INFORMATION SHEET FOR MID-LEVEL PRACTITIONER LIMITED PRESCRIPTIVE AUTHORITY FOR CONTROLLED SUBSTANCE SCHEDULES

A physician assistant who has been delegated prescriptive authority must obtain a mid-level practitioner controlled substances license. The collaborating physician must file with the Department a notice of written collaborative agreement, and a notice of delegation of prescriptive authority for Schedule II, III, IV or V controlled substances, as defined in the Illinois Controlled Substances Act. The delegation must be appropriate to the collaborating physician's practice and within the scope of the physician assistant's training. The collaborating physician must have a valid, current Illinois controlled substance license and federal registration with the Drug Enforcement Agency.

• An application for physician assistant controlled substances license must be fully completed and submitted to the Department together with the $5.00 fee. In addition, the Department must receive a Notice of Written Collaborative Agreement and a Notice of Delegated Authority for Controlled Substances. If the physician assistant is delegated authority for Schedule II controlled substances, the Department must receive an official transcript verifying that the physician assistant has completed of at least 45 graduate contact hours in pharmacology from a program accredited by the ARC-PA or its successor agency.

• Submit the completed application, forms and fee to:

Illinois Department of Financial and Professional Regulation
ATTN: Division of Professional Regulation
P.O. Box 7007
Springfield, IL 62791

• Delegated prescriptive authority for Schedule II, III, IV or V controlled substances will not be effective until the physician assistant controlled substances license has been granted and is effective.

The Department will send an acknowledgement letter to the collaborating physician with the effective dates for the delegated prescriptive authority once Department records are updated. The letter will be sent to the email address or fax number provided by the collaborating physician on the Notice of Written Collaborative Agreement.

• Note: If a collaborating physician is only delegating prescriptive authority for prescriptive drugs which are not Schedule II, III, IV, or V controlled substances, then a physician assistant controlled substances license is not required. However, the Department must receive a Notice of Written Collaborative Agreement and a Notice of Delegated Authority for Prescription Drugs.

• If a collaborative agreement or delegated prescriptive authority is terminated, a Notice of Termination of Collaboration and/or Delegated Authority must be submitted to the Department within 10 days of termination. It is the responsibility of the collaborating physician to submit the termination form to the Department to ensure that records are properly updated.

• A collaborating physician may collaborate with a maximum of 7 full-time equivalent physician assistants as described in Section 54.5 of the Medical Practice Act. A physician assistant may hold more than one professional position.

• A written collaborative agreement is required for all physician assistants to practice in Illinois, except for physician assistants in hospitals, hospital affiliates, or ambulatory surgical treatment centers as set forth in Section 7.7 of the Physician Assistant Practice Act.

• For physician assistants employed by a practice group or other entity employing multiple physicians, one of the physicians practicing at a location shall be designated the collaborating physician. The other physicians with the practice group or other entity who practice in the same general type of practice or specialty as the collaborating physician may collaborate with the physician assistant with respect to their patients.

• You may view the Act and Rules for your profession and download additional forms from the IDFPR web site at *www.idfpr.illinois.gov*.

(DO NOT USE THIS APPLICATION FOR RENEWAL OF AN EXISTING LICENSE)

IMPORTANT NOTICE: Completion of this form is required by 720 ILCS 570/301, et.seq. of the Illinois Compiled Statutes. Disclosure of information is mandatory. Furnishing by applicant of false or fraudulent information or failure to provide pertinent information constitutes grounds for denying such application or revoking any registration issued pursuant to such application.

APPLICATION FOR PHYSICIAN ASSISTANT MID-LEVEL PRACTITIONER ILLINOIS CONTROLLED SUBSTANCES LICENSE

1. A physician assistant may only prescribe or dispense prescriptions or orders for drugs and medical supplies within the scope of practice of the supervising physician who has submitted Supervision and Delegation Forms.
2. An Illinois Physician Assistant Mid-Level Practitioner Controlled Substances License is a prerequisite to a Federal Mid-Level Practitioner Controlled Substances Registration (DEA).
3. A physician assistant may only hold **ONE** Controlled Substance License

A. Type or print legibly with black ink only.

B. The fee is $5 - Make check payable to the Department of Financial and Professional Regulation. **THIS FEE IS NOT REFUNDABLE!**

C. Disclosure of your U.S. social security number, if you have one, is mandatory, in accordance with 5 Illinois Compiled Statutes 100/10-65 to obtain a license. The social security number may be provided to the Illinois Department of Public Aid to identify persons who are more than 30 days delinquent in complying with a child support order, or to the Illinois Department of Revenue to identify persons who have failed to file a tax return, pay tax, penalty or interest shown in a filed return, or to pay any final assessment or tax penalty or interest, as required by any tax Act administered by the Illinois Department of Revenue, or to other entities for verification of identification.

