



South Carolina Department of Labor, Licensing and Regulation
South Carolina Board of Medical Examiners
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P.O. Box 11289 • Columbia • SC • 29211
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llr.sc.gov/med

SUPERVISORY AGREEMENT

PRIMARY SUPERVISING MD/DO INFORMATION

License No.: _____

Last Name: _____ First: _____ Middle: _____ Suffix: _____

PHYSICIAN ASSISTANT INFORMATION

License No.: _____

Last Name: _____ First: _____ Middle: _____ Suffix: _____

PRIMARY SUPERVISING PHYSICIAN ATTESTATION

I hereby agree to become the primary supervising physician for the above-named physician assistant.

I understand as a supervising physician I must not enter into scope of practice guidelines or practice agreements with more than the equivalent of six full-time Advanced Practice Providers (APPs) with whom I am supervising or practice with greater than six individuals at any one time. S.C. Code § 40-47 40-47-195(D)(1)(c).

I understand that I must hold a permanent unrestricted authorization to practice medicine in this State and be actively practicing medicine within the physical boundaries of South Carolina or practice in North Carolina and Georgia, **provided that** I am employed by a hospital or integrated healthcare system that either owns hospitals in South Carolina or the hospital or integrated healthcare system employs physicians who primarily practice at a site physically located in South Carolina. The PA must also work at the same hospital or integrated healthcare system if you are practicing in North Carolina or Georgia.

I understand as the supervising physician that I maintain responsibility for the practice and conduct of the APPs as set forth by law. I understand I must notify the SC Medical Board, in writing, if this supervisory relationship changes.

Check the applicable box below:

- ☐ I am actively practicing medicine within the physical boundaries of South Carolina
- ☐ I primarily practice medicine in North Carolina or Georgia for a hospital or integrated healthcare system that either owns hospitals in South Carolina or employs physicians who primarily practice at a site in South Carolina.

Signature of Primary Supervising Physician

Date

Provide the **Physician's** Practice name and address or the name and address of the hospital or integrated healthcare system if practicing in NC/GA

Practice Name: _____

Address: _____ City: _____ State: _____ Zip: _____

PHYSICIAN ASSISTANT ATTESTATION

I understand I may only perform a medical act, task or function that is listed and approved on the scope of practice guidelines.

If a supervisory relationship is terminated, a current alternate supervising physician for the PA may serve as a supervising physician under the existing scope of practice guidelines for a period not to exceed 90 days until a new supervising physician is designated and new scope of practice guidelines are approved.

I understand I must notify the SC Medical Board in writing if this supervisory relationship changes.

Check the applicable box below:

- ☐ My supervising physician is actively practicing medicine within the physical boundaries of South Carolina.
- ☐ My supervising physician and I are employed by a hospital or integrated healthcare system in North Carolina or Georgia that either owns hospitals in South Carolina or employs physicians who primarily practice at a site in South Carolina and my supervising physician primarily practices in North Carolina or Georgia for that employer and I am physically located in South Carolina.

Signature of Physician Assistant

Date

Provide the **Physician Assistant's** Practice name and address or the name and address of the hospital or integrated healthcare system if the **Supervising Physician** is practicing in NC/GA

Practice Name: _____

Address: _____ City: _____ State: _____ Zip: _____