49-106 (REV. (9/09)

Regular Mailing Address
STATE BOARD OF MEDICINE
P.O. BOX 2649
HARRISBURG, PA 17105-2649
717-783-1400/717-787-2381
st-medicine@state.pa.us

NOV 2 2010

Courier Delivery Address
STATE BOARD OF MEDICINE
2601 NORTH THIRD STREET
HARRISBURG, PA 17110

APPLICATION FOR REGISTRATION AS A SUPERVISING PHYSICIAN

INSTRUCTIONS - Print or type all information. If the written agreement is identical for all supervisors, submit one application for each physician assistant. Attach the fee and written agreement.

FEE - $35.00 for each application with one primary and one substitute physician assistant supervisor. An additional $5.00 fee is due for each additional substitute supervisor. **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. Make check payable to the "Commonwealth of Pennsylvania." The fee cannot be transferred to another application. PLEASE NOTE**: If this application is not completed **within six months**, updates of certain sections will be required. If the application process has not been completed **within one year** from the date it was received, applicants will be also be required to submit an updated application and **another application processing fee.**

Upon approval of the application, the Board will issue an approval letter for the primary supervisor and provide a list of all substitute supervisors. These documents will be sent to the primary supervisor at the address provided on page one of the application.

REGARDLESS OF THE FILING DATE, A PHYSICIAN ASSISTANT CANNOT PRACTICE PRIOR TO THE BOARD'S APPROVAL OF THIS APPLICATION

PRIMARY SUPERVISING PHYSICIAN NAME/LICENSE NUMBER:

Wilson (LAST) Janet (FIRST) Lee (MIDDLE) MD-021813E (LIC NO.)

PHYSICIAN ASSISTANT NAME/LICENSE NUMBER:

ALBERT (LAST) AMY (FIRST) N (MIDDLE) MA-051885 (LIC NO.)

PRACTICE ADDRESS 8210 Caster Ave (STREET)

Philadelphia (CITY) Pa (STATE) 19152 (ZIP CODE)

PRACTICE TELEPHONE (215) 745-0308

PRIMARY SUPERVISING PHYSICIAN MUST COMPLETE THIS SECTION:

List your specialties gyn / womens health

Do you hold a membership in any American Boards of Medical Specialties? YES____ NO X

If yes, list Board(s)____

Do you hold hospital staff privileges? YES X NO____

If you have hospital staff privileges, indicate the hospital name(s).

Pennsylvania Hospital

49-106 (REV. (9/09)

NOV 2 2010

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 verify that I have reviewed the Medical Practice Act and Regulations of the State Board of Medicine. I recognize that I am obligated to comply with all the provisions of the Act and Regulations **including those provisions that require me to notify the Board of the termination of my agreement to supervise the physician assistant.** 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 and written agreement 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 work with the primary supervising physician 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 of Primary Supervising Physician — Date 10/20/10

Signature of Physician Assistant — Date 9/29/10

Name of Substitute Physician Assistant Supervisor Joel Lebed D.O.

License # 050075184

Signature Joel Lebed DO Date 10/20/10

Name of Substitute Physician Assistant Supervisor _____

License # _____

Signature _____ Date _____

Name of Substitute Physician Assistant Supervisor _____

License # _____

Signature _____ Date _____

Name of Substitute Physician Assistant Supervisor _____

License # _____

Signature _____ Date _____

(Attach 8 1/2 x 11 sheets with additional names if needed.)

49-106 (REV. (9/09)

NOV 2 2010

WRITTEN AGREEMENT

Janet Wilson
NAME OF PRIMARY SUPERVISING PHYSICIAN

AMY ALBERTPA-C
NAME OF PHYSICIAN ASSISTANT

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.**
Reproductive health care including H+P, diagnosis, treatment. Routine GYN care, STI dx/treatment, Pap supervision, IUD's, Implanon,
2. **Provide details regarding the time, place and manner of supervision and direction you will provide the physician assistant.** EMB. Weekly chart review, annual observation, available during all hours Center open.

3. **List the name, address, and practice setting (i.e. hospital, private practice, group practice, etc.) where the physician assistant will serve.**
Planned Parenthood SEPA, 8210 Easter Ave, Phila, Pa 19152

4. **Will the physician assistant prescribe and dispense drugs/therapeutic devices?**

YES X NO _____

If yes, list below any categories that the physician assistant will NOT be permitted to prescribe/dispense.

Antineoplastic agents	Diagnostic Agents	Eye / ENT preparations
Blood formation drugs	Electrolytic/Caloric/Water Balance	Smooth Muscle Relaxants
Coag/anticoagulation	Enzymes	
Thrombolytic/Antithrombolytic	Antitussives, mucolytic expectorants	
Cardiovascular	Gastrointestinal	

If yes, will Schedule II, III, IV and/or V controlled substances be prescribed and dispensed?

YES _____ NO X

Planned Parenthood®
Southeastern Pennsylvania

JOB DESCRIPTION

POSITION: **Clinician**

DEPARTMENT: **Patient Services**

REPORTS TO: **Center Manager/Medical Director**

PRIMARY FUNCTION/PURPOSE OF THE POSITION:

Certified Registered Nurse Practitioner, Nurse Midwife, or Physician Assistant or Physician to provide reproductive health care services to women and men. Under written Standing Orders of the Medical Director, the Clinician will function in an expanded role in the provision of reproductive health care for women and men. Performance and supervision of medical aspects of patient care in contraceptive center in accordance with PPSP Standing Orders and policies and procedures. It has been determined that the position of Clinician requires the performance of certain duties that place the employee at risk of an occupational exposure. For a list of position specific duties that are considered to place the Clinician at risk, see Occupational Exposure Determination of the Policy & Procedure Manual (Sect. XVI-B).

DUTIES AND RESPONSIBILITIES:

1. Takes and/or reviews and interprets a complete health history, including obstetric, gynecological, sexual, contraceptive, medical, surgical, family health and psychosocial and records findings accurately, legibly and succinctly.

2. Performs physical examinations with special emphasis on the reproductive system including heart and lung assessment, thyroid, abdominal, breast and pelvic examination for women and/or genital exam for men, appropriate screening procedures. Interprets finding of examination and records same.

3. Prescribes and provides appropriate contraceptive methods and/or treatments for specified medical conditions with Standing orders and tailored to the clients' health maintenance.

4. Provides relevant health instruction to include family planning, STD prevention, genetics, nutrition, sexual counseling and principles of heath promotion maintenance.

5. Consults with Medical Director or designated community gynecologist or refers clients with abnormal findings or in need of further care according to clinical judgment and standing orders.
6. Responsible for reviewing lab reports, reporting positive STDs and abnormal Pap results to appropriate agencies.

7. Responsible for follow-up pertaining to referrals, medical problems, lab tests, etc. with staff assistance.

8. Assists Center Managers and Center Assistants to insure smooth operation of the service (i.e. record keeping, laboratory testing, clerical functions, maintenance of facilities, development and implementation of phones appointment systems, and in providing excellent customer service).

8. Assists with orientation/training of new staff and/or students.

9. Participates in departmental and interdisciplinary committees that affect or determine policies related to the delivery of reproductive health care to the consumer and to the success of PPSP.

10. Participates in departmental meetings that affect and determine policies related to the role of the clinician.

11. Maintains continuing education requirements for licensure.

12. Practices in accordance with agency and PPFA Medical Standards and Guidelines.

13. Maintains cardiopulmonary resuscitation certificate.

14. Responsible for regular periodic medical in-services and medical supervision of non-clinical staff at center.

15. Participate in the Continuous Quality Improvement Program.

16. Adhere to OSHA regulations and participates in annual Infection Control training.

17. Provides clinic staff with annual Emergency Protocol review.

PROBLEM-SOLVING:

Independent medical decision-making within the protocol of PPSP.

FISCAL RESPONSIBILITY:

Responsible for determining tests and care needed for patient including whether to provide tests at a waived cost. Needs to be able to offer care within financial means or decision of patient.
Hands supplies of some types to patient prior to checkout at front desk.
Clinician productivity is a primary driver for bottom line for department.

CONTACTS:

Works extensively with patients seeking health services or health related information. Works with center team as well as traveling to other sites to work with other center team members. For medical care may be in contact with other health care providers outside agency. May serve as preceptor or host for students.

SUPERVISION:

As part of medical leadership at agency, is responsible for doing some of the training of Center Assistants and for planning implementation of policy or procedure changes in conjunction with Center Manager. Also responsible for oversight of follow-up if it is delegated to other staff members within the center.

EDUCATION, EXPERIENCE, TRAINING AND CERTIFICATION:

Licensed or certified as a Nurse Practitioner, Nurse Midwife or Physician's Assistant in the state of Pennsylvania. Training in a recognized program or its equivalent. Experience in reproductive heath care including STD's contraceptive, pregnancy sizing and options counseling essential. Experience in male examination is desirable.

Colposcopists/cryotherapy – must have state valid certification
LEEP – must be physician with appropriate training

QUALIFICATIONS:
Malpractice coverage assumed by clinician if individual coverage required by the State (i.e., CNMs). Must be willing to work three evenings or two evenings and/or Saturdays. Understands of OSHA regulations. Must be able to travel to other PP sites within tri-county area as needed

Understanding of and strong personal commitment to reproductive rights and the goals and philosophies of Planned Parenthood. **Planned Parenthood Southeastern Pennsylvania requires that every employee have an absolute commitment to a pro-choice philosophy and they have never taken an anti-abortion stance in public.**

Planned Parenthood®
Southeastern Pennsylvania

Tuesday, January 25, 2011

Dear Krista,

Enclosed you will find a copy of your letter requesting further information about my application as supervising physician for Amy Albert PA-C. Also, as you requested, there is a copy of the clinician job description at Planned Parenthood SEPA.

As you requested, I have outlined below the type of supervision which either myself or the back-up supervisory physician will provide in regards to the practice of Amy Albert PA-C.

- A monthly chart review is done to assure appropriate and comprehensive medical practice within the scope of the PPSP Policy and Procedure Manual and the Clinician Job Description
- An orientation of no less than 2 to 3 months where her practice is observed and she is introduced to the PPSP Policy and Procedure
- A clinical observation and chart review 3 months after completing the orientation
- A yearly observation and chart review thereafter
- Patients will be seen by myself or the back-up supervisory physician at any time upon the request of Ms. Albert or the patient
- A day long, quarterly meeting in which all PPSP clinicians participate for additional training, policy updates, and case studies

Please let me know if there is anything further you require.

Sincerely,

Janet L. Wilson M.D.

JAN 31 2011

1144 Locust Street • Philadelphia, PA 19107-6797 • (215) 351-5500 • FAX (215) 351-5595
Homepage: http://www.ppsp.org

COMMONWEALTH OF PENNSYLVANIA
STATE BOARD OF MEDICINE
P. O. BOX 2649
HARRISBURG, PENNSYLVANIA 17105
st-medicine@state.pa.us
www.dos.state.pa.us/med

November 19, 2010

Telephone: 717-783-1400/ 717-787-2381
Fax: 717-787-7769

JANET LEE WILSON 9849
8210 CASTOR AVENUE
PHILADELPHIA PA 19152

EVALUATOR: KRISTA

RE: AMY ALBERT, PA-C

Dear Doctor:

The Board has received your application for registration as a supervising physician. The items listed below are needed to complete your application.

- Please type your answers to the following on a separate sheet of paper as instructed in the application:
- A physician assistant can only perform those duties, treatments and procedures as specifically listed in the job description. Submit a job description listing all of the specific duties that will be performed.
- Provide more details describing 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. Indicate the frequency of patient visits in which you will be treating the patient (i.e., doctor will see patient every fifth visit), as well as the frequency with which you will review and cosign patient charts that the PA has made notations in.

APPLICATIONS NOT COMPLETED WITHIN SIX MONTHS WILL REQUIRE UPDATES OF CERTAIN DOCUMENTS.

When submitting the above information, please return a copy of this letter. A physician assistant may not practice prior to the Board's approval of the application.

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
STATE BOARD OF MEDICINE
P. O. Box 2649
Harrisburg, PA 17105-2649
www.dos.state.pa.us

February 2, 2011

JANET LEE WILSON
8210 CASTOR AVENUE
PHILADELPHIA PA 19152

RE: AMY N ALBERT

Dear Doctor:

Your application to supervise a physician assistant has been processed. Enclosed are your approval letters. You are reminded of the following:

The Board's regulations at 49 Pa. Code §18.151 define the role of a physician assistant. A copy of the regulations is available on our web site at www.dos.state.pa.us/med. The regulations authorize the physician assistant under appropriate direction and supervision by a physician assistant supervisor, to augment the physician's data gathering abilities in order to assist the physician in reaching decisions and instituting care plans for the physician's patients.

If you desire your physician assistant to provide services beyond those included in the regulations you must adhere to the statutory provisions which address delegation of medical services. Sections 17 and 21 of the Medical Practice Act, 63 P.S. §§422.17 and 422.21, address the use of non-physician in the performance of medical services.

The Board is unable to pre-approve procedures which are not contained in the regulation. As a government agency the Board's activities are limited to that authorized by the Medical Practice Act of 1985, 63 P.S. §§422.1 - 422.45. This information is available on our web site, also. The act does not confer authority on the Board to issue advisory opinions or pre-approve specific conduct. This issue has been addressed by the Pennsylvania Commonwealth Court, which is the Court having review authority over decisions of the Board. That Court has held that where the legislature has not provided authority for a licensing board to pre-approve conduct of its licensees, such pre-approval decisions are in the nature of an advisory opinion and thus a nullity. See Avis Rent A Car Systems v. Commonwealth Department of State, 548 A.2d 402 (Pa. Cmwlth. Ct. 1988).