Submit application and fee to:

Department of Financial and Professional Regulation
Division of Professional Regulation
320 West Washington, 3rd Floor
Springfield, Illinois 62786

PART I: Application Category Information

1. PROFESSION NAME	2. PROFESSION CODE	3. LICENSURE METHOD	4. FEE
Physician Assistant Mid-Level Practitioner Controlled Substances License	**385**	**Non-examination**	**$5**

PART II: Applicant Identifying Information

1. NAME LAST FIRST MIDDLE	2. TITLE	3. ILLINOIS PHYSICIAN ASSISTANT LICENSE NO.	4. UNITED STATES SOCIAL SECURITY NO.
	PA-C	**085**	___ ___ – ___ – ____

5. PERMANENT MAILING ADDRESS STREET | CITY | STATE/COUNTRY | ZIP CODE + | COUNTY

6. LOCATION (STREET/CITY/ZIP CODE) WHERE CONTROLLED SUBSTANCES LICENSE IS TO BE ISSUED.

FACILITY _____

STREET _____

CITY _____

IL _____ + ____

7. MAIDEN OR GIVEN SURNAME

8. CONTACT INFORMATION

Home/Cell (___) ___ – ____
Area Code

Email _____

Medical Staff/Credentialing Office Fax
(___) ___ – ____
Area Code

NAME (Last, First, MI):

SS#:

Profession:

PART III: Personal History Information *(This part must be completed by all Applicants)*	YES	NO
1. Have you ever been charged or convicted of any drug related criminal offense in any state or in federal court? *If yes, attach a statement for each conviction including dates and place of conviction, nature of the offense and, if applicable, the date of discharge from any penalty imposed.*		
2. Have you had or do you now have any disease or condition that interferes with your ability to perform the essential functions of your profession, including any disease or condition generally regarded as chronic by the medical community, i.e., (1) mental or emotional disease or condition; (2) alcohol or other substance abuse; (3) physical disease or condition, that presently interferes with your ability to practice your profession? *If yes, attach a detailed statement, including an explanation whether or not you are currently under treatment.*		
3. Have you been denied a professional license or permit or privilege of taking an examination, or had a professional license or permit ever disciplined in any way by any licensing authority in Illinois or elsewhere? *If yes, attach a detailed explanation.*		
4. Have you ever been discharged other than honorably from the armed service or from a city, county, state or federal position? *If yes, attach a detailed explanation.*		
5. Has any previous registration held by you under the Illinois Controlled Substances Act been surrendered, suspended, revoked, denied, placed on probation, or is pending action? *If yes, attach a detailed statement for each action, including dates and place of incident, and the nature of the offense.*		

PART IV: Child Support and/or Student Loan Information (Every applicant is required by law to respond to the following questions)

1. In accordance with 5 Illinois Compiled Statutes 100/10-65(c), applications for renewal of a license or a new license shall include the applicant's Social Security number, and the licensee shall certify, under penalty of perjury, that he or she is not more than 30 days delinquent in complying with a child support order. **Failure to certify shall result in disciplinary action, and making a false statement may subject the licensee to contempt of court.**

   Are you more than 30 days delinquent in complying with a child support order? Yes ☐ No ☐
   (NOTE: If you are not subject to a child support order, answer "no.")

2. In accordance with 20 Illinois Compiled Statutes 2105/2105-(5), "The Department shall deny any license or renewal authorized by the Civil Administrative Code of Illinois to any person who has defaulted on an educational loan or scholarship provided by or guaranteed by the Illinois Student Assistance Commission or any governmental agency of this State; however, the Department may issue a license or renewal if the aforementioned persons have established a satisfactory repayment record as determined by the Illinois Student Assistance Commission or other appropriate governmental agency of this State." (Proof of a satisfactory repayment record must be submitted.)

   Are you in default on an educational loan or scholarship provided/guaranteed by the Illinois Student Assistance Commission or other governmental agency of this State? Yes ☐ No ☐

PART V: Certifying Statement

I hereby apply for an Illinois Physician Assistant Mid-level Practitioner Controlled Substances License in accordance with the Illinois Controlled Substances Act. I certify that I have answered all questions on this application to the best of my knowledge.

Date of Application _____ Signature of Applicant _____

I UNDERSTAND THAT THE FEE IS NOT REFUNDABLE. My signature above authorizes the Department of Financial and Professional Regulation to reduce the amount of this check if the amount submitted is not correct. I understand this will be done only if the amount submitted is greater than the required fee hereunder, but in no event shall such reduction be made in an amount greater than $50.

Application must be completed in its entirety.
If not completed, it will be returned to the address noted on front of application.

IMPORTANT NOTICE: Completion of this form is necessary to accomplish the requirements outlined in 20 ILCS 2105 of the Civil Administrative Code. Disclosure of this information is REQUIRED.

HEALTH CARE WORKERS ADDITIONAL PERSONAL HISTORY QUESTIONS

SUPPORTING DOCUMENT

PHQ

1. NAME LAST FIRST MIDDLE

2. ADDRESS STREET, CITY, STATE, ZIP CODE

3. PROFESSIONAL LICENSE NUMBER (if any)
___ - ___ ___ ___ ___ ___

4. SOCIAL SECURITY NUMBER OR ITIN
___ ___ ___ - ___ ___ - ___ ___ ___ ___

Pursuant to 20 ILCS 2105-165(a), the Department requires the following professionals to disclose information regarding charges or convictions pertaining to certain offenses. **Please check applicable profession.**

- ☐ Acupuncturist
- ☐ Advanced Practice Registered Nurse
- ☐ Advanced Practice Registered Nurse - Full Practice Authority
- ☐ Athletic Trainer
- ☐ Audiologist
- ☐ Behavior Analyst
- ☐ Behavior Analyst Assistant
- ☐ Certified Midwife
- ☐ Chiropractic Physicians (D.C.)
- ☐ Dental Hygienist
- ☐ Dentist
- ☐ Genetic Counselor
- ☐ Licensed Practical Nurse
- ☐ Marriage and Family Therapist
- ☐ Marriage and Family Therapist Assoc.
- ☐ Music Therapist
- ☐ Naprapath
- ☐ Nursing Home Administrator
- ☐ Occupational Therapist
- ☐ Occupational Therapy Assistant
- ☐ Optometrist
- ☐ Orthotist
- ☐ Pedorthist
- ☐ Perfusionist
- ☐ Pharmacist
- ☐ Physical Therapist
- ☐ Physical Therapy Assistant
- ☐ Physicians, including Medical Doctors (M.D.), Doctors of Osteopathic Medicine (D.O.)
- ☐ Physician Assistant
- ☐ Professional Counselor (LPC)
- ☐ Professional Counselor, Clinical (LCPC)
- ☐ Psychologist, Clinical (LCP)
- ☐ Podiatrist
- ☐ Prosthetist
- ☐ Registered Nurse
- ☐ Registered Surgical Assistant
- ☐ Registered Surgical Technologist
- ☐ Respiratory Care Practitioner
- ☐ Sex Offender Associate
- ☐ Sex Offender Evaluator
- ☐ Sex Offender Treatment Provider
- ☐ Social Worker (LSW)
- ☐ Social Worker, Clinical (LCSW)
- ☐ Speech Pathologist

Any other license issued by the Department under the Acts listed in this Section and the Controlled Substances Act [740 ILCS 40], except for pharmacy technicians, issued to a person subject to the Code and this Part.

In order for your application to be evaluated, you must respond to each of the following questions:

	Yes	No
1) Are you currently charged with or have you been convicted of a criminal act that requires registration under the Sex Offender Registration Act? *	☐	☐
2) 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?	☐	☐
3) Are you required, as part of a criminal sentence, to register under the Sex Offender Registration Act? *	☐	☐
4) Are you currently charged with or have you been convicted of a forcible felony? *	☐	☐

*If **YES** to any of the above, attach a personal statement describing the circumstances of the charge or conviction and a certified copy of the court records regarding your charge or conviction, including the nature of the offense and date of discharge, if applicable, as well as a statement from the probation or parole office.*

Certification Statement

Under penalties of perjury, I declare that I have examined this Form and all supporting documents and/or information submitted by me in connection therewith, and to the best of my knowledge, they are true, correct, and complete.

