(385) Physician Assistant Controlled Substance License

Contents

General Information

A mid-level practitioner controlled substance license (385/CS) may be issued to a physician assistant (PA) whose supervising physician of record has delegated limited prescriptive authority for controlled substance Schedules II, III, IV, V. The physician is required to include and maintain the guidelines for the delegated authority in the written supervisory agreement. Copies of the acknowledgement letter from the Division, 385/CS and Federal DEA licenses are to be kept with the supervisory agreement. Agreements are not to be submitted with this application; however, they should be available upon request of the Division of Professional Regulation.

- When Division records are updated, the acknowledgment letter with effective dates will be emailed to the physician. To ensure receipt, the email listed on supervision notice should be for a medical staff, credentialing, or similar office located within the practice location. The letter is to be maintained with the written supervisory agreement.

- If a physician ceases supervisory control or wishes to terminate delegated prescriptive authority, the termination form must be completed within 10 days of termination. It is the responsibility of the physician to submit the termination form to ensure their record is updated.

- If the PA is supervised by more than one physician at a different location or in a different specialty, separate supervision and delegation forms shall be submitted by each physician delegating authority. A PA should only hold one 385/CS license for the purposes of prescribing at multiple locations.

- Prescriptive authority does NOT transfer from one physician to another physician. If a PA changes supervising physicians, updated employment and delegation forms must be submitted.

- The supervision notice must be on file before any delegation forms will be processed. Prescriptive authority may not be delegated by alternate supervising physicians.

- For practice groups or other entities employing multiple physicians, one of the physicians at that location may be designated as the supervising physician. The other physicians, who practice the same general type of medicine or specialty as the supervising physician, may supervise the PA with respect to their own patients without being deemed alternate supervising physicians as defined by the PA Practice Act. All designated physicians must be listed and maintained with the written guidelines.

- The supervising physician may only delegate controlled substances that s/he prescribes.

Instructions:

1. Prescriptive authority for schedules is not effective until the 385/CS license has been issued.

2. ***If the PA is to be delegated authority for Schedule II drugs, evidence of completion of at least 45 graduate contact hours in pharmacology from a program accredited by the ARC-PA or its successor agency is required.***

3. PA's will be required to complete annually at least five (5) hours of continuing education in pharmacology verified at the time of renewal.

4. It is mandatory that the permanent mailing address and/or business address be a street address. P.O. boxes are not acceptable. Your controlled substances registration must be issued to a street address.

5. You must select the drug schedules for which you are applying for. Drug schedules include:
   - Schedule II
   - Schedule III
   - Schedule IV
   - Schedule V

6. You have three (3) years from the date your application is received by the Department to complete the application process. If the process is not completed in three (3) years, your application will be denied and the fee forfeited.

7. Application fees for controlled substance licenses are $5.00 and are non-refundable.

8. A State controlled substances registration is a prerequisite for Federal controlled substances registration. The address on your Illinois controlled substances registration must be exactly the same address as your Federal registration. For information concerning Federal registration, you must contact:

Drug Enforcement Administration
230 South Dearborn, Suite 1200
Chicago, Illinois 60604
Telephone: 312/353-7875
Web site: www.deadiversion.usdoj.gov

Application Requirements

Designation	Requirements	Submitted:
Controlled Substance License Application	1. Completed online application including all of the following required information: • Public and Mailing Address • Social Security Number or an SSN Affidavit • Name Change Information • Date of Birth 2. Personal Information including: • Birth City • Birth State • Birth Country • Gender • Ethnicity 3. Select your delegating Physician from the grid and add the drug schedules they will be delegating to you: • Schedule II • Schedule III • Schedule IV • Schedule V 4. Would you like your controlled substance license to be issued to the business address of your delegating physician or would you like it to be issued to a different location? 5. If it is not issued to the location of your delegated physician enter the public address where it should be issued to. 6. Personal History questions related to the Health Care Workers Charged with or Convicted of Criminal Acts including: • Are you currently charged with or have you been convicted of a criminal act that requires registration under the Sex Offender Registration Act as a part of a criminal sentence? • Are you currently charged with or have you been convicted of a criminal battery against any patient in the course of patient care or treatment, including any offense based on sexual conduct or sexual penetration? • Are you currently charged with or have you been convicted of a forcible felony?	ONLINE PORTAL

	7. If you answered yes to any of the above statements, please attach a certified copy of the court records regarding your conviction, description of the nature of the offense, date of discharge, if applicable, and a statement from the probation or parole office. 8. Personal History Information including: • Criminal History • Felony Convictions • Dishonorable discharge from military service • Disease or conditions that may interfere with professional work • Denial of a prior professional license 9. Failure to comply with a child support order, defaulting on a student loan, or defaulting on taxes.	

