NEW YORK STATE OF OPPORTUNITY. Workers' Compensation Board

Supervising Physician Affirmation

Supervising Physician Information

Physician Name: _____

Business Address: _____

Email Address: _____

Board Authorization Number: # _____

All active WCB Rating Codes: _____

Physician Assistant Information

Physician Assistant's Name: _____

Business Address: _____

Affirmation

I am a health care provider duly licensed by the State of New York and hereby affirm the following:

1. I am duly authorized by the Board to treat workers' compensation claimants.
2. I am the responsible supervising physician for the above named physician assistant.
3. I understand that I must comply with all Board requirements relating to the supervision of physician assistants as set forth in section 6542 of the Education Law.
4. I understand that it is my responsibility to immediately notify the Board if I am no longer supervising such physician assistant.

My signature affirms that to the best of my knowledge and belief, the information I have provided is true and accurate.

_____ Date: _____

Signature

_____

Print Name