The Court has also held specific to the State Board of Medicine that the Medical Practice Act does not confer pre-approval authority to the Board. Such actions by the Board are outside the scope of power granted by the legislature. The Board's authority to decide issues concerning accepted ethical and quality standards of conduct arises in the context of promulgating regulations or in the context of a disciplinary action. See Morrison v. State Board of Medicine, 618 A.2d 1098 (Pa. Cmwlth. Ct. 1992). Outside the context of its regulations the Board lacks authority to provide you the pre-approval you seek.

In assessing whether the particular service is one which is appropriate for delegation under those regulations, the physician must comply with the Board's delegation regulations contained at 49 PA Code; Section 18.401 – 18.402 which is also available on our web site. The physician retains responsibility for the medical service performed, whether performed personally or delegated to another person. Determine the level of skill and knowledge necessary to the safe performance of the procedure. Research the medical community's accepted practices, review the medical literature, and review the practice with experts in the field. Assess the competency of the individual who will provide the service. Ascertain whether performing the procedure on the particular patient creates any special risk. Provide supervision and monitoring appropriate to the difficulty of the procedure, the skill of the delegatee, and the risk to the particular patient.

We trust this information will assist you in exercising professional judgment regarding the appropriate utilization of your physician assistant.

Sincerely,

State Board of Medicine

Enclosures

PHYSICIAN ASSISTANT AMY AUBERT MA051885

PRIMARY PHYSICIAN JANET WILSON MD021813E

SUBS 1

	APPROVED	PENDING
FEE	11/19	
APPLICATION	11/19	
WRITTEN AGREEMENT	02/02	11/19

LIST ALL D/T/P MORE INFO ON T/P/M OF SUP.

PRACTICE LOCATION IS HOSPITAL Y OR (N)

PRESCRIPTION PRIV (Y) OR N

RESTRICTIONS LISTED (Y) OR N

APPROVED FOR SCHED 2,3,4 5 Y OR (N)

WA NUMBER: MX01301

myLicense Renewal Question Responses
License Number: MD021813E
Name : JANET LEE WILSON

Online Submission Date :

Renewal Question	Response
Are you submitting a name change with this renewal?	N
Are you licensed in another licensing jurisdiction in this profession (any status)?	N
Since your last renewal, has a licensing jurisdiction taken any disciplinary action against you?	N
Since your last renewal, have you been convicted of a crime?	N
Since your last renewal, have you withdrawn an application for licensure in another licensing juristiction?	N
Have you met your current CE requirements?	Y
Since your last renewal, have your provider privileges been terminated by any medical assistance agency for cause?	N
Since your last renewal, have you had practice privileges denied, revoked or restricted in a hospital or health care facility?	N
Since your last renewal, have you had your DEA registration denied, revoked or restricted?	N
Since your last renewal, have you been arrested for criminal homicide, aggravated assault, sexual offenses or drug offenses in any state, territory or country?	N
Do you maintain current medical professional liability insurance in the Commonwealth?	Y
Medical Renewal - Since your last renewal, have you been the subject of a civil malpractice law suit?	N
Are you submitting a name change with this renewal?	N
Are you licensed in another licensing jurisdiction in this profession (any status)?	N
Since your last renewal, has a licensing jurisdiction taken any disciplinary action against you?	N
Since your last renewal, have you been convicted of a crime?	N
Since your last renewal, have you withdrawn an application for licensure in another licensing juristiction?	N
Have you met your current CE requirements?	Y
Since your last renewal, have your provider privileges been terminated by any medical assistance agency for cause?	N
Since your last renewal, have you had practice privileges denied, revoked or restricted in a hospital or health care facility?	N
Since your last renewal, have you had your DEA registration denied, revoked or restricted?	N
Since your last renewal, have you been arrested for criminal homicide, aggravated assault, sexual offenses or drug offenses in any state, territory or country?	N
Do you maintain current medical professional liability insurance in the Commonwealth?	Y
Medical Renewal - Since your last renewal, have you been the subject of a civil malpractice law suit?	N

Mailed 10/28/96
EW

Official Use Only 015373

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND
OCCUPATIONAL AFFAIRS

MD-021813-E

WILSO RNEW

THIS IS YOUR RENEWAL NOTICE

STATE BOARD OF MEDICINE
P.O. BOX 8414
HARRISBURG, PA. 17105-8414

JANET LEE WILSON
[redacted]

YOUR CURRENT LICENSE TO PRACTICE MEDICINE AND SURGERY IN PENNSYLVANIA WILL EXPIRE ON DECEMBER 31, 1996. TO RENEW THROUGH DECEMBER 31, 1998 PLEASE COMPLETE THE QUESTIONS BELOW AND SUBMIT A CHECK OR MONEY ORDER IN THE AMOUNT OF $80.00, MADE PAYABLE TO THE "COMMONWEALTH OF PA." RECORD YOUR LICENSE NUMBER ON THE FRONT OF YOUR PAYMENT. A LATE PENALTY FEE OF $5.00 PER MONTH WILL BE CHARGED FOR RENEWALS POSTMARKED AFTER DECEMBER 31, 1996. A PROCESSING FEE OF $20.00 WILL BE CHARGED FOR ANY CHECK OR MONEY ORDER RETURNED UNPAID BY YOUR BANK, REGARDLESS OF THE REASON. IF YOU HAVE A CHANGE IN NAME AND/OR ADDRESS, INDICATE THE CHANGE NEXT TO THE PRE-PRINTED NAME AND ADDRESS ABOVE AND ATTACH A COPY OF LEGAL DOCUMENTATION OF THE NAME CHANGE.

NOTICE: IF YOU PRACTICE IN PENNSYLVANIA, YOU MUST MAINTAIN THE REQUIRED AMOUNT OF PROFESSIONAL LIABILITY INSURANCE AND PAY THE REQUIRED FEE AND CAT FUND SURCHARGE. FAILURE TO DO SO WILL RESULT IN SUSPENSION OR REVOCATION OF YOUR LICENSE.

ANY DISCIPLINARY ACTION TAKEN IN ANOTHER STATE, TERRITORY OR COUNTRY SHALL BE REPORTED TO THE BOARD ON THE BIENNIAL RENEWAL NOTICE OR WITHIN 30 DAYS OF FINAL DISPOSITION, WHICHEVER IS SOONER.

THE FOLLOWING QUESTIONS MUST BE ANSWERED. IF YOU ANSWER "YES" TO QUESTIONS 2, 3, 4, OR 5 BELOW, PLEASE PROVIDE COMPLETE DETAILS ON 8 1/2 X 11 SHEETS OF PAPER AND INCLUDE COPIES OF LEGAL DOCUMENTS, IF ANY.

YES	NO		
( )	(X)	1.	DO YOU HOLD A LICENSE TO PRACTICE MEDICINE AND SURGERY IN ANY OTHER JURISDICTION? IF YES, LIST EACH ONE ON THE BACK.
( )	(X)	2.	SINCE YOUR LAST RENEWAL, HAS ANY DISCIPLINARY ACTION BEEN TAKEN AGAINST YOUR LICENSE IN ANOTHER STATE, TERRITORY OR COUNTRY?
( )	(X)	3.	SINCE YOUR LAST RENEWAL, HAVE YOU BEEN CONVICTED, FOUND GUILTY OR NOLO CONTENDERE, OR RECEIVED PROBATION WITHOUT VERDICT AS TO ANY FELONY OR MISDEMEANOR, INCLUDING ANY DRUG LAW VIOLATION, IN ANY STATE OR FEDERAL COURT?
( )	(X)	4.	SINCE YOUR LAST RENEWAL, HAVE YOU HAD PRACTICE PRIVILEGES DENIED, REVOKED OR RESTRICTED IN A HOSPITAL OR OTHER HEALTH CARE FACILITY?
( )	(X)	5.	SINCE YOUR LAST RENEWAL, HAVE YOU HAD YOUR DEA REGISTRATION DENIED, REVOKED OR RESTRICTED OR HAVE YOU HAD YOUR PROVIDER PRIVILEGES TERMINATED BY ANY MEDICAL ASSISTANCE AGENCY FOR CAUSE?

IF YOU WANT YOUR LICENSE PLACED ON "INACTIVE" STATUS PLACE AN "X" IN THE BLANK TO THE RIGHT. ____
NO FEE IS REQUIRED. YOU ARE STILL REQUIRED TO ANSWER THE QUESTIONS ABOVE.

SIGN AND DATE BELOW AND PROVIDE THE REQUESTED INFORMATION

SOCIAL SECURITY NUMBER: [redacted] DATE OF BIRTH: [redacted]

NAME OF MEDICAL SCHOOL Creighton University YEAR OF GRADUATION 1977

I CERTIFY THAT THE INFORMATION CONTAINED IN THIS APPLICATION IS TRUE AND CORRECT UNDER 18 PA. C.S. SECTION 4904 RELATING TO UNSWORN FALSIFICATION TO AUTHORITIES.

SIGNATURE Janet Wilson MD DATE 10/1/96

DRQ-2408-2

Official Use Only 03/736

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND
OCCUPATIONAL AFFAIRS

MD 021813 E
WILSO RNEW

THIS IS YOUR RENEWAL NOTICE - REQUIRED FEE - $125.00

STATE BOARD OF MEDICINE
P.O. BOX 8414
HARRISBURG, PA 17105-8414

JANET LEE WILSON
[redacted]

YOUR CURRENT LICENSE TO PRACTICE MEDICINE AND SURGERY IN PENNSYLVANIA WILL EXPIRE ON DECEMBER 31, 1998. TO RENEW YOUR LICENSE THROUGH DECEMBER 31, 2000, COMPLETE THE QUESTIONS BELOW AND RETURN WITH A CHECK OR MONEY ORDER IN THE AMOUNT OF $125.00 MADE PAYABLE TO THE "COMMONWEALTH OF PA." WRITE YOUR LICENSE NUMBER ON THE FRONT OF THE PAYMENT. A LATE FEE OF $5.00 PER MONTH WILL BE CHARGED FOR RENEWALS POSTMARKED AFTER DECEMBER 31, 1998. A PROCESSING FEE OF $20.00 WILL BE CHARGED FOR ANY CHECK OR MONEY ORDER UNPAID BY YOUR BANK, REGARDLESS OF THE REASON. IF YOU HAVE A CHANGE IN NAME AND/OR ADDRESS, INDICATE THE CHANGE NEXT TO THE PRE-PRINTED NAME AND ADDRESS ABOVE. A NAME CHANGE REQUIRES SUBMISSION OF A COPY OF A COURT ORDER, MARRIAGE CERTIFICATE, DIVORCE DECREE OR OTHER OFFICIAL DOCUMENT.

NOTICE: IF YOU PRACTICE IN PENNSYLVANIA, YOU MUST MAINTAIN THE REQUIRED AMOUNT OF PROFESSIONAL LIABILITY INSURANCE AND PAY THE REQUIRED FEE AND CAT FUND SURCHARGE. FAILURE TO DO SO WILL RESULT IN SUSPENSION OR REVOCATION OF YOUR LICENSE.

ANY DISCIPLINARY ACTION TAKEN IN ANOTHER STATE, TERRITORY OR COUNTRY SHALL BE REPORTED TO THE BOARD ON THE BIENNIAL RENEWAL NOTICE OR WITHIN 30 DAYS OF FINAL DISPOSITION, WHICHEVER IS SOONER.

THE FOLLOWING QUESTIONS MUST BE ANSWERED. IF YOU ANSWER "YES" TO QUESTIONS 2, 3, 4, OR 5 BELOW, YOU MUST PROVIDE COMPLETE DETAILS ON 8 1/2 X 11 SHEETS OF PAPER AND INCLUDE COPIES OF LEGAL DOCUMENTS, IF ANY. FAILURE TO PROVIDE DOCUMENTS WILL DELAY THE PROCESS.

YES NO

( ) (X) 1. DO YOU HOLD A LICENSE TO PRACTICE MEDICINE AND SURGERY IN ANY OTHER JURISDICTION? IF YES, LIST EACH ONE BELOW.

( ) (X) 2. SINCE YOUR LAST RENEWAL, HAS ANOTHER STATE, TERRITORY OR COUNTRY TAKEN ANY DISCIPLINARY ACTION (INCLUDES VOLUNTARY SURRENDER OF A LICENSE) AGAINST YOU OR FILED CHARGES AGAINST YOU THAT HAVE NOT BEEN RESOLVED IN YOUR FAVOR?

( ) (X) 3. SINCE YOUR LAST RENEWAL, HAVE YOU BEEN CONVICTED, FOUND GUILTY, PLEADED NOLO CONTENDERE, RECEIVED PROBATION WITHOUT VERDICT, OR RECEIVED ANY OTHER DISPOSITION (EXCLUDING ACQUITTAL OR DISMISSAL), WITH RESPECT TO ANY CRIMINAL OFFENSE, INCLUDING ANY DRUG LAW VIOLATIONS, OR DO YOU HAVE ANY CRIMINAL CHARGES PENDING AND UNRESOLVED IN ANY STATE OR FEDERAL COURT? (A SUMMARY TRAFFIC VIOLATION SHOULD NOT BE CONSIDERED AS A CRIMINAL OFFENSE.)

( ) (X) 4. SINCE YOUR LAST RENEWAL, FOR DISCIPLINARY REASONS HAVE YOU WITHDRAWN AN APPLICATION FOR A LICENSE, HAD AN APPLICATION FOR A LICENSE DENIED OR REFUSED, OR AGREED NOT TO REAPPLY FOR A LICENSE IN ANOTHER STATE, TERRITORY OR COUNTRY? A LICENSE INCLUDES A REGISTRATION OR CERTIFICATION.

( ) (X) 5. SINCE YOUR LAST RENEWAL, HAVE YOU HAD PRACTICE PRIVILEGES DENIED, REVOKED, SUSPENDED, RESTRICTED, SURRENDERED IN LIEU OF DISCIPLINE OR EMPLOYMENT TERMINATED IN A HOSPITAL OR ANY HEALTH CARE FACILITY?