Signature of Applicant _____ Email _____ Date _____

* DEFINITIONS

730 ILCS 150 et. seq:—Acts that require Sex Offender Registration:

(B) As used in this Article, “sex offense” means:

(1) A violation of any of the following Sections of the Criminal Code of 1961:

11-20.1 (child pornography),
11-20.3 (aggravated child pornography),
11-6 (indecent solicitation of a child),
11-9.1 (sexual exploitation of a child),
11-9.2 (custodial sexual misconduct),
11-9.5 (sexual misconduct with a person with a disability),
11-15.1 (soliciting for a juvenile prostitute),
11-18.1 (patronizing a juvenile prostitute),
11-17.1 (keeping a place of juvenile prostitution),
11-19.1 (juvenile pimping),
11-19.2 (exploitation of a child),
11-25 (grooming),
11-26 (traveling to meet a minor),
12-13 (criminal sexual assault),
12-14 (aggravated criminal sexual assault),
12-14.1 (predatory criminal sexual assault of a child),
12-15 (criminal sexual abuse),
12-16 (aggravated criminal sexual abuse),
12-33 (ritualized abuse of a child).

An attempt to commit any of these offenses.

(1.5) A violation of any of the following Sections of the Criminal Code of 1961, when the victim is a person under 18 years of age, the defendant is not a parent of the victim, the offense was sexually motivated as defined in Section 10 of the Sex Offender Management Board Act, and the offense was committed on or after January 1, 1996:

10-1 (kidnapping),
10-2 (aggravated kidnapping),
10-3 (unlawful restraint),
10-3.1 (aggravated unlawful restraint).

(1.6) First degree murder under Section 9-1 of the Criminal Code of 1961, when the victim was a person under 18 years of age and the defendant was at least 17 years of age at the time of the commission of the offense, provided the offense was sexually motivated as defined in Section 10 of the Sex Offender Management Board Act.

(1.7) (Blank).

(1.8) A violation or attempted violation of Section 11-11 (sexual relations within families) of the Criminal Code of 1961, and the offense was committed on or after June 1, 1997.

(1.9) Child abduction under paragraph (10) of subsection (b) of Section 105 of the Criminal Code of 1961 committed by luring or attempting to lure a child under the age of 16 into a motor vehicle, building, house trailer, or dwelling place without the consent of the parent or lawful custodian of the child for other than a lawful purpose and the offense was committed on or after January 1, 1998, provided the offense was sexually motivated as defined in Section 10 of the Sex Offender Management Board Act.

(1.10) A violation or attempted violation of any of the following Sections of the Criminal Code of 1961 when the offense was committed on or after July 1, 1999:

10-4 (forcible detention, if the victim is under 18 years of age), provided the offense was sexually motivated as defined in Section 10 of the Sex Offender Management Board Act,
11-6.5 (indecent solicitation of an adult),
11-15 (soliciting for a prostitute, if the victim is under 18 years of age),
11-16 (pandering, if the victim is under 18 years of age),
11-18 (patronizing a prostitute, if the victim is under 18 years of age),
11-19 (pimping, if the victim is under 18 years of age).

(1.11) A violation or attempted violation of any of the following Sections of the Criminal Code of 1961 when the offense was committed on or after August 22, 2002:

11-9 (public indecency for a third or subsequent conviction).

(1.12) A violation or attempted violation of Section 5.1 of the Wrongs to Children Act (permitting sexual abuse) when the offense was committed on or after August 22, 2002.

(2) A violation of any former law of this State substantially equivalent to any offense listed in subsection (B) of this Section.

(C) A conviction for an offense of federal law, Uniform Code of Military Justice, or the law of another state or a foreign country that is substantially equivalent to any offense listed in subsections (B), (C), (E), and (E5) of this Section shall constitute a conviction for the purpose of this Article.

