



**PHYSICIAN ASSISTANT'S RESPONSIBLE PHYSICIAN  
and DRUG PRESCRIPTION PROTOCOL**

Please enter required information, including signatures and dates on page 2 and page 4.  
Mail or fax form.

Physician Assistant's Name: \_\_\_\_\_

License Number: \_\_\_\_\_

Responsible Physician's Name:: \_\_\_\_\_

License Number: \_\_\_\_\_

1. Description of the physician's practice and way in which the physician assistant is to be utilized (please include the routine duties of the physician assistant, the type of practice, and the practice setting):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Practice locations, including hospitals, at which the physician assistant will routinely perform acts constituting the practice of medicine and surgery:

\_\_\_\_\_  
\_\_\_\_\_

3. I understand the responsible physician will always be available for communication with the physician assistant within 30 minutes during the performance of patient service by the physician assistant.

4. I understand that failure to adequately direct and supervise the physician assistant in accordance with Physician Assistant Licensure Act, or rules and regulations adopted under such statutes by the board, would constitute grounds for revocation, suspension, limitation or censure of the responsible physician's license to practice medicine and surgery in the state of Kansas.

5. I understand a current copy of this form shall be provided to the Board office and maintained at the usual practice locations of the responsible physician and that any changes or amendments thereto will be provided to the board within 10 days.
  
6. Attached is a completed Drug Prescription Protocol Form provided by the board which specifies categories of drugs, medicines and pharmaceuticals for which the physician assistant is prohibited from supplying or transmitting.
  
7. The signature of a designated physician who shall routinely provide direction and supervision to the physician assistant in the temporary absence of the responsible physician is required:

Name of Designated Physician: \_\_\_\_\_

License Number: \_\_\_\_\_

\_\_\_\_\_  
Signature of Designated Physician

\_\_\_\_\_  
Date

8. Indicate the procedures to be followed to notify the designated physician upon such temporary absence of the responsible physician:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I have carefully read the questions in the foregoing request form and have answered them completely, and I declare under penalty of perjury that my answers and all statements contained herein are true and correct.

\_\_\_\_\_  
Signature of Responsible Physician

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

Physician Assistant's Name: \_\_\_\_\_

License Number: \_\_\_\_\_

Responsible Physician's Name: \_\_\_\_\_

License Number: \_\_\_\_\_

A Drug Prescription Protocol as authorized by the responsible physician must be submitted to the Board for the physician assistant to prescribe drugs or request, receive, sign for and distribute to patients professional samples. Further, in no case shall the scope of the authority of the physician assistant to prescribe drugs, exceed the normal and customary practice of the responsible physician in the prescribing of drugs. To prescribe controlled substances, the physician assistant must register with the Drug Enforcement Administration.

The physician assistant is authorized to prescribe controlled substances as follows:

	<b>NONE</b>	<b>ALL</b>	<b>ALL EXCEPT Specify below</b>
Schedule II and II-N	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Schedule III and III-N	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Schedule IV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Schedule V	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Exceptions:

\_\_\_\_\_  
\_\_\_\_\_

<b>INFORMATION PERTAINING TO DEA REGISTRATION</b>	<b>YES</b>	<b>NO</b>
Responsible physician has a current DEA number?	<input type="checkbox"/>	<input type="checkbox"/>
Physician assistant has a current DEA number?	<input type="checkbox"/>	<input type="checkbox"/>
Responsible physician and physician assistant have DEA registrations for prescribing of controlled substances in all schedules?	<input type="checkbox"/>	<input type="checkbox"/>

If the answer is "no" to any of the above, please provide explanation:

\_\_\_\_\_  
\_\_\_\_\_

The physician assistant is authorized to prescribe **non-controlled** drugs as follows:

	NONE Within Class	ALL Within Class	ALL Except Specify Below
Analgesics (non-narcotic)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anthelmintics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antifungals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antihistamines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antihypertensives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antinauseants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antispasmodics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bronchodilators	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Contraceptives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cough Suppressants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decongestants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diuretics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Expectorants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Estrogens	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Progesterone Preparations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhoidal Preparations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Injectables	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skeletal Muscle Relaxants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Topical Ophthalmic Preparations, Except Steroids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Otic Preparations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginitis Preparations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vitamins and Minerals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Topical Preparations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Steroids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anti-Anxiety and Anti-Depressants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (SPECIFY BELOW)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other/Exceptions:

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The physician assistant's authority to request, receive and sign for professional samples and to distribute professional samples to patients is identical to the physician assistant's authority to prescribe non-controlled substances, except:

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\_\_\_\_\_  
Signature of Responsible Physician

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date