



Washington State Department of  
**Health**

Medical Quality Assurance Commission

P.O. Box 47866

Olympia, WA 98504-7866

Phone – Last name begins with:

360.236.2766 (A–L)

360.236.2767 (M–Z)

## Physician Assistant Remote Site Request Form

A remote site is defined as a setting physically separate from the supervising physician's primary place for meeting patients or a setting where the physician is present less than twenty-five percent of the practice time of the licensee. ([WAC 246-918-120](#))

Complete only if the physician assistant will be practicing in a remote site.

### Physician Assistant Data

Physician Assistant Name

Work Phone #

Remote Business Address

City

State

Zip Code

Contact Email Address

Contact Phone #

### Supervising Physician Data (MD Only)

Physician Name

Work Phone #

Primary Business Address

City

State

Zip Code

Contact Email Address

Contact Phone #

### Alternate Supervising Physician Data (MD or DO)

Physician Name

Work Phone #

Primary Business Address

City

State

Zip Code

Contact Email Address

Contact Phone #

### Physician Group

Business Name

Specialty?

Primary Business Address

City

State

Zip Code

Contact Name

Contact Phone #

Contact Email Address

Medial Staff Office Phone #

**Remote Site Practice Questions:**

Practice Sites (Please mark all that applies to this request	How many hours per week does the PA spend at each setting?	How many hours per does the supervising MD spend at each setting?	How many hours per week are the supervising MD and PA at each setting at the same time?
Supervising physician's primary practice site			
Primary care or specialty care clinic			
Mental health facility			
Hospital			
Emergency room			
Ambulatory surgical center			
Free standing urgent care clinics			
Chemical dependency settings			
Nursing home/Rehabilitation			
Home visit			
Adult family home visits			
Hospice care			
Correctional facility			
Retail clinics			
Medical spas			
Occupational medicine			
Other – Please describe			
<b>Note:</b> Percentage of time should equal 100%			

1. Will this physician assistant practice in more than one remote site setting?  Yes  No

If yes, list other sites starting with this remote site. If not applicable please not N/A:

Name of Physician	Address	Phone #
_____	_____	_____
_____	_____	_____
_____	_____	_____

2. Describe the general duties to be performed by the physician assistant in each of the remote site settings selected above. (Attach additional paper if necessary)

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3. Describe the remote settings plan for supervision, such as face to face discussion, chart reviews, joint rounding, conference calls, performance evaluations, etc. (Attach additional paper if necessary)

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**Agreement:**

The information in this practice plan is accurate, and we agree to abide by its terms.

_____ Print Name	_____ Signature of Physician Assistant	_____ Date
_____ Print Name	_____ Signature of Supervising Physician	_____ Date
_____ Print Name	_____ Signature of Alternate Physician (Not applicable if group practice)	_____ Date

**Termination:**

If this practice plan is terminated, both the supervising physician and physician assistant must notify the Medical Quality Assurance Commission in writing of that termination by either a letter or email. ([WAC 246-918-110](#)) Send notification to Medical Quality Assurance Commission, PO Box 47866, Olympia, Washington 98504 or by email to [medical.commission@doh.wa.gov](mailto:medical.commission@doh.wa.gov) or by fax to 360.236.2795.