MARYLAND BOARD OF PHYSICIANS
P.O. BOX 2571
BALTIMORE, MD 21215
www.mbp.state.md.us

TERMINATION OF EMPLOYMENT (DELEGATION AGREEMENT) REPORT

REPORTING REQUIREMENTS: Hospitals, related institutions, alternative health care systems, or employers are required to report to the Board any termination of employment of the physician assistant for any reason, including quality of care issues within 5 days of the termination. Hospitals, related institutions, alternative health care systems, or employers are also required to report to the Board within 5 days any limitation, reductions or other changes of employment of the change of employment that might be grounds for disciplinary actions under Health Occupations Article, §15-314.

INSTRUCTIONS: Employers/Primary Supervising Physicians, please complete the applicable information on pages 1 and 2. Unless otherwise specified, termination notifications will be emailed to the primary supervising physician and the physician assistant.

1. EFFECTIVE DATE OF TERMINATION:

2. PHYSICIAN ASSISTANT INFORMATION:

License #:	
Last Name, (Suffix, Jr., III):	**First Name:**
Middle Name/Initial:	**Maiden Name:**
Email Address:	

3. PRIMARY SUPERVISING PHYSICIAN INFORMATION:

License #:	
Last Name, (Suffix, Jr., III):	**First Name:**
Middle Name/Initial:	**Maiden Name:**
Email Address:	

4. LOCATION(S) OF PRACTICE/HEALTH CARE FACILITY:

Facility/Practice Name:		
Department:		
Address:		
City:	State:	Zip code:

Facility/Practice Name:		
Department:		
Address:		
City:	State:	Zip code:

5. Reason(s) for Termination: Reasons may include, but are not limited to: voluntary resignation, quality of care issue, resignation after a notice of intent to terminate. Please provide supporting documentation, if applicable.

6. Reason(s) for limitation, reductions or other changes of employment that might be grounds for disciplinary actions under Health Occupations Article, §15-314.

7. Signatures

Name of Primary Supervising Physician/Employer in Print:

Signature Primary Supervising Physician/Employer:

Telephone Number: Date:

Email Address: