DEPARTMENT OF HEALTH
COUNCIL ON PHYSICIAN ASSISTANTS
P.O. BOX 6320
TALLAHASSEE, FL 32399-6320
(850) 245-4131
MQA_PhysicianAssistant@doh.state.fl.us

Instructions for Completing the Application for Licensure As a Prescribing Physician Assistant

IMPORTANT INFORMATION:

A supervisory physician may delegate to a fully licensed physician assistant the authority to prescribe or dispense any medication used in the supervisory physicians' practice, if such medication is not listed in Section 893, Florida Statutes and in accordance with Rule sections 64B8-30.008 and 64B15-6.0038, Florida Administrative Code.

A "fully licensed Physician Assistant" is defined as a physician assistant who has successfully passed the NCCPA examination, or other examination approved by the Board of Medicine and Osteopathic Medical Board, and has been issued a license, other than a temporary license, as authorized under Sections 458.347(7)(b) 2, and 458.347(7)(f) and 459.022(7)(e) F.S.

An applicant for licensure as a prescribing physician assistant shall, together with the supervising physician, jointly file an application for licensure on a form provided by the Council. Only physicians with an active Florida license, which is not on probation, are eligible to be supervisors for prescribing physician assistants as authorized by Rules 64B8-30.003(4) and 64B15-6.003(2), F. A.C. Multiple physicians may be listed on the same application form provided that all supervising physicians practice in the same specialty area and in the same practice setting.

BEFORE APPLYING THE APPLICANT SHALL HAVE COMPLETED A PRESCRIPTIVE COURSE APPROVED BY THE BOARDS.

A three-hour course approved by the Boards in prescriptive practice, which course shall cover the limitations, responsibilities, and privileges involved in prescribing medicinal drugs or evidence that the applicant has received education comparable to the continuing education course as part of an accredited physician assistant training program.

THE APPLICANT MUST SUBMIT THE FOLLOWING WITH THE APPLICATION:

1. **Part A** of the application, which must be fully completed and signed by the physician assistant applicant.

Note*:*
Separate application forms are required for each distinct specialty area of practice, as well as, separate employment settings. Satellite offices within the same practice are not considered separate employment settings.

2. **Part B** of the application must be fully completed and signed by **each** supervising physician. Part B of the application may be duplicated in sufficient number to allow for completion by **each** supervising physician

3. **Application and License Fees.** The **non-refundable application fee** for licensure as a prescribing physician assistant shall be **$200**. The fee for initial licensure as a prescribing physician assistant shall be **$200**. The total fee shall be **$400**. No additional fees will be required for any additional applications for distinct specialty areas of practice and/or a change or addition in distinct practice setting during the same biennium. Attach a personal check, money order or cashier's check payable to the Florida Department of Health. The license must be renewed biennially. Each renewal period is from February 1 even year through January 31 even year.

4. A copy of your certificate of completion of a three-hour course in prescriptive practice.

Note:
It is acceptable, and preferred that large documents be reduced to 8.5" by 11".
If adequate space is not provided on the application form to respond to the requested information, please attach additional sheets as necessary.

Mail the completed application, fee and supporting documentation to:

Department of Health
Council on Physician Assistants
P.O. Box 6320
Tallahassee, Fl 32399-6320

Information / documentation submitted to the board after mailing the application and fee must be mailed to:

Department of Health
Council on Physician Assistants
4052 Bald Cypress Way, Bin # C-03
Tallahassee, Fl 32399-3253

	Department of Health **Council on Physician Assistants** **P.O. Box 6320** **Tallahassee, Fl 32399-6320** **(850) 245-4131** **Application For Licensure as a Prescribing Physician Assistant**	**For Deposit/Receipt Use Only** **CLIENT 1512**

Application Fee: $200 **Initial Certification Fee: $200** **Total Fee: $400**	**The Application Fee Is Non –refundable. The Application Should Be Typed or printed Legibly.**

The biennial licensure period is from February 1 even year through January 31 even year.

PART A
TO BE COMPLETED BY THE PHYSICIAN ASSISTANT:

FL License #	PA			
Name: (Please Print)				
	First	MN	Last	
Mailing Address:				
	Number	Street Name		
	City	State	Zip	
Practice Location:				
	Number	Street Name		
	City	State	Zip	
Office Telephone #:				

Are you or have you ever been certified as a prescribing physician assistant in Florida? Yes ☐ No ☐	If yes, please state your Prescribing License Number _____ and specialty area of practice _____.

On page 5, list the name and license number of each supervising physician. Only supervising physicians of the same specialty area of practice may be included on this application.

_____

LIST SPECIALTY AREA FOR THIS APPLICATION

Note:
The Florida Board of Medicine recognizes only those specialties approved by the American Board of Medical Specialties, American Board of Pain Medicine, American Board of Facial Plastic & Reconstructive Surgery and the American Association of Physician Specialist, Inc. The Board of Osteopathic Medical recognizes specialties accredited by the American Osteopathic Association and the American Council on Graduate Medical Education. A separate application must be completed for each specialty area of practice and each separate practice/ employment setting.

BOARD APPROVED PRESCRIPTIVE COURSES:

The applicant shall have completed a three-hour course approved by the Boards in prescriptive practice, which course shall cover the limitations, responsibilities, and privileges involved in prescribing medicinal drugs.

CHECK THE PROGRAM YOU COMPLETED	
Florida Academy of Physician Assistants (FAPA) Course	
University of Florida Physician Assistant Program	
Nova Southeastern University Physician Assistant Program	
Barry University Physician Assistant Program	
Keiser University Physician Assistant Program (Master of Science)	

AFFIRMATION OF PHYSICIAN ASSISTANT:

I, _____hereby declare that I have been delegated by my supervising physician(s) named herein, the authority to prescribe, pursuant to a written agreement, any medication used in my supervising physician's practice pursuant to Sections 458.347(4)(e), and 459.022,(4)(e) F.S. and are not listed in Chapter 893, F.S. and in accordance with the formulary rule 64B8-30.008 and 64B15.006, Florida Administrative Code.

I further state that I have completed at least three (3) classroom hours in prescriptive practice conducted by an accredited program approved by the Board of Medicine and the Board of Osteopathic Medical which course covers the limitations, responsibilities, and privileges involved in prescribing medicinal drugs.

I hereby state that the statements herein are true and accurate to the best of my knowledge.

_____

Signature of Applicant Date

PART B
THIS MUST BE COMPLETED BY EACH SUPERVISING PHYSICIAN:
This form may be copied in sufficient numbers to allow for completion

Physician's Name:			
	First	MI	Last
Physician's Florida Medical License Number:		Physician's Specialty Area of Practice:	
Physician's Primary Practice Location:			
	Address Number Street Name		
	City	State	Zip
Business Phone #:			
Physician's Secondary Practice Location:			
	Address Number Street Name		
	City	State	Zip
Business Phone #:			

I, _____, state that I have delegated to
(Please Print Name of Physician)

_____, license number PA_____
(Please Print Name of Physician Assistant)

the authority to prescribe, pursuant to a written agreement on file at our practice location, any medication used in my practice if such medication is not listed in Section 893, Florida Statutes and in accordance with rule the formulary rule 64B8-30.008 and 64B15-6.0038, F.A.C.

I further acknowledge that the Physician Assistant named herein is fully licensed under, and complies with the provisions of Sections 458.347(4)(e) and 459.022(4)(e), Florida Statutes, and the rules promulgated thereunder.

I have knowledge that the Physician Assistant named herein has completed the three-hour prescriptive practice course which covers the limitations, responsibilities, and privileges involved in prescribing medicinal drugs.

These statements herein are true and accurate to the best of my knowledge.

_____

Signature of Supervising Physician: Date Signed: