A mid-level practitioner controlled substance license (385/CS) may be issued to a physician assistant (PA) whose supervising physician of record has delegated limited prescriptive authority for controlled substance Schedules II, III, IV, V. The physician is required to include and maintain the guidelines for the delegated authority in the written supervisory agreement. Copies of the acknowledgement letter from the Division, 385/CS and Federal DEA licenses are to be kept with the supervisory agreement. Agreements are not to be submitted with this application; however they should be available upon request of the Division of Professional Regulation.

- Application must be fully completed and submitted with the required fee and the delegation form PHA-CS. Prescriptive authority for Schedules is not effective until the 385/CS license has been issued.

- When Division records are updated, the acknowledgment letter with effective dates will be faxed to the physician. Letters are not mailed. To ensure receipt, the fax number listed on supervision notice should be for a medical staff, credentialing, or similar office located within the practice location. The letter is to be maintained with the written supervisory agreement.

- If a physician ceases supervisory control or wishes to terminate delegated prescriptive authority, the termination form must be completed within 10 days of termination. It is the responsibility of the physician to submit the termination form to ensure their record is updated.

- If the PA is supervised by more than one physician at a different location or in a different specialty, separate supervision and delegation forms shall be submitted by each physician delegating authority. A PA should only hold one 385/CS license for the purposes of prescribing at multiple locations.

- PA's holding active 085/PA and 385/CS licenses, who are changing employment and/or delegated prescriptive authority, may fax updated employment and delegation forms to (217) 524-2169. The signed originals must be mailed.

- Prescriptive authority does NOT transfer from one physician to another physician. If a PA changes supervising physicians, updated employment and delegation forms must be submitted.

- PHA-CS forms without Schedules marked will not be processed and will result in delayed issuance.

- The supervision notice must be on file before any delegation forms will be processed. Prescriptive authority may not be delegated by alternate supervising physicians.

- For practice groups or other entities employing multiple physicians, one of the physicians at that location may be designated as the supervising physician. The other physicians, who practice the same general type of medicine or specialty as the supervising physician, may supervise the PA with respect to their own patients without being deemed alternate supervising physicians as defined by the PA Practice Act. All designated physicians must be listed and maintained with the written guidelines.

- If the PA is to be delegated authority for Schedule II drugs, evidence of completion of at least 45 graduate contact hours in pharmacology from a program accredited by the ARC-PA or its successor agency is required.

- PA's will be required to complete annually at least five (5) hours of continuing education in pharmacology verified at the time of renewal.

- The supervising physician may only delegate controlled substances that s/he prescribes.

- All forms must be typed or legibility printed in black ink. Application and forms are periodically updated. Visit the IDFPR Web site at www.idfpr.com to ensure you are using the current forms.

- Please allow 4-6 weeks for processing of new applications and changes in delegation.
The Mid-Level Practitioner Controlled Substance License (385/CS) application and fee may be submitted when applying for the physician assistant license (085/PA). FEES ARE NOT REFUNDABLE. Failure to properly complete the application or submit the required fee will delay licensure. Normal processing time is 4-6 weeks after the Division receives the application and/or forms during non-peak times. Submit the completed application and required fee to:

IDFPR - Division of Professional Regulation
320 West Washington, 3rd Floor
Springfield, Illinois 62786

APPLICATION COMPLETION GUIDE

PART II - APPLICANT IDENTIFYING INFORMATION
• Name, address, Social Security number, maiden or given surname listed
• Indicate the Illinois address where the 385/CS license is to be issued, including department or suite number.
• Applicant’s contact number and email address.

PART III – PERSONAL HISTORY INFORMATION
• If you answer affirmatively to any question, additional documentation and review will be required. Submit a detailed statement and applicable documentation for any affirmative response.

PART IV – CHILD SUPPORT and/or STUDENT LOAN INFORMATION
• If you answer affirmatively to either question, additional documentation and review will be required. Submit a detailed statement and applicable documentation for any affirmative response.

PART V – CERTIFYING STATEMENT
• Original signature and date are required

FORMS COMPLETION GUIDE

CCA FORM
• Required from all health care workers. If you submitted the 385/CS application with your 085/PA application, only one CCA form is required.

