Person Info
Name: LEE ANTHONY TRIPP
Address Info
Street Address [redacted] **Email** [redacted]@msn.com
Phone [redacted]
Fax
City philadelphia
State PA
Zipcode 19107
Country 82
County philadelphia

Are you submitting a name change with this renewal?	N
Have you met your current CE requirements?	Y
Have you completed 2 hours of Board-approved continuing education in child abuse recognition and reporting?	Y
Do you hold, or have you ever held, a license, certificate, permit, registration or other authorization to practice a profession or occupation in any state or jurisdiction?	Y
If you answered yes to the above questions, please provide the profession and state or jurisdiction.	Illinois
Since your initial application or last renewal, whichever is later, have you had disciplinary action taken against a professional or occupational license, certificate, permit, registration or other authorization to practice a profession or occupation issued to you in any state or jurisdiction or have you agreed to voluntary surrender in lieu of discipline?	N
Do you currently have any disciplinary charges pending against your professional or occupational license, certificate, permit or registration in any state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you withdrawn an application for a professional or occupational license, certificate, permit or registration, had an application denied or refused, or for disciplinary reasons agreed not to apply or reapply for a professional or occupational license, certificate, permit or registration in any state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you been convicted (found guilty, pled guilty or pled nolo contendere), received probation without verdict or accelerated rehabilitative disposition (ARD), as to any criminal charges, felony or misdemeanor, including any drug law violations? Note: You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.	N
Do you currently have any criminal charges pending and unresolved in any state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you had your DEA registration denied, revoked or restricted?	N
Since your initial application or your last renewal, whichever is later, have you had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority?	N
Since your initial application or your last renewal, whichever is later, have you ever had practice privileges denied, revoked, suspended, or restricted by a hospital or any health care facility?	N
Since your initial application or your last renewal, whichever is later, have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?	N
Since your initial application or last renewal, whichever is later, have you engaged in the intemperate or habitual use or abuse of alcohol or narcotics, hallucinogenics or other drugs or substances that may impair judgment or coordination?	[redacted]
If yes, are you currently participating in the Pennsylvania Professional Health Monitoring Program?	
Since your initial application or your last renewal, whichever is later, have you been the subject of a civil malpractice lawsuit?	N
If yes, please submit a copy of the entire Civil Complaint, which must include the filing date and the date you were served. Submit a statement which includes complete details of the complaints that have been filed against you. PLEASE NOTE: If you previously reported the complaint to the Board you will only need to provide the docket number here:	
Do you maintain current medical professional liability insurance in the Commonwealth of Pennsylvania?	Y
If you answer "No", please provide an explanation or reason for an exemption request.	

Date Submitted: Monday, November 10, 2014

Education Info

No education records

Employment Information

No employment records

Person Info
Name:LEE ANTHONY TRIPP
Address Info
Street Address: [redacted] **Email:** [redacted]@msn.com
Phone [redacted]
Fax
Cityphiladelphia
StatePA
Zipcode19107
Country82
Countyphiladelphia

Survey Response Summary
Question Response Summary

Are you submitting a name change with this renewal?	N
Do you hold a license/certificate (active, inactive or expired) to practice in any other state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you had disciplinary action taken against your license, certificate or registration issued to you in any profession in any other state or jurisdiction?	N
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, or accelerated rehabilitative disposition(ARD) as to any felony or misdemeanor, including any drug law violations, or do you have any criminal charges pending and unresolved in any state or jurisdiction? You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.	N
Since your initial application or last renewal, whichever is later, have you withdrawn an application for a license, certificate or registration, had an application denied or refused, or for disciplinary reasons agreed not to reapply for a license, certificate or registration in any profession in any other state or jurisdiction?	N
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?	N
Since your last renewal, 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, email or fax the docket number to the Board. (email at st-medicine@state.pa.us or fax at 717-787-7769)	N

Since your initial application or last renewal, whichever is later, have you had your DEA registration denied, revoked or restricted?	N
Since your initial application or last renewal, whichever is later, have you had practice privileges denied, revoked or restricted in a hospital or health care facility?	N
Since your initial application or last renewal, whichever is later, have your provider privileges been denied, revoked or restricted by any medical assistance agency for cause?	N
Do you maintain current medical professional liability insurance in the Commonwealth of Pennsylvania?	Y
Have you met your current CE requirements?	Y

Education Information

No education records

Employment Information

No employment records

remarks

Remarks:

Continuing Education Information

No CE Course records

Person Info
Name:LEE ANTHONY TRIPP
Address Info
Street Address [redacted] **Email** [redacted]@msn.com
Phone [redacted]
Fax
Cityphiladelphia
StatePA
Zipcode19107
Country82
Countyphiladelphia

Are you submitting a name change with this renewal?	N
Have you completed your current CE requirements?	Y
Do you hold, or have you ever held, a license, certificate, permit, registration or other authorization to practice any health-related profession in any state or jurisdiction?	Y
If you answered yes to the above question, please provide the profession and state or jurisdiction	Illinois
Since your initial application or last renewal, whichever is later, have you had disciplinary action taken against a professional or occupational license, certificate, permit, registration or other authorization to practice a profession or occupation issued to you in any state or jurisdiction or have you agreed to voluntary surrender in lieu of discipline?	N
Do you currently have any disciplinary charges pending against your professional or occupational license, certificate, permit or registration in any state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you withdrawn an application for a professional or occupational license, certificate, permit or registration, had an application denied or refused, or for disciplinary reasons agreed not to apply or reapply for a professional or occupational license, certificate, permit or registration in any state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you been convicted (found guilty, pled guilty or pled nolo contendere), received probation without verdict or accelerated rehabilitative disposition (ARD), as to any criminal charges, felony or misdemeanor, including any drug law violations? Note: You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.	N
Do you currently have any criminal charges pending and unresolved in any state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you had your DEA registration denied, revoked or restricted?	N
Since your initial application or your last renewal, whichever is later, have you had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority?	N
Since your initial application or your last renewal, whichever is later, have you ever had practice privileges denied, revoked. suspended, or restricted by a hospital or any health care facility?	N
Since your initial application or your last renewal, whichever is later, have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?	N
Since your initial application or last renewal, whichever is later, have you engaged in the intemperate or habitual use or abuse of alcohol or narcotics, hallucinogenics or other drugs or substances that may impair judgment or coordination?	[redacted]
Since your initial application or your last renewal, whichever is later, have you been the subject of a civil malpractice lawsuit?	N
If yes, please submit a copy of the entire Civil Complaint, which must include the filing date and the date you were served. PLEASE NOTE: If you previously reported the complaint to the Board you will only need to provide the docket number here:	
Have you completed 2 hours of Board-approved continuing education in child abuse recognition and reporting?	Y
Do you maintain current medical professional liability insurance in the Commonwealth of Pennsylvania?	Y
If you answer "No", please provide an explanation or reason for an exemption request.	
Please provide the zip code of your primary employer/practice location. This data is being collected for the purpose of identifying healthcare professionals during state emergencies and may be provided to the Pennsylvania Emergency Management Agency for official use only.	19107

