

**IMPORTANT NOTICE:** Completion of this form is required by 225 ILCS 95/1, et.seq. of the Illinois Compiled Statutes. Disclosure of this information is mandatory. Any person who is found to have knowingly violated any provision of this Act is subject to discipline under the Act.

## Notification of Termination of Supervisory Control (Physician Assistant)

### INSTRUCTIONS

If a physician assistant ceases to be in the supervisory control of a supervising physician whose notice of employment is currently on file with the Department of Financial and Professional Regulation, such supervising physician shall give written notice to the Department **within 10 days** of the termination. This form must be **typed or printed** and submitted by the supervising physician to:

Department of Financial and Professional Regulation  
ATTN: Division of Professional Regulation  
320 West Washington Street, 3rd Floor, MED-1  
Springfield, Illinois 62786

This notice, as well as other forms required for physician assistants, can be downloaded from the IDFPR Web site at: [www.idfpr.com](http://www.idfpr.com).

### PHYSICIAN ASSISTANT INFORMATION

1. NAME

2. LICENSE NUMBER

85-\_\_\_\_\_

Signature of Physician Assistant: \_\_\_\_\_

### PRIMARY SUPERVISING PHYSICIAN INFORMATION

1. NAME

2. LICENSE NUMBER

036 - \_\_\_\_\_

3. NAME AND ADDRESS OF HOSPITAL/FACILITY (Street, City, State, Zip Code)

4. BUSINESS TELEPHONE NUMBER (Include Area Code)

5. FAX NUMBER (Include Area Code)

Date primary supervisory control **was terminated**: \_\_\_\_\_

Signature of Primary Supervising Physician: \_\_\_\_\_

## Notification of Termination of Delegated Prescriptive Authority for Legend Drugs and/or Controlled Substances

Complete this section as official notification you are terminating the delegated prescriptive authority for legend drugs and/or controlled substances for the physician assistant named herein. This person is no longer delegated to prescribe and/or dispense by this supervising physician:

Legend Drugs

Controlled Substances

\_\_\_\_\_  
Date of Termination of Prescriptive Authority

\_\_\_\_\_  
Signature of Delegating Physician