Guam Board of Allied Health Examiners

194 Hernan Cortez Ave., Terlaje Prof. Bldg., Ste. 213
Hagåtña, Guam 96910

Collaborative Practice Agreement for Physician Assistants

The Physician Assistant (PA) will only prescribe medicines outlined in the list below under the supervision of his or her Supervising Physician. The Supervising Physician and the PA will determine the appropriate medications to be prescribed under his or her scope of practice and submit the Collaborative Practice Agreement (CPA) to the Guam Board of Allied Health Examiners (GBAHE), the Guam Board of Medical Examiners (GBME), and the Guam Board of Examiners for Pharmacy (GBEP).

The original CPA will be kept in the Physician Assistant's file at the Health Professional Licensing Office (HPLO).

The PA may prescribe from these categories checked in the following list:

A. Drugs:	Exceptions applicable to each category:
☐ 01 Anesthetics	_____
☐ 02 Anti-Infective	_____
☐ 03 Anti-Neoplastics/Immunosuppresants	_____
☐ 04 Cardiovascular Medications	_____
☐ 05 Autonomic/CNS Drugs	_____
☐ 06 Dermatologic Drugs	_____
☐ 07 Diagnostic Agents	_____
☐ 08 Ear-Nose-Throat Medications	_____
☐ 09 Endocrine Medications	_____
☐ 10 Gastrointestinal Medications	_____
☐ 11 Immunologicals and Vaccines	_____
☐ 12 Muskuloskeletal Medications	_____
☐ 13 Nutritional Products, Electrolytes and Blood Modifiers	_____
☐ 14 OB/GYN Medications	_____
☐ 15 Opthalmin Medications	_____
☐ 16 Respiratory Medications	_____
☐ 17 Urological Medications	_____
☐ 18 Poisoning and Drug Dependence	_____
☐ 19 Analgesics	_____
☐ 20 Stimulants	_____
☐ 21 Tranquillizers	_____

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APPLICATION TO SUPERVISE A PHYSICIAN ASSISTANT

GENERAL INFORMATION

1. Name of Physician: _____
   (Last Name) (First Name) (Middle)
2. Mailing Address: _____
   (Street or PO Box #) (City) (State) (Zip Code)
3. Phone Number: _____ _____ 4. Guam Medical License Number: _____
   (Office) (Cell)
5. Indicate Residency Training Completed: _____
   (Where) (Specialty) (Date)
6. Have you ever applied for approval to supervise a Physician Assistant? Yes _____ No _____
   If answer is "Yes", give name(s), type(s), date(s), location(s) and details._____
   _____
   _____
7. Is this application being submitted in conjunction with another physician's application to supervise said Physician Assistant?
   Yes _____ No _____
   If "Yes", list names of other physicians who will supervise the same Physician Assistant: _____
   _____
   _____
8. Who will be your Physician Assistant? _____

GENERAL INFORMATION

1. Type (e.g., Family, Industrial, etc.) and Specialty: _____
   If Family Practice, indicate percentage of time spent in the following:
   Surgery _____ Medicine _____ OB/GYN _____ Pediatrics _____ Other _____
2. Are you Board Certified? Yes _____ No _____ Date of Certification _____
   Indicate which Board specialty _____ Are you Board Eligible? Yes _____ No _____
3. Indicate: Solo Practice _____ Group Practice _____ Number in Group _____
4. Name of Group _____ Single-Specialty _____ Multi-Specialty _____
5. Have you ever had your hospital staff privileges denied, suspended, revoked? Yes _____ No _____
   If yes, explain: _____
   _____
6. Have you ever had any medical license suspended, revoked, or otherwise disciplined? Yes _____ No _____
   If yes, explain: _____
   _____

USE AND NEEDS PROJECTIONS

1. Describe fully how you propose to utilize a Physician Assistant, i.e., duties to be performed by the Physician Assistant.
   _____
   _____
2. Protocols and specific plans for supervision of the Physician Assistant, i.e., frequency of the chart review, availability for immediate in-person consultation, situations beyond ability and scope of Physician Assistant.
   _____
   _____
3. Protocol for patients examined by a Physician Assistant and who require prescription medicine. _____
   _____
   _____
4. Type of health care facility in which the Physician Assistant will be functioning _____
   _____
5. Physician's relationship to facility(ies) _____
   _____

