



Washington State Department of  
**Health**  
 Medical Quality Assurance Commission  
 PO Box 47866  
 Olympia, WA 98504-7866  
 360-236-2750

**Medical Quality Assurance Commission**  
[Medical.Commission@doh.wa.gov](mailto:Medical.Commission@doh.wa.gov)  
**Fax: 360-236-2795**

## Request to Add or Change Alternate Supervisor

Certified Physician Assistant     
  Physician Assistant     
  Physician Assistant-Surgical Assistant

Physician Assistant Name: \_\_\_\_\_

Current Primary Physician Sponsor/Supervisor: \_\_\_\_\_

Business Phone: \_\_\_\_\_

We request the following physician to be added as an alternate supervisor to the current approved delegation agreement:

Name of alternate physician: \_\_\_\_\_

Current Alternate Physician Practice Address: \_\_\_\_\_

I certify I have reviewed the current physician assistant rules and regulations for the above licensed physician assistant and hereby accept my responsibility as an Alternate Physician.

\_\_\_\_\_  
 Signature of Alternate Physician Date (mm/dd/yyyy)

We, the undersigned, hereby certify under penalty of perjury under the laws of the state of Washington that the foregoing information in this attachment to the delegation agreement is correct to the best of our knowledge and belief. We, again, further certify that we have reviewed the current statutes, rules, and regulations of Washington State pertaining to physician assistants and the practice description and understand our duties and responsibilities as outlined in [WAC 246-918](#) and [RCW 18.71A.050](#).

\_\_\_\_\_  
 Signature of Physician Assistant Date (mm/dd/yyyy)

\_\_\_\_\_  
 Signature of Supervising Physician Date (mm/dd/yyyy)

**For Office use only**

Approved     
  Disapproved     
 Review date \_\_\_\_\_

Signature \_\_\_\_\_