

**PRIMARY PHYSICIAN SUPERVISOR REGISTRATION FORM**

**Colorado Board of Medical Examiners**

**1560 Broadway, Suite 1300, Denver, CO 80202; (303) 894-2433 / FAX (303) 869-0261**

This form is to be completed and forwarded to the Colorado Medical Board upon the formation of a supervisory relationship between a primary physician supervisor and a physician assistant in conformance with Board Rule 400, Licensure of and Practice by Physician Assistants. Secondary supervisors are not required to register with the board.

**CHECK ONE OF THE FOLLOWING:**

- This is a new registration of a primary physician supervisor (check this if you are a first time PA to Colorado)
- This is a change of primary physician supervisor, replacing Dr. \_\_\_\_\_.
- This is an additional primary physician supervisor (check this if you are working for more than one employer.)

**SECTION 1: To be completed by Physician Assistant**

Name of Physician Assistant: \_\_\_\_\_  
(Type or Print Legibly)

Colorado License Number: \_\_\_\_\_

Practice Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

By my signature, I certify that I have reviewed Board Rule 400 regarding Licensure of and Practice by Physician Assistants. I understand that I must comply with this rule as well as and all rules and statutes of the Colorado Medical Board when practicing as a physician assistant in Colorado.

I understand that this primary physician supervisor/physician assistant relationship remains in effect until rescinded in writing to the Board by either party. If rescinded, I further understand I may not practice as a physician assistant until a new primary physician supervisor has been properly registered with the Board.

\_\_\_\_\_  
**Signature of Physician Assistant** \_\_\_\_\_  
**Date**

**SECTION 2: To be completed by the Primary Physician Supervisor**

Name of Primary Supervising Physician: \_\_\_\_\_  
(Type or Print Legibly)

Colorado License Number: \_\_\_\_\_

Practice Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

By my signature, I certify that I have reviewed Board Rule 400 regarding Licensure of and Practice by Physician Assistants. I understand that I must comply with this rule as well as all rules and statutes of the Colorado Medical Board when practicing as a physician and serving as a Primary Physician Supervisor in Colorado.

I understand that this primary physician supervisor/physician assistant relationship remains in effect until rescinded in writing to the Board by either party.

I understand that I may not be the "primary physician supervisor," as described in the rules, for more than two physician assistants, unless I have requested and been granted a specific waiver of this provision of the rule. I understand that I may be a secondary physician supervisor for physician assistants other than the those for whom I am the primary physician supervisor. However, I may supervise **only two physician assistants at one moment in time.**

\_\_\_\_\_  
**Signature of Primary Physician Supervisor** \_\_\_\_\_  
**Date**