Date Submitted: Monday, December 05, 2016

Education Info

No education records

Employment Information

No employment records

Person Info
Name:LEE ANTHONY TRIPP
Address Info
Street Address [redacted] **Email:** [redacted]@msn.com
Phone [redacted]
Fax
Cityphiladelphia
StatePA
Zipcode19107
Country82
Countyphiladelphia

Survey Response Summary
Question Response Summary

Are you submitting a name change with this renewal?	N
Do you hold a license/certificate (active, inactive or expired) to practice in any other state or jurisdiction?	Y
Since your initial application or last renewal, whichever is later, have you had disciplinary action taken against your license, certificate or registration issued to you in any profession in any other state or jurisdiction?	N
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, or accelerated rehabilitative disposition(ARD) as to any felony or misdemeanor, including any drug law violations, or do you have any criminal charges pending and unresolved in any state or jurisdiction? You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.	N
Since your initial application or last renewal, whichever is later, have you withdrawn an application for a license, certificate or registration, had an application denied or refused, or for disciplinary reasons agreed not to reapply for a license, certificate or registration in any profession in any other state or jurisdiction?	N
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?	N
Since your last renewal, 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, email or fax the docket number to the Board. (email at st-medicine@state.pa.us or fax at 717-787-7769)	N

Since your initial application or last renewal, whichever is later, have you had your DEA registration denied, revoked or restricted?	N
Since your initial application or last renewal, whichever is later, have you had practice privileges denied, revoked or restricted in a hospital or health care facility?	N
Since your initial application or last renewal, whichever is later, have your provider privileges been denied, revoked or restricted by any medical assistance agency for cause?	N
Do you maintain current medical professional liability insurance in the Commonwealth of Pennsylvania?	Y
Have you met your current CE requirements?	Y

Education Information

No education records

Employment Information

No employment records

remarks

Remarks:

Continuing Education Information

No CE Course records

Person Info
Name:LEE ANTHONY TRIPP
Address Info
Street Address [redacted] **Email:** [redacted]@msn.com
Phone [redacted]
Fax
Cityphiladelphia
StatePA
Zipcode19107
Country82
Countyphiladelphia

Survey Response Summary
Question Response Summary

Are you submitting a name change with this renewal?	N
Do you hold a license/certificate (active, inactive or expired) to practice in any other state or jurisdiction?	Y
Since your initial application or last renewal, whichever is later, have you had disciplinary action taken against your license, certificate or registration issued to you in any profession in any other state or jurisdiction?	N
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, or accelerated rehabilitative disposition(ARD) as to any felony or misdemeanor, including any drug law violations, or do you have any criminal charges pending and unresolved in any state or jurisdiction? You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.	N
Since your initial application or last renewal, whichever is later, have you withdrawn an application for a license, certificate or registration, had an application denied or refused, or for disciplinary reasons agreed not to reapply for a license, certificate or registration in any profession in any other state or jurisdiction?	N
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?	N
Since your last renewal, 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, email or fax the docket number to the Board. (email at st-medicine@state.pa.us or fax at 717-787-7769)	N

Since your initial application or last renewal, whichever is later, have you had your DEA registration denied, revoked or restricted?	N
Since your initial application or last renewal, whichever is later, have you had practice privileges denied, revoked or restricted in a hospital or health care facility?	N
Since your initial application or last renewal, whichever is later, have your provider privileges been denied, revoked or restricted by any medical assistance agency for cause?	N
Do you maintain current medical professional liability insurance in the Commonwealth of Pennsylvania?	Y
Have you met your current CE requirements?	Y

Education Information

No education records

Employment Information

No employment records

remarks

Remarks:

Continuing Education Information

No CE Course records

[redacted]

TARGET SHEET

Board: Medicine

Date Created:
02/03/2010

Licensee Full Name:
LEE ANTHONY TRIPP

License No:
MX000994

APPL 2028451

Laura Lee Blechner
[redacted]
Limerick, PA 19468
[redacted]

22 January 2010

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

Re: Laura Lee Blechner, License # MA002853L

To whom it may concern:

I am writing to inform you of my decision to stop working under the supervision of Dr. Lee Tripp (License # MX000994). I have not entered another practice arrangement at this time and am working as a full time parent right now. I understand that I will need to notify the state board when I decide to return to work as a Physician Assistant and register my new practice agreement and supervising physician at that time.

Thank you for your attention.

Sincerely,

Laura Lee Blechner, PA-C

cc. Dr. Lee Tripp
Betty Nixon

Person Info
Name:LEE ANTHONY TRIPP
Address Info
Street Address [redacted] **Email** [redacted]@msn.com
Phone [redacted]
Fax
Cityphiladelphia
StatePA
Zipcode19107
Country82
Countyphiladelphia

Are you submitting a name change with this renewal?	N
Have you completed your current CE requirements?	Y
Do you hold, or have you ever held, a license, certificate, permit, registration or other authorization to practice any health-related profession in any state or jurisdiction?	Y
If you answered yes to the above question, please provide the profession and state or jurisdiction	Illinois
Since your initial application or last renewal, whichever is later, have you had disciplinary action taken against a professional or occupational license, certificate, permit, registration or other authorization to practice a profession or occupation issued to you in any state or jurisdiction or have you agreed to voluntary surrender in lieu of discipline?	N
Do you currently have any disciplinary charges pending against your professional or occupational license, certificate, permit or registration in any state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you withdrawn an application for a professional or occupational license, certificate, permit or registration, had an application denied or refused, or for disciplinary reasons agreed not to apply or reapply for a professional or occupational license, certificate, permit or registration in any state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you been convicted (found guilty, pled guilty or pled nolo contendere), received probation without verdict or accelerated rehabilitative disposition (ARD), as to any criminal charges, felony or misdemeanor, including any drug law violations? Note: You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.	N
Do you currently have any criminal charges pending and unresolved in any state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you had your DEA registration denied, revoked or restricted?	N
Since your initial application or your last renewal, whichever is later, have you had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority?	N
Since your initial application or your last renewal, whichever is later, have you ever had practice privileges denied, revoked, suspended, or restricted by a hospital or any health care facility?	N
Since your initial application or your last renewal, whichever is later, have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?	N
Since your initial application or last renewal, whichever is later, have you engaged in the intemperate or habitual use or abuse of alcohol or narcotics, hallucinogenics or other drugs or substances that may impair judgment or coordination?	[redacted]
Since your initial application or your last renewal, whichever is later, have you been the subject of a civil malpractice lawsuit?	N
If yes, please submit a copy of the entire Civil Complaint, which must include the filing date and the date you were served. PLEASE NOTE: If you previously reported the complaint to the Board you will only need to provide the docket number here:	
Have you completed 2 hours of Board-approved continuing education in child abuse recognition and reporting?	Y
Do you maintain current medical professional liability insurance in the Commonwealth of Pennsylvania?	Y
If you answer "No", please provide an explanation or reason for an exemption request.	
Please provide the zip code of your primary employer/practice location. This data is being collected for the purpose of identifying healthcare professionals during state emergencies and may be provided to the Pennsylvania Emergency Management Agency for official use only.	19107

Date Submitted: Monday, December 05, 2016

Education Info

No education records

Employment Information

No employment records

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

Official Use Only 001990

MD-037200-E

TRIPP RNEW

THIS IS YOUR RENEWAL NOTICE

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

LEE ANTHONY TRIPP
[redacted]
GLASSBORO, NJ 08028

YOUR CURRENT LICENSE TO PRACTICE MEDICINE AND SURGERY IN PENNSYLVANIA WILL EXPIRE ON DECEMBER 31, 1994. TO RENEW THROUGH DECEMBER 31, 1996 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, 1994. 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.