PHYSICIAN ASSISTANT – NOTICE OF SUPERVISORY CONTROL
• Form must be submitted or updated before the 385/CS license will be issued.
• Fax number to medical staff, credentialing or similar office where the acknowledgment will be faxed in order to expedite credentialing.

NOTICE OF DELEGATED AUTHORITY FOR PRESCRIPTION DRUGS AND CONTROLLED SUBSTANCES (PHA-CS)
• Supervising physician must indicate the Schedules delegated to the PA, provide their Illinois Controlled Substance License Number (336), list the date of delegation*, sign and date. Failure to mark the Schedules to be delegated will delay issuance.
• The PHA-CS form also includes non-controlled substance prescription drugs not categorized as schedule drugs (formally Legend Drugs).

*SCHEDULE AUTHORITY IS NOT EFFECTIVE UNTIL THE MID-LEVEL LICENSE IS ISSUED.

NOTICE OF TERMINATION OF SUPERVISION and/or DELEGATED AUTHORITY
• When supervisory control and/or prescriptive authority is terminated, the supervising physician is required to submit the termination form within 10 days of termination. It is the responsibility of the supervising physician to submit the termination form in order to remove the physician assistant from Division records.
1. A physician assistant may only prescribe or dispense prescriptions or orders for drugs and medical supplies within the scope of practice of the supervising physician who has submitted Supervision and Delegation Forms.

2. An Illinois Physician Assistant Mid-Level Practitioner Controlled Substances License is a prerequisite to a Federal Mid-Level Practitioner Controlled Substances Registration (DEA).

3. A physician assistant may only hold **ONE** Controlled Substance License

Submit application and fee to: Department of Financial and Professional Regulation Division of Professional Regulation 320 West Washington, 3rd Floor Springfield, Illinois 62786

<table>
<thead>
<tr>
<th>PART I: Application Category Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. PROFESSION NAME: Physician Assistant Mid-Level Practitioner Controlled Substances License</td>
</tr>
<tr>
<td>2. PROFESSION CODE: 385</td>
</tr>
<tr>
<td>3. LICENSURE METHOD: Non-examination</td>
</tr>
<tr>
<td>4. FEE: $5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PART II: Applicant Identifying Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. NAME LAST FIRST MIDDLE</td>
</tr>
<tr>
<td>2. TITLE: PA-C</td>
</tr>
<tr>
<td>3. ILLINOIS PHYSICIAN ASSISTANT LICENSE NO: 085</td>
</tr>
<tr>
<td>4. UNITED STATES SOCIAL SECURITY NO:</td>
</tr>
<tr>
<td>5. PERMANENT MAILING ADDRESS STREET CITY STATE/COUNTRY ZIP CODE COUNTY</td>
</tr>
<tr>
<td>6. LOCATION (STREET/CITY/ZIP CODE) WHERE CONTROLLED SUBSTANCES LICENSE IS TO BE ISSUED:</td>
</tr>
<tr>
<td>7. MAIDEN OR GIVEN SURNAME</td>
</tr>
<tr>
<td>8. CONTACT INFORMATION</td>
</tr>
<tr>
<td>Home/Cell (______) __ __ - _____ __</td>
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<tr>
<td>Email:</td>
</tr>
<tr>
<td>Medical Staff/Credentialing Office Fax (______) __ __ - _____ __</td>
</tr>
</tbody>
</table>
### PART III: Personal History Information *(This part must be completed by all Applicants)*

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Have you ever been charged or convicted of any drug related criminal offense in any state or in federal court? <strong>If yes, attach a statement for each conviction including dates and place of conviction, nature of the offense and, if applicable, the date of discharge from any penalty imposed.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Have you had or do you now have any disease or condition that interferes with your ability to perform the essential functions of your profession, including any disease or condition generally regarded as chronic by the medical community, i.e., (1) mental or emotional disease or condition; (2) alcohol or other substance abuse; (3) physical disease or condition, that presently interferes with your ability to practice your profession? <strong>If yes, attach a detailed statement, including an explanation whether or not you are currently under treatment.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Have you been denied a professional license or permit or privilege of taking an examination, or had a professional license or permit ever disciplined in any way by any licensing authority in Illinois or elsewhere? <strong>If yes, attach a detailed explanation.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Have you ever been discharged other than honorably from the armed service or from a city, county, state or federal position? <strong>If yes, attach a detailed explanation.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Has any previous registration held by you under the Illinois Controlled Substances Act been surrendered, suspended, revoked, denied, placed on probation, or is pending action? <strong>If yes, attach a detailed statement for each action, including dates and place of incident, and the nature of the offense.</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### PART IV: Child Support and/or Student Loan Information *(Every applicant is required by law to respond to the following questions)*

