PHYSICIAN ASSISTANT – SUPERVISING PHYSICIAN ADDENDUM

For NED Use Only

REG:

PHYSICIAN ASSISTANT INFORMATION

Physician Assistant Name: _____

NED Registration Number or "New": _____

State of Hawaii license no. (PVL): _____ Expiration date: _____

Federal DEA no. (if applicable): _____ Expiration date: _____

SUPERVISING PHYSICIAN INFORMATION

I, _____, hereby certify that I am a physician licensed to practice medicine in the State of Hawaii and registered under Section 329-33, HRS. I understand and retain full professional and legal responsibility for the performance of the listed physician assistant in accordance with Chapter 329-1 HRS (Physician Assistant). My Hawaii State license and federal DEA numbers are as shown below.

State of Hawaii license no. (PVL): _____ Expiration date: _____

Federal DEA no.: _____ Expiration date: _____

PRIMARY BUSINESS LOCATION[1]

Individual Affiliated Organization (if applicable): _____

Business address: _____

City: _____ State: HI Zip code: _____

Drug Schedules: ☐ II Narcotic ☐ II Non-Narcotic ☐ III Narcotic ☐ III Non-Narcotic ☐ IV ☐ V

Activities: ☐ Administer (from other stock) ☐ Prescribe

[1] Section to be completed if the listed supervising physician will be supervising the physician assistant at their primary business location.

ADDITIONAL PRESCRIBE ONLY LOCATIONS[2]

Additional prescribe only locations must match the supervising physician's locations on file. For additional locations, attach a separate sheet.

Business name (if applicable)	Address (street, building, unit, city, and zip code)

ATTESTATION OF PHYSICIAN ASSISTANT

Chapter 329-42(a)(4), Hawaii Revised Statutes, states that it is unlawful for any person who knowingly or intentionally furnishes false or fraudulent material information in or omit any material information from, any application, report or other document required to be kept or filed under this chapter, or any record required to be kept by this chapter.

Physician Assistant's Signature _____ Date _____

ATTESTATION & AUTHORIZATION OF SUPERVISING PHYSICIAN

As the supervising physician or osteopathic physician supervising this subordinate physician assistant, I retain full professional and legal responsibility for the performance of the physician assistant at the above listed address(es) and delegate the authority to administer and/or prescribe tile above listed scheduled drugs. Hawaii Administrative Rules Title 16, Chapter 85.

Supervising Physician's Signature _____ Date _____

[2] Section to be completed if the listed supervising physician will be supervising the physician assist at their additional prescribe location(s).