YOU ARE HEREBY NOTIFIED THAT IF YOU ARE PRACTICING IN THIS COMMONWEALTH, YOU ARE REQUIRED TO FURNISH SATISFACTORY PROOF TO THE OFFICE OF THE MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND THAT YOU ARE IN COMPLIANCE WITH THE HEALTH CARE SERVICES MALPRACTICE ACT.

IF, SINCE YOUR LAST RENEWAL, YOU HAVE EXPERIENCED DIFFICULTIES AS A RESULT OF ALCOHOL OR OTHER DRUGS SUCH AS DIAGNOSIS OF/TREATMENT FOR CHEMICAL DEPENDENCY OR ABUSE OR ARRESTS FOR CHEMICAL USE-RELATED OFFENSES, YOU MAY CONTACT THE BUREAU'S IMPAIRED PROFESSIONAL PROGRAM FOR CONFIDENTIAL INFORMATION AND ASSISTANCE AT 1-800-554-3428.

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.

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.

THE FOLLOWING QUESTIONS MUST BE ANSWERED AND YOU MUST SIGN BELOW

	YES	NO
1. DO YOU HOLD A LICENSE TO PRACTICE MEDICINE AND SURGERY IN ANY OTHER JURISDICTION? IF YES, LIST EACH ONE.	( )	(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 PLEADED 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?	( )	(X)

IF YOU WISH TO HAVE YOUR LICENSE PLACED ON "INACTIVE" STATUS, CHECK HERE ( ).
(NOTE: IF REQUIRED FOR INACTIVE STATUS, YOU ARE STILL REQUIRED TO ANSWER THE ABOVE QUESTIONS AND SIGN BELOW.)

SIGNATURE _____ DATE _____

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

Official Use Only 002192

MD-037200-E

TRIPP RNEW

THIS IS YOUR RENEWAL NOTICE

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

LEE ANTHONY TRIPP
[redacted]
GLASSBORO, NJ 08028

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 MCF 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

( ) (✓) 1. DO YOU HOLD A LICENSE TO PRACTICE MEDICINE AND SURGERY IN ANY OTHER JURISDICTION? IF YES, LIST EACH ONE ON THE BACK.
( ) (✓) 2. SINCE YOUR LAST RENEWAL, HAS ANY DISCIPLINARY ACTION BEEN TAKEN AGAINST YOUR LICENSE IN ANOTHER STATE, TERRITORY OR COUNTRY?
( ) (✓) 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?
( ) (✓) 4. SINCE YOUR LAST RENEWAL, HAVE YOU HAD PRACTICE PRIVILEGES DENIED, REVOKED OR RESTRICTED IN A HOSPITAL OR OTHER HEALTH CARE FACILITY?
( ) (✓) 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 Temple University Health Science Center YEAR OF GRADUATION 6/81

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 [redacted] M.D. DATE 9/30/96

DUPLICATE

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

M D - 037200 - E

TRIPP RNEW

THIS IS YOUR RENEWAL NOTICE - REUQIRED FEE - $125.00

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

LEE ANTHONY TRIPP
[redacted]
WILLIAMSTOWN NJ 08094

YOUR CURRENT LICENSE TO PRACTICE MEDICINE AND SURGERY IN PENNSYLVANIA WILL EXPIRE 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 RETURNED UNPAID BY YOUR BANK, REGARDLESS OF THE REASON. IF YOUR 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 REVOCATIONS 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. FAILURE TO PROVIDE DOCUMENTS WILL DELAY THE PROCESS.

YES NO
( ) (✓) 1. DO YOU HOLD A LICENSE TO PRACTICE MEDICINE AND SURGERY IN ANY OTHER JURISDICTION? IF YES, LIST EACH ONE BELOW.

( ) (✓) 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?

(✓) ( ) 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.)

( ) (✓) 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.

( ) (✓) 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?

( ) (✓) 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 QUESTIONS ABOVE.

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 [redacted] DATE 12/4/98

December 21, 1998

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

To The State Board Of Medicine:

As a supplement to my answer on Question Three (3), please be advised that during the tax year 1990, I provided services as a physician on an independent contractor basis. My employer failed to provide me with a Form 1099 at the end of the year and no withholding allowance was taken from the wages paid me. I changed jobs from one location to another and did not keep track of my responsibility to make quarterly estimated tax payments or file a tax return for the year. The U.S. Government decided to file a misdemeanor charge against me as a result.

I completely cooperated with the U.S. Government and accepted responsibility for my failure to file an income tax return for the tax year 1990 by way of a negotiated plea agreement with the United States Attorney on July 23, 1997.

The plea agreement called for me to serve a probationary term of three (3) years which I have been successfully complying with since the Judge imposed that term on November 12, 1997. I am attaching to this statement a five (5) page Judgment as signed by the Honorable Robert B. Kugler, United States Magistrate Judge from the District Court of New Jersey which indicates a misdemeanor offense and the terms and conditions of my probation.

Please know that I have never been charged (or convicted) of any other criminal offense prior to or since this incident. I have never nor am I now charged with any other criminal offense. I am a law-abiding citizen. I accepted responsibility for my lack of compliance with the tax laws and have abided by the terms and conditions of my probation. I have since filed my tax return for the tax year 1990 and am making payments to the IRS for the amount of money I owe, including interest and penalty, according to my ability to pay.

Very truly yours,

Lee A. Tripp

Dr. Lee Anthony Tripp

AO 245 S (Rev. 4/90) Sheet 1 - Judgment in a Criminal Case

UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

16

UNITED STATES OF AMERICA

v.

Case Number CR 97-m-1079

LEE TRIPP
Defendant.

FILED

NOV 12 1997

AT 8:30 M
WILLIAM T. WALSH
CLERK

JUDGMENT IN A CRIMINAL CASE
(For Offenses Committed On or After November 1, 1987)

The defendant, LEE TRIPP, was represented by A. Charles Peruto, Jr.

On motion of the United States, the Court has dismissed Count 2 of the Information.