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>
| 1. In accordance with 5 Illinois Compiled Statutes 100/10-65(c), applications for renewal of a license or a new license shall include the applicant's Social Security number, and the licensee shall certify, under penalty of perjury, that he or she is not more than 30 days delinquent in complying with a child support order. **Failure to certify shall result in disciplinary action, and making a false statement may subject the licensee to contempt of court.**

Are you more than 30 days delinquent in complying with a child support order? **Yes** ☐  **No** ☐

*(NOTE: If you are not subject to a child support order, answer “no.”)*

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>
| 2. In accordance with 20 Illinois Compiled Statutes 2105/2105-(5), "The Department shall deny any license or renewal authorized by the Civil Administrative Code of Illinois to any person who has defaulted on an educational loan or scholarship provided by or guaranteed by the Illinois Student Assistance Commission or any governmental agency of this State; however, the Department may issue a license or renewal if the aforementioned persons have established a satisfactory repayment record as determined by the Illinois Student Assistance Commission or other appropriate governmental agency of this State." (Proof of a satisfactory repayment record must be submitted.)

Are you in default on an educational loan or scholarship provided/guaranteed by the Illinois Student Assistance Commission or other governmental agency of this State? **Yes** ☐  **No** ☐

### PART V: Certifying Statement

I hereby apply for an Illinois Physician Assistant Mid-level Practitioner Controlled Substances License in accordance with the Illinois Controlled Substances Act. I certify that I have answered all questions on this application to the best of my knowledge.

---

Date of Application ___________________________  Signature of Applicant ___________________________

**I UNDERSTAND THAT THE FEE IS NOT REFUNDABLE.** My signature above authorizes the Department of Financial and Professional Regulation to reduce the amount of this check if the amount submitted is not correct. I understand this will be done only if the amount submitted is greater than the required fee hereunder, but in no event shall such reduction be made in an amount greater than $50.

---

*Application must be completed in its entirety. If not completed, it will be returned to the address noted on front of application.*
IMPORTANT NOTICE: Completion of this form is necessary to accomplish the requirements outlined in 225 of the Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

HEALTH CARE WORKERS CHARGED WITH OR CONVICTED OF CRIMINAL ACTS

1. NAME LAST FIRST MIDDLE
2. ADDRESS STREET, CITY, STATE, ZIP CODE
3. PROFESSIONAL LICENSE NUMBER (if any)
   ___ ___ "___ ___ ____
4. SOCIAL SECURITY NUMBER
   ___ ___ "___ ___ ___

Pursuant to 20ILCS 2105-165(a), the Department requires the following professionals to disclose information regarding convictions pertaining to certain offenses. Please check applicable profession.

- Acupuncturists
- Advanced Practice Registered Nurses
- Advanced Practice Registered Nurse - Full Practice Authority
- Athletic Trainers
- Audiologists
- Clinical Psychologists
- Clinical Social Workers
- Dental Hygienists
- Dentists
- Genetic Counselors
- Licensed Clinical Professional Counselors
- Licensed Practical Nurses
- Licensed Social Workers
- Marriage and Family Therapists
- Medication Aide
- Naprapaths
- Nursing Home Administrators
- Occupational Therapists
- Occupational Therapy Assistants
- Optometrists
- Orthotists
- Pedorthists
- Percussionists
- Pharmacists
- Physical Therapists
- Physical Therapy Assistants
- Physicians, including Medical Doctors (M.D.), Doctors of Osteopathic Medicine (D.O.), and Chiropractic Physicians (D.C.)
- Physician Assistants
- Podiatrists
- Professional Counselors
- Prosthetists
- Registered Nurses
- Registered Surgical Assistants
- Registered Surgical Technologists
- Respiratory Care Practitioners
- Speech Pathologists

Any other license issued by the Department under the Acts listed in this Section and the Controlled Substances Act [740 ILCS 40], except for pharmacy technicians, issued to a person subject to the Code and this Part.