Application Fees

Fees collected through the licensing process are NOT REFUNDABLE OR TRANSFERABLE.		
Complete	**License Type**	**Submitted:**
	(385) Physician Assistant Controlled Substance License …… $5.00	ONLINE PORTAL
NOTES: All major credit and debit cards as well as ACH and eCheck are accepted.		

IMPORTANT NOTICE: Completion of this form is required by 225 ILCS 95/1, et.seq. of the Illinois Compiled Statutes. Disclosure of this information is mandatory. Any person who is found to have knowingly violated any provision of this Act is subject to discipline under the Act.

PHYSICIAN ASSISTANT NOTICE OF SUPERVISORY CONTROL

SUPERVISING PHYSICIAN: Complete this form as official notification you have entered a written supervisory agreement with the physician assistant (PA) below. The PA shall not perform any medical procedure or other task delegated by a supervising physician until the NOTICE OF SUPERVISORY CONTROL form is submitted to the Division. Mail completed form to:

IDFPR - Division of Professional Regulation
320 West Washington, 3rd Floor
Springfield, Illinois 62786

If you cease supervisory control of PA, you are required to complete and submit the NOTICE OF TERMINATION OF SUPERVISION AND/OR DELEGATED AUTHORITY within ***10*** days of termination.

Acknowledgement letters are ***faxed***, not mailed, and are to be maintained with the written supervisory agreement. It is the responsibility of the supervising physician to maintain within the written supervisory agreement, documentation each time s/he designates an alternate supervising physician. The documentation shall include the effective dates for alternate supervision. The supervising physician shall provide a copy of this documentation to the Division only upon request.

PA's working in a practice group or other entity in which multiple physicians are employed, one of the physicians at the location may be designated as the supervising physician. The other physicians within that practice group or entity who practice in the same general type of medicine or specialty as the supervising physician may supervise the PA with respect to their patients without being deemed alternate supervising physicians as definedbythePhysicianAssistantPracticeAct.

All forms must be typed or legibily printed in black ink. Forms are periodically updated. Visit the IDFPR Web site at www.idfpr.illinois.gov to
ensure you are using the current forms. **Please allow 4-6 weeks from receipt for processing**.

PHYSICIAN ASSISTANT INFORMATION

1. NAME OF PHYSICIAN ASSISTANT	2. ILLINOIS LICENSE NUMBERS	3. EMPLOYMENT STATUS
	085-_____ 385-_____	☐ FULL-TIME ☐ PART-TIME

4. CONTACT INFORMATION FOR PHYSICIAN ASSISTANT

TELEPHONE ( ) _____

EMAIL _____ Signature _____

PRIMARY SUPERVISING PHYSICIAN INFORMATION

1. SUPERVISING PHYSICIAN NAME	2. ILLINOIS LICENSE NUMBERS	3. DATE SUPERVISORY CONTROL WILL BEGIN
	036-_____ 336-_____	____/____/____

4. PRACTICE ADDRESS (Street, City, State, Zip Code)	5. PHONE NUMBER OF PRACTICE (Include Area Code)
	( ) _____
	6. MEDICAL STAFF/CREDENTIALING FAX
	( ) _____

NOTE: A physician may supervise a maximum of five (5) full-time equivalent (FTE) physician assistants. However, this number shall be reduced by the number of collaborative agreements the supervising physician maintains. The combined total of PA's and APN's **cannot** exceed five.

Supervisory Agreements with PA's, excluding above: Number of FTE PAs _____ Part-time PA's _____

Collaborating Agreements with APN's: _____

Signature of Supervising Physician: _____ Date Signed _____

IMPORTANT NOTICE: Completion of this form is required by 225 ILCS 95/1, et.seq. of the Illinois Compiled Statutes. Disclosure of this information is mandatory. Any person who is found to have knowingly violated any provision of this Act is guilty of a Class A misdemeanor.	**Notice of Delegated Authority for Prescription and Schedule Controlled Substances**	**PHA-CS**

SUPERVISING PHYSICIAN: Complete this form as official notification you are delegating limited prescriptive authority to the physician assistant named herein. The *NOTICE OF SUPERVISORY CONTROL* and the delegation form must be submitted prior to authority being processed*. Mail forms to:

IDFPR - Division of Professional Regulation
320 West Washington, 3rd Floor
Springfield, Illinois 62786

Should you cease supervisory control and/or terminate delegated prescriptive authority, you must notify the Division within ***10*** days of termination by completing the *NOTICE OF TERMINATION OF SUPERVISION AND/OR DELEGATED PRESCRIPTIVE AUTHORITY*.

All forms must be typed or legibility printed in black ink. Forms are periodically updated. Visit the IDFPR Web site at www.idfpr.illinois.gov to ensure you are using the current forms. **Please allow 4-6 weeks for processing of new applications and changes in supervision and/or delegation**.

1. NAME OF PHYSICIAN ASSISTANT (Last, First, Middle Initial)	2. DATE OF BIRTH __ __ / __ __ / __ __ __ __ Month Day Year	3. SOCIAL SECURITY NUMBER __ __ __ - __ __ - __ __ __ __
4. HOME ADDRESS STREET, CITY, STATE, ZIP CODE	5. **Physician Assistant Mid-level Practitioner Controlled Substances License** **3 8 5** Profession Name / Profession Code	
6. TELEPHONE NUMBER	7. LICENSE NUMBERS OF PHYSICIAN ASSISTANT **085 -** **385 -**	

This is to certify I am the supervising physician and have delegated limited prescriptive authority to my physician assistant, _____, to prescribe and/or dispense prescription drugs, including controlled substances
(Printed name of physician assistant)
categorized as Schedule II, III, IV, V, as defined in Article II of the Illinois Controlled Substances Act. The physician assistant named above may prescribe and/or dispense prescription drugs and the controlled substance Schedules marked below.

I further certify the delegation of prescriptive authority is appropriate to my practice and within the scope of the physician assistant's training. The delegated prescriptive authority guidelines will be outlined and maintained, along with the acknowledgment letter in the physician assistant's written supervisory agreement.

Schedule II* ☐ **YES** ☐ **NO** **Schedule III** ☐ **YES** ☐ **NO**
Schedule IV ☐ **YES** ☐ **NO** **Schedule V** ☐ **YES** ☐ **NO**

Such delegation of Schedule II shall be in accordance with the provisions set forth in Section 303.05 a)1)B) of the Illinois Controlled Substances Act

_____ **036-** _____ **336-**
Printed Name of Delegating Physician

_____ _____
Signature of Delegating Physician / Date Signed

_____ _____
Date of Delegated Prescriptive Authority / Fax Number

***SCHEDULE AUTHORITY IS NOT EFFECTIVE UNTIL THE LICENSE IS ISSUED.**

IMPORTANT NOTICE: Completion of this form is required by 225 ILCS 95/1, et.seq. of the Illinois Compiled Statutes. Disclosure of this information is mandatory. Any person who is found to have knowingly violated any provision of this Act is subject to discipline under the Act.

Notice of Termination of Supervision and/or Delegated Authority (Physician Assistant)

SUPERVISING PHYSICIAN: If you cease supervisory control of physician assistant on your record, you are required to submit the NOTICE OF TERMINATION OF SUPERVISION AND/OR DELEGATED AUTHORITY within ***10*** days of termination.

IDFPR - Division of Professional Regulation
320 West Washington, 3rd Floor
Springfield, Illinois 62786

All forms must be typed or legibility printed in black ink. Forms are periodically updated. Visit the IDFPR Web site at www.idfpr.illinois.gov to ensure you are using the current forms. **Please allow 4-6 weeks from receipt for processing.**

PHYSICIAN ASSISTANT INFORMATION

1. NAME OF PHYSICIAN ASSISTANT	2. ILLINOIS LICENSE NUMBERS 085-_____ 385-_____
3. CONTACT NUMBER FOR PHYSICIAN ASSISTANT ( ) _____	4. EMAIL _____

Signature _____

PRIMARY SUPERVISING PHYSICIAN INFORMATION

1. SUPERVISING PHYSICIAN NAME	2. ILLINOIS LICENSE NUMBERS 036-_____ 336-_____
3. PRACTICE ADDRESS (Street, City, State, Zip Code)	4. PHONE NUMBER OF PRACTICE (Include Area Code) ( ) _____
	5. MEDICAL STAFF/CREDENTIALING FAX ( ) _____

Date Supervisory Control and Delegated Prescriptive Authority was Terminated: _____
Month - Day - Year

Signature of Primary Supervising Physician: _____ Date Signed _____

COMPLETE THIS SECTION IF YOU ARE TERMINATING DELEGATED PRESCRIPTIVE AUTHORITY BUT WILL CONTINUE SUPERVISORY CONTROL OF THE PHYSICIAN ASSISTANT NAMED ABOVE

1. SUPERVISING PHYSICIAN NAME	2. ILLINOIS LICENSE NUMBERS 036-_____ 336-_____
3. PRACTICE ADDRESS (Street, City, State, Zip Code)	4. PHONE NUMBER OF PRACTICE (Include Area Code) ( ) _____
	5. MEDICAL STAFF/CREDENTIALING FAX ( ) _____

Date Delegated Prescriptive Authority was Terminated: _____
Month - Day - Year

Signature of Supervising Physician: _____ Date Signed _____