The defendant pleaded guilty to count(s) 1. Accordingly, the defendant is adjudged guilty of such count(s), involving the following offense(s):

Title & Section	Nature of Offense	Date Offense Concluded	Count Number(s)
26 USC 7203	Failure to file tax return	04/15/91	1

As pronounced on 11/12/97, the defendant is sentenced as provided in pages 2 through 5 of this Judgment. The sentence is imposed pursuant to the Sentencing Reform Act of 1984.

It is ordered that the defendant shall pay to the United States a special assessment of $ 25.00, for count(s) 1, which shall be due immediately.

It is further ordered that the defendant shall notify the United States Attorney for this district within 30 days of any change of name, residence, or mailing address until all fines, restitution, costs, and special assessments imposed by this Judgment are fully paid.

Signed this the 12th day of November, 1997.

HON. ROBERT B. KUGLER, United States Magistrate Judge

I HEREBY CERTIFY that the above and foregoing is a true and correct copy of the original on file in my office.
UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY
WILLIAM T. WALSH, CLERK
By: Deputy Clerk

Defendant's SSAN: 184-46-8821
Defendant's Date of Birth: 12/09/52
Defendant's Address: 1310 Nightshade Drive, Williamstown, NJ 08094

ENTERED ON THE DOCKET
DATE 11/13/97
WILLIAM T. WALSH, CLERK
By: Deputy Clerk

Defendant: LEE TRIPP
Case Number: CR 97-m-1079

PROBATION

The defendant is hereby placed on probation for a term of three (3) year(s).

While on probation, the defendant shall not commit another federal, state, or local crime; shall not illegally possess a controlled substance; shall comply with the standard conditions that have been adopted by this court (set forth below); and shall comply with the following additional conditions:

1. If this judgment imposes a fine, special assessment, costs or restitution obligation, it shall be a condition of probation that the defendant pay any such fine, assessment, costs and restitution.

2. The defendant shall not own or possess a firearm or destructive device.

3. The defendant is to be confined to his residence for a period of TWO months commencing at the direction of the probation office. The defendant shall be required to be at this residence at all times except for approved absences for gainful employment, community service, religious services, medical care, educational or training programs and at other such times as may be specifically authorized by the probation office. The defendant shall wear an electronic monitoring device and follow electronic monitoring procedures. The defendant shall permit the probation officer access to the residence at all times and maintain a telephone at the residence without any custom services or portable, cordless equipment. The defendant shall comply with any other specific conditions of home confinement as the probation officer requires. The defendant shall pay the costs of electronic monitoring, specifically $4.97 per day.

4. The defendant is to fully cooperate with the Internal Revenue Service by filing all delinquent or amended returns within six months of the sentance date and to timely file all future returns that come due during the period of probation. The defendant is to properly report all correct taxable income and claim only allowable expenses on those returns. The defendant is to provide all appropriate documentation in support of said returns. Upon request, the defendant is to furnish the Internal Revenue Service with information pertaining to all assets and liabilities, and the defendant is to fully cooperate by paying all taxes, interest and penalties duel, and otherwise comply with the tax laws of the United States.

5. The defendant shall provide the U.S. Probation Office with full disclosure of his financial records to include yearly income tax returns upon the request of the U.S. Probation Office. The defendant shall cooperate with the probation officer in the investigation of his financial dealings and shall provide truthful monthly statements of his income.

6. The defendant shall refrain from the use of alcohol and shall submit to testing to ensure compliance. It is further ordered that the defendant submit to evaluation and treatment if directed by the U.S. Probation Office. The defendant shall abide by the rules of any program and remain in treatment until satisfactorily discharged with the approval of the U.S. Probation Office.

7. The defendant shall refrain from the illegal possession and/or use of drugs and shall submit to urinalysis or other forms of testing to assure compliance. It is further ordered that the defendant shall submit to drug treatment, on an outpatient or inpatient basis, if directed by the U.S. Probation Office. The Defendant shall abide by the rules of any program and shall remain in treatment until satisfactorily discharged with the approval of the U.S. Probation Office.

8. The defendant shall participate in a mental health program for evaluation and/or treatment if directed by the U.S. Probation Office. The defendant shall remain in treatment until satisfactorily discharged and with the approval of the U.S. Probation Office.

Defendant: LEE TRIPP
Case Number: CR 97-m-1079

PROBATION

STANDARD CONDITIONS OF PROBATION

While the defendant is on probation pursuant to this Judgment:

1)The defendant shall not leave the judicial district without the permission of the court or probation officer.
2)The defendant shall report to the probation officer as directed by the court or probation officer and shall submit a truthful and complete written report within the first five days of each month.
3)The defendant shall answer truthfully all inquiries by the probation officer and follow the instructions of the probation officer.
4)The defendant shall support his or her dependents and meet other family responsibilities.
5)The defendant shall work regularly at a lawful occupation unless excused by the probation officer for schooling, training, or other acceptable reasons.
6)The defendant shall notify the probation officer within seventy-two hours of any change in residence or employment.
7)The defendant shall refrain from excessive use of alcohol and shall not purchase, possess, use, distribute or administer any narcotic or other controlled substance, or any paraphernalia related to such substances.
8)The defendant shall not frequent places where controlled substances are illegally sold, used, distributed, or administered.
9)The defendant shall not associate with any persons engaged in criminal activity, and shall not associate with any person convicted of a felony unless granted permission to do so by the probation officer.
10)The defendant shall permit a probation officer to visit him or her at any time at home or elsewhere and shall permit confiscation of any contraband observed in plain view by the probation officer.
11)The defendant shall notify the probation officer within seventy-two hours of being arrested or questioned by a law enforcement officer.
12)The defendant shall not enter into any agreement to act as an informer or a special agent of a law enforcement agency without the permission of the court.
13)As directed by the probation officer, the defendant shall notify third parties of risks that may be occasioned by the defendant's criminal record or personal history or characteristics, and shall permit the probation officer to make such notifications and to confirm the defendant's compliance with such notification requirement.

Defendant: LEE TRIPP
Case Number: CR 97-m-1079

FINE

The defendant shall pay a fine of $ 1,000.00.

If the fine is not paid, the court may sentence the defendant to any sentence which might have been originally imposed. See 18 U.S.C. § 3614.

Defendant: LEE TRIPP
Case Number: CR 97-n-1079

STATEMENT OF REASONS

The court adopts the factual findings and guideline application in the presentence report.

Guideline Range Determined by the Court:
Total Offense Level:
Criminal History Category:
Imprisonment Range: months to life
Supervised Release Range: to years
Fine Range: $ to $
Restitution: $

The sentence is within the guideline range, that range does not exceed 24 months, and the court finds no reason to depart from the sentence called for by application of the guidelines.

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

Official Use Only

MD-037200-L

TRIPP RNEW

THIS IS YOUR RENEWAL NOTICE - REQUIRED FEE - $125.00

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

LEE ANTHONY TRIPP
[redacted]
WILLIAMSTOWN, NJ 08094

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

(✓) ( ) 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. Illinois

( ) (✓) 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?