( ) (X) 6. SINCE YOUR LAST RENEWAL, HAVE YOU HAD YOUR DEA REGISTRATION DENIED, REVOKED OR RESTRICTED OR HAVE YOU HAD YOUR PROVIDER PRIVILEGES TERMINATED BY ANY MEDICAL ASSISTANCE AGENCY FOR CAUSE?

IF YOU WANT YOUR LICENSE PLACED ON "INACTIVE" STATUS PLACE AN "X" IN THE BLANK TO THE RIGHT. ____
NO FEE IS REQUIRED. YOU ARE STILL REQUIRED TO ANSWER THE QUESTION, SIGN AND DATE BELOW.

MY REPRESENTATIONS AND RESPONSES IN THIS DOCUMENT ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT THEY ARE SUBJECT TO THE PENALTIES OF 18 PA. C.S. 4904, RELATING TO UNSWORN FALSIFICATION TO AUTHORITIES.

SIGNATURE Janet Lee Wilson DATE 7/24/98

0000047918

Official Use Only 042168

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND
OCCUPATIONAL AFFAIRS

MD-021813-E

WILSO RNEW

THIS IS YOUR RENEWAL NOTICE -- REQUIRED FEE - $125.00

STATE BOARD OF MEDICINE
P.O. BOX 8414
HARRISBURG, PA 17105-8414

JANET LEE WILSON
[redacted]

YOUR CURRENT LICENSE TO PRACTICE MEDICINE AND SURGERY IN PENNSYLVANIA WILL EXPIRE ON DECEMBER 31, 2000. TO RENEW YOUR LICENSE THROUGH DECEMBER 31, 2002, COMPLETE THE QUESTIONS BELOW AND RETURN WITH A CHECK OR MONEY ORDER IN THE AMOUNT OF $125.00 MADE PAYABLE TO THE "COMMONWEALTH OF PA." WRITE YOUR LICENSE NUMBER ON THE FRONT OF THE PAYMENT. A LATE FEE OF $5.00 PER MONTH WILL BE CHARGED FOR RENEWALS POSTMARKED AFTER DECEMBER 31, 2000. A PROCESSING FEE OF $20.00 WILL BE CHARGED FOR ANY CHECK OR MONEY ORDER UNPAID BY YOUR BANK, REGARDLESS OF THE REASON. IF YOU HAVE A CHANGE IN NAME AND/OR ADDRESS, INDICATE THE CHANGE NEXT TO THE PRE-PRINTED NAME AND ADDRESS ABOVE. A NAME CHANGE REQUIRES SUBMISSION OF A COPY OF A COURT ORDER, MARRIAGE CERTIFICATE, DIVORCE DECREE OR OTHER OFFICIAL DOCUMENT.

NOTICE: IF YOU PRACTICE IN PENNSYLVANIA, YOU MUST MAINTAIN THE REQUIRED AMOUNT OF PROFESSIONAL LIABILITY INSURANCE AND PAY THE REQUIRED FEE AND CAT FUND SURCHARGE. FAILURE TO DO SO WILL RESULT IN SUSPENSION OR REVOCATION OF YOUR LICENSE.

ANY DISCIPLINARY ACTION TAKEN IN ANOTHER STATE, TERRITORY OR COUNTRY SHALL BE REPORTED TO THE BOARD ON THE BIENNIAL RENEWAL NOTICE OR WITHIN 30 DAYS OF FINAL DISPOSITION, WHICHEVER IS SOONER.

THE FOLLOWING QUESTIONS MUST BE ANSWERED. IF YOU ANSWER "YES" TO QUESTIONS 2, 3, 4, OR 5 BELOW, YOU MUST PROVIDE COMPLETE DETAILS ON 8 1/2 X 11 SHEETS OF PAPER AND INCLUDE COPIES OF LEGAL DOCUMENTS, IF ANY. FAILURE TO PROVIDE DOCUMENTS WILL DELAY THE PROCESS.

YES NO

( ) (X) 1. DO YOU HOLD A LICENSE TO PRACTICE MEDICINE AND SURGERY (ACTIVE OR INACTIVE, CURRENT OR EXPIRED) IN ANY OTHER JURISDICTION? IF YES, LIST EACH ONE. _____

( ) (X) 2. SINCE YOUR LAST RENEWAL, HAS ANOTHER STATE, TERRITORY OR COUNTRY TAKEN ANY DISCIPLINARY ACTION (INCLUDES VOLUNTARY SURRENDER OF A LICENSE) AGAINST YOU OR FILED CHARGES AGAINST YOU THAT HAVE NOT BEEN RESOLVED IN YOUR FAVOR?

( ) (X) 3. SINCE YOUR LAST RENEWAL, HAVE YOU BEEN CONVICTED, FOUND GUILTY, PLEADED NOLO CONTENDERE, RECEIVED PROBATION WITHOUT VERDICT, OR RECEIVED ANY OTHER DISPOSITION (EXCLUDING ACQUITTAL OR DISMISSAL), WITH RESPECT TO ANY CRIMINAL OFFENSE, INCLUDING ANY DRUG LAW VIOLATIONS, OR DO YOU HAVE ANY CRIMINAL CHARGES PENDING AND UNRESOLVED IN ANY STATE OR FEDERAL COURT? (A SUMMARY TRAFFIC VIOLATION SHOULD NOT BE CONSIDERED AS A CRIMINAL OFFENSE.)

( ) (X) 4. SINCE YOUR LAST RENEWAL, FOR DISCIPLINARY REASONS HAVE YOU WITHDRAWN AN APPLICATION FOR A LICENSE, HAD AN APPLICATION FOR A LICENSE DENIED OR REFUSED, OR AGREED NOT TO REAPPLY FOR A LICENSE IN ANOTHER STATE, TERRITORY OR COUNTRY? A LICENSE INCLUDES A REGISTRATION OR CERTIFICATION.

( ) (X) 5. SINCE YOUR LAST RENEWAL, HAVE YOU HAD PRACTICE PRIVILEGES DENIED, REVOKED, SUSPENDED, RESTRICTED, SURRENDERED IN LIEU OF DISCIPLINE OR EMPLOYMENT TERMINATED IN A HOSPITAL OR ANY HEALTH CARE FACILITY?

( ) (X) 6. SINCE YOUR LAST RENEWAL, HAVE YOU HAD YOUR DEA REGISTRATION DENIED, REVOKED OR RESTRICTED OR HAVE YOU HAD YOUR PROVIDER PRIVILEGES TERMINATED BY ANY MEDICAL ASSISTANCE AGENCY FOR CAUSE?

IF YOU WANT YOUR LICENSE PLACED ON "INACTIVE" STATUS PLACE AN "X" IN THE BLANK TO THE RIGHT. _____
NO FEE IS REQUIRED. YOU ARE STILL REQUIRED TO ANSWER THE QUESTION, SIGN AND DATE BELOW.

MY REPRESENTATIONS AND RESPONSES IN THIS DOCUMENT ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT THEY ARE SUBJECT TO THE PENALTIES OF 18 PA. C.S. 4904, RELATING TO UNSWORN FALSIFICATION TO AUTHORITIES.

SIGNATURE Janet Lee Wilson DATE 9/22/00

00004848

STATE BOARD OF MEDICINE

RENEWAL APPLICATION - MD

RETURN TO:

State Board of Medicine
PO Box 8414
Harrisburg, PA 17105-8414

Janet Lee Wilson MD
Full Name

[redacted]
Street Address

[redacted] MD0 218136
City State Zip Code License number

Check if appropriate.

☐ ADDRESS CHANGE – The address above is a new address and not on file with the Board

☐ NAME CHANGE – The name above is not the current name on the licensure records. (You must submit a photocopy of a legal document verifying name change (i.e., marriage certificate, divorce decree or legal document indicating retaking of a maiden name, etc.)

SECTION A - THE FOLLOWING LICENSE RENEWAL QUESTIONS MUST BE ANSWERED

		If YES to question 2, 3, 4, 5, 6, 7 or 8 – provide details AND attach certified copies of legal document(s).
	Y	1. Do you hold a license (active, inactive or expired) to practice in any other state or jurisdiction? List:
	Y	2. Since your initial application or last renewal, whichever is later, have you had disciplinary action taken against your license in any other state or jurisdiction?
	Y	3. Since your initial application or last renewal, whichever is later, have you withdrawn an application for a license, had an application for a license denied or refused, or agreed not to reapply for a license in any state or jurisdiction?
	Y	4. Since your initial application or last renewal, whichever is later, have you been convicted, found guilty or pleaded nolo contendere, or received probation without verdict as to any felony or misdemeanor, including any drug law violations, or any criminal charges pending and unresolved in any state or jurisdiction?
	Y	5. Since your initial application or last renewal, whichever is later, have you been arrested for criminal homicide, aggravated assault, sexual offenses or drug offenses in any state, territory or country?
	Y	6. Since your initial application or last renewal, whichever is later, have you had practice privileges denied, revoked or restricted in a hospital or other health care facility?
	Y	7. Since your initial application or last renewal, whichever is later, have you had your DEA registration denied, revoked or restricted or have you had your provider privileges terminated by any medical assistance agency for cause?
	Y	8. Since your initial application or last renewal, whichever is later, have you been the subject of a civil malpractice law suit? If yes, please submit a copy of the entire Civil Complaint which must include the filing date and the date you were served.
		**If you previously reported the complaint to the Board provide the docket number.
Y		9a. Do you provide health care services to patients within the Commonwealth of PA?
Y		b. If yes, is the percentage of patients that you provide care for in the Commonwealth 20% or more of your practice?
Y		c. If the percentage is 20% or more, do you have professional liability insurance?

SECTION B - CONTINUING EDUCATION – SELECT ONE BELOW. *You are required to retain your official continuing education certificates of completion earned for this license renewal period until December 31, 2008 and provide them to the Board if requested.*

☑ During this renewal cycle (1/1/03 to 12/31/04) I have completed the required 25 hours of continuing education in courses granted AMA category 1 or 2 approval with at least 3 hours in patient safety/risk management.

☐ I am currently enrolled/have participated in an accredited training program during this renewal cycle (1/1/03 to 12/31/04) and I am exempt from the continuing education requirement.

MD021813E

SECTION D – VERIFICATION OF INFORMATION

I verify that this form is in the original format as supplied by the Department of State and has not been altered or otherwise modified in any way. I am aware of the criminal penalties for tampering with public records or information pursuant to 18 PA C.S. 4911 and that any false statement made is subject to the penalties of 18 PA C.S. 4904 relating to unsworn falsification to authorities and may result in my license being disciplined.

Signature of Licensee (Mandatory) _____ Date: 10/20/04

☐ I will not be practicing this profession in Pennsylvania after the expiration date indicated below and request inactive status. No fee is required.

☐ I am retired from practice but desire to keep my license active to treat immediate family members. I am exempt from the medical professional liability insurance and CME requirements. Renewal must be completed and fee required.

EXPIRATION DATE →	December 31, 2004
FEE – PHYSICIAN - COMMONWEALTH OF PENNSYLVANIA →	$100.00

Write your license number on your payment. A $20.00 fee will be assessed for returned payments.
CME Fee: $35.00 exempt or, pursuant to a moratorium, will be waived if postmarked BEFORE 12-31-04
PLAY IT SAFE! OPERATING ON AN EXPIRED LICENSE MAY RESULT IN DISCIPLINARY ACTIONS AND ADDITIONAL MONETARY PENALTIES.

TO ENSURE YOU RECEIVE YOUR NEW LICENSE BEFORE IT EXPIRES
RETURN BY: NOVEMBER 30, 2004

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
STATE BOARD OF MEDICINE

RENEWAL APPLICATION – Physician and Surgeon (MD)

Janet Lee Wilson
Full Name

[redacted]
[redacted]
City State Zip Code

MD021813E
License Number

RETURN TO:
State Board of Medicine
PO Box 8414
Harrisburg, PA 17105-8414

Check if appropriate

☐ ADDRESS CHANGE – The address above is a new address and not on file with the Board.

☐ NAME CHANGE – The name above is not the current name on the licensure records. (You must submit a photocopy of a legal document verifying name change (i.e.) marriage certificate, divorce decree or legal document indicating retaking of a maiden name, etc.)

☐ I will not be practicing this profession in Pennsylvania after the expiration date indicated below and request inactive status. No fee is required.

☐ I will be retiring from practice but desire to place my license on active-retired status which will allow me to treat immediate family members. I am exempt from the CME requirements. Renewal must be completed and fee required.

SECTION A - THE FOLLOWING LICENSE RENEWAL QUESTIONS MUST BE ANSWERED

YES	NO	*If you answered yes to questions 2-8 provide details AND attach certified copies of legal document(s).* IF YOU ALREADY REPORTED THE INFORMATION TO THE BOARD PRIOR TO THIS RENEWAL, YOU DO NOT NEED TO REPORT IT AGAIN
	X	1. Do you hold a license to practice this profession in any other state or jurisdiction? LIST:
	X	2. Since your initial application or your last renewal, have you had disciplinary action taken against your license in any state or jurisdiction?
	X	3. Since your initial application or your last renewal, have you withdrawn an application for a license, had an application for a license denied or refused, or agreed not to reapply for a license in any state or jurisdiction?
	X	4. Since your initial application or your last renewal, have you been convicted, found guilty or pleaded nolo contendere, or received probation without verdict as to any felony or misdemeanor, including any drug law violations, or any criminal charges pending and unresolved in any state or jurisdiction?
	X	5. Since your initial application or your last renewal, have you been arrested for criminal homicide, aggravated assault, sexual offenses or drug offenses in any state, territory or country?
	X	6. Since your initial application or your last renewal, have you had practice privileges denied, revoked or restricted in a hospital or other health care facility?
	X	7. Since your initial application or your last renewal, have you had your DEA registration denied, revoked or restricted or have you had your provider privileges terminated by any medical assistance agency for cause?
	X	8. Since your initial application or your last renewal, have you been the subject of a civil malpractice lawsuit? If yes, please submit a copy of the entire Civil Complaint, which must include the filing date and the date you were served. **If you previously reported the complaint to the Board provide the docket number
X		9. Do you maintain current medical professional liability insurance in the Commonwealth of Pennsylvania?

