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STATE OF DELAWARE  
DEPARTMENT OF STATE  
DIVISION OF PROFESSIONAL REGULATION  
BOARD OF MEDICAL PRACTICE

TELEPHONE: (302) 744-4500  
FAX: (302) 739-2711  
WEBSITE: WWW.DPR.DELAWARE.GOV

**PHYSICIAN ASSISTANT APPLICATION FOR PRESCRIPTIVE AUTHORITY**

**PLEASE TYPE OR PRINT ALL INFORMATION. INCOMPLETE APPLICATIONS  
WILL BE RETURNED.**

**SECTION A:**

I am applying for Prescriptive Authority in the State of Delaware. Check one:

- Controlled
- Non-Controlled

Check one:

- I am applying for a Delaware Physician's Assistant license.
- I am submitting this application due to a change in my supervising physician(s).

Enter your Delaware Physician Assistant license number: C5- \_\_\_\_\_

Complete one of these forms *for each business/facility* where the Physician's Assistant will be practicing.

**SECTION B: PERSONAL INFORMATION**

\_\_\_\_\_ Last Name First Name MI

\_\_\_\_\_ Street/P.O. Box Apartment #

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

\_\_\_\_\_ Name of Business/Practice: \_\_\_\_\_

\_\_\_\_\_ Business/Facility Address: \_\_\_\_\_

\_\_\_\_\_ Business Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

**SECTION C: CONTROLLED AND NON CONTROLLED PRESCRIPTIVE**

**AUTHORITY** - This section must be completed by the supervising physician for each physician assistant who is applying for Controlled and Non Controlled Prescriptive Authority. You may duplicate and complete this page to include additional supervising physician(s) in your practice. If this form is duplicated, attach all duplicates to the application.

\_\_\_\_\_  
Name of Supervising Physician (Print Legibly)                      Specialty

\_\_\_\_\_  
Delaware Physician License Number      Federal DEA Number      Delaware DEA Number

I, \_\_\_\_\_ can prescribe the following schedules:  
Name of supervising physician (Print Legibly)

Schedule II, III, IV, V  , Schedule III, IV, V  , Schedule IV, V  , Schedule V

**The Physician Assistant identified on this form in Section B is authorized to prescribe controlled substances under my supervision for the following schedules:**

Schedule II, III, IV, V  , Schedule III, IV, V  , Schedule IV, V  , Schedule V

The Physician Assistant identified in Section B may request and issue professional samples of controlled legend medications. I am delegating this authority. Yes  No

**As the supervising physician I may not at any given time supervise more than two (2) physician assistants, unless a regulation of the board increases or decreases the number, pursuant to 24 Del C, Section 1771(e).**

Please list the number of Physician Assistants you are currently supervising: \_\_\_\_\_

\_\_\_\_\_  
Signature of Supervising Physician    Date

**SECTION D: CERTIFICATION**

By signing this form, the physician assistant and the supervising physician (if appropriate) agree that the above information is true and accurate and that the physician assistant or the supervising physician shall promptly by submitting a new application for Prescriptive Authority to notify the Board of Medical Practice of all changes of supervising physician(s) and schedule(s) authorized.

\_\_\_\_\_  
Signature of Applicant    Date