OREGON MEDICAL BOARD
1500 SW 1st Ave, Suite 620 • Portland, OR 97201
(971) 673-2700 or (877) 254-6263 *(toll free in Oregon)*
Website address: www.oregon.gov/bme

Filing Deadline:		Committee Meeting:		Next Board Meeting:	
Temporary approval date:			Board approval date:		

REVISION TO THE BOARD APPROVED PRACTICE DESCRIPTION

This form will be returned if it is not typed. Faxes/Copies will not be accepted.

Physician Assistant Name:			***Oregon PA license #***
PA's PRIMARY Practice Address (for this practice only) ***Practice Name and Address:***			
City:	***State & Zip Code:***	***County:***	***Business Phone #***
Supervising Physician's Name:		❒ **MD** ❒ **DO**	***Oregon License #***
PRIMARY Practice Name and Address:			
City:	***State& Zip Code::***	***Practice Specialty:***	

I AM REQUESTING THE FOLLOWING ADDITIONAL MEDICAL AND SURGICAL SERVICES TO BE ADDED TO THE PRACTICE DESCRIPTION OF THE ABOVE PA

Please do not use abbreviations. List the frequency and quantity that these procedures have been performed by you as well as the physician assistant in the space provided. Submit any documentation of the PA's training with this request form.	SELECT LEVEL OF SUPERVISION REQUESTED
	☐ Personal ☐ Direct ☐ General
	☐ Personal ☐ Direct ☐ General
	☐ Personal ☐ Direct ☐ General
	☐ Personal ☐ Direct ☐ General
Supervising physician sign here to attest that this PA is competent to perform these procedures at the level of supervision you have requested:	

Signature of Supervising Physician: ______________________________ **Date**: __________

Signature of Physician Assistant: ______________________________ **Date:** __________