SECTION B - CONTINUING EDUCATION – SELECT ONE BELOW. *You are required to retain your official continuing education certificates of completion earned for this license renewal period until December 31, 2008.*

☒ During this renewal cycle (1/1/05-12/31/06) I have completed the required 100 hours of continuing education with at least 20 hours in courses granted AMA category 1 approval and at least 12 credit hours in approved activities in the area of patient safety/risk management

☐ I am currently enrolled/have participated in an accredited training program during this renewal cycle (1/1/05-12/31/06) and I am exempt from the continuing education requirement

LICENSE NUMBER PD-[illegible]

SECTION D - VERIFICATION OF INFORMATION

I verify that this form is in the original format as supplied by the Department of State and has not been altered or otherwise modified in any way. I am aware of the criminal penalties for tampering with public records or information pursuant to 18 PA C.S. 4911 and that any false statement made is subject to the penalties of 18 PA C.S. 4904 relating to unsworn falsification to authorities and may result in my license being disciplined.

Signature of Licensee (Mandatory): [signature] Date 10/30/06

EXPIRATION DATE: →	December 31, 2006
FEE – Payable to "COMMONWEALTH OF PENNSYLVANIA" →	$[illegible]

Write your license number on your payment. *A $20.00 fee will be assessed for returned payments.*
LATE FEE = a $5.00 per month, or part of a month will be assessed if postmarked AFTER 12-31-06
PRACTICING ON AN EXPIRED LICENSE MAY RESULT IN DISCIPLINARY ACTIONS AND ADDITIONAL MONETARY PENALTIES

TO ENSURE YOU RECEIVE YOUR NEW LICENSE BEFORE IT EXPIRES
RETURN BY: DECEMBER 1, 2006

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
STATE BOARD OF MEDICINE
P O Box 2649
Harrisburg, PA 17105-2649
www.dos.state.pa.us

October 31, 2000

JANET LEE WILSON
[redacted]

RE: ERIN MARIE DUHAIME

Dear Doctor:

Your application to supervise a physician assistant has been processed. Enclosed are your approval letters. You are reminded of the following:

The Board's regulations at 49 Pa. Code §18.151 define the role of a physician assistant. A copy of the regulations is available on our web site at www.dos.state.pa.us/md. The regulations authorize the physician assistant under appropriate direction and supervision by a physician assistant supervisor to augment the physician's data gathering abilities in order to assist the physician in reaching decisions and instituting care plans for the physician's patients.

If you desire your physician assistant to provide services beyond those included in the regulations you must adhere to the statutory provisions which address delegation of medical services. Sections 17 and 21 of the Medical Practice Act, 63 P.S. §§422.17 and 422.21, address the use of non-physician in the performance of medical services.

The Board is unable to pre-approve procedures which are not contained in the regulation. As a government agency the Board's activities are limited to that authorized by the Medical Practice Act of 1985, 63 P.S. §§422.1 - 422.45. This information is available on our web site also. The act does not confer authority on the Board to issue advisory opinions or pre-approve specific conduct. This issue has been addressed by the Pennsylvania Commonwealth Court, which is the Court having review authority over decisions of the Board. That Court has held that where the legislature has not provided authority for a licensing board to pre-approve conduct of its licensees, such pre-approval decisions are in the nature of an advisory opinion and thus a nullity. See Avis Rent A Car Systems v. Commonwealth Department of State, 548 A.2d 402 (Pa. Cmwlth Ct. 1988).

The Court has also held specific to the State Board of Medicine that the Medical Practice Act does not confer pre-approval authority to the Board. Such actions by the Board are outside the scope of power granted by the legislature. The Board's authority to decide issues concerning accepted ethical and quality standards of conduct arises in the context of promulgating regulations or in the context of a disciplinary action. See Mangigian v. State Board of Medicine, 618 A.2d 1208 (Pa. Cmwlth Ct. 1992). Outside the context of its regulations the Board lacks authority to provide you the pre-approval you seek.

In assessing whether the particular service is one which is appropriate for delegation under these regulations, the physician must comply with the Board's delegation regulations contained at 49 Pa Code, Section 18.101 - 18.402 which is also available on our web site. The physician retains responsibility for the medical services performed, whether performed personally or delegated to another person. Determine the level of skill and knowledge necessary in the safe performance of the procedure. Research the medical community's accepted practices, review the medical literature, and review the practice with experts in the field. Assess the competency of the individual who will provide the service. Ascertain whether performing the procedure on the particular patient creates any special risk. Provide supervision and monitoring appropriate to the difficulty of the procedure, the skill of the delegatee, and the risk to the particular patient.

We trust this information will assist you in exercising professional judgment regarding the appropriate utilization of your physician assistant.

Sincerely,

State Board of Medicine

Enclosures

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

Courier Delivery Address
STATE BOARD OF MEDICINE
2601 NORTH THIRD STREET
HARRISBURG, PA 17110

APPLICATION FOR REGISTRATION AS A SUPERVISING PHYSICIAN

INSTRUCTIONS - Print or type all information. If the written agreement is identical for all supervised, submit one application for each physician assistant. Attach the fee and written agreement.

FEE - $15.00 for each application with one primary and one substitute physician entered thereon. An additional $5.00 fee is due for each additional substitute supervisor. **NOTE**: A processing fee of $25.00 will be charged for any check or money order returned unpaid by your financial institution regardless of reason for non-payment. Make check payable to the "Commonwealth of Pennsylvania." The fee cannot be transferred to another application.

Upon approval of this application, the Board will issue an approval letter to the primary supervising physician and a set of all suitable supervisors. These documents are to be sent to the primary supervisor at the address provided on page one of the application.

NOTE: PENNSYLVANIA LAW REQUIRES THAT YOU MAINTAIN A COPY OF THIS APPLICATION AND ALL ATTACHMENTS.

REGARDLESS OF THE FILING DATE, A PHYSICIAN ASSISTANT CANNOT PRACTICE PRIOR TO THE BOARD'S APPROVAL OF THIS APPLICATION.

PRIMARY SUPERVISING PHYSICIAN NAME, LICENSE NUMBER

(last) (first) (mi) (suffix)

PHYSICIAN ASSISTANT NAME, LICENSE NUMBER

(last) (first) (mi) (suffix)

PRACTICE ADDRESS

(city) (state) (zip)

PRACTICE TELEPHONE

PRIMARY SUPERVISING PHYSICIAN MUST COMPLETE THIS SECTION

Are you board certified?

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

If YES, list Boards(s)

Do you hold hospital staff privileges? YES NO

If you have hospital staff privileges, indicate the hospital name(s)

VERIFICATION

I am aware and knowledgeable of the duties of physician assistants in accordance with the rules and regulations of the State Board of Medicine. I certify that I have reviewed the Medical Practice Act and the rules of the State Board of Medicine. I recognize that I am obligated to comply with all the provisions of the Act and Regulations including those provisions that require me to notify the Board of the termination of my agreement to supervise the physician assistant. I recognize that I retain full responsibility and legal liability for the performance of the physician assistant and the care and treatment of the physician assistant's patients.

I certify that the statements in this application and collaborative agreement are true and correct to the best of my knowledge and belief. I understand that false statements are 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 license.

The physician assistant described in this application will work with the primary supervising physician and substitute physician assistant supervisors listed on the application. The physician assistant will only perform medical services for the patients under the care of the primary and substitute supervising physicians.

Signature of Primary Supervising Physician _____ Date 9/1/21

Signature of Physician Assistant _____ Date 9/1/21

Name of Substitute Physician Assistant Supervisor Leo Anthony Tripp

License # MD-032120-E

Signature _____ Date 9/1/21

Name of Substitute Physician Assistant Supervisor _____

License # _____

Signature _____ Date _____

Name of Substitute Physician Assistant Supervisor _____

License # _____

Signature _____ Date _____

Name of Substitute Physician Assistant Supervisor _____

License # _____

Signature _____ Date _____

(Attach 8 1/2 x 11 sheets with additional names if needed.)

Physician Assistant Written Agreement
Planned Parenthood Southeastern Pennsylvania

1. The Physician Assistant will see patients in the office setting. The Physician Assistant functions include but are not limited to:
   A. Performing reproductive health histories and physicals on female and male patients, and identifying normal and abnormal findings
   B. Assessing male patients for sexually transmitted infections and abnormalities of the reproductive tract
   C. Managing the following gynecological problems:
      - Breast problems including galactorrhea, postpartum breast conditions, nipple discharge, and pain
      - Pregnancy
      - Sexually transmitted infections
      - Non-STI vulvar and vaginal infections
      - Pelvic inflammatory disease
      - Menopause
      - Amenorrhea, abnormal uterine bleeding, dysfunctional uterine bleeding, post menstrual complications
   D. Assessing the behavioral and psychosocial aspects of illness
      - Chronic illness
      - Anemia
   E. Offering appropriate birth control options following review of the medical history and gynecological examination
   F. Referring patients to the supervising physician when potentially unsafe conditions are noted in the practice and tasks of the Physician Assistant. Referrals within Planned Parenthood may include colposcopy, vulvar biopsy, abortion, hospital referral, circumcision, and H.I.V. services
   G. Referring patients to primary care providers or specialists for services not provided by Planned Parenthood
   H. Initiating request for lab work and collecting specimens
   I. Identifying normal and abnormal findings on lab studies
   J. Performing follow-up on abnormal labs and referrals
   K. Performing the following clinical procedures:
      - Venipuncture
      - Vaginal wet mounts, KOH preparations
      - IUD removal
      - Topical administration of prescription oral contraceptives and emergency contraception
      - Performing wet mounts and urine pregnancies
2. Physician supervision and direction will occur at least weekly in the office during normal office hours. This will include a weekly review of charts and direction of the Physician Assistant as needed. Telephone consults will also be available.
3. The Physician Assistant will be employed at 1144 Locust St.
   Philadelphia, PA 19107

Janet Wilson, M.D.
Name of Physician Supervisor — Signature of Physician Supervisor

Lee A. Tripp, M.D.
Name of Alternate Physician Supervisor — Signature of Alternate Physician Supervisor

Name of Physician Assistant — Signature of Physician Assistant

Date

Planned Parenthood®
Southeastern Pennsylvania

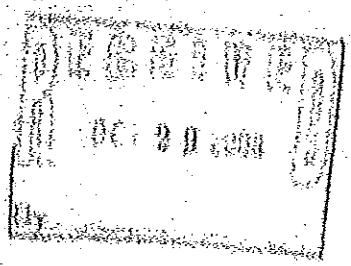
Monday, October 27, 200x

STATE BOARD OF MEDICINE
2601 North 3rd Street
Harrisburg, Pa 17110

Dear Sir/Madam,

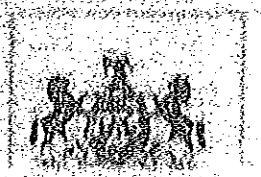
Enclosed you will find a check for $$$.00 to cover the cost of registering Dr Janet Wilson as the Supervising Physician and Dr. Leo Trupp as the Substitute Physician Assistant Supervisor for Erin Dubowitz P.A.-C. The application was sent approximately one month ago but, unfortunately, without the check.

Thank you for your assistance with this application.



Sincerely,

Deborah J Leuman MSN, CRNP
Clinical Services Coordinator



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) 787-8561
(717) 783-1400

FAX: (717) 787-7162
www.dos.state.pa.us

October 16, 2008

ZACHARY WEAVER

[redacted]

ERIE, ERIE COUNTY PENNSYLVANIA 16

Dear Doctor:

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

No fee was received with the application. Please send the $10 application fee

EVALUATOR: ZACHARY B

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.

WRITTEN AGREEMENT CHANGE FORM

A. PRIMARY SUPERVISOR NAME, ADDRESS, WRITTEN AGREEMENT NUMBER (IF)

B. NAME AND LICENSE NUMBER OF THE PHYSICIAN ASSISTANT (PA) CURRENTLY WORKING UNDER THIS AGREEMENT

C. NAME AND LICENSE NUMBER OF THE PHYSICIAN ASSISTANT (PA) TO BE ADDED

D. LIST THE NAME AND LICENSE NUMBER OF THE SUBSTITUTE PHYSICIAN (MD OR DO) TO BE ADDED

E. LIST THE NAME AND LICENSE NUMBER OF THE SUBSTITUTE PHYSICIAN (MD OR DO) TO BE DELETED

If you answer yes to any of the following questions, please follow all instructions outlined on the Instruction page.

F. WILL THERE BE ANY CHANGE IN JOB DUTIES? YES NO

WILL THERE BE ANY CHANGE TO THE PRESCRIBING/DISPENSING PRIVILEGES? YES NO

IF CHANGING THE PRESCRIBING/DISPENSING PRIVILEGES, CHECK THE CONTROLLED SUBSTANCE SCHEDULES THAT WILL BE PRESCRIBED AND DISPENSED:

NOTE: Physician Assistants are not permitted to prescribe/dispense Schedule I controlled substances.

SCHEDULE II ____
SCHEDULE III ____
SCHEDULE IV ____
SCHEDULE V ____

IS THE ADDRESS OF THE PRACTICE LOCATION CHANGING? YES NO

ARE YOU ADDING PRACTICE LOCATIONS? YES NO

ARE YOU DELETING PRACTICE LOCATIONS? YES NO

X SIGNATURE OF PRIMARY SUPERVISOR _____ DATE _____

SIGNATURE OF PHYSICIAN ASSISTANT _____ DATE _____

SIGNATURE OF NEW SUBSTITUTE _____ DATE _____

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
STATE BOARD OF MEDICINE
P. O. Box 2649
Harrisburg, PA 17105-2649
www.dos.state.pa.us

February 15, 2007

JANET LEE WILSON
1144 LOCUST STREET
PHILADELPHIA PA 19107

RE: JAMIE LYNN PAULITS

Dear Doctor:

This is in response to your application to supervise a physician assistant. To the degree that the documents you submitted indicate that you intend for the physician assistant to perform services not specifically authorized by the Board's regulations, you are reminded of the following:

The Board's regulations at 49 Pa. Code §18.151 define the role of a physician assistant. A copy of the regulations is enclosed.

The regulations authorize the physician assistant under appropriate direction and supervision by a physician assistant supervisor, to augment the physician's data gathering abilities in order to assist the physician in reaching decisions and instituting care plans for the physician's patients. The regulations identify specific procedures which physician assistants are authorized to perform. Although the list of procedures is not all inclusive, it identifies those procedures which may be considered pre-approved.

If you desire your physician assistant to provide services beyond those included in the regulations you must adhere to the statutory provisions which address delegation of medical services. Sections 17 and 21 of the Medical Practice Act, 63 P.S. §§422.17 and 422.21, address the use of non-physician in the performance of medical services. A copy of the Act is enclosed.

The Board is unable to pre-approve procedures which are not contained in the regulation. As a government agency the Board's activities are limited to that authorized by the Medical Practice Act of 1985, 63 P.S. §§422.1 - 422.45. The act does not confer authority on the Board to issue advisory opinions or pre-approve specific conduct. This issue has been addressed by the

Pennsylvania Commonwealth Court, which is the Court having review authority over decisions of the Board. That Court has held that where the legislature has not provided authority for a licensing board to pre-approve conduct of its licensees, such pre-approval decisions are in the nature of an advisory opinion and thus a nullity. See Avis Rent A Car Systems v. Commonwealth, Department of State, 548 A.2d 402 (Pa. Cmwlth. Ct. 1988).

The Court has also held specific to the State Board of Medicine that the Medical Practice Act does not confer pre-approval authority to the Board. Such actions by the Board are outside the scope of power granted by the legislature. The Board's authority to decide issues concerning accepted ethical and quality standards of conduct arises in the context of promulgating regulations or in the context of a disciplinary action. See Morrison v. State Board of Medicine, 616 A.2d 1069 (Pa. Cmwlth. Ct. 1992). Outside the context of its regulations the Board lacks authority to provide you the pre-approval you seek.

In assessing whether the particular service is one which is appropriate for delegation under those regulations, the physician must comply with the Board's delegation regulations contained at 49 PA Code, Section 18.401 - 18.402 (copy enclosed). The physician retains responsibility for the medical service performed, whether performed personally or delegated to another person. Determine the level of skill and knowledge necessary to the safe performance of the procedure. Research the medical community's accepted practices, review the medical literature, and review the practice with experts in the field. Assess the competency of the individual who will provide the service. Ascertain whether performing the procedure on the particular patient creates any special risk. Provide supervision and monitoring appropriate to the difficulty of the procedure, the skill of the delegatee, and the risk to the particular patient.

We trust this information will assist you in exercising professional judgment regarding this matter.

Sincerely,

State Board of Medicine

MA005918

Regular Mailing Address
State Board of Medicine
P.O. Box 2649
Harrisburg, PA 17105-2649
Phone 717-783-1400 or 717-782-2381 email address

Courier Delivery Address
State Board of Medicine
2601 North Third Street
Harrisburg, PA 17110

APPLICATION FOR REGISTRATION AS A SUPERVISING PHYSICIAN

INSTRUCTIONS – Type or print all information in the spaces provided. Sign the application and have it notarized for all substitutes, as well as the primary supervising physician applicant. Attach the fee and required attachments.

FEE – A fee of $ for each application for primary and one substitute physician supervisor is required. An additional fee of $ shall be due for each additional substitute supervisor. A processing fee of $20.00 will be charged for any check or money order returned unpaid by your financial institution. Checks or money orders must be made payable to "Commonwealth of Pennsylvania." The fee cannot be refunded once the application is processed.

Upon approval of the application, the Board will issue an approval letter for the primary supervisor and provide a list of all substitute supervisors. These documents will be sent to the primary supervisor at the address provided on page one of the application.

NOTE: PENNSYLVANIA LAW REQUIRES THAT YOU MAINTAIN A COPY OF THIS APPLICATION AND ALL ATTACHMENTS.

***REGARDLESS OF THE FILING DATE, A PHYSICIAN ASSISTANT CANNOT PRACTICE PRIOR TO THE BOARD'S APPROVAL OF THIS APPLICATION.**

PRIMARY SUPERVISING PHYSICIAN NAME/LICENSE NUMBER:

Watson (Last) Janet (First) L (Middle) MD 021613 (License No.)

PHYSICIAN ASSISTANT NAME/LICENSE NUMBER:

Paulis (Last) Jaime (First) MD 052910 (License No.)

PRACTICE ADDRESS 1144 Locust St

Philadelphia (City) Pa (State) 19107 (Zip Code)

PRACTICE TELEPHONE 215 351-5501

(3-19) 1689 (11/06)

Primary supervising physician must complete this section

What your specialties Family Practice

Do you hold a membership in any American Boards of Medical Specialties
YES _____ NO X

If yes, list boards(s) _____

Do you hold hospital staff privileges?
YES X NO _____

If you have hospital staff privileges, indicate the hospital name(s).

Catholic

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 verify that I have reviewed the Medical Practice Act and Regulations of the State Board of Medicine. I recognize that I am obligated to comply with all the provisions of the Act and Regulations including those provisions that require me to notify the Board of the termination of my agreement to supervise the physician assistant. 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 I will not provide primary supervision to more than two physician assistants.

I verify that the statements in this application and written agreement 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 work with the primary supervising physician 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 of Primary Supervising Physician _____ Date 1/30/07

Signature of Physician Assistant _____ Date 1/30/07

Name of Substitute Physician Assistant Supervisor _____

Signature _____ Date 1/30/07 MD# 058031

Name of Substitute Physician Assistant Supervisor _____

Signature _____ Date _____ MD# _____

Name of Substitute Physician Assistant Supervisor _____

Signature _____ Date _____ MD# _____

(Attach 8 1/2 x 11 sheets with additional names if needed.)

WRITTEN AGREEMENT

Janet Wilson — Janine Poulos

(name of osteopathic physician) (name of physician assistant)

INSTRUCTIONS: Please provide the following information for questions 1 and 2 on pages 1 1/2 & 2. If above will attach to this form, answer each section on the attachment. This information on this agreement must be agreed to by all supervisors listed on page 2.

1. Describe the functions/tasks to be performed by the physician assistant.

   See earlier agreement attached

2. Provide details regarding the time, place and extent of supervision and direction that will control the physician assistant.

3. What are the name, address and practice setting (e.g., hospital, private practice, group practice, clinic) where the physician assistant will serve.

   Planned Parenthood clinic

4. Will the physician assistant prescribe and dispense drugs/therapeutic devices?

   Yes ✓ No

   If "yes", list below any limitations that the physician assistant will not be permitted to prescribe/dispense.

5. Will the physician assistant prescribe controlled substances be prescribed and dispensed?

   Yes ✓ 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.

Physician Assistant Written Agreement
Planned Parenthood Southeastern Pennsylvania

1. The Physician Assistant will see patients in the office setting. The Physician Assistant functions/tasks will include:
   - A. Performing reproductive health histories and physicals on female and male patients, and identifying normal and abnormal findings
   - B. Assessing male patients for sexually transmitted infections and abnormalities of the reproductive tract
   - C. Assessing the following gynecological problems:
     - Breast problems including galactorrhea, postpartum breast conditions, masses/nodularity, nipple discharge, and pain
     - Pregnancy
     - Sexually Transmitted Infections
     - Non-STI vulvar and vaginal infections
     - Pelvic Inflammatory Disease
     - Menopause
     - Amenorrhea/Abnormal uterine bleeding/dysfunctional uterine bleeding
     - Post abortion examinations
   - D. Assessing the following non-gynecological problems
     - Urinary Tract Infections
     - Anemia
   - E. Offering appropriate birth control options following review of the medical history and gynecological examination
   - F. Referring patients to the supervising physician when patients' needs require care outside of the functions and tasks of the Physician Assistant. Referrals within Planned Parenthood might also include colposcopy, vulvar biopsy, abortion, Norplant removal, sterilization, and IUD insertion.
   - G. Referring patients to primary care providers or specialists for services not provided by Planned Parenthood
   - H. Initiating request for lab work and collecting specimens
   - I. Identifying normal and abnormal findings on lab studies
   - J. Performing follow-up on abnormal labs and referrals
   - K. Performing the following clinical procedures:
     - Venipuncture
     - Vaginal foreign body removal
     - IUD removal
     - Topical administration of trichloracetic acid or podophyllum to HPV
     - Performing wet mounts and urine microscopy
2. Physician supervision and direction will occur at least weekly in the office during normal office hours. This will include a weekly review of charts and direction of the Physician Assistant as needed. Telephone contact will also be available.
3. The Physician Assistant will be utilized at: 1144 Locust St.
   Philadelphia, Pa. 19107

Name of Primary Physician Assistant Supervisor

Signature of Primary Physician Assistant Supervisor

Name of Substitute Physician Assistant Supervisor

Signature of Substitute Physician Assistant Supervisor

Name of Physician Assistant

Signature of Physician Assistant

Date

PHYSICIAN ASSISTANT Pendlis, Jamie

PRIMARY PHYSICIAN Wilson, Janet

SUBSTITUTE PHYSICIAN 1

	APPROVED	PENDING
FEE	OK	
APPLICATION	OK	
WRITTEN AGREEMENT	Dupe	
DRUG LIST	No Schedules	

Prescription (Y) N

Hosp. Tel Y (N)

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

APPROVAL LTR ISSUED 2-15-07

License # MX0635998

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) 787-0769
www.dos.state.pa.us

December 15, 2004

JANET L WILSON MD
PPSP
1144 LOCUST STREET
PHILADELPHIA PA 19107

RE: AMY CLEVENSTINE, 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 only perform those duties as specifically indicated in the written agreement. Any additions must be submitted to and receive approval from the Board. The supervising physician (s) is fully responsible for the physician assistant.

Sincerely,

State Board of Medicine

PHYSICIAN ASSISTANT Crossstine, Amy

PRIMARY PHYSICIAN Watson, James T

SUBSTITUTE PHYSICIAN —

	APPROVED	PENDING
FEE	OK	35.00
APPLICATION	OK	Copy - need original pgs 3 for signature need originals of WACES resp WACES w/appl.
WRITTEN AGREEMENT	WAllen	
DRUG LIST	OK	

Prescription (Y) N

Hospital Y (N)

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

APPROVAL LTR ISSUED —

License # VVK003194

49-136 (REV. (5/03)
STATE BOARD OF MEDICINE
P.O. BOX 2649
HARRISBURG, PA 17105-2649
717-783-1400
717-787-2161

COURIER ADDRESS
STATE BOARD OF MEDICINE
2601 NORTH THIRD STREET
HARRISBURG, PA 17110

MX 0 0 3 1 9 4

APPL

Trans. No. _____
Amount $ 35.00
Date 10-29-07

APPLICATION FOR REGISTRATION AS A PHYSICIAN ASSISTANT SUPERVISOR

NOTE: A PHYSICIAN ASSISTANT CAN ONLY BE REGISTERED UNDER THREE PRIMARY SUPERVISORS AT ONE HEALTH CARE FACILITY.

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 - $35.00 for each application with one primary and one substitute physician assistant supervisor. An additional $5.00 fee is due for each additional substitute supervisor listed. 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. MAKE CHECK PAYABLE TO "COMMONWEALTH OF PENNSYLVANIA." FEE IS NOT REFUNDABLE.

PLEASE PRINT OR TYPE ALL INFORMATION

PRIMARY PHYSICIAN ASSISTANT SUPERVISOR NAME/LICENSE NUMBER:

Wilson (LAST) Janet (FIRST) L. (MIDDLE) MD 031813 E (LIC NO.)

PHYSICIAN ASSISTANT NAME/LICENSE NUMBER:

Clevenshire (LAST) Amy (FIRST) N. (MIDDLE) X PA-MA051885 (LIC NO.)

PRACTICE ADDRESS PPSP 1144 Locust St (STREET)

Phila. (CITY) Pa (STATE) 19107 (ZIP CODE)

PRACTICE TELEPHONE 215 351-5546

49-106 (REV. 5/03)

Primary Physician Assistant Supervisor must complete:

List Specialties: Women's Health

Do you hold a membership in any American Boards of Medical Specialties
YES _____ NO X

If yes, list Board(s) _____

If you have hospital staff privileges, indicate hospital name(s).

Graduate Hospital

Pennsylvania Hospital

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 verify that I have reviewed the Medical Practice Act and Regulations of the State Board of Medicine. I recognize that I am obligated to comply with all the provisions of the Act and Regulations including those provisions that require me to notify the Board of the termination of my agreement to supervise the physician assistant. 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 of Primary Physician Assistant Supervisor _____ Date 9/15/04

Name of Substitute Physician Assistant Supervisor Lee Tripp

Signature _____ Date _____ MD# 037200

Name of Substitute Physician Assistant Supervisor _____

Signature _____ Date _____ MD#

Name of Substitute Physician Assistant Supervisor _____

Signature _____ Date _____ MD#

(Attach 8 1/2 x 11 sheets with additional names if needed.)

