New Jersey Office of the Attorney General
Division of Consumer Affairs
State Board of Medical Examiners
Physician Assistant Advisory Committee
140 East Front Street, 3rd Floor, P.O. Box 183
Trenton, New Jersey 08625
Tel.: (609) 826-7100
Fax: (609) 777-0956

Verification of Supervision/Employment

Note: Please print information on this form.

As of_____, _____, License #25 MP_____
Date Physician Assistant

will be engaging in practice as a Physician Assistant under my direct Supervision.

_____
Print name of Supervising Physician | Field of Practice | N.J. Physician License Number

_____ Facility type (circle one): Inpatient or Outpatient _____
Name of Practice/Facility | Telephone number (include area code)

_____
Street address | City | State | ZIP code

_____
Employer (if different from above)

_____
Street address | City | State | ZIP code

In my absence, a plenary licensed Physician Designee will provide supervision.

Supervising Physician's Affidavit

I, the supervising physician, have read the statute, N.J.S.A. 45:9-27.10 et seq., and accept the responsibility for its implementation, and I certify that the forgoing statements made by me are true. I am aware that if any of the statements made by me are willfully false, I am subject to disciplinary action.

I also verify that I am a plenary licensed physician in the State of New Jersey and that my license is in good standing.

_____ _____ _____
Print Supervising Physician's name | Signature of Supervising Physician | Date

_____ _____ _____
Print Employer's name | Signature of Employer | Date

_____ _____ _____
Print Physician Assistant's name | Signature of Physician Assistant | Date