaska.Gov*
Website: *ProfessionalLicense.Alaska.Gov/StateMedicalBoard*

Physician Assistant – Certified
Verification of Hours of Supervision

In accordance with 12 AAC 40.410 (e and f), physician assistants must complete 160 hours of direct and immediate supervised work before practicing at a remote location. Please complete this form and return to the address above.
You must hold a valid permit before working.

Physician Assistant

Full Name:		**Contact Phone:**	
Address:	P.O. Box or Street City State Zip		

Collaborating Physician

Full Name:		**Contact Phone:**	
Address:	P.O. Box or Street City State Zip		

Documented Hours of Supervised Work

Date	No. of Hours	Date	No. of Hours	Date	No. of Hours	Date	No. of Hours

Total Hours Submitted: 0

Physician Assistant Signature:		**Date Signed:**	
Collaborating Physician Signature:		**Date Signed:**	

THE STATE of ALASKA

Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing

ADM

FOR DIVISION USE ONLY

State of Alaska
PO Box 110806, Juneau, AK 99811
Phone: (907) 465-2550

Credit Card Payment Form

All major credit cards are accepted. For security purposes, do not email credit card information. Include this credit card payment form with your application.

Name of Applicant or Licensee:			
Profession Type *(e.g., Acupuncture)*:		**License Number *(if applicable)*:**	
I wish to make payment by credit card for the following *(check all that apply):*			**AMOUNT**
☐ **Application Fee:**			
☐ **License or Renewal Fee:**			
☐ **Other *(fine, exam, etc.)*:**			
1.			
2.			
		TOTAL:	0

Name *(as shown on credit card)*:			
Mailing Address:			
Phone Number:		**Email *(Optional)*:**	
Signature of Credit Card Holder:	X		

CREDIT CARD INFO: Your payment cannot be processed unless all fields are completed.

1. Credit Card Number:		**All 3 fields MUST be completed.**
2. Expiration Date:		**This section will be destroyed after the payment is processed.**
3. Security Code:		