49-10s (REV. (5/03)

WRITTEN AGREEMENT

[signature] [signature]

[illegible] [illegible]

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.

_____

_____

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 ?
YES ✓ NO

5. Will the physician assistant prescribe and dispense drugs?

YES ✓ NO _____ If yes, please complete page 4.

If yes, will Schedule III, IV and/or V controlled substances be prescribed and dispensed? YES _____ NO ✓ (NOTE: Physician Assistants are not permitted to prescribe Schedule I and II controlled substances.)

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.

49-106 (REV. (5/03)

PRESCRIBING AND DISPENSING DRUGS BY PHYSICIAN ASSISTANT

Print or type name

Janet Wilson — Amy Clevenstine

(name of physician assistant supervisor) — (physician assistant)

If you answered "YES" to question number 6 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.
- ✓ (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: Mydriatics 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) Obstetrics.
- (vi) Radioactive agents.
- (vii) Unclassified therapeutic agents.
- (viii) Devices.
- (ix) Pharmaceutical aids.

Physician Assistant Written Agreement
Planned Parenthood Southeastern Pennsylvania

1. The Physician Assistant will see patients in the office setting. The Physician Assistant functions/tasks will include:
   - A. Performing reproductive health histories and physicals on female and male patients, and identifying normal and abnormal findings
   - B. Assessing & treating (per protocol) male patients for sexually transmitted infections and abnormalities of the reproductive tract
   - C. Assessing & treating (per protocol) the following gynecological problems:
     - Breast problems including galactorrhea, nonpuerperal breast conditions, mastodynia, nipple discharge, and pain
     - Pregnancy
     - Sexually Transmitted Infections
     - Non-STI vulvar and vaginal infections
     - Pelvic Inflammatory Disease
     - Menopause
     - Amenorrhea/Abnormal uterine bleeding/dysfunctional uterine bleeding
     - Post abortion examinations
   - D. Assessing & treating (per protocol) the following non-gynecological problems:
     - Urinary Tract Infections
     - Anemia
   - E. Offering appropriate birth control options following review of the medical history and gynecological examination
   - F. Referring patients to the supervising physician when patients' needs require care outside of the functions and tasks of the Physician Assistant. Referrals within Planned Parenthood will also include colposcopy, vulvar biopsy, abortion, Norplant removal, sterilization, and IUD insertion
   - G. Referring patients to primary care providers or specialists for services not provided by Planned Parenthood
   - H. Initiating request for lab work and collecting specimens
   - I. Identifying normal and abnormal findings on lab studies
   - J. Performing follow-up on abnormal labs and referrals
   - K. Performing the following clinical procedures:
     - Venipuncture
     - Vaginal foreign body removal
     - IUD removal
     - Topical administration of trichloracetic acid or podophyllum to HPV
     - Performing wet mounts and urine microscopy
2. Physician supervision and direction will occur at least weekly in the office during normal office hours. This will include a weekly review of charts and direction of the Physician Assistant as needed. Telephone contact will also be available.
3. The Physician Assistant will be utilized at: 1144 Locust St.
   Philadelphia, Pa. 19107

Todd L. Wilson
Name of Primary Physician Assistant Supervisor

Signature of Primary Physician Assistant Supervisor

Lee A. Tripp, M.S
Name of Substitute Physician Assistant Supervisor

Signature of Substitute Physician Assistant Supervisor

X Amy N. Clevenstine
Name of Physician Assistant

Signature of Physician Assistant

X 7/16/04
Date

49-198 (REV. (5/04)
STATE BOARD OF MEDICINE
P.O. BOX 2649
HARRISBURG, PA 17105-2649
717-783-1500
717-787-2381

COURIER ADDRESS
STATE BOARD OF MEDICINE
2601 NORTH THIRD STREET
HARRISBURG, PA 17110

MX

APPL

Trans. No.
Amount
Date

APPLICATION FOR REGISTRATION AS A PHYSICIAN ASSISTANT SUPERVISOR

NOTE: A PHYSICIAN ASSISTANT CAN ONLY BE REGISTERED UNDER THREE PRIMARY SUPERVISORS AT ONE HEALTH CARE FACILITY.

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 - $35.00 for each application with one primary and one substitute physician assistant supervisor. An additional $3.00 fee is due for each additional substitute supervisor listed. 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. MAKE CHECK PAYABLE TO "COMMONWEALTH OF PENNSYLVANIA." FEE IS NOT REFUNDABLE.

PLEASE PRINT OR TYPE ALL INFORMATION

PRIMARY PHYSICIAN ASSISTANT SUPERVISOR NAME/LICENSE NUMBER:

Wilson (LAST) Janet (FIRST) L. (MIDDLE) MD 023913 E (DEGREE)

PHYSICIAN ASSISTANT NAME/LICENSE NUMBER:

Cleveringa (LAST) Amy (FIRST) N. (MIDDLE) PA (DEGREE)

PRACTICE ADDRESS PCSP 1144 Locust St (STREET)

Phila (CITY) PA (STATE) 19107 (ZIP CODE)

BUSINESS TELEPHONE 215-351-3546

Primary Physician Assistant Supervisor must complete:

Name of Practice: Lawrence Health

Is the practice a member of any American Board of Medical Specialties

(ABMS)? X

If yes, name of board:

If you have received state privileges, indicate hospital name:

Grandview Hospital

Greenwood Hospital

VERIFICATION

I will direct and oversee the medical care that the above physician assistant is providing in accordance with the rules and regulations of the State Board of Medicine. I certify that I have reviewed the Medical Practice Act and regulations of the State Board of Medicine. I certify that I am authorized to supervise all the activities of the duty and scope of practice including those provisions that require me to notify the Board of the termination of my agreement to supervise the physician assistant. I certify that I have 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 copy that is attached 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 cancellation of my registration.

The physician assistant identified in this application will only provide medical services to the patients under the care of the primary and substitute supervising physicians listed in this application.

Signature of Primary Physician Assistant Supervisor _____ Date 11/4/04

Name of Substitute Physician Assistant Supervisor Lee Tripp

Signature Lee G. Tripp Date 11/3/04 MD 037200

Name of Substitute Physician Assistant Supervisor _____

Signature _____ Date _____ MD _____

Name of Substitute Physician Assistant Supervisor _____

Signature _____ Date _____ MD _____

(Attach 8 1/2 x 11 sheets with additional names if needed.)

49-101 (REV. (5/03)

WRITTEN AGREEMENT

X _____ _____

PROPOSED PHYSICIAN ASSISTANT SUPERVISOR PHYSICIAN ASSISTANT APPLICANT

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.

_____

_____

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? YES ✓ NO _____

5. Will the physician assistant prescribe and dispense drugs?

YES ✓ NO _____ If yes, please complete page 4.

If yes, will Schedule III, IV and/or V controlled substances be prescribed and dispensed? YES _____ NO ✓ (NOTE: Physician Assistants are not permitted to prescribe Schedule I and II controlled substances.)

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.

49-106 (REV. 5/03)

PRESCRIBING AND DISPENSING DRUGS BY PHYSICIAN ASSISTANT

Print or type name

Janet L. Wilson — PRIMARY PHYSICIAN ASSISTANT SUPERVISOR

Amy Clevenstine — 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.
- ✓ (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 mydriatics 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.

Physician Assistant Written Agreement
Planned Parenthood Southeastern Pennsylvania

1. The Physician Assistant will see patients in the office setting. The Physician Assistant functions/tasks will include:
   - A. Performing reproductive health histories and physicals on female and male patients, and identifying normal and abnormal findings
   - B. Assessing male patients for sexually transmitted infections and abnormalities of the reproductive tract
   - C. Assessing the following gynecological problems
     - Amenorrhea
     - Breast problems including galactorrhea, postpartum breast conditions, masses/nodularity, nipple discharge, and pain
     - Pregnancy
     - Sexually Transmitted Infections
     - Non- STI vulvar and vaginal infections
     - Pelvic Inflammatory Disease
     - Menopause
     - Abnormal uterine bleeding/dysfunctional uterine bleeding
     - Post abortion examinations
   - D. Assessing the following non-gynecological problems
     - Urinary Tract Infections, Anemia, Smoking
   - E. Offering appropriate birth control options following review of the medical history and gynecological examination
   - F. Referring patients to the supervising physician when patients' needs require care outside of the functions and tasks of the Physician Assistant. Referrals within Planned Parenthood might also include colposcopy, vulvar biopsy, abortion, Norplant removal, sterilization, and IUD insertion.
   - G. Referring patients to primary care providers or specialists for services not provided by Planned Parenthood
   - H. Initiating request for lab work and collecting specimens
   - I. Identifying normal and abnormal findings on lab studies
   - J. Performing follow-up on abnormal labs and referrals
   - K. Performing the following clinical procedures:
     - Venipuncture
     - Vaginal foreign body removal
     - IUD removal
     - Topical trichloroacetic acid or podophyllum to HPV
     - Performing wet mounts and urine microscopy
2. Physician supervision and direction will occur at least weekly in the office during normal office hours. This will include a weekly review of charts and direction of the Physician Assistant as needed. Telephone contact will also be available if necessary.
3. The Physician Assistant will be utilized at: 1144 Locust St.
   Philadelphia, Pa. 19107

Name of Primary Physician Assistant Supervisor

Signature of Primary Physician Assistant Supervisor

Name of Substitute Physician Assistant Supervisor

Signature of Substitute Physician Assistant Supervisor

Name of Physician Assistant

Signature of Physician Assistant

Date

WRITTEN AGREEMENT CHANGE FORM

TO BE COMPLETED WHEN REPORTING A CHANGE IN STATUS - DUPLICATE AS NEEDED

PRIMARY SUPERVISOR NAME, ADDRESS, AND LICENSE NUMBER:

Brad L. Wilson (MD081813)
1144 Locust St
Phila, PA 19107

NAME AND LICENSE NUMBER OF THE PHYSICIAN ASSISTANT WORKING UNDER YOUR AGREEMENT:

- **If applying under the Medical Board, a new supervisor application must be submitted.**

Amy Clevenstine

NAME AND LICENSE NUMBER OF THE PHYSICIAN ASSISTANT YOU ARE DELETING:

Barb Keogh MA-000890-L

LIST ANY SUBSTITUTE PHYSICIANS YOU ARE DELETING:

Lee Hopf

LIST ANY SUBSTITUTE PHYSICIANS YOU ARE ADDING:

- **If the primary supervisor is an MD, $5.00 is required for each additional substitute.**

THE FOLLOWING MUST BE CHECKED:

	YES	NO
WILL THERE BE ANY CHANGE IN PROTOCOL?		✓
WILL THERE BE ANY CHANGE TO DRUG LIST (MEDICAL ONLY)		✓

IF "YES" WAS ANSWERED - THE FOLLOWING MUST BE ATTACHED:

- *A CURRENT WRITTEN AGREEMENT*
- *LIST OF JOB DUTIES*
- *DRUG LIST (PRIMARY SUPERVISOR IS AN MD)*

SIGNATURE OF SUPERVISOR Jon Wilson DATE: 11/3/21

SIGNATURE OF PHYSICIAN ASSISTANT _____ DATE: _____

SIGNATURE OF NEW SUBSTITUTE _____ DATE: _____

NOTE: PHYSICIAN ASSISTANTS CANNOT HAVE MORE THAN 3 SUPERVISORS
SUPERVISING PHYSICIANS CANNOT HAVE MORE THAN 2 PA'S

WRITTEN AGREEMENT CHANGE FORM

TO BE COMPLETED WHEN REPORTING A CHANGE IN STATUS - DUPLICATE AS NEEDED

PRIMARY SUPERVISOR NAME, ADDRESS, AND LICENSE NUMBER:
Lee Tripp (MD037200E)
1144 Locust St
Phila, Pa 19107

NAME AND LICENSE NUMBER OF THE PHYSICIAN ASSISTANT WORKING UNDER YOUR AGREEMENT:
- If applying under the Medical Board, a new supervisor application must be submitted.

NAME AND LICENSE NUMBER OF THE PHYSICIAN ASSISTANT YOU ARE DELETING:
Mary Conway MA-001498-L

LIST ANY SUBSTITUTE PHYSICIANS YOU ARE DELETING:
Janet Wilson

LIST ANY SUBSTITUTE PHYSICIANS YOU ARE ADDING:
- If the primary supervisor is an MD, $5.00 is required for each additional substitute.

THE FOLLOWING MUST BE CHECKED:

	YES	NO
WILL THERE BE ANY CHANGE IN PROTOCOL?		✓
WILL THERE BE ANY CHANGE TO DRUG LIST (MEDICAL ONLY)		✓

IF "YES" WAS ANSWERED - THE FOLLOWING MUST BE ATTACHED:

- *A CURRENT WRITTEN AGREEMENT*
- *LIST OF JOB DUTIES*
- *DRUG LIST (PRIMARY SUPERVISOR IS AN MD)*

SIGNATURE OF SUPERVISOR Lee G. Tripp Jr. DATE: 10/03/07

SIGNATURE OF PHYSICIAN ASSISTANT _____ DATE: _____

SIGNATURE OF NEW SUBSTITUTE _____ DATE: _____

NOTE: PHYSICIAN ASSISTANTS CANNOT HAVE MORE THAN 3 SUPERVISORS
SUPERVISING PHYSICIANS CANNOT HAVE MORE THAN 2 PA'S

Planned Parenthood®
Southeastern Pennsylvania

Pennsylvania State Board of Medicine
P.O. Box 2649
Harrisburg, Pa. 17105-2649

Wednesday, November 3, 2004

Dear Terry,

As you instructed in our phone conversation on Monday, I have enclosed new copies of 2 change forms, an application for registration as a PA supervisor, and the written agreement for Amy Clevenstine with the original signatures.

