| **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 guilty of a Class A misdemeanor. | **Notification of Delegated Prescriptive Authority** | **PHA-CS** |
|---|---|---|

COLLABORATIONG PHYSICIAN: Complete this form as official notification you are delegating limited prescriptive authority to the physician assistant named herein. The *NOTICE OF WRITTEN COLLABORATIVE AGREEMENT* 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
Fax: 217-524-2169
Email: FPR.MedicalUnit@illinois.gov

If you terminate the agreement and/or terminate delegated prescriptive authority, you must notify the Division within ***10*** days by completing the *NOTICE OF TERMINATION OF COLLABORATION 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<br>__ __ / __ __ / __ __ __ __<br>Month Day Year | 3. SOCIAL SECURITY NUMBER<br>__ __ __ - __ __ - __ __ __ __ |
|---|---|---|
| 4. HOME ADDRESS STREET, CITY, STATE, ZIP CODE | 5.<br>**Physician Assistant Mid-level Practitioner Controlled Substances License** **3 8 5**<br>Profession Name / Profession Code | |
| 6. HOME/CELL TELEPHONE NUMBER | 7. LICENSE NUMBERS OF PHYSICIAN ASSISTANT<br>**085 -** **385 -** | |

This is to certify I am the collaborating physician and have delegated limited prescriptive authority to my physician assistant, _____, to prescribe and/or dispense prescription drugs, including controlled substances
(Printed name of physician assistant)
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 collaborative agreement.

**Schedule II*** ☐ **YES** ☐ **NO** **Schedule III** ☐ **YES** ☐ **NO**
**Schedule IV** ☐ **YES** ☐ **NO** **Schedule V** ☐ **YES** ☐ **NO**

***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 of Delegated Prescriptive Authority

**036-** **336-**
**ILLINOIS MEDICAL STAFF/CREDENTIALING OR PHYSICIAN:**

_____
Fax

_____
Email

***SCHEDULE AUTHORITY IS NOT EFFECTIVE UNTIL THE LICENSE IS ISSUED.**