* DEFINITIONS

A **"forcible felony"**, for the purposes of Section 2105-165 of the Code (section numbers are from the Criminal Code of 1961 [720 ILCS 5]) and 68 Illinois Administrative Code 1130.120 is one or more of the following offenses:

a) First Degree Murder (Section 9-1);
b) Intentional Homicide of an Unborn Child (Section 9-1.2);
c) Second Degree Murder (Section 9-2);
d) Voluntary Manslaughter of an Unborn Child (Section 9-2.1);
e) Drug-induced Homicide (Section 9-3.3);
f) Kidnapping (Section 10-1);
g) Aggravated Kidnapping (Section 10-2);
h) Unlawful Restraint (Section 10-3);
i) Aggravated Unlawful Restraint (Section 10-3.1);
j) Forcible Detention (Section 10-4);
k) Involuntary Servitude (Section 10-9(b));
l) Involuntary Sexual Servitude of a Minor (Section 10-9(c));
m) Trafficking in Persons (Section 10-9(d));
n) Criminal Sexual Assault (Section 11-1.20);
o) Aggravated Criminal Sexual Assault (Section 11-1.30);
p) Predatory Criminal Sexual Assault of a Child (Section 11-1.40);
q) Criminal Sexual Abuse (Section 11-1.50);
r) Aggravated Criminal Sexual Abuse (Section 11-1.60);
s) Aggravated Battery (Section 12-3.05);
t) Compelling Organization Membership of Persons (Section 12-6.5);
u) Compelling Confession or Information by Force or Threat (Section 12-7);
v) Home Invasion (Section 12-11);
w) Robbery (Section 18-1);
x) Armed Robbery (Section 18-2);
y) Vehicular Hijacking (Section 18-3);
z) Aggravated Vehicular Hijacking (Section 18-4);
aa) Aggravated Robbery (Section 18-5);
bb) Terrorism (Section 29D-14.9);
cc) Causing a Catastrophe (Section 29D-15.1);
dd) Possession of a Deadly Substance (Section 29D-15.2);
ee) Making a Terrorist Threat (Section 29D-20);
ff) Falsely Making a Terrorist Threat (Section 29D-25);
gg) Material Support for Terrorism (Section 29D-29.9);
hh) Hindering Prosecution of Terrorism (Section 29D-35);
ii) Boarding or Attempting to Board an Aircraft with Weapon (Section 29D-35.1);
jj) Armed Violence (Section 33A-2); and
kk) Attempt (Section 8-4) of any of the above specified offenses.

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 WRITTEN COLLABORATIVE AGREEMENT

COLLABORATING PHYSICIAN: Complete and submit this form as official notification that you have entered into a written collaborative agreement with a physician assistant under the Physician Assistant Practice Act of 1987 (225 ILCS 95/). All forms must be typed or legibly printed in ink. The physician assistant listed below shall not perform any tasks or duties delegated by the collaborating physician until this form is completed and submitted to the Division.

Completed forms may be submitted to the Division as follows: Email form to FPR.MedicalUnit@illinois.gov; Fax form to 217-524-2169; or Mail form to IDFPR - Division of Professional Regulation, 320 West Washington, 3rd Floor, Springfield, Illinois 62786.

Submitted forms will be processed by the Division in the order in which they are received. It may take at least 4-6 weeks for a submitted form to be processed by the Division. After the form is processed, the Division will email or fax an acknowledgment letter to the collaborating physician. The acknowledgment letter must be maintained by the collaborating physician along with the signed, written collaborative agreement. The collaborating physician shall provide a copy of such documentation to the Division upon request.

If the written collaborative agreement is terminated, the collaborating physician must, within 10 days of termination, complete and submit to the Division a NOTICE OF TERMINATION OF COLLABORATION form.

A written collaborative agreement is required for all physician assistants to practice in Illinois, except for physician assistants in hospitals, hospital affiliates, or ambulatory surgical treatment centers as set forth in Section 7.7 of the Physician Assistant Practice Act.

For physician assistants employed by a practice group or other entity employing multiple physicians, one of the physicians practicing at a location shall be designated the collaborating physician. The other physicians with the practice group or other entity who practice in the same general type of practice or specialty as the collaborating physician may collaborate with the physician assistant with respect to their patients.

Forms are periodically updated. To ensure that you are using the current form, visit the IDFPR website at: ***https://idfpr.illinois.gov/profs/Physician-Assistant.asp***.