In order for your application to be evaluated, you must respond to each of the following questions:

1) Are you currently charged with or have you been convicted of a criminal act that requires registration under the Sex Offender Registration Act? *
   Yes No

2) Are you currently charged with or have been convicted of a criminal battery against any patient in the course of patient care or treatment, including any offense based on sexual conduct or sexual penetration?
   Yes No

3) Are you required, as part of a criminal sentence, to register under the Sex Offender Registration Act? *
   Yes No

4) Are you currently charged with or have you been convicted of a forcible felony? *
   Yes No

If YES to any of the above, attach a certified copy of the court records regarding your conviction, the nature of the offense and date of discharge, if applicable, as well as a statement from the probation or parole office.

Certification Statement

Under penalties of perjury, I declare that I have examined this Form and all supporting documents and/or information submitted by me in connection therewith, and to the best of my knowledge, they are true, correct, and complete.

Signature of Applicant Email Date
* DEFINITIONS

730 ILCS 150 et. seq.—Acts that require Sex Offender Registration:

(B) As used in this Article, “sex offense” means:

(1) A violation of any of the following Sections of the Criminal Code of 1961:

- 11-20.1 (child pornography),
- 11-20.3 (aggravated child pornography),
- 11-6 (indecent solicitation of a child),
- 11-9.1 (sexual exploitation of a child),
- 11-9.2 (custodial sexual misconduct),
- 11-9.5 (sexual misconduct with a person with a disability),
- 11-15.1 (soliciting for a juvenile prostitute),
- 11-18.1 (patronizing a juvenile prostitute),
- 11-17.1 (keeping a place of juvenile prostitution),
- 11-19.1 (juvenile pimping),
- 11-19.2 (exploitation of a child),
- 11-25 (grooming),
- 11-26 (traveling to meet a minor),
- 12-13 (criminal sexual assault),
- 12-14 (aggravated criminal sexual assault),
- 12-14.1 (predatory criminal sexual assault of a child),
- 12-15 (criminal sexual abuse),
- 12-16 (aggravated criminal sexual abuse),
- 12-33 (ritualized abuse of a child).

An attempt to commit any of these offenses.

(1.5) A violation of any of the following Sections of the Criminal Code of 1961, when the victim is a person under 18 years of age, the defendant is not a parent of the victim, the offense was sexually motivated as defined in Section 10 of the Sex Offender Management Board Act, and the offense was committed on or after January 1, 1996:

- 10-1 (kidnapping),
- 10-2 (aggravated kidnapping),
- 10-3 (unlawful restraint),
- 10-3.1 (aggravated unlawful restraint).

(1.6) First degree murder under Section 9-1 of the Criminal Code of 1961, when the victim was a person under 18 years of age and the defendant was at least 17 years of age at the time of the commission of the offense, provided the offense was sexually motivated as defined in Section 10 of the Sex Offender Management Board Act.

(1.7) Blank.

(1.8) A violation or attempted violation of Section 11-11 (sexual relations within families) of the Criminal Code of 1961, and the offense was committed on or after June 1, 1997.

(1.9) Child abduction under paragraph (10) of subsection (b) of Section 105 of the Criminal Code of 1961 committed by luring or attempting to lure a child under the age of 16 into a motor vehicle, building, house trailer, or dwelling place without the consent of the parent or lawful custodian of the child for other than a lawful purpose and the offense was committed on or after January 1, 1998, provided the offense was sexually motivated as defined in Section 10 of the Sex Offender Management Board Act.

(1.10) A violation or attempted violation of any of the following Sections of the Criminal Code of 1961 when the offense was committed on or after July 1, 1999:

- 10-4 (forcible detention, if the victim is under 18 years of age), provided the offense was sexually motivated as defined in Section 10 of the Sex Offender Management Board Act,
- 11-6.5 (indecent solicitation of an adult),
- 11-15 (soliciting for a prostitute, if the victim is under 18 years of age),
- 11-16 (pandering, if the victim is under 18 years of age),
- 11-18 (patronizing a prostitute, if the victim is under 18 years of age),
- 11-19 (pimping, if the victim is under 18 years of age).

