

Wisconsin Department of Safety and Professional Services

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MEDICAL EXAMINING BOARD

CHANGE IN SUPERVISING PHYSICIAN

Med 8.07(1) Practice. (1) Scope and Limitations. In providing medical care, the entire practice of any physician assistant shall be under the supervision of one or more licensed physician.

Med 8.05(4) Licensure; Renewal. At the time of licensure and each biennial registration of licensure thereafter, a physician assistant shall list with the board the name and address of the supervising physician and shall notify the board within 20 days of any change of a supervising physician.

Med 8.02 (6) "Supervision". means to coordinate, direct, and inspect the accomplishments of another, or oversee with powers of direction and decision the implementation of one's own or another's intention.

Med 8.10 Physician to physician assistant ratio. (1) No physician may supervise more than 4 on-duty physician assistants at any time unless a written plan to do so has been submitted to and approved by the board. Nothing herein shall limit the number of physician assistants for whom a physician may provide supervision over time. A physician assistant may be supervised by more than one physician while on duty. (2) A supervising physician shall be available to the physician assistant at all times for consultation either in person or within 15 minutes of contact by telecommunication or other means.

Med 10.02 (1) "Adequate supervision". means a physician should be competent to perform the delegated medical act, and must have reasonable evidence that the supervised individual is minimally competent to perform the act under the circumstances.

Complete the following and return to the Medical Examining Board at the address listed below.

PHYSICIAN ASSISTANT

NAME (Please Print):	LICENSE NUMBER:
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PREVIOUS SUPERVISING PHYSICIAN ON RECORD

NAME (Please Print):	LICENSE NUMBER:
STARTING DATE:	ENDING DATE:

SUPERVISING PHYSICIAN - See Med 8.05(4) above (only one supervising physician is required).

NAME (Please Print):	SIGNATURE:	DATE:
LICENSE NUMBER:		
STARTING DATE:	ENDING DATE (For Substitute Only):	

Wisconsin Department of Safety and Professional Services

OTHER SUPERVISING PHYSICIAN ON RECORD

NAME (Please Print):	SIGNATURE:	DATE:
LICENSE NUMBER:		
STARTING DATE:	ENDING DATE (For Substitute Only):	

NAME (Please Print):	SIGNATURE:	DATE:
LICENSE NUMBER:		
STARTING DATE:	ENDING DATE (For Substitute Only):	

NAME (Please Print):	SIGNATURE:	DATE:
LICENSE NUMBER:		
STARTING DATE:	ENDING DATE (For Substitute Only):	

NAME (Please Print):	SIGNATURE:	DATE:
LICENSE NUMBER:		
STARTING DATE:	ENDING DATE (For Substitute Only):	

NAME (Please Print):	SIGNATURE:	DATE:
LICENSE NUMBER:		
STARTING DATE:	ENDING DATE (For Substitute Only):	

Return completed form to:
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