COLLABORATING PHYSICIAN INFORMATION

1. COLLABORATING PHYSICIAN NAME

2. ILLINOIS LICENSE NUMBERS
036-_____
336-_____

3. DATE AGREEMENT WILL BEGIN
____/____/_____

4. ILLINOIS PRACTICE ADDRESS (Street, City, State, Zip Code)

5. ILLINOIS PHONE NUMBER OF PRACTICE (Include Area Code)
( )

6. ILLINOIS MEDICAL STAFF/CREDENTIALING OR PHYSICIAN
Fax: ( )
Email:

PHYSICIAN ASSISTANT INFORMATION

1. NAME OF PHYSICIAN ASSISTANT

2. ILLINOIS LICENSE NUMBERS
085-_____
385-_____

3. EMPLOYMENT STATUS (See Below)
☐ FULL-TIME
☐ PART-TIME

4. CONTACT INFORMATION FOR PHYSICIAN ASSISTANT

HOME/CELL TELEPHONE ( )

PERSONAL EMAIL REQUIRED

SIGNATURE

The Physician Assistant Practice Act allows a collaborating physician to collaborate with a maximum of 7 full-time equivalent physician assistants. “Full-time equivalent” means the equivalent of 40 hours per week per individual. You must indicate the number of full-time physician assistants and part time physician assistants you currently have collaborative agreements with, including the physician assistant listed above.

Full-time physician assistants _____ Part-time physician assistants _____

Signature of Collaborating 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.	**Notification of Delegated Prescriptive Authority**	**PHA-CS**

A physician assistant controlled substances license is required if a collaborating physician is delegating limited prescriptive authority for controlled substances categorized as Schedule II, III, IV or V, as defined in the Illinois Controlled Substances Act. The collaborating physician must submit a NOTICE OF WRITTEN COLLABORATIVE AGREEMENT and a NOTICE OF DELEGATED AUTHORITY FOR SCHEDULE CONTROLLED SUBSTANCES to the Department.

COLLABORATING PHYSICIAN: Complete this form as official notification that you are delegating limited prescriptive authority to the physician assistant named herein.

If a collaborative agreement or delegated prescriptive authority is terminated, the collaborating physician must notify the Department within 10 days of termination by completing the NOTICE OF TERMINATION OF COLLABORATION AND/OR DELEGATED AUTHORITY (PHYSICIAN ASSISTANT).

Completed forms may be Emailed to: **FPR.MedicalUnit@illinois.gov**; Faxed to 217-524-2169; or Mailed to: IDFPR - Division of Professional Regulation, 320 West Washington Street, 3rd Floor, Springfield, IL 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 for processing of new applications and changes in collaboration 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. HOME/CELL TELEPHONE NUMBER	7. LICENSE NUMBERS OF PHYSICIAN ASSISTANT **085 -** **385 -**	

This is to certify that I am a collaborating physician and have delegated limited prescriptive authority to 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 the Illinois Controlled Substances Act. The physician assistant named above may prescribe and/or dispense prescription drugs and the controlled substances 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, in the physician assistant's written collaborative 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

_____
Printed Name of Collaborating Physician

_____
Signature of Collaborating Physician

_____
Date of Delegated Prescriptive Authority

036- **336-**
ILLINOIS MEDICAL STAFF/CREDENTIALING OR PHYSICIAN:

_____
Fax

_____
Email

***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 Collaboration and/or Delegated Authority (Physician Assistant)

COLLABORATING PHYSICIAN: If you are no longer collaborating with a physician assistant or if you have terminated delegated prescriptive authority for a physician assistant, you must submit a NOTICE OF TERMINATION OF COLLABORATION AND/OR DELEGATED AUTHORITY (PHYSICIAN ASSISTANT) to the Department within 10 days of termination.

Completed forms may be Emailed to: **FPR.MedicalUnit@illinois.gov**; Faxed to 217-524-2169; or Mailed to: IDFPR – Division of Professional Regulation, 320 West Washington Street, 3rd Floor, Springfield, IL 62786.

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

PHYSICIAN ASSISTANT INFORMATION

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

Signature _____

COLLABORATING PHYSICIAN INFORMATION

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

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

Signature of Collaborating Physician: _____ Date Signed _____

COMPLETE THIS SECTION IF YOU ARE ONLY TERMINATING DELEGATED PRESCRIPTIVE AUTHORITY BUT WILL CONTINUE A COLLABORATIVE AGREEMENT WITH THE PHYSICIAN ASSISTANT NAMED ABOVE

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

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

Signature of Collaborating Physician: _____ Date Signed _____