(1.11) A violation or attempted violation of any of the following Sections of the Criminal Code of 1961 when the offense was committed on or after August 22, 2002:

- 11-9 (public indecency for a third or subsequent conviction).

(1.12) A violation or attempted violation of Section 5.1 of the Wrongs to Children Act (permitting sexual abuse) when the offense was committed on or after August 22, 2002.

(2) A violation of any former law of this State substantially equivalent to any offense listed in subsection (B) of this Section.

(C) A conviction for an offense of federal law, Uniform Code of Military Justice, or the law of another state or a foreign country that is substantially equivalent to any offense listed in subsections (B), (C), (E), and (E5) of this Section shall constitute a conviction for the purpose of this Article.
A “forcible felony”, for the purposes of Section 2105-165 of the Code (section numbers are from the Criminal Code of 1961 [720 ILCS 5]) and 68 Illinois Administrative Code 1130.120 is one or more of the following offenses:

a) First Degree Murder (Section 9-1);
b) Intentional Homicide of an Unborn Child (Section 9-1.2);
c) Second Degree Murder (Section 9-2);
d) Voluntary Manslaughter of an Unborn Child (Section 9-2.1);
e) Drug-induced Homicide (Section 9-3.3);
f) Kidnapping (Section 10-1);
g) Aggravated Kidnapping (Section 10-2);
h) Unlawful Restraint (Section 10-3);
i) Aggravated Unlawful Restraint (Section 10-3.1);
j) Forcible Detention (Section 10-4);
k) Involuntary Servitude (Section 10-9(b));
l) Involuntary Sexual Servitude of a Minor (Section 10-9(c));
m) Trafficking in Persons (Section 10-9(d));

n) Criminal Sexual Assault (Section 11-1.20);
o) Aggravated Criminal Sexual Assault (Section 11-1.30);
p) Predatory Criminal Sexual Assault of a Child (Section 11-1.40);
q) Criminal Sexual Abuse (Section 11-1.50);
r) Aggravated Criminal Sexual Abuse (Section 11-1.60);
s) Aggravated Battery (Section 12-3.05);
t) Compelling Organization Membership of Persons (Section 12-6.5);
u) Compelling Confession or Information by Force or Threat (Section 12-7);
v) Home Invasion (Section 12-11);
w) Robbery (Section 18-1);
x) Armed Robbery (Section 18-2);
y) Vehicular Hijacking (Section 18-3);
z) Aggravated Vehicular Hijacking (Section 18-4);

aa) Aggravated Robbery (Section 18-5);
bb) Terrorism (Section 29D-14.9);
cc) Causing a Catastrophe (Section 29D-15.1);

dd) Possession of a Deadly Substance (Section 29D-15.2);

ee) Making a Terrorist Threat (Section 29D-20);
ff) Falsely Making a Terrorist Threat (Section 29D-25);

 gg) Material Support for Terrorism (Section 29D-29.9);

 hh) Hindering Prosecution of Terrorism (Section 29D-35);

 ii) Boarding or Attempting to Board an Aircraft with Weapon (Section 29D-35.1);
 jj) Armed Violence (Section 33A-2); and

 kk) Attempt (Section 8-4) of any of the above specified offenses.
**PHYSICIAN ASSISTANT NOTICE OF WRITTEN COLLABORATIVE AGREEMENT**

**COLLABORATING PHYSICIAN:** Complete and submit this form as official notification that you have entered into a written collaborative agreement with a physician assistant under the Physician Assistant Practice Act of 1987 (225 ILCS 95/). All forms must be typed or legibly printed in ink. The physician assistant listed below shall not perform any tasks or duties delegated by the collaborating physician until this form is completed and submitted to the Division.

Completed forms may be submitted to the Division as follows: Email form to FPR.MedicalUnit@illinois.gov; Fax form to 217-524-2169; or Mail form to IDFPR - Division of Professional Regulation, 320 West Washington, 3rd Floor, Springfield, Illinois 62786.

Submitted forms will be processed by the Division in the order in which they are received. It may take at least 4-6 weeks for a submitted form to be processed by the Division. After the form is processed, the Division will email or fax an acknowledgment letter to the collaborating physician. The acknowledgment letter must be maintained by the collaborating physician along with the signed, written collaborative agreement. The collaborating physician shall provide a copy of such documentation to the Division upon request.

