



Washington State Department of

Health

Medical Quality Assurance Commission

P.O. Box 47866

Olympia, WA 98504-7866

360-236-2750

Medical Quality Assurance Commission

Medical.Commission@doh.wa.gov

Fax: 360-236-2795

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. See [RCW 18.71A.035](#).

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

Physician Assistant Data			
Physician Assistant Name:		License #	
Remote Business Address:			
City:		State:	Zip:
Phone (enter 10 digit #)	Email address:		
Primary Supervising Physician Data (MD Only)			
Physician Name:		License #	
Primary Business Address:			
City:		State:	Zip:
Phone (enter 10 digit #)	Email address:		
Alternate Supervising Physician Data (MD or DO)			
Physician Name:		License #	
Primary Business Address:			
City:		State:	Zip:
Phone (enter 10 digit #)	Email address:		
Physician Group			
Business Name:			Specialty:
Primary Business Address:			
City:		State:	Zip:
Medical Staff Office Phone #:	Contact name and email address:		

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

If yes, list all remote sites below. If more than two, please attach additional pages.

Remote Site Practice Questions:

Practice Sites (Please mark all that is applicable to this request.)	How many hours per week does the PA spend at each setting?	How many hours per week 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:			
Remote Site Address:			
Remote Site Address:			

2. Describe the general duties to be performed by the physician assistant in each remote site. Attach additional pages if necessary.

3. Describe the remote site plan for supervision, such as face-to-face discussion, chart reviews, joint rounding, conference calls, performance evaluations, etc. Attach additional pages if necessary.

4. In addition to the PA, describe the other medical staffing (MD or DO) at the remote site, if any.

Agreement:

The information in this delegation agreement is accurate to the best of our knowledge and belief.

Print Name Signature of Physician Assistant Date

Print Name Signature of Supervising Physician Date

Print Name Signature of Alternate Physician Date

If you have listed a designated alternate, the signature of the Alternate Physician is required.