Return to: eMedNY
PO Box 4610
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SUPERVISING PHYSICIAN CERTIFICATION

This Form Must Be Completed and Signed by Each Supervising Physician.

1. Physician Name: _____

2. Physician License Number: _____

3. Physician National Provider Identifier (NPI) (Required): _____
   Physician Provider # (Required): _____

4. Physician Telephone Number: _____

5. Physician Current Service Address: _____

   _____

   _____

6. Detail the salary arrangements you have with your Physician Assistant. If the Physician Assistant is salaried by a Physician/Physician Group, attach a copy of the signed contract. If the Physician Assistant is salaried by a Hospital/Facility, attach a letter from the Chief Financial Officer of the Hospital/Facility explaining how the Physician & Physician Assistant salaries are related to the Hospitals/Facilities Medicaid Cost Report. Salary documentation is required in order to add a Supervising Physician to the Registered Physician Assistant's provider file.

7. Will the Physician Assistant practice at the same service location(s) at which you practice?

   ☐ Yes ☐ No

   If no is checked, list locations where the Physician Assistant will practice.
   _____
   _____
   _____

8. Detail how supervision is carried out.
   _____
   _____
   _____

CERTIFICATION STATEMENT

In accordance with the requirements of the Law and Regulations of the State Department of Education, I have agreed to supervise Physician Assistant _____ in the manner detailed in my response to question 8.

Physician Assistant National Provider Identifier (NPI) (Required): _____

Physician Assistant Medicaid Provider # (Required): _____

Physician Signature _____

Print Name _____ Date _____