Practice Agreement Amendment

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Filing an Amendment

This form can be used to file technical amendments to an existing practice agreement. If a practice agreement needs to be amended to change the scope of practice, delegation of duties not previously included or a change in the communication provision or protocols, a new practice agreement needs to be filed with the WMC. Completed amendments can be sent to medical.delegations@wmc.wa.gov.

I am filing an amendment for an existing practice agreement between:

Physician Assistant Name	
Supervising Physician Name	
Alternate Physician Name	
Practice Agreement Number	
Effective Date	

I am requesting the following amendments to be made:

Practice Agreement Field	Currently Document	Requested Amendment	Does this provider need to be removed from the existing practice agreement?
Physician Assistant Name			
Physician Assistant License Number			
Physician Assistant Phone Number			
Physician Assistant Email			
Primary Practice Address			
Supervising Physician Name			
Supervising Physician License Number			
Supervising Physician Phone Number			
Supervising Physician			

Email			
Alternate Physician Name			
Alternate Physician License Number			
Alternate Physician Phone Number			
Alternate Physician Email			

I am requesting that the following physicians be added to the existing practice agreement:

Name	License Number	Email	Phone Number	Primary Physician?	Alternate Physician?

Signatures

1. The physician assistant must sign/approve these amendments.

☐ I have reviewed these amendments and they are true to the best of my knowledge.

Physician Assistant Name:

Physician Assistant Signature:

Date:

2. Any supervising or alternate physician that is being added to the practice agreement through this amendment must review the existing practice agreement and approve these changes.

☐ I have reviewed the existing practice agreement and understand the duties and responsibilities of the physician assistant, the supervising physician, and alternate physicians.

Supervising Physician Name:

Supervising Physician Signature:

Date:

☐ I have reviewed the existing practice agreement and understand the duties and responsibilities of the physician assistant, the supervising physician, and alternate physicians.

Supervising Physician Name:

Supervising Physician Signature:

Date:

☐ I have reviewed the existing practice agreement and understand the duties and responsibilities of the physician assistant, the supervising physician, and alternate physicians.

Alternate Physician Name:

Alternate Physician Signature:

Date: