

Physician Assistant Dispensing Notification

Dispensing Notification

Board of Medicine / Board of Osteopathic Medicine
P.O. Box 6330

Tallahassee, FL 32314-6330

Fax: (850) 488-0596





Email: MQA.PhysicianAssistant@FLHealth.gov

This form must be completed by the supervisory physician. No fee is required.

A supervisory physician may delegate to the prescribing physician assistant the authority to dispense any medication used in the supervisory physician's practice unless such medication is listed in Rule 64B8-30.008/64B15-6.0038, Florida Administrative Code. A prescribing physician assistant may only dispense for a supervisory physician who is registered with the Board of Medicine/Board of Osteopathic Medicine as a dispensing practitioner in compliance with section 465.0276, Florida Statutes. Attach additional copies of this form if necessary.

Physician Name:			
	First	Middle	Last/Surname
Physician License N	umber: ME or DO_		
The above physicia	n has delegated d	ispensing authority to	the Physician Assistant(s) listed below.
Physician Assistant	's Name:		
Physician Assistant	's License Number:	: PA	
Physician Assistant	's Name:		
Physician Assistant	's License Number:	: PA	
Physician Assistant	's Name:		
Physician Assistant	's License Number:	: PA	
Physician Signature:			Effective Date:
			MM/DD/YYYY
I am withdrawing dis canceled effective:	pensing authority w	ith the above Physician	Assistant(s) and request the dispensing authority be
_	MM/DD/YYYY		