

## STATEMENT OF SPONSORING PHYSICIAN FOR PHYSICIAN ASSISTANT

I hereby request that \_\_\_\_\_ (hereafter "PA") be allowed to function in accordance with the approved Physician Assistant Delineation of Privileges set forth herein.

I have a Delegation Agreement with this PA, which meets all requirements and which the PA and I will review annually. This Delegation Agreement covers all services included in the position summary and includes a statement that I will exercise supervision over the PA and retain professional and legal responsibility for the care he/she renders. If the position summary includes prescribing authority, I have submitted a Prescribing Authority Form to the Arizona Regulatory Board of Physician Assistants.

I acknowledge that a patient visit by my PA does not substitute for my visit. I will countersign and date my PA's history and physicals, discharge summaries and procedural notes (orders and progress notes will not require countersignature).

If I provide medical liability coverage for this PA, I agree to notify Banner Gateway Medical Center immediately upon notification by my carrier, of any change in coverage or carrier that may affect me or the above named PA.

I further agree to notify Banner Gateway Medical Center immediately if my professional relationship with the PA is terminated or otherwise restricted in any way.

I am currently a member in good standing of the Banner Gateway Medical Center Medical Staff. Any suspensions or terminations, temporary or permanent, of my membership or privileges Banner Gateway Medical Center Medical Staff shall result in the suspension or termination of the PA's ability to practice at Banner Gateway Medical Center, at least until a new supervising physician is identified.

I acknowledge that I am responsible for all aspects of the PA's care, including quality of care and for supervising the PA appropriately. As the sponsoring physician, I am responsible for only delegating healthcare tasks the PA can perform safely and has been granted the privilege to perform. I am familiar with the PA's qualifications, character, competence, and health status and believe that he/she is qualified to provide the services requested and can safely and appropriately perform the identified tasks included on the scope of practice checklist.

I acknowledge that I am responsible for the PA's professional conduct. This includes appropriate patient and staff interaction and compliance with all laws governing the performance of healthcare tasks.

In the event the PA is/has been granted the privilege to prescribe, I understand that I am responsible for monitoring prescribing practices to assure compliance with all applicable laws.

\_\_\_\_\_  
Sponsoring Physician Signature

Date: \_\_\_\_\_

\_\_\_\_\_  
Sponsoring Physician Printed Name