If the written collaborative agreement is terminated, the collaborating physician must, within 10 days of termination, complete and submit to the Division a NOTICE OF TERMINATION OF COLLABORATION form.

A written collaborative agreement is required for all physician assistants to practice in Illinois, except for physician assistants in hospitals, hospital affiliates, or ambulatory surgical treatment centers as set forth in Section 7.7 of the Physician Assistant Practice Act.

For physician assistants employed by a practice group or other entity employing multiple physicians, one of the physicians practicing at a location shall be designated the collaborating physician. The other physicians with the practice group or other entity who practice in the same general type of practice or specialty as the collaborating physician may collaborate with the physician assistant with respect to their patients.

Forms are periodically updated. To ensure that you are using the current form, visit the IDFPR website at www.idfpr.com/profs/Physician-Assistant.asp.

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### COLLABORATING PHYSICIAN INFORMATION

<table>
<thead>
<tr>
<th>1. COLLABORATING PHYSICIAN NAME</th>
<th>2. ILLINOIS LICENSE NUMBERS</th>
<th>3. DATE AGREEMENT WILL BEGIN</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>036-_______________</td>
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<tr>
<td></td>
<td>336-_______________</td>
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</tbody>
</table>

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<thead>
<tr>
<th>4. ILLINOIS PRACTICE ADDRESS (Street, City, State, Zip Code)</th>
<th>5. ILLINOIS PHONE NUMBER OF PRACTICE (Include Area Code)</th>
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<tbody>
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</table>

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<thead>
<tr>
<th>6. ILLINOIS MEDICAL STAFF/CREDENTIALING OR PHYSICIAN</th>
<th>Email:</th>
</tr>
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<tbody>
<tr>
<td>Fax: ( )</td>
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</tbody>
</table>

### PHYSICIAN ASSISTANT INFORMATION

<table>
<thead>
<tr>
<th>1. NAME OF PHYSICIAN ASSISTANT</th>
<th>2. ILLINOIS LICENSE NUMBERS</th>
<th>3. EMPLOYMENT STATUS (See Below)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>085-_______________</td>
<td>FULL-TIME</td>
</tr>
<tr>
<td></td>
<td>385-_______________</td>
<td>PART-TIME</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. CONTACT INFORMATION FOR PHYSICIAN ASSISTANT</th>
<th>SIGNATURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>HOME/CELL TELEPHONE ( )</td>
<td></td>
</tr>
<tr>
<td>PERSONAL EMAIL REQUIRED</td>
<td></td>
</tr>
</tbody>
</table>

The Physician Assistant Practice Act allows a collaborating physician to collaborate with a maximum of 7 full-time equivalent physician assistants. “Full-time equivalent” means the equivalent of 40 hours per week per individual. You must indicate the number of full-time physician assistants and part time physician assistants you currently have collaborative agreements with, including the physician assistant listed above.

Full-time physician assistants _____ Part-time physician assistants _____

Signature of Collaborating Physician ___________________________ Date Signed ________________

IL486-1884 9/18 (MD-PA) PA Employment Notification
SUPERVISING PHYSICIAN: Complete this form as official notification you are delegating limited prescriptive authority to the physician assistant named herein. The NOTICE OF SUPERVISORY CONTROL and the delegation form must be submitted prior to authority being processed*. Mail forms to:

IDFPR - Division of Professional Regulation  
320 West Washington, 3rd Floor  
Springfield, Illinois 62786

Should you cease supervisory control and/or terminate delegated prescriptive authority, you must notify the Division within 10 days of termination by completing the NOTICE OF TERMINATION OF SUPERVISION AND/OR DELEGATED PRESCRIPTIVE AUTHORITY.

All forms must be typed or legibility printed in black ink. Forms are periodically updated. Visit the IDFPR Web site at www.idfpr.com to ensure you are using the current forms. Please allow 4-6 weeks for processing of new applications and changes in supervision and/or delegation.