I have read and fully understand the Physician Assistant Regulations promulgated by the Guam Board of Allied Health Examiners and apply for approval to supervise a Physician Assistant in the Territory of Guam in accordance with those laws and state under penalty of perjury under the laws of the Territory of Guam that I am the person whose signature is affixed below and that all statements made are true in every respect, and understand that mis-statements or omissions of material facts may be cause for denial of this application or revocation of any approval granted.

_____ _____
Signature of Physician Date

All information is mandatory. Failure to provide any of the mandatory information will result in the application being rejected as incomplete. Each individual has the right to review his/her file maintained by the agency, subject to the provisions of the Information Practices Act.

B. Controlled Substances:

☐ Schedule II (not applicable) ☐ Schedule IV
☐ Schedule III (not applicable) ☐ Schedule V

Identification:

DEA Certificate Number

_____ _____
Name of Physician Assistant (Print & Signature)

DEA Certificate Number

_____ _____
Name of Supervising Physician (Print & Signature)

Practice Sites:

_____ _____
Name of Primary Practice Site on Guam Practice Setting

Location Address: _____
(Street) (City) (State) (Zipcode)

_____ _____
Name of Secondary Practice Site on Guam Practice Setting

Location Address: _____
(Street) (City) (State) (Zipcode)

I, _____, Physician Assistant, and

_____, MD/DO, the Supervising

Physician, agree to the following scope of practice:

The Physician Assistant (PA) working in this practice will provide medical services within the education, training and experience of the PA that are delegated by and within the scope of practice of the Supervising Physician. These services include but are not limited to: histories and physical examinations (surface, oral, rectal and pelvic): ordering and/or performing diagnostic and therapeutic procedures; formulating a working diagnosis; developing and implementing a treatment plan; prescribing medications and other treatment modalities; monitoring the effectiveness of therapeutic interventions; assisting at surgery; performing minor surgical procedures including wound treatments, skin and soft tissue debridements, closures, biopsies, incision and drainage of abscesses; splinting and casting of minor fractures; offering counseling and education to meet patient needs; and making appropriate referrals. The PA will work under indirect supervision with a high degree of independence and will confer with the Supervising Physician when necessary to determine appropriate diagnosis, treatment or referral.

C. Procedures Performed by the Physician Assistant: Exceptions applicable to each category:

- ☐ Administration of local and digital anesthesia _____
- ☐ Complicated laceration repair to include suturing, stapling and adhesives _____
- ☐ Uncomplicated laceration repair to include suturing, stapling and adhesives _____
- ☐ Removal of foreign bodies from eyes, nose, skin and wounds _____
- ☐ Minor surgical procedures, such as skin biopsies, mole, cyst and wart removals _____
- ☐ Drainage of subungual hematomas _____
- ☐ Incision and drainage of abscesses _____
- ☐ Urethral catheterization _____
- ☐ Pelvic examination, diagnostic and therapeutic _____
- ☐ Placement of peripheral venous access _____
- ☐ Placement of intraosseous route _____
- ☐ Endotracheal intubation _____
- ☐ Advanced cardiac life support procedures _____
- ☐ Venipuncture _____
- ☐ Application of splints and casts _____
- ☐ Arthrocentesis _____
- ☐ Reduction of closed dislocations _____

_____ _____

Name of Physician Assistant (Print & Signature) Date

_____ _____

Name of Supervising Physician (Print & Signature) Date

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SUPERVISING PHYSICIAN FORM

FOR

PHYSICIAN ASSISTANT

Physician Assistant's Name: _____

Physician Assistant's Address: _____
(Street or PO Box #)

_____
(City) *(State)* *(Zip Code)*

Supervising Physician	Specialty	Signature

Statement from Supervising Physician specifying specialty areas in which the Physician Assistant should provide services:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____