State Medical Board of Ohio

30 E. Broad Street, 3rd Floor, Columbus, OH 43215-6127

Richard A. Whitehouse, Esq.
Executive Director

(614) 466-3934
med.ohio.gov

APPLICATION INSTRUCTIONS FOR A PHYSICIAN ASSISTANT CERTIFICATE TO PRESCRIBE AND VERIFICATION OF COMPLETION OF PROVISIONAL PERIOD OF PHYSICIAN-DELEGATED PRESCRIPTIVE AUTHORITY

Section 4730.47 of the Ohio Revised Code allows for a physician assistant that has completed their provisional period of physician-delegated prescriptive authority to apply for a new Certificate to Prescribe. In order to receive a Certificate to Prescribe the attached application must be completed and sent to the Board with the appropriate fee.

General Instructions

Once the form has been completed, it is to be returned directly to the State Medical Board of Ohio at the address on the form with a check or money order made payable to Richard Cordray, Ohio Treasurer, in the amount of $100.00.

Application processing time is 10-12 weeks. Please be advised that all information submitted will be thoroughly investigated and individuals will be contacted regarding their application as the Board deems necessary.

Once the application is approved by the Board, a Certificate to Prescribe will be issued. Verification of this certificate must be done on our website at www.med.ohio.gov under the licensee profile and status option.

Section 1: To be completed by the physician assistant

The physician assistant who was issued a provisional Certificate to Prescribe in the State of Ohio and has completed the provisional period as required under section 4730.45 of the Ohio Revised Code, must complete Section 1 of this form and forward it to the supervising physician who agreed to act as the primary supervising physician during the provisional period of physician-delegated prescriptive authority.

Section 2: To be completed by the supervising physician that agreed to act as the primary supervising physician for this applicant during the provisional period of physician-delegated prescriptive authority

The primary supervising physician who supervised the provisional period of physician-delegated prescriptive authority for this applicant must complete Section 2 of this form certifying that the applicant has completed the required number of hours under the appropriate levels of supervision as required by section 4730.45 of the Ohio Revised Code. This must at a minimum include 500 hours of on-site supervision and last at least for a 6 month period as required by 4730-2-04(C) of the Ohio Administrative Code.

Please note that only the physician who completed Form A of your provisional certificate to practice application may complete this application. If you worked in a setting where your were prescribing for more than one physician, the physician who completed form A of your provisional certificate to practice application must be willing to accept and testify to the prescribing that you have done under the supervision of other physicians. This is also applies to any prescribing that you have done in another State or Jurisdiction and you wish to be considered for your full certificate to prescribe.

Application for Physician Assistant
CERTIFICATE TO PRESCRIBE

Application fee: $100.00; check or money order made payable to: Treasurer, State of Ohio

Mail completed form and application fee to:
State Medical Board of Ohio
30 East Broad Street, 3rd Floor
Columbus, Ohio 43215

SECTION 1 - APPLICANT INFORMATION
(To be completed *by applicant* and sent to applicable supervising physician)

Physician Assistant Full Name**:** _____

Certificate to Practice Number: _____ Provisional Certificate to Prescribe Number: _____

Street address_____ City_____ State, zip_____

Supervising Physician Name: _____ Supervision Agreement Number: _____

I certify that I have successfully completed the provisional period of physician – delegated prescriptive authority, under the supervision of the physician listed below, pursuant to Section 4730.45 of the Ohio Revised Code.

_____
Physician Assistant Signature Date

SECTION 2 – VERIFICATION OF PROVISIONAL PERIOD OF PHYSICIAN-DELEGATED PRESCRIPTIVE AUTHORITY
(To be completed *by the supervising physician* and sent directly to the Board at the above address)

Dates of provisional period of physician – delegated prescriptive authority:

Start (Month/Day/Year): _____

End (Month/Day/Year): _____

Hours of on-site supervision: _____

Hours of off-site or other supervision: _____

Total hours of supervision: _____

I certify that the above named Physician Assistant has successfully completed the provisional period of physician – delegated prescriptive authority pursuant to Chapter 4730. of the Ohio Revised Code.

_____
Supervising Physician Signature Date