To: Alabama Board of Medical Examiners

As a covering (back-up) physician providing supervision for Physician Assistant _____, P. A., by signing this document, I hereby affirm that:

1. I am familiar with the current rules regarding physician assistants;

2. I am familiar with the job description filed by _____, M. D./D. O. (primary sponsoring physician), and _____, P. A., RA# _____;

3. I will be accountable for adequately supervising the medical care rendered pursuant to the job description; and

4. I will approve the drug type, dosage, quantity and number of refills of legend drugs which the assistant is authorized to prescribe in the job description.

When the primary supervising physician is off duty, out of town, or not on call and not immediately available to respond to patient medical needs, the physician assistant is not authorized to perform any act or render any treatments unless another qualified physician **in the same partnership, group, medical professional corporation or physician practice foundation or with whom the primary supervising physician shares call is on call and is immediately available to supervise the physician assistant** and has previously filed with the Board this letter stating that he or she assumes all responsibility for the actions of the physician assistant during the temporary absence of the primary supervising physician.

I will assume all responsibility for the actions of the assistant during the temporary absence of the primary supervising physician.

Relationship with primary supervising physician: (check one below)

- ☐ Partnership
- ☐ Professional Group
- ☐ Medical Professional Corporation
- ☐ Physician Practice Foundation
- ☐ Physician sharing call

Medical specialty of covering physician _____

_____ _____
Print physician name License number

_____ _____
Physician signature Date

Covering physician's telephone number (___) _____ Fax (___) _____