Government of the District of Columbia
Department of Health

PHYSICIAN ASSISTANT (PA)
DELEGATION AGREEMENT FORM

This document is to be filed with the Board of Medicine. A duplicate copy is to be kept on site at the primary place of practice. The Delegation Agreement must be signed by both the physician assistant and supervising physician.

If you have any questions, you may email the Board of Medicine at dcbomed@dc.gov.

SECTION 1: PHYSICIAN ASSISTANT

First Name:	**MI:**	**Last Name:**
Date of Birth:	**Gender:** ☐ Male ☐ Female	**DC Lic. #:**

SECTION 2: SUPERVISING PHYSICIAN

First Name:	**MI:**	**Last Name:**
Date of Birth:	**Gender:** ☐ Male ☐ Female	**DC Lic. #:**

SECTION 3: PRACTICE LOCATION(S)

List **ALL** practice locations where the physician assistant(s) will be providing patient care. Use additional sheets if necessary.

PRACTICE LOCATION #1		
Practice Name:		
Practice Address:		
City:	**State:**	**Zip Code:**
Department:	**Phone #:**	

PRACTICE LOCATION #2		
Practice Name:		
Practice Address:		
City:	**State:**	**Zip Code:**
Department:	**Phone #:**	

PRACTICE LOCATION #3		
Practice Name:		
Practice Address:		
City:	**State:**	**Zip Code:**
Department:	**Phone #:**	

SECTION 4: PRONOUNCEMENT OF DEATHS

Indicate whether the physician assistant may pronounce the death of a patient, pursuant to 17 DCMR § 4911.3?

☐ Yes ☐ No

SECTION 5: PRESCRIPTIVE AUTHORITY

Indicate below those drugs and/or devices the physician assistant is delegated to prescribe.

1. **Medical Devices?**		☐ Yes ☐ No
2. **Non-Controlled Medications?**		☐ Yes ☐ No
3. **Controlled Substance Medications?**	☐ Schedule I ☐ Schedule II ☐ Schedule III ☐ Schedule IV ☐ Schedule V	

This delegation of prescriptive authority **DOES NOT** include the following medications:

SECTION 6: MEDICAL MARIJUANA

Indicate whether the physician assistant may recommend medical marijuana, pursuant to DC Official Code §§ 7-1671.01 and 7-1671.04

☐ Yes ☐ No

SECTION 7: GENERAL DELEGATION OF DUTIES

List below all other duties the physician assistant is delegated to perform that are within that physician assistant's education and training, as well as within the scope of practice of the supervising physician. Use additional sheets if necessary.

SECTION 8: QUALITY ASSURANCE

Each physician assistant and the supervising physician listed on this delegation agreement must complete a practice advisory review on a quarterly basis and document the review on a form kept on file in a personnel file at the location in which the physician assistant practices.

☐ **I understand the requirement for quarterly practice advisory review and agree to comply with the regulation.**

SECTION 9: SIGNATURES

I hereby attest that the information given in this Delegation Agreement, including all writings and exhibits attached hereto, is true and complete to the best of my knowledge. I understand that the making of a false statement on this form, including all writings and exhibits attached hereto, is punishable by criminal penalties.

SIGNATURE OF PHYSICIAN ASSISTANT:	**DATE:**
SIGNATURE OF SUPERVISING PHYSICIAN	**DATE:**

REPORT FRAUD, WASTE, AND ABUSE: To report fraud, waste, or abuse within the District government, contact the DC Office of the Inspector General's hotline by phone at 1-800-521-1639 (toll free) or 202-724-TIPS (8477), by email at hotline.oig@dc.gov, or by TTY at 711. For additional information, visit the Office of the Inspector General's website at https://oig.dc.gov.