PHYSICIAN ASSISTANT
SPECIAL SERVICES PLAN

Mail completed application to:
State Medical Board of Ohio
ATTN: Physician Assistant Program Administrator
30 East Broad Street, 3rd Floor
Columbus, Ohio 43215-6127

MUST BE COMPLETED BY AN APPROVED SUPERVISING PHYSICIAN

PURPOSE

An approved Special Services Plan is required before a physician assistant may perform any procedure that is beyond the services authorized under the Physician Supervisory Plan and as outlined in Chapter 4730.09 Ohio Revised Code, in office practices only.

PART I

- Provide the supervising physician's name exactly as it is listed on the Supervisory Plan. Be sure to list all locations where the physician assistant will perform this procedure. Designate a contact person to receive all notices from the State Medical Board of Ohio with regard to this Special Services Plan including but not limited to all notices that may be required by R.C. Chapter 4730 and/or R.C. Chapter 119.

PART II

- Describe the Quality Assurance process that will apply to the physician assistant in performing the procedure requested in this Special Services Plan.

PART III

- Indicate the level of supervision that will apply to the physician assistant in performing this procedure after the initial training period.

PART IV

- Complete this information on a separate sheet of paper; those sheets should then be attached to and submitted with the application. The enclosed form may used as a worksheet for your convenience.

PART V

- The supervising physician must sign the affidavit of supervising physician form, indicating which procedures they are applying for approval.

- Even though you may only ask for approval of one procedure per application the supervising physician only needs to sign part V once.

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PART I:
SUPERVISING PHYSICIAN INFORMATION

Supervising Physician Name (last, first, middle):			
Supervising Physician supervision agreement number:			
Practice Address:			
City:	*County:*	*State:*	*Zip Code:*
Office Phone Number: ( )		*Office Fax Number:* ( )	

The Credential mail address is the address where all mailings will be sent regarding this application.

Credential Mail Address:		
City:	*State:*	*Zip Code:*
Contact Person:	*Office Phone Number:* ( )	*Office Fax Number:* ( )

SPECIFIC PROCEDURE FOR WHICH YOU ARE REQUESTING APPROVAL
Please note that you may only request one procedure per application.

Procedure:

LIST ALL LOCATIONS WHERE THE PA WILL BE PERFORMING THIS PROCEDURE:
If this procedure will be performed in a health care facility as defined in Ohio Revised Code 4730.01(C) this application does not need to be completed. If additional space is needed attach a separate sheet of paper.

Office Practice Name:			
Practice Address:			
City:	County:	State:	Zip Code:
Office Phone Number: ( )		Office Fax Number: ( )	

Office Practice Name:			
Practice Address:			
City:	County:	State:	Zip Code:
Office Phone Number ( )		Office Fax Number: ( )	

Part II : Quality Assurance

Describe the Quality Assurance process that will apply to the physician assistant. The quality assurance process must, at a minimum, document each time the procedure is performed, the outcome, the regular review of such documentation by the supervising physician and plans for ongoing performance improvement.

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PART III:

Check the level(s) of supervision that apply and the percentages for each (must equal 100%):

Direct Supervision:

- ☐ Yes 100%
- ☐ Percent of time: **%**
- ☐ None

"Direct supervision" means that the supervising physician is actually in sight of the Physician Assistant when the Physician Assistant is performing the procedure requiring direct supervision. Although the physician may be performing some other task at the same time, he is physically present in the same room, so that he may immediately provide direction or assume the performance of the task if difficulties arise. It does not require that the physician be watching "over the shoulder" of the Physician Assistant as would be required during the training period to ensure that the Physician Assistant is competent to perform the task. The term "immediate presence" means that direct supervision is being provided.

