MARYLAND BOARD OF PHYSICIANS
P.O. BOX 2571
Baltimore, MD 21215
410-764-4775
www.mbp.state.md.us

PHYSICIAN ASSISTANT DELEGATION AGREEMENT MODIFICATION FORM: ADDING ADDITIONAL PRACTICE LOCATION(S)

INSTRUCTIONS: Please complete only if there is an existing active delegation agreement on file with the Board. Complete the information below and send the form to the above address.

1. PHYSICIAN ASSISTANT INFORMATION:

Physician Assistant Name:	Maryland License #:
Work #:	Cell #:
Email Address:	

2. PRIMARY SUPERVISING PHYSICIAN INFORMATION:

Primary Supervising Physician Name:	Maryland License #:
Work #:	Cell #:
Email Address:	

3. PRACTICE SETTING: Describe the setting(s) in which the physician assistant will practice:

☐ Hospital ☐ Public Health Facility ☐ Ambulatory Surgical Facility ☐ Nursing Home ☐ HMO

☐ Private Practice ☐ Urgent Care Center ☐ Detention Center/ Correctional Facility

☐ Other _____

4. LOCATION(S): For additional locations, please use a separate sheet of paper. Include Practice Setting type, names of physician assistant and primary supervising physician. Please sign and date each sheet of paper.

Facility/Practice Name:		
Practice Setting Type:		
Address:		
City:	State:	Zip code:
Contact Name:	Telephone #:	
Facility/Practice Name:		
Practice Setting Type:		
Address:		
City:	State:	Zip code:
Contact Name:	Telephone #:	

5. PRIMARY SUPERVISING PHYSICIAN SIGNATURE:

_____ _____

Supervising Physician Name (Print) Date

_____

Supervising Physician's Original Signature