(✓) ( ) 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.)

( ) (✓) 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.

( ) (✓) 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?

( ) (✓) 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: [redacted] DATE: 11/27/2000

State Board of Medicine
P.O. Box 8414
Harrisburg, PA 17105-8414

Lee A. Tripp, M.D.
[redacted]
Williamstown, NJ 08094

November 27, 2000

Dear State Board of Medicine,

At the time of my last renewal, I made the Board aware of a guilty plea that I entered in July 1997 in reference to my failure to file an income tax return in 1990. I received 3 years probation, a fact of which I also made the Board aware.

In October of 1999, I was charged with violating my probation to which I plead not guilty. The case went to trial on 1/14/00 and I was found guilty of violating my probation. My probation was revoked and I was sentenced to 6 months at the Kintock Group Community Center in Philadelphia. That 6-month term was successfully completed on July 9, 2000. Information was forwarded to the State Board of Medicine from the Federal Courts in Camden New Jersey in January 2000 concerning this matter.

I have no other legal issues concerning this matter or any others.

Truly Yours,

[redacted]

Lee A. Tripp, M.D.

```
CPAA4 (S40423)          SENTENCE MONITORING                    06-13-2000
PAGE 001                   COMPUTATION DATA                    14:44:51
                          AS OF 06-13-2000

REGNO..: 19984-050 NAME: TRIPP, LEE

FBI NO.:                                        DATE OF BIRTH: [redacted]
ARS1...: CPA/A-DES
UNIT...:                                        QUARTERS.....:
DETAINERS.....: NO                              NOTIFICATIONS: NO

THE FOLLOWING SENTENCE DATA IS FOR THE INMATE'S CURRENT COMMITMENT.
THE INMATE IS PROJECTED FOR RELEASE: 07-09-2000 VIA FT REL

----------------------CURRENT JUDGMENT/WARRANT NO: 010----------------------

COURT OF JURISDICTION.....: NEW JERSEY
DOCKET NUMBER.....: CR 97-M-1079
JUDGE.....: KUGLER
DATE SENTENCED/PROBATION IMPOSED: 11-12-1997
DATE PROBATION REVOKED.....: 01-18-2000
TYPE OF PROBATION REVOKED.....: REG
DATE COMMITTED.....: 02-15-2000
HOW COMMITTED.....: PROBATION VIOL (US OR DC CD)
PROBATION IMPOSED.....: NO

                  FELONY ASSESS  MISDMNR ASSESS  FINES          COSTS
NON-COMMITTED..:  $00.00         $25.00          $1,000.00      $00.00

RESTITUTION...:  PROPERTY: NO  SERVICES: NO      AMOUNT:  $00.00

-------------------------CURRENT OBLIGATION NO: 010-------------------------
OFFENSE CODE....: 193
OFF/CHG: 26:7203; FAILURE TO FILE TAX RETURN
         (PROBATION VIOLATOR)

SENTENCE PROCEDURE.....: 3559 SRA SENTENCE
SENTENCE IMPOSED/TIME TO SERVE.:      6 MONTHS
DATE OF OFFENSE.....: 04-15-1991

G0002       MORE PAGES TO FOLLOW
```

CPAA1 540423 SENTENCE MONITORING 06-13-2000
PAGE 002 OF 002 COMPUTATION DATA 14:44:51
AS OF 06-13-2000

REGNO.: 19984-050 NAME: TRIPP, NEE

CURRENT COMPUTATION NO: 010

COMPUTATION 010 WAS LAST UPDATED ON 06-13-2000 AT CPA AUTOMATICALLY

THE FOLLOWING JUDGMENTS, WARRANTS AND OBLIGATIONS ARE INCLUDED IN CURRENT COMPUTATION 010: 010 010

DATE COMPUTATION BEGAN: 01-18-2000
TOTAL TERM IN EFFECT: 6 MONTHS
TOTAL TERM IN EFFECT CONVERTED: 6 MONTHS

JAIL CREDIT

FROM DATE	THRU DATE
10-30-1993	10-30-1993
07-23-1997	07-23-1997
06-26-1998	06-26-1998
11-18-1999	11-18-1999
01-14-2000	01-17-2000

TOTAL PRIOR CREDIT TIME: 8
TOTAL INOPERATIVE TIME: 0
TOTAL GCT POSSIBLE: 0
TOTAL GCT AWARDED: 0
STATUTORY RELEASE DATE (CURRENT): 07-09-2000
SIX MONTH /10% DATE: 06-22-2000
EXPIRATION FULL TERM DATE: 07-09-2000

PROJECTED SATISFACTION DATE: 07-09-2000
PROJECTED SATISFACTION METHOD: FT REL

REMARKS: DEFENDANT WAS DELIVERED TO THE KINTOCK GROUP CSC, PHILA., PA ON 02-15-00. COMPUTATION WAS UPDATED 06-13-00, TO AMEND JAIL CREDIT.

COMPUTED BY: [signature] 06-21-00
AUDITED BY: [signature]

G0000 TRANSACTION SUCCESSFULLY COMPLETED

STATE BOARD OF MEDICINE
P. O. Box 2649
Harrisburg, PA 17105-2649
www.dos.state.pa.us

December 28, 2004

LEE ANTHONY TRIPP
[redacted]
WILLIAMSTOWN NJ 08094

RE: MD037200E

ONLINE RENEWAL DISCREPANCY NOTICE

Dear Licensee:

Thank you for processing your license renewal on-line.

As per the instructions on the web renewal site, "yes" answers to several questions requires submission of documentation before the license record can be renewed. The record reflects that you answered "yes" to one of the questions. You are required to send the Board the appropriate documentation regarding that answer as indicated below.

Please be advised that your license will not be renewed until such time as the required information is received.

- ☐ Question 1 – "Are you submitting a name change with this renewal?" A COPY OF THE LEGAL DOCUMENT RELATING TO YOUR NAME CHANGE MUST BE SUBMITTED (MARRIAGE CERTIFICATE, DIVORCE DECREE OR LEGAL COURT DOCUMENT)
- ☐ Question 3 – "Since your last renewal, has a licensing jurisdiction taken any disciplinary action against you?" CERTIFIED COPIES OF ALL DOCUMENTS REGARDING THE ACTION MUST BE SENT TO THE BOARD.
- ☐ Question 4 – "Since your last renewal, have you been convicted of a crime?" CERTIFIED COPIES OF ALL DOCUMENTS REGARDING THE CONVICTION (STATEMENT OF CHARGES AND JUDGMENT/SENTENCING ORDER) MUST BE SENT TO THE BOARD
- ☐ Question 5 – "Since your last renewal, have you withdrawn an application for licensure in another licensing jurisdiction?" DETAILED EXPLANATION MUST BE SENT TO THE BOARD.
- ☐ Question 8 – "Since your last renewal, have your provider privileges been terminated by any medical assistance agency for cause?" CERTIFIED COPIES OF ALL DOCUMENTS REGARDING THE TERMINATION MUST BE SENT TO THE BOARD.
- ☐ Question 9 – "Since your last renewal, have you had practice privileges denied, revoked or restricted in a hospital or health care facility?" CERTIFIED COPIES OF ALL DOCUMENTS REGARDING THE ACTION MUST BE SENT TO THE BOARD.
- ☐ Question 10 – "Since your initial application or your last renewal, have you had your DEA registration denied, revoked or restricted?" CERTIFIED COPIES OF ALL DOCUMENTS MUST BE SENT TO THE BOARD
- ☐ Question 34 – Since your last renewal, have you been arrested for criminal homicide, aggravated assault, sexual offenses or drug offenses in any state territory or country? CERTIFIED COPIES OF ALL COURT DOCUMENTS MUST BE SENT TO THE BOARD
- ☐ Question 39 – Since your last renewal, have any malpractice complaints been filed against you?" COMPLETE COPY OF THE COMPLAINT MUST BE SENT TO THE BOARD. IF YOU HAVE ALREADY REPORTED THE COMPLAINT TO THE BOARD, PLEASE INDICATE SUCH AND INDICATE DOCKET NUMBER

You answered "no" to the question of meeting the continuing education requirement. Your license cannot be renewed until you have met the requirement. A blank renewal application is enclosed for certifying that you have met the requirements and should be returned at that time.

NOTE

In order to process your renewal in a timely manner, please make sure a copy of this letter is attached to the required documents and indicate you renewed on-line.

STATE BOARD OF MEDICINE

RENEWAL APPLICATION - MD

Lee A. Tripp, M.D.
Full Name

[redacted]
Street Address

Williamstown NJ 08094 MD-037200-E
City State Zip Code 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.)

SECTION A - THE FOLLOWING LICENSE RENEWAL QUESTIONS MUST BE ANSWERED

YES	NO	If YES to question 2, 3, 4, 5, 6, 7 or 8 – provide details AND attach certified copies of legal document(s).
✓		1. Do you hold a license (active, inactive or expired) to practice in any other state or jurisdiction? List: Illinois
	✓	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?
	✓	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?
	✓	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?
	✓	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?
	✓	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?
	✓	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?
	✓	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 _____
✓		9a. Do you provide health care services to patients within the Commonwealth of PA?
✓		b. If yes, is the percentage of patients that you provide care for in the Commonwealth 20% or more of your practice?
✓		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, 2006 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.

LICENSE NUMBER: _____

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) [redacted] Date: 12/31/04

☐ 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 →	[redacted]
Pay this amount to "COMMONWEALTH OF PENNSYLVANIA" →	$360.00

Make sure license number is on your payment. A $35.00 fee will be assessed for returned payments.
A late fee of $10 per month, or part of a month, will be assessed if postmarked AFTER 12-31-04.
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: NOVEMBER 30, 2004

Online Renewal

[redacted]

TARGET SHEET

Board: Medicine

Date Created:
10/29/2004

Licensee Full Name:
LEE ANTHONY TRIPP

License No:
MX001652

APPL 2095968

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 (MD 037200 E)

[redacted]

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 PHYSICIAN ASSISTANT(S)

Mary Conway MA [illegible]

LIST ANY SUBSTITUTE PHYSICIANS YOU ARE AGREEING

Janet Wilson

LIST ANY SUBSTITUTE PHYSICIANS YOU ARE AGREEING

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

THE FOLLOWING MUST BE CHECKED:

WILL THERE BE ANY CHANGE IN SUPERVISION? **YES** **NO**

WILL THERE BE ANY CHANGE IN SUBSTITUTE SUPERVISORS? **YES** **NO**

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

- *A CURRENT WRITTEN AGREEMENT*
- *LIST OF ADDITIONS*
- *DRUG LIST IF PRIMARY SUPERVISOR IS AN MD*

SIGNATURE OF SUPERVISOR [signature] *DATE* 7/11/11

SIGNATURE OF PHYSICIAN ASSISTANT *DATE*

SIGNATURE OF NEW SUPERVISOR *DATE*

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

[redacted]

TARGET SHEET

Board: Medicine

Date Created:
05/08/2009

Licensee Full Name:
LEE ANTHONY TRIPP

License No:
MN000994

APPL 2028451

Planned Parenthood®
Southeastern Pennsylvania

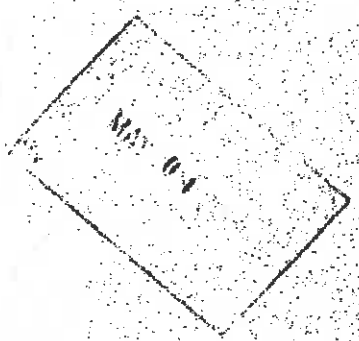
Thursday, April 30, 2009

Dear Sir/Madam,

It has been brought to my attention that the written agreement MA000994 of my license for Laura Blechner PAC was inactivated in 2003. Apparently this occurred when my medical license lapsed for a short period of time. Laura has continued to practice at Planned Parenthood SEPA since that time. It was never my intention to dissolve this relationship, nor did I realize that this agreement was inactivated.

I am writing at this time to request that the written agreement for Laura Blechner PAC be reactivated as soon as possible. Please direct communication to Deb Lennon, Clinical Services Coordinator, in order to expedite any paperwork that may be required.

I sincerely apologize for this misunderstanding.



Sincerely,

[redacted]

Lee Tepp MD

1144 Locust Street • Philadelphia PA 19107-6434 • 215-351-2500 • FAX 215-351-2538
Telephone 800-230-PLAN (7526)

[redacted]

TARGET SHEET

Board: Medicine

Date Created:
12/12/2005

Licensee Full Name:
LEE ANTHONY TRIPP

License No:
MX004512

APPL	2350644

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

December 12, 2005

LEE A TRIPI
PLANNED PARENTHOOD SEPA
[redacted]
PHILADELPHIA, PA 19107

RE: KAREN R MCKINNEY, PA-C

Dear Doctor:

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

Sincerely,

State Board of Medicine

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

December 12, 2005

LEE ANTHONY TRIPP
PLANNED PARENTHOOD SEPA
[redacted]
PHILADELPHIA PA 19107

RE: KAREN ROGAN MCKINNEY

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, 540 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 (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 to exercise your professional judgment regarding this matter.

Sincerely,

State Board of Medicine

(49-108) (REV. 12/95)
STATE BOARD OF MEDICINE
P.O. BOX 2649
HARRISBURG, PA 17105-2649
717-783-1400
717-787-2191

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 are applicable, are identical for all supervisors, submit one application for each physician and attach [illegible] this application. Attach fee and written agreement along with drug list, if applicable. PENNSYLVANIA LAW REQUIRES THAT YOU MAINTAIN A COPY OF THIS APPLICATION AND ALL ATTACHMENTS.

