4. Male clients may also receive the following services and laboratory tests:
   a. Inspection of penis, including meatus, retraction of foreskin, and expression of any discharge from urethra
   b. Palpation of scrotal contents and review of self testicular exam
   c. Inspection of perianal area, if indicated as exposed site
   d. Rectal exam as indicated
   e. urine specimen for Chlamydia and gonorrhea testing
   f. Presumptive treatment of an STI

5. If a patient appears to be affected by one STI, there is an increased risk for a concurrent infection with another organism. Once the diagnosis of a STI is made, an even more diligent search for other infections is required by

- Searching for the same pathogen in different places;
- Searching for different pathogens in the same place;
- Searching for other conditions in different places;

E. LABORATORY

1. All contracted STI sites are required to provide:
   a. Gonorrhea and chlamydia screening on all men and women
   b. Serology screening

2. All clients should be offered HIV testing and given appropriate pretest counseling.

3. Any male patient with urethral discharge, dysuria, or who has had contact to chlamydia should have a chlamydia and GC screening.

4. If a woman has not had a Pap smear in more than one year, a Pap smear may be provided.

030118 0362

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
STATE BOARD OF MEDICINE
P.O. BOX 2649
HARRISBURG, PA 17105

Telephone: (717) 787-2381
(717) 783-1400

Fax: (717) 787-7769
www.dos.state.pa.us

November 12, 2002

JAMES N ANASTI MD
[redacted]

RE: JILL BLOOM, PA-C

Dear Doctor:

The Board is in receipt of your physician assistant supervisor application. The following is required so your application can be re-evaluated.

A substitute supervisor is needed. This doctor will need to complete page 2.

A physician assistant can only perform those duties as specifically listed in the job description. Your job description is vague. Submit a complete list of all duties that will be performed. Refer to the enclosed Rules and Regulations for a sample job description.

Indicate the frequency of on-site supervision you will provide.

Answer question number 4.

NOTE: PLEASE RETURN A COPY OF THIS LETTER WHEN SUBMITTING THE ABOVE INFORMATION. THE PHYSICIAN ASSISTANT MAY NOT BEGIN WORKING UNDER YOUR EMPLOY UNTIL YOUR SUPERVISOR APPLICATION HAS BEEN APPROVED.

030118 0362

PHYSICIAN ASSISTANT Bloom, Jill

PRIMARY PHYSICIAN Anasti, James

SUBSTITUTE PHYSICIAN

	APPROVED	PENDING
FEE	11/8/02	Took $35
APPLICATION		11/8 - needs sub
WRITTEN AGREEMENT		11/8 - answer #4 - freq of on site supr - # rogue
DRUG LIST	11/8	

- Send confirm drug list

Y OR (N) SCHED 3, 4, &/OR 5

APPROVAL LTR ISSUED

030116 0362

COMMONWEALTH OF PENNSYLVANIA
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www.dos.state.pa.us

November 21, 2002

JAMES NUNCIE ANASTI MD
[redacted]

RE: JILL BLOOM PA-C

Dear Doctor:

The State Board of Medicine has approved your supervisor application for the above named physician assistant. The approval letters are enclosed. Please note a physician assistant may prescribe, administer, and dispense drugs within the permissible physician assistant prescription formulary as listed on page four of the supervisor application. For drugs outside the permissible formulary, a physician assistant may only relay and/or execute an order of the supervising physician (s). The supervising physician (s) is fully responsible for the physician assistant.

Sincerely,

State Board of Medicine

SPOA 1438 (REV. (8/98)

For official use only 010572 0042

STATE BOARD OF MEDICINE
P.O. BOX 2649
HARRISBURG, PA 17105-2649
717-783-1400
717-787-2381

COURIER ADDRESS
STATE BOARD OF MEDICINE
124 PINE STREET
HARRISURG PA 17101

MD-056874-L

Anast SUPR SS

Trans. No.
Amount
Date

APPLICATION FOR REGISTRATION AS A PHYSICIAN ASSISTANT SUPERVISOR

INSTRUCTIONS - If written agreement and drug list (if applicable) are identical for all supervisors, submit one application for each physician assistant. Complete and sign this application. Attach fee and written agreement along with drug list, if applicable.

FEE - $45.00 for each application with one primary and one substitute physician assistant supervisor. An additional $5.00 fee is due for each additional supervisor listed.

MAKE CHECK PAYABLE TO "COMMONWEALTH OF PENNSYLVANIA." FEE IS NOT REFUNDABLE.

NOTE: A PROCESSING FEE OF $20.00 WILL BE CHARGED FOR ANY CHECK OR MONEY ORDER RETURNED UNPAID BY YOUR FINANCIAL INSTITUTION, REGARDLESS OF REASON FOR NON-PAYMENT.

PLEASE PRINT OR TYPE ALL INFORMATION

PRIMARY PHYSICIAN ASSISTANT SUPERVISOR NAME/LICENSE NUMBER:

Anasti James Nuncio MD-056874-L
LAST FIRST MIDDLE LIC NO.

3213-L

PHYSICIAN ASSISTANT NAME/CERTIFICATION NUMBER:

Goodwin Debra P. MA-
LAST FIRST MIDDLE CERT NO.

~~Certificate No.~~ 1043739

PRACTICE ADDRESS 801 Ostrum Street
STREET

Bethlehem PA 18015
CITY STATE ZIP CODE

PRACTICE TELEPHONE (610) 954-4670

SPOA 1438 (REV. (8/98)

Primary Physician Assistant Supervisor must complete:

List Specialties OB/GYN

Do you hold a membership in any American Boards of Medical Specialties ✓ YES ____ NO

If yes, list Board(s) American Board of OB/GYN Reproductive Endocrinology and Infertility

If you have hospital staff privileges, indicate hospital name(s) St. Luke's Hospital Bethlehem

VERIFICATION

I will direct and exercise supervision over the named physician assistant in accordance with the rules and regulations of the State Board of Medicine. I recognize that I retain full professional and legal responsibility for the performance of the physician assistant and the care and treatment of the physician assistant's patients.

I verify that the statements in this application, written agreement and drug list (if applicable) are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa. C.S. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my registration.

The physician assistant identified in this application will only assist the primary physician assistant supervisor and substitute physician assistant supervisor(s) listed in this application. This physician assistant will only provide medical services to the patients under the care of the primary and substitute supervisor(s) named in this application.

[signature] 1-21-00

Signature of Primary Physician Assistant Supervisor Date

Name of Substitute Physician Assistant Supervisor Joe Merola MD 011841 E

Signature [signature] Date 1/24/00 MD# AM2411039

Name of Substitute Physician Assistant Supervisor _____

Signature _____ Date _____ MD# _____

Name of Substitute Physician Assistant Supervisor _____

Signature _____ Date _____ MD# _____

Substitute Physician Assistant Supervisor _____

e _____ Date _____ MD# _____

(1/2 x 11 sheets with additional names if needed.)

SPOA 1438 (REV. (8/98)

010572 0042

WRITTEN AGREEMENT

[signature]
PRIMARY PHYSICIAN ASSISTANT SUPERVISOR

Debra P. Hardwin, PA-C
PHYSICIAN ASSISTANT SIGNATURE

INSTRUCTIONS: Please provide the following information for questions 1 and 2 on 8 1/2 x 11 sheets and attach to this form. Number each section on the attachment. The information on this agreement must be identical for all supervisors listed on page 2.

1. Describe the functions/tasks to be delegated to the physician assistant, including the manner in which the physician assistant will be assisting each named physician, instructions for the use of the physician assistant in the performance of delegated functions/tasks and medical regimens to be administered or relayed by the physician assistant.

2. Describe the time, place and manner of supervision and direction you will provide the physician assistant, including the frequency of personal contact with the physician assistant.

3. Identify the location and practice setting (i.e. hospital, private practice, group practice, etc.) where the physician assistant will serve.

