Board *of* Medicine
Council on Physician Assistants
4052 Bald Cypress Way Bin C-03
Tallahassee, FL 32399-3253

Board *of* Osteopathic Medicine
4052 Bald Cypress Way Bin C-06
Tallahassee, FL 32399-3257

Supervision Data Form

This form must be updated by the physician assistant as a condition of practice. Pursuant to section (s.) 458.347(7)(d), Florida Statutes (F.S.) and s. 459.022(7)(d), F.S., upon employment, a licensed physician assistant must notify the department in writing within 30 days after such employment and after subsequent changes in supervision.

1. PHYSICIAN ASSISTANT (PA) INFORMATION

Name: _____ **Florida License #:** PA _____
Last/Surname First Middle

Mailing Address: _____ _____ _____
Street/P.O. Box Apt. No. City

_____ _____ _____ _____
State ZIP Country Home/Cell Telephone

List All Current Practice Locations

1. Facility Name:		
Address:		Suite No.:
City:	State:	ZIP:

2. Facility Name:		
Address:		Suite No.:
City:	State:	ZIP:

3. Facility Name:		
Address:		Suite No.:
City:	State:	ZIP:

4. Facility Name:		
Address:		Suite No.:
City:	State:	ZIP:

5. Facility Name:		
Address:		Suite No.:
City:	State:	ZIP:

Submit **all pages** of the form. The form will **not be accepted without** the physician assistant's signature. Make additional copies of any pages as necessary.

Name: ______________________ License #: PA______________

2. ADDING SUPERVISING PHYSICIAN(S)

Name of Supervising Physician	Florida Medical License #
Supervising Physician Specialty	**Supervision Start Date (MM/DD/YYYY)**

Name of Supervising Physician	Florida Medical License #
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Name of Supervising Physician	Florida Medical License #
Supervising Physician Specialty	**Supervision Start Date (MM/DD/YYYY)**

Submit **all pages** of the form. The form will **not be accepted without** the physician assistant's signature. Make additional copies of any pages as necessary.

Name: ______________________________ License #: PA______________

3. DELETING SUPERVISING PHYSICIAN(S) INFORMATION

All dates must be in MM/DD/YYYY format.

Supervising Physician to be Deleted	Florida Medical License #	Deletion Date

Supervising Physician to be Deleted	Florida Medical License #	Deletion Date

Supervising Physician to be Deleted	Florida Medical License #	Deletion Date

Supervising Physician to be Deleted	Florida Medical License #	Deletion Date

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Supervising Physician to be Deleted	Florida Medical License #	Deletion Date

Submit **all pages** of the form. The form will **not be accepted without** the physician assistant's signature. Make additional copies of any pages as necessary.

Supervision Data Form

Name: _____ License #: PA_____

4. ADDING PRACTICE LOCATION(S) INFORMATION

1. Facility Name:		
Address:		Suite No.:
City:	State:	ZIP:

2. Facility Name:		
Address:		Suite No.:
City:	State:	ZIP:

3. Facility Name:		
Address:		Suite No.:
City:	State:	ZIP:

4. Facility Name:		
Address:		Suite No.:
City:	State:	ZIP:

5. Facility Name:		
Address:		Suite No.:
City:	State:	ZIP:

6. Facility Name:		
Address:		Suite No.:
City:	State:	ZIP:

7. Facility Name:		
Address:		Suite No.:
City:	State:	ZIP:

8. Facility Name:		
Address:		Suite No.:
City:	State:	ZIP:

Submit **all pages** of the form. The form will **not be accepted without** the physician assistant's signature. Make additional copies of any pages as necessary.