Fax to PAMC Medical Staff Office 907-212-4865 or email medical.staff@providence.org

PROVIDENCE Alaska Medical Center

Medical Student

Supervising Physician Form and Scope of Practice

P l e a s e P r i n t

Name of Medical Student:	Name of Supervising Physician: ***(Must be a member of the ACTIVE Medical Staff at PAMC)***
Dates of /Rotation:	Department/Specialty:

Please place a check mark next to the appropriate Scope of Practice.
Duties/Privileges may not exceed those outlined in Medical Staff Policy MS 900-040.

☐	**1st & 2nd Year Medical Students**	**Scope of Practice**
	These students shall have no independent privileges. They may see patients only under the supervision of the supervising physician. They may observe obstetrical and surgical procedures, after assuring consent has been obtained from the patient.	
	These students may write-up history and physicals or progress notes; however, this information will not be entered directly into the patient's chart.	

☐	**3rd & 4th Year Medical Students**	**Scope of Practice**
	The medical student may write admission history and physical examinations, write progress notes and write orders. All notes and orders must be read, corrected or agreed with, and signed by the supervising physician or assigned resident. These orders must be co-signed before being implemented.	
	Medical students may draw blood, start IV's, or do other limited invasive procedures, only under the direct supervision of the supervising physician or assigned resident.	
	The Medical Student may scrub or act as an assistant in surgery or assist in delivering babies under the direct supervision of the supervising physician and only after assuring consent from the patient.	

I hereby agree to abide by the selected Scope of Practice and Policies & Procedures of Providence Alaska Medical Center.

_____ _____
Signature of Medical Student Date

SUPERVISING PHYSICIAN

I hereby attest to the qualifications of this applicant. As supervising physician, I will assume the responsibility of seeing that the Medical Student will perform only those tasks, which he/she is authorized to perform as authorized by the Providence Health & Services Alaska Region Board. I understand I have full responsibility for all actions or omissions of this student at Providence Alaska Medical Center. I understand I am responsible for the active supervision of this Medical Student and that my responsibilities require me to be ready to assume the care of any patient treated by him/her. Should my supervising relationship with this Medical Student change, I understand I am responsible for all care provided by him/her until I provide written notification to the Medical Staff Office that the relationship has changed. I agree to co-sign all chart notes and orders written (within 24 hours) by the Medical Student. I will write progress notes in the patient charts that will establish the full extent of the Medical Student's involvement with the care of each patient.

_____ _____
Signature of Supervising Physician Date

☐ **Check here if you are the group Medical Director and are signing on behalf of your entire group.** – *If the group Medical Director signs on behalf of the group, then there is no need to obtain signatures from additional group members.*

When I am unavailable, I will make arrangements to inform the Medical Center and the Medical Student which Active Medical Staff Member has consented to act as a substitute Supervising Physician in my absence. This substitute Supervising Physician will be ready to assume the care of any patient treated by this Student in my absence.

The following Active Staff Members have consented to supervise the Student in my absence or in addition to my agreed supervision:

_____ _____ _____ _____
Name of Covering Physician Date Name of Covering Physician Date

_____ _____ _____ _____
Name of Covering Physician Date Name of Covering Physician Date

Fax to PAMC Medical Staff Office 907-212-4865 or email medical.staff@providence.org