Family planning health center

4. The name(s) of physician(s) who is/are willing to act as a substitute physician assistant supervisor in your absence are all listed on page 2 of this application ?
X YES ____ NO

5. Will the physician assistant prescribe and dispense drugs?
X YES ____ NO If yes, please complete page 4.

If yes, will Schedule III, IV and/or V controlled substances be prescribed and dispensed? ____ YES X NO

NOTE: The Regulations of the State Board of Osteopathic Medicine do not permit a physician assistant to prescribe or dispense drugs when practicing under the supervision of an osteopathic physician.

SPOA 1430 (REV. 8/98)

PRESCRIBING AND DISPENSING DRUGS BY PHYSICIAN ASSISTANT

Print or type name

James Amast, MD
PRIMARY PHYSICIAN ASSISTANT SUPERVISOR

Debra P. Cosclai, PA-C
PHYSICIAN ASSISTANT

If you answered "YES" to question number 5 in the written agreement, please check those categories which the physician assistant will be permitted to prescribe and dispense drugs.

1. Categories from which a physician assistant may prescribe and dispense without limitation are as follows:

___(i) Antihistamines.
___(ii) Anti-infective agents.
___(iii) Cardiovascular drugs.
_X_(iv) Contraceptives - for example, foams and devices.
___(v) Diagnostic agents.
___(vi) Disinfectants - for agents used on objects other than skin.
___(vii) Electrolytic, caloric and water balance.
___(viii) Enzymes.
___(ix) Antitussives, expectorants and mucolytic agents.
___(x) Gastrointestinal drugs.
___(xi) Local anesthetics.
___(xii) Serums, toxoids and vaccines.
___(xiii) Skin and mucous membrane agents.
___(xiv) Smooth muscle relaxants.
___(xv) Vitamins.

2. Categories from which a physician assistant may prescribe and dispense subject to exclusions and limitations listed:

___(i) Autonomic drugs. Drugs excluded under this category:
Sympathomimetic (adrenergic) agents.
___(ii) Blood formation and coagulation. Drugs excluded under this category:
(A) Anti-coagulants and coagulants.
(B) Thrombolytic agents.
___(iii) Central nervous system agents. Drugs excluded under this category:
(A) General anesthetics.
(B) Monoamine oxidase inhibitors.
___(iv) Eye, ear, nose and throat preparations. Drugs limited under this category: Miotics and mydriatrics used as eye preparations require specific approval from the physician assistant supervisor for a named patient.
___(v) Hormones and synthetic substitutes. Drugs excluded under this category:
(A) Pituitary hormones and synthetics.
(B) Parathyroid hormones and synthetics.

PLEASE NOTE:

Categories from which a physician assistant may not prescribe or dispense are as follows:

(i) Antineoplastic agents.
(ii) Dental agents.
(iii) Gold compounds.
(iv) Heavy metal antagonists.
(v) Oxytocics.
(vi) Radioactive agents.
(vii) Unclassified therapeutic agents.
(viii) Devices.
(ix) Pharmaceutical aids.

010572 0042

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www.dos.state.pa.us

February 11, 2000

JAMES N ANASTI MD
[redacted]

RE: DEBRA GOODWIN, PA-C

Dear Doctor:

The Board is in receipt of your physician assistant supervisor application. The following is required so your application can be re-evaluated.

Please answer questions one and two of the written agreement: 1) Describe the functions/tasks to be delegated to the physician assistant, including the manner in which the physician assistant will be assisting each named physician, instructions for the use of the physician assistant in the performance of delegated functions/tasks and medical regimens to be administered or relayed by the physician assistant.

2) Describe the time, place and manner of supervision and direction you will provide the physician assistant, including the frequency of personal contact with the physician assistant.

NOTE: PLEASE RETURN A COPY OF THIS LETTER WHEN SUBMITTING THE ABOVE INFORMATION. THE PHYSICIAN ASSISTANT MAY NOT BEGIN WORKING UNDER YOUR EMPLOY UNTIL YOUR SUPERVISOR APPLICATION HAS BEEN APPROVED.