MASSACHUSETTS GENERAL HOSPITAL
PHYSICIAN ASSISTANTS
AUTHORIZATION TO PRACTICE

NAME: ____
Please Print

MGH ID NUMBER: ____

JOB CODE: ____

MGH ADDRESS: ____

MGH PHONE NUMBER: ____

MGH Email Address: ____

MASSACHUSETTS GENERAL HOSPITAL

GUIDELINES FOR PHYSICIAN ASSISTANT PRACTICE
FORM B

(Please check activities that apply to your practice and add any additional information)

NATURE OF PRACTICE:

Describe primary patient population(s) including age and primary diagnoses as well as the setting(s) care is provided.

SPECIFIC GUIDELINES/PROTOCOLS FOR MAJOR INVASIVE PROCEDURES FOR THIS PRACTICE:

Describe the written protocols which have been developed with the supervising physician, that specify the level of supervision the service requires, eg direct (physician in the room), personal (physician in the building) or general (physician available by telephone).

SITUATIONS WHICH REQUIRE REFERRAL OR CONSULTATION

- ☐ Diagnostic dilemmas.
- ☐ Patient not responding to current treatment and/or interventions
- ☐ Patient and/or family request

Other:

PROVISIONS FOR MANAGING EMERGENCIES:

- ☐ Immediate notification and consultation with supervising physician or his/her designee.
- ☐ Employing emergency measures as necessary.
- ☐ If in an outpatient setting, transfer of the patient to an emergency department.

Other:

SCOPE OF PRESCRIPTIVE PRACTICE:

Pursuant to Board of Registration in Medicine Regulations, 244 CMR 4.00; Massachusetts General Lawsc94C, Massachusetts Board of Registration, 243 CMR 2.10; and Department of Health Regulations, 105 CMR 700.001- 700.010:

☐ Prescribes Schedule II-VI medications in accordance with guidelines developed with the supervising physician.

☐ Has a current license from the Massachusetts Department of Public Health, Division of Food and Drugs

☐ When prescribing controlled substances, has a certificate from the Drug Enforcement Administration.

☐ Consultation with the attending physician is obtained when:
  A. Medication/treatment failures occur
  B. Medication/treatment is outside the individual practitioner guidelines

Other:

METHODS FOR MONITORING PRESCRIPTIVE PRACTICES:

☐ Initial prescriptions for Schedule II medications will be reviewed within 96 hours either by telephone, chart review or in-person consultation.

☐ The supervising physician will review an appropriate sample of my prescriptions every quarter through rounds, chart reviews, or other mechanisms. The sample will include initial prescriptions issued by me.

☐ I will maintain documentation of these reviews for two years.

Other:

SCOPE OF PRACTICE FORM FOR PHYSICIAN ASSISTANTS

CLINICAL AREA: ____

NAME: ____ Initial ______

Renewal ______

REQUESTED		Scope of Practice	ACTION		
YES	NO	GENERAL SERVICES	Approved	Conditions	Denied
		Obtains health and medical history, performs physical examination, and constructs problem list.			
		Collects, records, and interprets patient data.			
		Orders appropriate laboratory, radiologic, and other diagnostic studies.			
		Interprets studies performed/ordered.			
		Initiates consultations and referrals.			
		Prescribes medications as specified in Guidelines.			
		Assesses patients to determine need for physician attention.			
		Obtains informed consent for the following procedures: (list)			

REQUESTED		SPECIAL PROCEDURES (Please include each procedure as well as the method for achieving and maintaining competence, and level of supervision the service requires)	ACTION		
YES	NO		Approved	Conditions	Denied
		Scope of Practice GENERAL SERVICES			

ACKNOWLEDGMENT OF PRACTITIONER:
I have requested only those specific privileges which by education, training, current experience and demonstrated performance I am qualified to perform and which I wish to exercise at The Massachusetts General Hospital.
I understand that:

A. In exercising any specified privileges granted and in carrying out the responsibilities assigned to me, I am constrained by any hospital and medical staff policies and rules applicable generally and applicable to the particular situation.
B. Any restriction on the specified privileges granted to me is waived in an emergency situation.

CERTIFICATION SIGNATURES:

Physician Assistant ______________________________ ____________
(Signature) (Date)

Supervising Physician:
______________________________ ____________
(Signature) (Date)

______________________________ ____________
(Signature) (Date)

CONDITIONS/EXCEPTIONS:
The preceding specified services have been approved with the following conditions and/or exceptions:

PROFESSIONAL ACTIVITY	CONDITION/MODIFICATION/EXCEPTION

APPROVAL SIGNATURE:
Health Professions Staff Committee
Designee ______________________________ ____________
(Signature) (Date)

AUTHORIZATION SIGNATURE:
Senior Vice President for Patient Care
Chief Nurse Executive
Chair, PCS Executive Committee ______________________________ ____________
(Signature) (Date)

Effective From: _____/____/____ to ____/____/____