Physician Assistant Dispensing Registration

Board of Medicine
P.O. Box 6330
Tallahassee, FL 32314-6330
Fax: (850) 488-0596
Email: MQA.PhysicianAssistant@FLHealth.gov

This form must be completed by the supervisory physician. *No fee is required.*

A supervisory physician may delegate to the prescribing physician assistant the authority to dispense any medication used in the supervisory physician's practice unless such medication is listed in Rule 64B8-30.008/64B15-6.0038, Florida Administrative Code. A prescribing physician assistant may only dispense for a supervisory physician who is registered with the Board of Medicine as a dispensing practitioner in compliance with section 465.0276, Florida Statutes. Attach additional copies of this form if necessary.

Physician Assistant Name: _____
First Middle Last/Surname

Physician Assistant License Number: PA_____

The following physician(s) have delegated dispensing authority to the Physician Assistant listed above.

Physician Name:	
Physician License Number (ME or DO):	
Specialty:	
Physician Signature:	Effective Date (MM/DD/YYYY):

Physician Name:	
Physician License Number (ME or DO):	
Specialty:	
Physician Signature:	Effective Date (MM/DD/YYYY):

Physician Name:	
Physician License Number (ME or DO):	
Specialty:	
Physician Signature:	Effective Date (MM/DD/YYYY):

I am withdrawing dispensing authority with the above Physician Assistant(s) and request the dispensing registration be canceled effective:

_____
MM/DD/YYYY