PRIMARY SUPERVISING PHYSICIAN ACKNOWLEDGEMENT OF ADDITIONAL SUPERVISING PHYSICIANS

I,

I, **PRIMARY SUPERVISING PHYSICIAN: (PRINT)**_____ **,** hereby

acknowledge that **PHYSICIAN ASSISTANT: (PRINT)** _____ **,** will practice under the supervision of the additional Substitute Supervising Physicians named below. These physicians have been given a copy of the written agreement filed with the Commonwealth of Pennsylvania State Board of Medicine. They understand that they are responsible for the actions of this PA when s/he covers their patients, and that they must supervise the PA according to the Written Agreement.

Printed name of Substitute Physician Assistant Supervisor _____

MD #_____

Printed name of Substitute Physician Assistant Supervisor _____

MD #_____

Printed name of Substitute Physician Assistant Supervisor _____

MD #_____

Printed name of Substitute Physician Assistant Supervisor _____

MD #_____

Printed name of Substitute Physician Assistant Supervisor _____

MD #_____

Printed name of Substitute Physician Assistant Supervisor _____

MD #_____

Printed name of Substitute Physician Assistant Supervisor _____

MD #_____

PRIMARY SUPERVISING PHYSICIAN: (SIGNATURE)_____

DATE:_____