We would greatly appreciate anything you can do to expedite this application. If you will recall, you received and processed copies of the forms that I sent out over a month ago. It is very frustrating knowing that both of us ended up having copies of the originals, and not knowing what happened to the originals. I would imagine your job is frustrating on a regular basis and thankless. Let me rectify that by thanking you for the help you have given us on this particular submission, as well as many others in the past.

Sincerely,

Deborah J. Lennon MSN, CRNP

1144 Locust Street • Philadelphia, PA 19107-6797 • (215) 351-5500 • FAX (215) 351-5593
E-mail: ppsp@ppsp.org • Homepage: http://www.ppsp.org

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

October 29, 2004

JANET L WILSON MD
PLANNED PARENTHOOD SOUTHEASTERN PENNA
1144 LOCUST STREET
PHILADELPHIA PA 19107

RE: AMY N CLEVENSTINE, 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 submit originals of page two and three of the application. We must have original signatures to process the application.

Please send the originals of the Written Agreement Change Forms to delete the old physician assistants. I must have original signatures, not copies.

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 SUPERVISON APPLICATION HAS BEEN APPROVED.

WRITTEN AGREEMENT CHANGE FORM

A. PRIMARY SUPERVISOR NAME, ADDRESS, WRITTEN AGREEMENT NUMBER:

Daniel L. Watson, MD MX0033194
Planned Parenthood SEPA
1144 Locust St., Phila, PA 19107

B. NAME AND LICENSE NUMBER OF THE PHYSICIAN ASSISTANT CURRENTLY WORKING UNDER YOUR AGREEMENT:

Amy Clevenstine MA051885

C. NAME AND LICENSE NUMBER OF THE PHYSICIAN ASSISTANT YOU ARE ADDING **(OSTEOPATHIC BOARD ONLY)**:

D. NAME AND LICENSE NUMBER OF THE PHYSICIAN ASSISTANT YOU ARE DELETING:

Amy Clevenstine MA051885

E. LIST THE NAME AND LICENSE NUMBER OF THE SUBSTITUTE PHYSICIAN YOU ARE ADDING:

- **If the primary supervisor is an MD, $5.00 is required for each additional substitute.**

F. LIST THE NAME AND LICENSE NUMBER OF THE SUBSTITUTE PHYSICIAN YOU ARE DELETING:

G. WILL THERE BE ANY CHANGE IN PROTOCOL? YES NO

WILL THERE BE ANY CHANGE TO DRUG LIST (MEDICAL ONLY) YES NO

IF CHANGING THE DRUG LIST, WILL SCHEDULE III, IV, AND/OR V CONTROLLED SUBSTANCES BE PRESCRIBED AND DISPENSED? YES NO

(NOTE: Physician Assistants are not permitted to prescribe Schedule I and II controlled substances.)

X SIGNATURE OF PRIMARY SUPERVISOR _____ DATE: 11/4/06

SIGNATURE OF PHYSICIAN ASSISTANT _____ DATE: 10/26/06

X SIGNATURE OF NEW SUBSTITUTE _____ DATE _____

49-306 (REV. 6/03)

STATE BOARD OF MEDICINE
P.O. BOX 2649
HARRISBURG, PA 17105-2649
717-783-1400
717-787-3581

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

MX 0 0 / 4 4 / 1 5

W S C A P P L

Trans. No.
Recpt. #
Date

APPLICATION FOR REGISTRATION AS A PHYSICIAN ASSISTANT SUPERVISOR

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

FEE - $35.00 for each application with one primary and one alternate physician assistant supervisor. An additional $5.00 fee is due for each additional substitute supervising physician.

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

NOTE: A PROCESSING FEE OF $10.00 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:

[illegible] [illegible] L [illegible] MD-[illegible] MD
LAST FIRST MIDDLE LIC #

PHYSICIAN ASSISTANT NAME/LICENSE NUMBER:

VAUGHN BARBARA A MD-096910-L MD
LAST FIRST MIDDLE LIC #

PRACTICE ADDRESS 1144 Locust / 1210 Castor Ave
STREET

Philadelphia PA 19104 / 19152
CITY STATE ZIP CODE

PRACTICE TELEPHONE (215) 967-5746 / 215-921-5762

19-106 (REV. 03/02)

WRITTEN AGREEMENT

[signature] [signature]

SUPERVISING PHYSICIAN ASSISTANT SUPERVISOR — 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.

Performing exams, diagnosing + treating minor exams, prescribing certain medications, referrals for more care, etc.

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.

Weekly personal contact, available via cell phone, email, etc.

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

family practice clinic

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 ?
YES ✓ NO _____

5. Will the physician assistant prescribe and dispense drugs?

YES ✓ NO _____ If yes, please complete page 4.

If yes, will Schedule III, IV and/or V controlled substances be prescribed and dispensed? YES _____ NO ✓ (NOTE: Physician Assistants are not permitted to prescribe Schedule I and II controlled substances.)

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.

Planned Parenthood®
Southeastern Pennsylvania

May 8, 2003

State Board of Medicine
P.O. Box 2649
Harrisburg, Pa. 17105-2649

Dear Sirs,

Enclosed, please find an application for Physician Assistants in our employment. The supervising MD is already registered with you.

Please let me know if I need to complete any other forms for this process.

Thank you for your help.

Sincerely,

Sarah Daukaus CRNP

Sarah Daukaus CRNP
Clinician Coordinator
215-351-5543

1144 Locust Street • Philadelphia, PA 19107-6797 • (215) 351-5500 • FAX (215) 351-5593
E-mail: ppsp@ppsp.org • Homepage: http://www.ppsp.org

POSITION: Clinician

ACCOUNTABLE TO: Center Manager (Administrative)
Medical Director (Medical)

GENERAL RESPONSIBILITIES:

Under written Standing Orders of the Medical Director, the Clinician will function in an expanded role in the provision of reproductive health care for women. Performance and supervision of medical aspects of patient care in contraceptive center in accordance with PPSP Standing Orders and policies and procedures.

SPECIFIC DUTIES:

1. Takes and/or reviews and interprets a complete health history, including obstetric, gynecologic, sexual, contraceptive, medical, surgical, family health and psychosocial and records findings accurately, legibly and succinctly.

2. Performs physical examinations with special emphasis on the reproductive system including heart and lung assessment, thyroid, abdominal, breast and pelvic examination for women and/or genital exam for men, appropriate screening procedures. Interprets finding of examination and records same.

3. Prescribes and provides appropriate contraceptive methods and/or treatments and specified medical conditions with Standing orders and tailored to the clients' maintenance.

4. Provides relevant health instruction to include family planning, STD prevention, genetics, nutrition, sexual counseling and principles of health promotion maintenance.

5. Consults with Medical Director of designated community gynecologist or refers clients with abnormal findings or in need of further care according to clinical judgement and standing orders.

6. Responsible for follow-up pertaining to referrals, medical problems, lab tests, etc. with staff assistance.

7. Assists Center Managers and Center Assistants to insure smooth operation of the service i.e. record keeping, laboratory testing, clerical functions, maintenance of facilities and development of phones appointment systems.

8. Assists with orientation/training of new staff and/or students.

9. Participates in departmental and interdisciplinary committees which affect or determine policies related to the delivery of reproductive health care to the consumer.

10. Participates in departmental meetings which affect and determine policies related to the role of the clinician.

11. Maintains continuing education requirements for licensure.

12. Practices in accordance with agency and PPFA Medical Standards and Guidelines.

13. Maintains cardiopulmonary resuscitation certificate.

14. Responsible for regular periodic medical in-house service and medical supervision on nonclinical staff at center.

QUALIFICATIONS:

Licensed or certified as a Nurse Practitioner, Nurse Midwife, or Physician's Assistant in the State of Pennsylvania. Training in a recognized program or its equivalent. Experience in reproductive health care including STDs, contraceptives, pregnancy sizing, and options counseling essential. Experience in male examination desirable. Malpractice coverage assumed by clinician if individual coverage required by the State (i.e., CNMs). Must be willing to work some evenings and/or Saturdays. Understanding of and strong personal commitment to reproductive rights and goals and philosophies of Planned Parenthood.

_____ _____

Employee Signature Date

PLANNED PARENTHOOD IS AN EQUAL OPPORTUNITY EMPLOYER

5/93

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) 787-7251
www.dos.state.pa.us

May 14, 2003

JANET L WILSON MD
1144 LOCUST STREET
PHILADELPHIA PA 19107

RE: BARBARA REGOR 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.

Submit a **job description** listing the **specific duties** that will be performed. Refer to the enclosed Rules and Regulations for a sample job description. Note, a physician assistant can only perform those duties as specifically listed in the job description.

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.

MA-108 (REV. 11/02)

STATE BOARD OF MEDICINE
P.O. BOX 2649
HARRISBURG, PA 17105-2649
717-783-1400
717-787-7381

COURIER ADDRESS
STATE BOARD OF MEDICINE
124 PINE STREET
HARRISBURG, PA 17101

MX 0 0 1 6 1 7
W I L S O APPL

Trans. No.
Amount $35.00
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 - $35.00 for each affiliation with one primary and one substitute physician assistant supervisor. An additional $5.00 fee is due for each additional substitute 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 DRAFT WHICH IS RETURNED UNPAID BY A FINANCIAL INSTITUTION, REGARDLESS OF REASON FOR NON-PAYMENT.

PLEASE PRINT OR TYPE ALL INFORMATION

PRIMARY PHYSICIAN ASSISTANT SUPERVISOR NAME/LICENSE NUMBER:

Wilson (LAST) Janet (FIRST) (MIDDLE) MD-0061616 (LICENSE NO.)

PHYSICIAN ASSISTANT NAME/LICENSE NUMBER:

Wilson (LAST) Nancy (FIRST) (MIDDLE) PA-001389-L (LICENSE NO.)

PRACTICE ADDRESS 1144 Locust St. (STREET)

Philadelphia (CITY) Penna (STATE) 19107 (ZIP CODE)

PRACTICE TELEPHONE 215 351-5560

1 19-106 (REV. (3/02)

WRITTEN AGREEMENT

[illegible] MD

supervising physician signature

[illegible] MS

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 supervisory listed on page 2.

1. Describe the functions/tasks to be delegated to the physician assistant. Indicate the manner in which the physician assistant will be assisting each named supervisor. 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. Family Planning Services (OTC and treatment) Appropriate referrals

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. Weekly review of Charts Weekly personal contact.

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

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? YES ✓ NO

5. Will the physician assistant prescribe and dispense drugs? Under Standing orders

YES ✓ NO If yes, please complete page 4.

If yes, will Schedule III, IV and/or V controlled substances be prescribed and dispensed? YES NO ✓ (NOTE: Physician Assistants are not permitted to prescribe Schedule I and II controlled substances.)

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.

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

May 14, 2003

JAMES L WILSON MD
1144 LOCUST STREET
PHILADELPHIA PA 19107

RE: TRACY GRAHAM PA-[illegible]

Dear Doctor:

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

Submit a **job description** listing the **specific duties** that will be performed. Refer to the enclosed rules and regulations for a sample job description. Note, a physician assistant may only perform those duties as specifically listed in the job description.

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.

POSITION: Clinician

ACCOUNTABLE TO: Center Manager (Administrative)
Medical Director (Medical)

GENERAL RESPONSIBILITIES:

Under written Standing Orders of the Medical Director, the Clinician will function in an expanded role in the provision of reproductive health care for women. Performance and supervision of medical aspects of patient care in contraceptive center in accordance with PPSP Standing Orders and policies and procedures.

SPECIFIC DUTIES:

1. Takes and/or reviews and interprets a complete health history, including obstetric, gynecologic, sexual, contraceptive, medical, surgical, family health and psychosocial and records findings accurately, legibly and succinctly.

2. Performs physical examinations with special emphasis on the reproductive system including heart and lung assessment, thyroid, abdominal, breast and pelvic examination for women and/or genital exam for men, appropriate screening procedures. Interprets finding of examination and records same.

3. Prescribes and provides appropriate contraceptive methods and/or treatments and specified medical conditions with Standing orders and tailored to the clients' maintenance.

4. Provides relevant health instruction to include family planning, STD prevention, genetics, nutrition, sexual counseling and principles of health promotion maintenance.

5. Consults with Medical Director of designated community gynecologist or refers clients with abnormal findings or in need of further care according to clinical judgment and standing orders.

6. Responsible for follow-up pertaining to referrals, medical problems, lab tests, etc. with staff assistance.

7. Assists Center Managers and Center Assistants to insure smooth operation of the service i.e. record keeping, laboratory testing, clerical functions, maintenance of facilities and development of phones appointment systems.

8. Assists with orientation/training of new staff and/or students.

9. Participates in departmental and interdisciplinary committees which affect or determine policies related to the delivery of reproductive health care to the consumer.

10. Participates in departmental meetings which affect and determine policies related to the role of the clinician.

11. Maintains continuing education requirements for licensure.

12. Practices in accordance with agency and PPFA Medical Standards and Guidelines.

13. Maintains cardiopulmonary resuscitation certificate.

14. Responsible for regular periodic medical in-house service and medical supervision on nonclinical staff at center.

QUALIFICATIONS:

Licensed or certified as a Nurse Practitioner, Nurse Midwife, or Physician's Assistant in the State of Pennsylvania. Training in a recognized program or its equivalent. Experience in reproductive health care including STDs, contraceptives, pregnancy sizing, and options counseling essential. Experience in male examination desirable. Malpractice coverage assumed by clinician if individual coverage required by the State (i.e., CNM's). Must be willing to work some evenings and/or Saturdays. Understanding of and strong personal commitment to reproductive rights and goals and philosophies of Planned Parenthood.

