# PHYSICIAN ASSISTANT SITE VISIT / INTERVIEW FORM

*{In accordance with Subchapter 32S – Physician Assistant Regulations 21 NCAC 32S.0101-0118, eff. 5/1/2004}*

Name: _____ Date: _____ Start Time:_____
Location of Interview/Inspection: _____ _____End Time: _____
Home Address: _____ Home Phone #: _____
_____ DOB: _____
_____ Social Security #: _____

PA License Number: *[Section .0116]* _____Proof of licensure: Yes _____ No _____
IF license is **Temporary**, Licensing Exam schedule: [see *Section .0103* of Chapter 32/Physician Assistant Regulations] _____
(According to *[c]*, temporary license expires 30 days after PA receives notice of non-passing scores on second attempt of taking a licensing exam. PA must notify Board within **15 days** upon receipt of scores.)

Annual Registration Certificate*: (30 days after PA's birthday) *[Sections .0105&.0116]*
Available for inspection: Yes _____ No _____ Certificate #: _____
Other states currently licensed as a PA: _____

**PRACTICE INFORMATION**:
Work Address: _____ Work Phone #: _____
_____ ext.#: _____
_____

Type Practice: _____ Usual Working Hours: _____ Hours/Week: _____

Primary Supervising Physician: _____
Back-up Supervising Physician(s): _____
_____
Back-up Supervising Physician(s) list available for inspection: Yes_____ No_____

Number of patients PA sees per day: Avg: _____ Max: _____ Min: _____
Hospital privileges: Yes _____ No _____ Hospital(s): _____
Rural health clinic?: Yes _____ No _____
Schedule/Other Practice site(s) where PA sees patients in this practice arrangement in typical week:
_____
_____

Who owns the practice?_____

Does NP have any ownership interest in the practice? (If yes, describe the ownership) _____
_____

Other Extenders same practice site: _____
(Name, specify if NP or PA) _____
_____

**CONTINUING MEDICAL EDUCATION**: *[Section .0106]*
CME during previous 2 year period*[a]*: (100 hours of which 40 hrs American Academy of PA/Category I required) 2 Year Period: _____ to _____ Documentation available for inspection: Yes____ No____
List CME _____
_____
_____

**PRESCRIPTIVE AUTHORITY**: *[Section .0109]*
Dispensing from site(s): Yes _____ No _____ Samples distributed: Yes ____ No ____
Are any Controlled Substance samples distributed: Yes _____ No _____
*Voided Rx blank attached: Yes _____ No _____
Does it contain PA's name, address & practice telephone number? Yes ___ No ___
Does it contain PA's license number? Yes ___ No ___
Does it contain a supervising physician's name & telephone number? Yes ___ No ___
* Some large institutions have prescription pads with the practitioners' names listed but without each practitioner's license and DEA numbers typed on them. In this situation, the PA should provide a copy of a prior prescription that he or she has written.

DEA Privileges: Yes _____ No _____ Schedules: _____ DEA #: _____
DEA registration certificate available for inspection: Yes ____No____ Exp. Date: _____
Does the PA's DEA # appear on Rxs for controlled substances Yes ____ No ____
PA aware of 30 day limit for dosage units of schedules 2, 2N, 3, and 3N :*{B}* Yes _____ No _____

Written instructions for prescribing drugs and written policy for periodic review *[1 & 2]* Yes___ No____
Were prescriptions by PA on file at local pharmacies audited: Yes ____* No _____
*If yes, time period considered? _____
Were controlled substances prescribed? Yes ____ No _____
Comments/Other observations: _____

Were Charts requested during the audit? Yes _____ No _____ Number: ____
Readily Producible: Yes____ No ____ Documentation legible: Yes ____ No ____
Comments: _____

If corresponding chart entries to match prescriptions were checked, did documentation of rxs meet requirements of 21NCAC32S.0109(6)? Yes____ No ____*
*If No, explain discrepancies and attach documentation: _____
_____

**SUPERVISION**: *[Section .0110]*
Supervising Physician on site at all times: Yes _____ No _____
Frequency of face-to-face, one-on-one contact with Primary supervising MD (check one):
_____ Daily _____Weekly _____ Bi-Monthly _____Monthly ____Other: _____

Frequency of other direct communications via telecommunication with Primary supervising MD (check one):
_____ Daily _____Weekly _____ Bi-Monthly _____Monthly ____Other: _____

Frequency of any contact with any of Backup Supervising MDs on record (check one):
_____ Daily _____Weekly _____ Bi-Monthly _____Monthly ____Other: _____

Date/time of most recent contact with primary or a backup supervising MD: _____

PA able to produce signed Statement of Supervisory Arrangements *[b]* Yes _____ No _____ (Required to be available for inspection)

PA able to produce Documentation of Quality Improvement meetings: Yes_____ No_____ (Meetings are required monthly for first 6 months in new practice arrangement; thereafter are required no less than every 6 months)*[Section .0110(b)]*
Dates of most recent Quality Improvement Meetings:
Date: _____ Clinical problems discussed: _____
Date: _____ Clinical problems discussed: _____
Date: _____ Clinical problems discussed: _____
Meeting documentation signed & dated by PA & supervising physician?*[Section .0110(b)]*:Yes___No___
Copy of documentation obtained: Yes ___ No__
If not available for review, why not? _____
_____

**IDENTIFICATION REQUIREMENTS**: *[section .0116]*
Appropriate name tag: Yes _____ No _____
Other methods of identification at practice site(s): _____

**CONCLUSIONS:**
Discrepancies summarized: _____
_____
_____
_____
_____
_____

PA advised of discrepancies: Yes ____ No _____
Primary Supervising MD advised of site check and discrepancies (if any): Yes _____ No _____
Date MD notified: _____ by Meeting ____ by Phone Contact ____

If any items not available at time of inspection, date PA indicates can produce? _____
Return visit or site check recommended by Investigator completing this form: Yes _____ No _____

Comments: _____
_____
_____

Investigator completing this inspection and form: _____