



STATE OF TENNESSEE  
DEPARTMENT OF HEALTH  
HEALTH RELATED BOARDS  
227 FRENCH LANDING, SUITE 300  
HERITAGE PLACE METRO CENTER  
NASHVILLE, TENNESSEE 37243

COMMITTEE ON PHYSICIAN ASSISTANTS  
(800) 778-4123, ext. 24384 or (615) 532-3202, ext. 24384

**SUPERVISING PHYSICIANS**

This section must be completed by the supervising physician(s).  
(This page may be duplicated if necessary)

List all practice settings:

1) **Setting:**

\_\_\_\_\_  
Supervising Physician Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Tennessee Medical License Number

2) **Setting:**

\_\_\_\_\_  
Supervising Physician Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Tennessee Medical License Number

3) **Setting:**

\_\_\_\_\_  
Supervising Physician Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Tennessee Medical License Number

4) **Setting:**

\_\_\_\_\_  
Supervising Physician Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Tennessee Medical License Number

**ATTACHMENT 5**

**TENNESSEE BOARD OF MEDICAL EXAMINERS'  
COMMITTEE ON PHYSICIAN ASSISTANTS**

**AUTHORIZATION FOR PRESCRIBING FOR PHYSICIAN ASSISTANTS**

**Supervising Physician**

\_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone Number \_\_\_\_\_

Field of Practice \_\_\_\_\_

Medical License Number \_\_\_\_\_

**Physician Assistant**

\_\_\_\_\_

Field of Practice \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone Number \_\_\_\_\_ TN License Number \_\_\_\_\_

Check the class of drugs you desire to delegate:

- |  |   |
|--|---|
| _____ Analgesics                               | _____ Enzymes                                 |
| _____ Anesthetics                              | _____ Expectorants and Cough Preparations     |
| _____ Antihistamines                           | _____ Eye, Ear, Nose, and Throat Preparations |
| _____ Anti-infective Agents                    | _____ Gastrointestinal Drugs                  |
| _____ Anti-inflammatory Agents                 | _____ Hormones and Synthetic Substitutes      |
| _____ Anti-neoplastic Agents                   | _____ Hyperglycemic Agents                    |
| _____ Antispasmodics and Anticholinergics      | _____ Migraine Preparations                   |
| _____ Antivirals                               | _____ Muscle Relaxant Preparations            |
| _____ Arthritis Medications                    | _____ Narcotic Antagonists                    |
| _____ Autonomic Drugs                          | _____ Oxytocics                               |
| _____ Blood Derivatives                        | _____ Psychotropics                           |
| _____ Blood Formation and Coagulation          | _____ Serum, Toxoids, and Vaccine             |
| _____ Birth Control Drugs and Devices          | _____ Skin and Mucous Membrane Preparations   |
| _____ Bronchodilators/Anti-asthma Drugs        | _____ Smoking Cessation Aids                  |
| _____ Cardiovascular Drugs                     | _____ Smooth Muscle Relaxants                 |
| _____ Central Nervous system Drugs             | _____ Spasmolytic Agents                      |
| _____ Contraceptives                           | _____ Sympathomimetics and Combination        |
| _____ Diabetic Agents                          | _____ Vitamins                                |
| _____ Diagnostic Agents                        | _____ Unclassified Therapeutic                |
| _____ Decongestants                            | _____ Other _____                             |
| _____ Electrolytic, Caloric, and Water Balance | _____   |
|  | _____   |

Check the type **and** schedule of controlled drugs you desire to delegate:

<u>Type</u>	<u>Schedule II</u>	<u>Schedule III</u>	<u>Schedule IV</u>	<u>Schedule V</u>
_____ None	_____	_____	_____	_____
_____ Barbiturates	_____	_____	_____	_____
_____ Benzodiazepines	_____	_____	_____	_____
_____ Depressants	_____	_____	_____	_____
_____ Narcotics	_____	_____	_____	_____
_____ Stimulants	_____	_____	_____	_____
_____ Other (Please List)	_____	_____	_____	_____
	_____	_____	_____	_____

I, \_\_\_\_\_ MD/DO, License Number \_\_\_\_\_  
Please print

I, \_\_\_\_\_ MD/DO, License Number \_\_\_\_\_  
Please print

I, \_\_\_\_\_ MD/DO, License Number \_\_\_\_\_  
Please print

I, \_\_\_\_\_ MD/DO, License Number \_\_\_\_\_  
Please print

do hereby delegate the above prescribing authority to \_\_\_\_\_ PA of whom I am  
the supervising physician and will assume the responsibility according to TCA §63-19-107.

I, \_\_\_\_\_ PA do hereby accept the delegated function of prescribing authorization  
and will utilize it as such according to TCA §63-19-107.

\_\_\_\_\_  
Signature of Physician Assistant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Supervising Physician

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Supervising Physician

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Supervising Physician

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Supervising Physician

\_\_\_\_\_  
Date