BlueCross BlueShield of Oklahoma

Physician Assistants
Supervising/ Collaborating/Monitoring Physician Protocols/Duties/Scope of Practice Supplemental Questionnaire

Section 1: Collaborating/Supervising/Monitoring Physician

Physician Assistants are statutorily required to be supervised/monitored by a physician licensed to practice in the state where they currently practice and who is designated as the primary collaborating/supervising physician (or an alternate physician can also provide supervision).

Applicant's Name:_____ **Degree:**_____**Specialty:**_____

Collaborating/Supervising/Monitoring Physician Name: _____ **Degree:**_____

Illinois and Texas: (This physician must be licensed in the same state of practice and in the same networks as the applicant.)

Oklahoma: (This physician must be licensed in the same state of practice, in the same networks and the same specialties as the applicant.)

Collaborating/Supervising/Monitoring Physician Medical License: No:_____ **State:**_____

Alternate Collaborating/Supervising/Monitoring Physician (if applicable):_____ **Degree:**_____

Illinois and Texas: (This physician must be licensed in the same state of practice and in the same networks as the applicant.)

Oklahoma: (This physician must be licensed in the same state of practice, in the same networks and the same specialties as the applicant.)

Alternate Collaborating/Supervising/Monitoring Physician Medical License: No:_____ **State:**_____

Section 2: Protocols/Duties/Scope of Practice

In my current position with _____, Collaborating/Supervising/Monitoring Physician, I have reviewed, understand, agreed upon and signed along with my Supervising Physician, protocols or other written authorization which defines my duties and role as a Physician Assistant in a manner that promotes professional judgment commensurate with my education and experience. A copy of the protocols/duties/scope of practice is maintained onsite (at my primary office location).

ATTESTATION: I certify the information provided by me on this document is true, correct and complete to the best of my knowledge and belief. I understand and agree that any misstatement or omission of information concerning my collaborating/supervising physician and the established protocols/duties/scope of practice may constitute grounds for withdrawal of the application for consideration.

_____

Signature: Applicant **Date**

_____

Printed Name