VERIFICATION - SUPERVISING PHYSICIAN

Access this form via website at: **cca.hawaii.gov/pvl**

SUBMIT THE ORIGINAL FORM. COPIES WILL NOT BE ACCEPTED.

BOARD USE

☐ AMD current?
☐ MD current?

Check one:

◯ New license ◯ Notification of changes to my record ◯ Reactivation*

PHYSICIAN'S ASSISTANT

Name of Physician Assistant *(LAST, First, Middle)*	Hawaii License No. AMD -	Registration No. or Scheduled Test Date
Mailing Address		Date of Birth
		PERSONAL E-Mail Address
		Is this a new Email address? ◯ YES ◯ NO

SUPERVISING PHYSICIAN

Check and complete **ONE** of the paragraphs below, then sign and complete information at the bottom.

☐ I , ______________________ , M.D./D.O., hereby state that I will direct and exercise supervision over the above-named physician assistant in accordance with Subchapter 6 of Chapter 16-85, Hawaii Administrative Rules, of the State of Hawaii Medical Board. I recognize that I retain full professional and legal responsibility for the performance of the above-named physician assistant and the care and treatment of the patient.

Effective Date of Direction and Supervision: ______________________

☐ I , ______________________ , M.D./D.O., hereby state that I am **no longer** directing the activities of the above-named physician assistant as defined under Subchapter 6 of Chapter 16-85, Hawaii Administrative Rules, of the State of Hawaii Medical Board.

Termination Date of Direction and Supervision: ______________________

______________________ ______________________
Signature of Supervising Physician Date Signature of Physician Assistant Date

Print Name of Physician: ______________________

License No. of Physician: MD - / DO - ______________________

If you are reactivating your license, complete a "Reactivation" application and submit it <u>along</u> with the <u>original</u> "Verification - Supervising Physician" form <u>and</u> $12 payable to: *Commerce & Consumer Affairs. (check must be in U.S. dollars and be from a U.S. financial institution.)

Fillable forms are located at the Board's website at: **cca.hawaii.gov/pvl**.

Mail to:

Physician Assistant
DCCA, PVL Licensing Branch
P.O. Box 3469
Honolulu, HI 96801

OR

Deliver to office location:

335 Merchant Street, Room 301
Honolulu, HI 96813

Phone: (808) 586-3000

This material can be made available for individuals with special needs. Please call the Licensing Branch Manager at (808) 586-3000 to submit your request