1. NAME OF PHYSICIAN ASSISTANT (Last, First, Middle Initial)  
2. DATE OF BIRTH  
   Month / Day / Year  
3. SOCIAL SECURITY NUMBER  
   __ __ __ / __ __ __ / __ __ __ __

4. HOME ADDRESS STREET, CITY, STATE, ZIP CODE
5. PHYSICIAN ASSISTANT MID-LEVEL PRACTITIONER  
   CONTROLLED SUBSTANCES LICENSE  
   Profession Name  
   Profession Code

6. TELEPHONE NUMBER
7. LICENSE NUMBERS OF PHYSICIAN ASSISTANT  
   085 - 385 -

This is to certify I am the supervising physician and have delegated limited prescriptive authority to my physician assistant, ____________________________ , to prescribe and/or dispense prescription drugs, including controlled substances categorized as Schedule II, III, IV, V, as defined in Article II of the Illinois Controlled Substances Act. The physician assistant named above may prescribe and/or dispense prescription drugs and the controlled substance Schedules marked below.

I further certify the delegation of prescriptive authority is appropriate to my practice and within the scope of the physician assistant's training. The delegated prescriptive authority guidelines will be outlined and maintained, along with the acknowledgment letter in the physician assistant's written supervisory agreement.

<table>
<thead>
<tr>
<th>Schedule II</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schedule IV</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Schedule III</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Schedule V</td>
<td>YES</td>
<td>NO</td>
</tr>
</tbody>
</table>

*Such delegation of Schedule II shall be in accordance with the provisions set forth in Section 303.05 a)(1)(B) of the Illinois Controlled Substances Act

Printed Name of Delegating Physician

Signature of Delegating Physician

Date Signed

Date of Delegated Prescriptive Authority

Fax Number

*SCHEDULE AUTHORITY IS NOT EFFECTIVE UNTIL THE LICENSE IS ISSUED.
**Notice of Termination of Supervision and/or Delegated Authority**

(Physician Assistant)

**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.

**SUPERVISING PHYSICIAN:** If you cease supervisory control of physician assistant on your record, you are required to submit the **NOTICE OF TERMINATION OF SUPERVISION AND/OR DELEGATED AUTHORITY** within 10 days of termination.

IDFPR - Division of Professional Regulation
320 West Washington, 3rd Floor
Springfield, Illinois 62786

All forms must be typed or legibility printed in black ink. Forms are periodically updated. Visit the IDFPR Web site at www.idfpr.com to ensure you are using the current forms. **Please allow 4-6 weeks from receipt for processing.**

### PHYSICIAN ASSISTANT INFORMATION

1. NAME OF PHYSICIAN ASSISTANT

2. ILLINOIS LICENSE NUMBERS
   - 085-________________
   - 385-________________

3. CONTACT NUMBER FOR PHYSICIAN ASSISTANT
   - ( )

4. EMAIL
   - ____________________________

Signature __________________________________ Date Signed _________________

### PRIMARY SUPERVISING PHYSICIAN INFORMATION

1. SUPERVISING PHYSICIAN NAME

2. ILLINOIS LICENSE NUMBERS
   - 036-________________
   - 336-________________

3. PRACTICE ADDRESS (Street, City, State, Zip Code)

4. PHONE NUMBER OF PRACTICE (Include Area Code)
   - ( )

5. MEDICAL STAFF/CREDENTIALING FAX
   - ( )

Date Supervisory Control and Delegated Prescriptive Authority was Terminated: _____________________ Month - Day - Year

Signature of Primary Supervising Physician: __________________ Date Signed _________________

### COMPLETE THIS SECTION IF YOU ARE TERMINATING DELEGATED PRESCRIPTIVE AUTHORITY BUT WILL CONTINUE SUPERVISORY CONTROL OF THE PHYSICIAN ASSISTANT NAMED ABOVE

1. SUPERVISING PHYSICIAN NAME

2. ILLINOIS LICENSE NUMBERS
   - 036-________________
   - 336-________________

3. PRACTICE ADDRESS (Street, City, State, Zip Code)

4. PHONE NUMBER OF PRACTICE (Include Area Code)
   - ( )

5. MEDICAL STAFF/CREDENTIALING FAX
   - ( )

Date Delegated Prescriptive Authority was Terminated: _____________________ Month - Day - Year

Signature of Supervising Physician: __________________ Date Signed _________________