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 [illegible] UNPAID BY YOUR FINANCIAL INSTITUTION. [illegible] *MAKE CHECK PAYABLE TO "COMMONWEALTH OF PENNSYLVANIA." FEE IS NOT REFUNDABLE.*

PLEASE PRINT OR TYPE ALL INFORMATION

PRIMARY PHYSICIAN ASSISTANT SUPERVISOR NAME/LICENSE NUMBER

Tripp (LAST) Lee (FIRST) H (MIDDLE) MD 041200 (LICENSE NO.)

PHYSICIAN ASSISTANT NAME/LICENSE NUMBER

McKinney (LAST) Karen (FIRST) R (MIDDLE) PA 22 253 813 (LICENSE NO.)

PRACTICE ADDRESS: Planned Parenthood SEPA, 1144 Locust St (STREET)

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

PRACTICE TELEPHONE: [redacted]

49-10s (REV. 1-05)

Primary Physician Assistant Supervisor must complete:

List Specialties OB-Gyn

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

If yes, list Board(s) ____

If you have hospital staff privileges, indicate hospital name(s):
N/A

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, writing agreement and any 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 render to primary physician assistant supervisor and substitute physician assistant supervisors listed in this application. This physician assistant will only provide medical services to the patients under the care of the primary and substitute supervising physicians listed in this application.

[redacted]
Signature of Primary Physician Assistant Supervisor

11/10/05
Date

Name of Substitute Physician Assistant Supervisor Joel Lebel DO

Signature [redacted] Date 11/10/05 MD OC003518L

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

19-108 (REV. (2/05))

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

WRITTEN AGREEMENT

Lee A. Tripp, M.D. ____________________ Lee S [illegible]

PRIMARY PHYSICIAN ASSISTANT SUPERVISOR ____________________ PHYSICIAN ASSISTANT SIGNATURE

See attached written agreement

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 oversight will be exercised, each supervising physician's 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 1 of this application:
YES ✓ NO ____

5. Will the physician assistant prescribe and dispense drugs?
YES ✓ NO ____ If yes, please complete page 4. when supervised by MD
No when supervised by DO
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.

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.

PRESCRIBING AND DISPENSING DRUGS BY PHYSICIAN ASSISTANT

Print or type name

Lee Trapp — PRIMARY PHYSICIAN ASSISTANT SUPERVISOR

Karen McKinley — 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 drugs without limitation and as follows:

	(i)	Antihistamines.
X	(ii)	Anti-infective agents.
X	(iii)	Cardiovascular drugs.
X	(iv)	Contraceptives - for example, loops and devices.
	(v)	Diagnostic agents.
	(vi)	Disinfectants - for agents used on drugs 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.
X	(xiii)	Skin and mucous membrane drugs.
	(xiv)	Smooth muscle relaxants.
	(xv)	Vitamins.

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

	(i)	**Autonomic drugs.** Drugs excluded under this category: (A) Sympathomimetic (adrenergic) agents.
	(ii)	**Blood formation and coagulation.** Drugs excluded under this category: (A) Anti-coagulant and coagulant. (B) Thrombolytic agents.
	(iii)	**Central nervous system agents.** Drugs excluded under this category: (A) Narcotic analgesics. (B) Muscarinic cholinergic blocking agents.
	(iv)	**Eye, ear, nose and throat preparations.** Drugs excluded under this category: Mydriatics and cycloplegics used to treat glaucoma require specific approval from the physician assistant supervisor for a named patient.
X	(v)	**Hormones and synthetic substitutes.** Drugs excluded under this category: (A) Pituitary hormones and analogs. (B) Pituitary (L) hormone antagonists.

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
     - 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

Lee A. Tripp, M.D.
Name of Primary Physician Assistant Supervisor

[redacted]
Signature of Primary Physician Assistant Supervisor

Joel R. Lebed, DO
Name of Substitute Physician Assistant Supervisor

[redacted]
Signature of Substitute Physician Assistant Supervisor

Karen R. McKinney
Name of Physician Assistant

[redacted]
Signature of Physician Assistant

11/10/05
Date

PHYSICIAN ASSISTANT

PRIMARY PHYSICIAN

SUBSTITUTE PHYSICIAN

	APPROVED	PENDING
FEE		
APPLICATION		
WRITTEN AGREEMENT		
DRUG LIST		

Prescription (Y) N

Hosp. Tel Y (N)

Y OR (N) SCHED 3, 4, 5/OR 6

APPROVAL LTR ISSUED

License #

TARGET SHEET

Board: Medicine

Date Created:
10/10/2008

Licensee Full Name:
LEE ANTHONY TRIPP

License No:
MD0045127

APPL 2350544

WRITTEN AGREEMENT CHANGE FORM

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

Lee Anthony Terpstra mx00455 12

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

Karen Regan McKinney MA25 1184

C. NAME AND LICENSE NUMBER OF THE PHYSICIAN ASSISTANT (MA) YOU ARE DELETING

Karen Regan McKinney

D. LIST THE NAME AND LICENSE NUMBER OF THE SUBSTITUTE PHYSICIAN (MD OR DO) YOU ARE ADDING

E. LIST THE NAME AND LICENSE NUMBER OF THE SUBSTITUTE PHYSICIAN (MD OR DO) YOU ARE DELETING

***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 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

SIGNATURE OF PRIMARY SUPERVISOR [redacted] DATE 12/1/08

SIGNATURE OF PHYSICIAN ASSISTANT [redacted] DATE 11/21/08

SIGNATURE OF NEW SUBSTITUTE ____ DATE ____

[redacted]

TARGET SHEET

Board: Medicine

Date Created:
10/10/2008

Licensee Full Name:
LEE ANTHONY TRIPP

License No:
MN0058815

APPL 2456143

WRITTEN AGREEMENT CHANGE FORM

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

Lee Anthony Tripp MX0053415

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

Alexandre Geronian MA0041927

C. NAME AND LICENSE NUMBER OF THE PHYSICIAN ASSISTANT (MA) YOU ARE DELETING

Alexandre Geronian MA0041927

D. LIST THE NAME AND LICENSE NUMBER OF THE SUBSTITUTE PHYSICIAN (MD OR DO) YOU ARE ADDING

E. LIST THE NAME AND LICENSE NUMBER OF THE SUBSTITUTE PHYSICIAN (MD OR DO) YOU ARE DELETING

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 DESIGNATED SCHEDULE(S) THAT WILL BE PRESCRIBED AND/OR 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

SIGNATURE OF PRIMARY SUPERVISOR [redacted] DATE 10/1/07

SIGNATURE OF PHYSICIAN ASSISTANT [redacted] DATE 9/21/07

SIGNATURE OF NEW SUBSTITUTE DATE

[redacted]

TARGET SHEET

Board: Medicine

Date Created:
12/12/2006

Licensee Full Name:
LEE ANTHONY TRIPP

License No:
MX005815

APPL 2456143

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

December 12, 2006

LEE ANTHONY TRIPP
[redacted]
PHILADELPHIA PA 19107

RE: ALEXANDRE GERONIAN

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 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, 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 (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 created 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

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

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

MX | 5/11/5 | 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 for applicant [illegible] all supervising doctors for applicant on each physician assistant's [illegible] this application. Attach the one written agreement signed with [illegible] application. PENNSYLVANIA LAW REQUIRES THAT YOU MAINTAIN A COPY OF THIS APPLICATION AND ALL ATTACHMENTS.

