

**PHYSICIAN ASSISTANT  
FORM C INSTRUCTIONS**

RETURN TO: MAINE BOARD OF LICENSURE IN MEDICINE  
137 STATE HOUSE STATION  
AUGUSTA, ME 04333-0137  
TEL: (207) 287-3601 FAX: (207) 287-6590

Please refer to Chapter 2 of the Board's Rules, which are available upon request by contacting the Board, or at [http://www.docboard.org/me/me\\_home.htm](http://www.docboard.org/me/me_home.htm)

A Physician Assistant (PA) practicing under delegation must hold a valid license and a **Certificate of Registration, which documents the supervision relationship**, as described in Chapter 2, Section 2, B of the Board's Rules.

- A. **Initial Registration:** Before beginning employment, each PA who is newly licensed or who has inactive status must be registered with a Primary Supervising Physician by filing a Form C registration with the Maine Board of Licensure in Medicine.
- B. **Primary Supervising Physician Change:** Each PA has **14 days** in which to notify the Board upon changing Primary Supervising Physicians or adding a Primary Supervising Physician. Effective January 1, 1998, a **\$100 late registration fee** will be assessed if the Form C registration is not filed within 14 days of beginning employment. Both the Physician Assistant and Primary Supervising Physician must sign the form. The PA is responsible to notify the Board when the supervising relationship ends.
- C. **Secondary Supervision:** In the temporary absence of the Primary Supervising Physician, the supervision of the named PA must be transferred to another licensed physician. The secondary supervisor must designate in writing in the written Plan of Supervision his/her willingness to accept the responsibility and liability for the performance of the named PA.
- D. **Termination:** You may use this form to notify the Board when the Primary Supervising Physician relationship has terminated. Please use a separate page if more space is needed. State the date of and reason for the termination and return the Board-issued Certificate Of Registration after it has been signed by the Primary Supervising Physician.
- E. **Multiple Work Site:** This means you work for more than one employing entity, and not that you work in more than one location for the same entity.

# FORM C: REGISTRATION OF PHYSICIAN ASSISTANT SUPERVISORY RELATIONSHIP

PLEASE PRINT OR TYPE ALL INFORMATION CLEARLY

\_\_\_\_\_  
Physician Assistant

\_\_\_\_\_  
Maine License No.

\_\_\_\_\_  
Primary Supervising Physician

\_\_\_\_\_  
Maine M.D. License No.

\_\_\_\_\_  
Primary Supervising Physician Email Address

\_\_\_\_\_  
Name/Address of Practice Setting:

\_\_\_\_\_  
SUPERVISION START DATE: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Tel: \_\_\_\_\_

Please check the appropriate box:

Fee

First time registration with a New Primary Supervising Physician (PSP) \$50  
(The first time registration is valid only upon approval by the Board).

Change of Primary Supervising Physician relationship\*. \$50  
(Registering a new PSP and terminating a relationship with a former PSP.  
Please refer to page 1, paragraph D, Termination.)

Renewal of Primary Supervising Physician relationship. File with license renewal. \$50

Renewal of multiple Primary Supervising Physician relationships. \$50 each  
(Fee is per registration - not to exceed \$250 per registration period.)

Renewal of Primary Supervising Physician relationship within 1 year of initial \$25  
registration of relationship. File with license renewal.

\*Termination of a Primary Supervising Physician relationship: fill out the fields below.

Name of Former Primary Supervising Physician: \_\_\_\_\_

Effective Relationship End Date: \_\_\_\_\_

Reason for termination: \_\_\_\_\_

\_\_\_\_\_

FORM C, Page 2  
**ATTESTATIONS**

**PHYSICIAN ASSISTANT**

I have read, fully understand, and accept the responsibilities and liability of a Physician Assistant as described in 32 M.R.S.A. § 3270-A and § 3270-B and in the current Chapter 2 of the Rules of the Board of Licensure in Medicine. I affirm that a written Plan of Supervision addressing the technical requirements of supervision as set forth in Chapter 2, Section 6 of the Rules has been prepared and is available for inspection at the above named practice setting. I agree to notify the Board of Licensure in Medicine in writing no later than 14 days after the effective date of any change to or addition of a Primary Supervising Physician.

I hereby certify that to the best of my knowledge and belief the statements made in this application are true and correct.

\_\_\_\_\_  
Signature, Physician Assistant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name Printed

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**PRIMARY SUPERVISING PHYSICIAN**

I have read, fully understand, and accept the responsibilities and liability for the supervision of a Physician Assistant as described in 32 M.R.S.A. § 3270-A and § 3270-B and in the current Chapter 2 of the Rules of the Board of Licensure in Medicine. I affirm that a written Plan of Supervision addressing the technical requirements of supervision as set forth in Chapter 2, Section 5 of the Rules has been prepared and is available for inspection at the above named practice setting.

I hereby certify that to the best of my knowledge and belief the statements made in this application are true and correct.

\_\_\_\_\_  
Signature, Primary Supervising Physician

\_\_\_\_\_  
Date