_____ _____

Employee Signature Date

PLANNED PARENTHOOD IS AN EQUAL OPPORTUNITY EMPLOYER

5/93

WRITTEN AGREEMENT CHANGE FORM

TO BE COMPLETED WHEN REPORTING A CHANGE IN STATUS - DUPLICATE AS NEEDED

PRIMARY SUPERVISOR NAME, ADDRESS, AND LICENSE NUMBER

Janet Wilson (MD 021213 E)
1144 Locust St
Phila, Pa 19107

NAME AND LICENSE NUMBER OF THE PHYSICIAN ASSISTANT WORKING UNDER YOUR AGREEMENT

- **If applying under the Medical Board, a new supervisor application must be submitted.**

Amy Cleversmine (license pending)

NAME AND LICENSE NUMBER OF THE PHYSICIAN ASSISTANT YOU ARE DELETING

Barb Keogh MD - 000590-L

LIST ANY SUBSTITUTE PHYSICIANS YOU ARE DELETING

Lee Tripp

LIST ANY SUBSTITUTE PHYSICIANS YOU ARE ADDING

- **If the primary supervisor is an MD, $5.00 is required for each additional substitute.**

THE FOLLOWING MUST BE CHECKED:

	YES	NO
WILL THERE BE ANY CHANGE IN PROTOCOLS?		✓
WILL THERE BE ANY CHANGE TO DRUG LIST (MD'S ONLY)		✓

IF "YES" WAS ANSWERED - THE FOLLOWING MUST BE ATTACHED:

- ***A CURRENT WRITTEN AGREEMENT***
- ***LIST OF JOB DUTIES***
- ***DRUG LIST (PRIMARY SUPERVISOR IS AN MD)***

SIGNATURE OF SUPERVISOR _____ DATE 7/16/04

SIGNATURE OF PHYSICIAN ASSISTANT _____ DATE _____

SIGNATURE OF NEW SUBSTITUTE _____ DATE 7/19/04

NOTE: PHYSICIAN ASSISTANTS CANNOT HAVE MORE THAN 3 SUPERVISORS
SUPERVISING PHYSICIANS CANNOT HAVE MORE THAN 2 PA'S

WRITTEN AGREEMENT CHANGE FORM

A. PRIMARY SUPERVISING PHYSICIAN'S NAME, ADDRESS AND TELEPHONE NUMBER AS:

Jared Lee Wilson MD

B. NAME AND TELEPHONE NUMBER OF THE PHYSICIAN ASSISTANT AS CURRENTLY CARRIED ON FILE:

Wendy Lynn Graham PA-C

C. NAME AND TELEPHONE NUMBER OF THE PHYSICIAN ASSISTANT AS YOU ARE REQUESTING:

Wendy Lynn Graham PA-C

D. LIST THE NAME AND TELEPHONE NUMBER OF THE SUPERVISING PHYSICIAN AS CURRENTLY ON FILE:

E. LIST THE NAME AND LICENSE NUMBER OF THE ALTERNATE SUPERVISING PHYSICIAN FOR THIS PERIOD:

If you answer yes to any of the following questions, please follow all instructions outlined on the instruction page.

F. WILL THERE BE ANY CHANGE IN SUPERVISION? YES NO

WILL THERE BE ANY CHANGE TO THE PRESCRIBING/DISPENSING PRIVILEGES? YES NO

IF CHANGING THE PRESCRIBING/DISPENSING PRIVILEGES, CHECK THE SCHEDULES TO BE ADDED OR DELETED AND INDICATE WHETHER THE PHYSICIAN IS ADDING OR DELETING.

NOTE: Physician Assistants are not permitted to prescribe/dispense Schedule II controlled substances.

SCHEDULE II ____

SCHEDULE III ____

SCHEDULE IV ____

SCHEDULE V ____

IS THE ADDRESS OF THE PRACTICE LOCATION CHANGING? YES NO

ARE YOU ADDING PRACTICE LOCATIONS? YES NO

ARE YOU DELETING PRACTICE LOCATIONS? YES NO

SIGNATURE OF PRIMARY SUPERVISOR _____ DATE _____

SIGNATURE OF PHYSICIAN ASSISTANT _____ DATE _____

SIGNATURE OF NEW SUPERVISOR _____ DATE _____

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
STATE BOARD OF MEDICINE
P.O. BOX 2649
HARRISBURG, PA 17105
717-783-1400
717-787-2301
November 9, 1995

Dear Doctor:

According to the records of the State Board of Medicine, you are registered as a physician assistant supervisor. In order to facilitate the issuance of DEA registration numbers to physician assistants who have been granted Board approval to prescribe and dispense drugs, the Board has been requested to secure information on whether or not the physician assistant will be prescribing and/or dispensing Schedule III, IV and/or V controlled substances.

If you indicated on the written agreement submitted to the Board with the application for registration as a physician assistant supervisor, that the physician assistant would be prescribing and/or dispensing drugs and listed the categories of drugs the physician assistant would be prescribing and the Board granted approval for such, please provide the information requested below. Forward the information to the Board at the above address as soon as possible so that information can be added to the Board's computer records. After it is added to the computer records, the Board will be able to inform the Drug Enforcement Administration, upon individual request, whether or not the physician assistant will be prescribing and/or dispensing Schedule III, IV and/or V controlled substances.

If the physician assistant you supervise is not approved to prescribe or dispense drugs, you may disregard this notice. Thank you for your cooperating in this matter.

Sincerely,

Cindy L. Warner, Chief
Physician/Podiatrist Unit

****

DRUG INFORMATION

Please complete this information if the physician assistant you supervise has been granted approval to prescribe or dispense drugs by the State Board of Medicine.

NAME OF PRIMARY SUPERVISOR [illegible] LAS No. MD-[illegible]

NAME OF PHYSICIAN ASSISTANT Joanne Rosenbaum CERT. NO. PA-[illegible]

WILL SCHEDULE III, IV AND/OR V CONTROLLED SUBSTANCES BE PRESCRIBED AND/OR DISPENSED BY THE PHYSICIAN ASSISTANT? ✓ YES ____ NO

SIGNATURE OF SUPERVISOR [illegible] DATE 11/13/95

SPOA 1438 (REV. 4/94)

920045 0002

OFFICIAL USE ONLY

MD 021813 E

W1150 SUPR

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

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

PHYSICIAN ASSISTANT NAME ROSENBAUM (LAST) JOANNE (FIRST) (MIDDLE) (MAIDEN)

PHYSICIAN ASSISTANT CERTIFICATION NUMBER MA-000171-L

PRACTICE ADDRESS 1124 Walnut St (STREET)

Philadelphia (CITY) PA (STATE) 19107 (ZIP CODE)

PRACTICE TELEPHONE (215) 923-1124

970055 0102

...ns ...se (REV. 4/94)

Primary Physician Assistant Supervisor must complete.

List Specialties Obstetrics Gynecology

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

If yes, list Board(s) _____

If you have hospital staff privileges, indicate hospital name(s).

Graduate Hospital

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.

Name of Primary Physician Assistant Supervisor Janet L. Wilson MD 025

Signature _____ Date 8/3/95 MD# MD021873

Name of Substitute Physician Assistant Supervisor Gene Bishop DO

Signature _____ Date 8/3/95 MD# 022994 025

Name of Substitute Physician Assistant Supervisor _____

Signature _____ Date _____ MD# _____

Name of Substitute Physician Assistant Supervisor _____

Signature _____ Date _____ MD# _____

Name of Substitute Physician Assistant Supervisor _____

Signature _____ Date _____ MD# _____

(Attach 8 1/2 x 11 sheets with additional names if needed.)

PRESCRIBING AND DISPENSING DRUGS BY PHYSICIAN ASSISTANT

Print or type name

_____ _____
PRIMARY PHYSICIAN ASSISTANT SUPERVISOR — 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.
- ✓ (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.

WRITTEN AGREEMENT

Jack L. Wilson, M.D.
PHYSICIAN ASSISTANT SUPERVISOR

Joanne Carrabine
PHYSICIAN ASSISTANT APPLICANT

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 where the physician assistant will serve.

Elizabeth Blackwell Health Ctr.
1124 Walnut St. 15212

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 ✓ YES ____ NO

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

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.

Question 1

The Physician Assistant shall augment the physician's data gathering abilities and assist the supervising physician in reaching decisions and instituting care plans for the physician's patients. The PA shall have the knowledge and competency to perform the following functions:

Clinical

1. Screen patients to determine need for physician attention
2. Review patient records to determine health status
3. Take a patient history
4. Perform a physical examination
5. Determine gestational age in early pregnancy
6. Record pertinent patient data
7. Make decisions regarding data gathering and appropriate management and treatment for the initial evaluation of a problem or the follow-up of a previously diagnosed condition
8. Prepare patient summaries
9. Initiate request for commonly performed laboratory and radiographic studies
10. Collect specimens for and carry out commonly performed analysis and office cultures
11. Identify normal and abnormal findings on history, physical examination, and commonly performed laboratory and radiographic studies
12. Initiate appropriate evaluation and emergency management for situations, for example: cardiac arrest
13. Perform clinical procedures such as:
    - A. Venipuncture
    - B. Intradermal Test
    - C. Electrocardiogram
    - D. Pelvic Ultrasound to Determine Gestational Age
    - E. Control of Hemmorrhage
    - F. Application of Dressing and Bandages
    - G. Removal of Superficial Foreign Bodies
    - H. Removal of Dermatologic Abnormalities
    - I. Cardiopulmonary Resuscitation, Adult
    - J. Carrying out Aseptic and Isolation Techniques
    - K. Insertion and Removal of IUD
    - L. Insertion of Subdermal Birth Control Implants
    - M. Endometrial Biopsy
    - N. Colposcopy
    - O. Bartholin Abscess Incision and Drainage
    - P. Breast Cyst Aspiration
    - Q. Lesion Destruction
    - R. Polyp Removal
14. Provide counseling and instruction regarding common patient problems
15. Obtain informed consent to medications and procedures

16. The PA may execute and relay those medical regimens as dictated by the supervising physician and/or described in this work agreement

Administrative

1. Maintain journal article file
2. Participate in decisions concerning daily operations
3. Evaluate protocols and flow sheets including immunization records
4. Participate in professional activities which will advance the PA Profession on a local, state and federal level
5. Participate in all required continuing medical education activities to maintain national certification
6. Coordinate quality assurance activities
7. Provide other services as directed by the primary supervising physician

Question 2

Primary supervision will be preformed in the office by Dr. Janet Wilson, with personal contact on a nearly daily basis. For those absences longer than 3 days, alternate supervision will be performed by the substitute physician assistant supervisors who meet all requirements of chart review and have personal contact with the PA at least weekly. Problem cases and those of educational interest will be discussed daily. Immediate access via telecommunication as always available.

920035 0102

Name of Primary Physician Jane Miller

Name of Physician Assistant Jane C. Robertson

Name of Substitute Physician Mac Bishop

APPLICATION	Approved	Pending
Judith	8-18-95	
WRITTEN AGREEMENT	8-11-95	
DRUG LIST		
Valerie	8-18-95	
DISCREPANCY LETTER SENT		
COMPUTER UPDATE		
APPROVAL LETTER SENT	8-21-95	
BOARD APPROVAL REQUIRED	Yes	No
REASON		

Signature of Board Member Date

July 16, 1996

Department of State
Bureau of Professional & Occupational Affairs
State Board of Medicine
P.O. Box 2649
Harrisburg, PA 17105-2649

To the State Board,

This is to inform you of the following;

1. Dr. Gene Bishop is no longer one of my supervising physicians, or substitute supervising physicians. Her MD # is 022902E.

2. I would like to add Dr. David Taub as a substitute supervising physician, his MD # and signature are listed below. Dr. Taub will be a substitute under my primary supervisor Dr. Janet Lee Wilson, MD-021813-E.

2. David Taub, MD # 042708-L _____

Thank you for making the appropriate changes.

PS

Sincerely,

Joanne Rosenbaum

Joanne Rosenbaum, PA-C
MA-001171-L
1124 Walnut St
Philadelphia, PA 19107
215-923-7577

Prim - MD-021813-E/ W/so

WA - 8/21/95
OL - 8/18/95

Elizabeth Blackwell
Health Center for Women
1124 Walnut Street
Philadelphia, PA 19107

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
STATE BOARD OF MEDICINE
P.O. BOX 2649
HARRISBURG, PA 17105
717-783-1400
717-787-2381

July 26, 1996

JOANNE ROSENBAUM PA-C
E B HLTH CNTR FOR WOMEN
1125 WALNUT STREET
PHILADELPHIA PA 19107

Dear Licensee:

We are in receipt of your request for registration of an additional substitute supervisor with the State Board of Medicine. The following is required so your request can be re-evaluated.

8/5/96
____ Check/money order in the amount of $5.00 made payable to the "Commonwealth of Pennsylvania."

_____ Written Agreement: Please indicate if the written agreement will remain the same as first approved on

_____ Drug List: Please indicate if the drug list will remain the same an first approved on

_____ Signatures

_____ Other:

NOTE: PLEASE RETURN A COPY OF THIS LETTER WHEN SUBMITTING THE ABOVE INFORMATION. THE PHYSICIAN ASSISTANT MAY NOT BEGIN WORKING UNDER THE SUBSTITUTE SUPERVISIOR'S EMPLOY UNTIL THIS REQUEST HAS BEEN PROCESSED.

970305 0403

December 16, 1996

Department of State
Bureau of Professional & Occupational Affairs
State Board of Medicine
P.O. Box 2649
Harrisburg, PA 17105-2649

Women's Center
8811 Germantown Ave
Philadelphia, PA 19118

This is to inform you of the following;

Dr. Janet Lee Wilson MD-021813-E and Dr. David Toub MD-042709-L are no longer my Supervising or Substitute supervising physicians. This change was effective October 15, 1996.

Enclosed is my new application with a new physician supervisor.

Sincerely,

Joanne Rosenbaum

Joanne Rosenbaum, PA-C
MA-001171-L

MD-021813-E/Wilson