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. [illegible] MAKE CHECK PAYABLE TO "COMMONWEALTH OF PENNSYLVANIA." *FEE IS NOT REFUNDABLE.*

PLEASE PRINT OR TYPE ALL INFORMATION.

PRIMARY PHYSICIAN ASSISTANT SUPERVISOR NAME/LICENSE NUMBER:

Trapp (LAST) Lee (FIRST) N (MIDDLE) 053200 (LICENSE #)

PHYSICIAN ASSISTANT NAME/LICENSE NUMBER:

Geronion (LAST) Alexandre (FIRST) [illegible] 051921 (LICENSE #)

[illegible] Address: [redacted] (STREET)

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

[illegible] Telephone: [redacted]

41.sc. (rev. 11/05)

Primary Physician Assistant Supervisor must complete:

List Specialties OB-GYN

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

If yes, list Boards: _____

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

None

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, 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.

[redacted] 11/16/06
Signature of Primary Physician Assistant Supervisor Date

Name of Sub[redacted] Supervisor Joel Leland

Signature [redacted] Date 11/16/06 MD# 05-0055184-L

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.)

49-10R (REV. 12/05)

WRITTEN AGREEMENT

Lee Tripp [redacted]

PRIMARY 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.

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.

Planned Parenthood SCPA, 1144 Locust St, Phila, Pa

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.

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.

PRESCRIBING AND DISPENSING DRUGS BY PHYSICIAN ASSISTANT

Print or type name

Lee Tripp — Alexandre Germain

(PRIMARY SUPERVISING PHYSICIAN) — (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: Mydrics and myliatrics 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:
     - Breast problems including galactorrhea, postpartum breast conditions, masses/nodularity, nipple discharge, and path
     - 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

[redacted] M.D.
Name of Primary Physician Assistant Supervisor — Signature of Primary Physician Assistant Supervisor

[redacted] T.O.
Name of Substitute Physician Assistant Supervisor — Signature of Substitute Physician Assistant Supervisor

Alexandree Gerard [redacted]
Name of Physician Assistant — Signature of Physician Assistant

11/13/06
Date

PHYSICIAN ASSISTANT Gevaisan Alexandre

PRIMARY PHYSICIAN Tsarp Lee

SUBSTITUTE PHYSICIAN 1

	APPROVED	PENDING
FEE	OK	
APPLICATION	OK	
WRITTEN AGREEMENT	Legal	
DRUG LIST	OK	

Prescription (Y) N

Hospital Y (N)

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

APPROVAL LTR ISSUED 12-12-06

License # MX0652815

[redacted]

TARGET SHEET

Board: Medicine

Date Created:
01/08/2009

Licensee Full Name:
LEE ANTHONY TRIPP

License No:
[redacted]

APPL 2665753

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

January 8, 2009

LEE ANTHONY TRIPP
[redacted]
PHILADELPHIA PA 19157

RE: LORI ANN HOLENCIK

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/pol. 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 diagnoses and instituting care plans for the physician's patients.

If you desire your physician assistant to provide services beyond those provided 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-physicians in the performance of medical services.

The Board is unable to pre-approve procedures which are not contained in the regulations. 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 does not, by law, do 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 18.401 – 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 the 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 supervisors, include one application for each physician assistant. Attach the fee and a copy of the agreement.

FEE - $25.00 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.

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

PHYSICIAN ASSISTANT NAME/LICENSE NUMBER

PRACTICE ADDRESS

PRACTICE TELEPHONE

PRIMARY SUPERVISING PHYSICIAN MUST COMPLETE THIS SECTION

List your specialties

Do you hold a certification in any American Board of Medical Specialties?

If yes, list Boards

Do you hold hospital staff privileges?

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

VERIFICATION

I will direct and exercise supervision over the named physician assistant in accordance with the laws 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 required 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 the 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 on 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 on this application will only work with the primary supervising physician and substitute physician assistant supervisor(s) listed on the application. The physician assistant will only provide medical services to the patients under the care of the primary and substitute supervisor(s) listed on this application.

[redacted] n/a

Signature of Primary Supervising Physician Date

[redacted]

Signature of Physician Assistant Date

Name of Substitute Physician Assistant Supervisor

License #

Signature [redacted] Date

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.)

WRITTEN AGREEMENT

[illegible] — NAME OF PRIMARY SUPERVISING PHYSICIAN

[illegible] — NAME OF PHYSICIAN ASSISTANT

INSTRUCTIONS: Please provide the following information for questions 1 and 2 or [illegible] where [illegible] form. Number each section on the attachment. The information [illegible] this agreement [illegible] late, on page 2.

1. **Describe the functions/tasks to be delegated to the physician assistant**

   See attached agreement

2. **Provide details regarding the time, place and manner of supervision and direction you will provide the physician assistant**

   See attached agreement

3. **List the name, address, and practice setting (i.e. hospital, private practice, group practice, etc.) where the physician assistant will serve**

   [illegible]

   [illegible]

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

   YES ✓ NO ____

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

   Antineoplastic agents, Cardiac [illegible]
   Hormones, [illegible] agents
   Blood formation, Electrolyte, [illegible]
   Coagulation/Anticoagulation, Enzymes
   Thrombolytic/Antithrombotic, [illegible]

   If yes, will Schedule II, III, IV and/or V 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:
     - 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 patient's needs require care outside of the functions and tasks of the Physician Assistant. Referrals within Planned Parenthood might also include colposcopy, cervical biopsy, abortion, Neoplan 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 processing 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 trichloracetic acid or podophyllin application
     - 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 review of charts and direction of the Physician Assistant as needed. Telephone contact and advice will be available if necessary.
3. The Physician Assistant will be utilized at [redacted] location(s).

Lee Hirsch
Name of Primary Physician Assistant Supervisor

[redacted]
Signature of Primary Physician Assistant Supervisor

Janet Weinstein
Name of Substitute Physician Assistant Supervisor

[redacted]
Signature of Substitute Physician Assistant Supervisor

Lori Heberlein
Name of Physician Assistant

[redacted]
Signature of Physician Assistant

6/7/13
Date

PHYSICIAN ASSISTANT

PRIMARY PHYSICIAN

SUBS 1

	APPROVED	PENDING
FEE	/	
APPLICATION	/	

WRITTEN AGREEMENT

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

APPROVAL LTR ISSUED

WA NUMBER MX