

SECTION II: INSTRUCTIONS TO THE SUPERVISING PHYSICIAN

1. By completing the information below, you are certifying that the permittee will be employed under the supervision of a physician who is licensed and currently registered to practice in New York State and that the employer agrees to abide by the conditions stipulated on the permit.
2. Limited permits expire one year from the date of issuance, or upon notice to the applicant by the Department that the application for licensure has been denied. See applicant instructions for further information.
3. If applicant requests more than one employer at the same time, a separate Form 5 must be completed by each supervising physician and each employer or physician.
4. The applicant may not practice as a physician assistant until the limited permit is issued.

CERTIFICATION OF SUPERVISION - (To Be Completed By Supervisor)

1. Applicant's name: _____
2. Employer:
Name: _____
(Enter full name - no initials)
Street: _____
City: _____ State: _____ Zip code: _____ - _____
Telephone: _____ Fax: _____ E-mail: _____
3. If practice site is different from employer address (item 2), provide that address:
Name: _____
Street: _____
City: _____ State: _____ Zip code: _____ - _____
Telephone: _____ Fax: _____ E-mail: _____
4. Direct supervision will be provided by:
Name of supervising physician: _____
(Please print or type)

CERTIFICATION

I certify that the applicant named above will be employed under my supervision. I am a licensed physician currently registered in New York State and agree to abide by the conditions stipulated on the permit.

I declare and affirm that the statements made in the foregoing certification are true, complete and correct. Any false or misleading information in, or in connection with this certification may be cause for disciplinary action against my license.

Signature of supervising physician _____

Date _____ / _____ / _____ N.Y. License No. _____

Employer or appointed designee: _____
(Please print or type)

Signature of employer: _____ Date: _____ / _____ / _____
mo. day yr.

Mail this form and appropriate fee to: New York State Education Department, Office of the Professions, PO Box 22063, Albany, NY 12201. DO NOT SEND CASH. Make check or money order payable to the New York State Education Department.