On-Site Supervision:

- ☐ Yes 100%
- ☐ Percent of time: **%**
- ☐ None

"On-site supervision" requires the physical presence of the supervising physician in the same location (i.e., the physician's office suite) as the Physician Assistant, but does not require his physical presence in the same room. This level of supervision is normally required by statute for all Physician Assistants practicing within a facility's emergency department, (See, Section 4730.21(D), Ohio Revised Code)

Off-Site Supervision:

- ☐ Yes 100%
- ☐ Percent of time: **%**
- ☐ None

"Off-site supervision" or "supervision" means that the supervising physician must be continuously available for direct communication with the physician assistant and must be in a location that under normal conditions is not more than sixty minutes travel time from the Physician Assistant's location. (See, Section 4730.21(A), Ohio Revised Code) Off-site supervision is appropriate for some procedures included in the standard utilization plan (subject to the additional restraints of Paragraph (D) of Section 4730.21, Ohio Revised Code), but would rarely be authorized for procedures requested on Special Services plans.

If you have selected more than one level of supervision, please explain, on a separate piece of paper, how you will determine which level of supervision will apply to the performance of the procedure at different times.

PART IV

Describe the minimum education, training and experience which will be required for ANY Physician Assistant performing <u>this</u> procedure.

Use this area as a checklist for a complete application:

This description must contain, at a minimum, the following information:

- ☐ Content and objectives of a didactic program, including referenced teaching methodology.
- ☐ Be certain to include copies of any and all text references and any Website information that would relate to this procedure.
- ☐ Minimum hours of activity in didactic component.
- ☐ Instructor for didactic component.
- ☐ Method used to assess successful completion.
- ☐ Content and objectives of clinical program, including a description of the teaching methodology.
- ☐ Be certain to include a detailed description of the procedure as if you were explaining the procedure to a patient. Be very specific in identifying the location on the body where this procedure will be performed and any other specific details pertaining to this procedure.
- ☐ Minimum hours of activity for clinical component.
- ☐ Instructor for clinical program.
- ☐ Number of procedures the physician assist will observe the physician in performing. (Please note that the Board and the committees have historically approved the PA in observing the physician in performing 25 procedures.) If this number seems high or low for this procedure please submit the rationale for needing to observe more or less procedures.
- ☐ Number of procedures the physician will observe the physician assistant in performing to determine competency. (Please note that the Board and the committees have historically approved the Physician in observing the PA in performing 25 procedures to determine competency.) If this number seems high or low for this procedure please submit the rationale for needing to observe more or less procedures.
- ☐ List any additional training or experience that would be required of the Physician Assistant prior to performance of this procedure.
- ☐ Submit a listing of all significant complications associated with the requested procedure and the processes in place to document and address those complications, should they occur. This would include measures to cover onsite and offsite supervision.
- ☐ Explain the need for a physician assistant to perform this procedure.
- ☐ Explain the benefits, pros/cons in a physician assistant performing this procedure.
- ☐ Who is making the determination that these tests/procedures need to be performed.
- ☐ Will the supervising physician see and evaluate each patient pre and post procedure.
- ☐ If this procedure is a diagnostic procedure, indicate whether a permanent visual record is maintained for the supervising physician's review and interpretation. If yes what type of record is obtained? Who reads and diagnoses the procedure.
- ☐ Provide any peer-reviewed articles on Physician Assistant or other ancillary Personnel performance of the requested procedure and rate of complications.

Failure to submit all required documentation will result in the delay of this application.

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PART V:
AFFIDAVIT OF SUPERVISING PHYSICIAN

EVEN THOUGH YOU MAY ONLY ASK FOR APPROVAL OF ONLY ONE PROCEDURE PER SPECIAL SERVICES APPLICATION THE SUPERVISING PHYSICIAN ONLY NEEDS TO SIGN AND SUBMIT PART V ONCE. LIST ALL PROCEDURES BELOW AND ATTACH A COPY TO EACH APPLICATION FOR A SPECIAL SERVICES PLAN.

List all of the Special Service procedures for which your are requesting approval:

I certify that the above statements are complete and accurate to the best of my knowledge and that all documents, forms or copies, thereof furnished or to be furnished to this Board with respect to this application are strictly true in every respect. I have read the general information and instructions for all applicants and that I have answered all questions in compliance with these instructions. I understand that as a supervising physician I assume legal liability for the services provided by the physician assistant(s) that are under my supervision.

Supervising Physician signature:	*Supervision Agreement #:*	*Date:*