CONSENT FOR TREATMENT BY PHYSICIAN ASSISTANT

PHYSICIAN ASSISTANTS ARE HEALTH CARE PROFESIONALS LICENSED TO PRACTICE MEDICINE WITH PHYSICIAN SUPERVISION. PHYSICIAN ASSISTANTS CONDUCT PHYSICAL EXAMS, DIAGNOSE AND TREAT ILLNESSES, ORDER AND INTERPRET TESTS, COUNSEL ON PREVENTIVE HEALTH CARE AND ASSIST IN SURGERY. PHYSICIAN ASSISTANTS ARE TRAINED IN INTENSIVE EDUCATION PROGRAMS ACCREDITED BY THE ACCREDITATION REVIEW COMMISSION ON EDUCATION FOR THE PHYSICIAN ASSISTANT. UPON GRADUATION THEY ARE REQUIRED TO TAKE A NATIONAL CERTIFICATION EXAM TO RECEIVE THEIR STATE LICENSURE.

I UNDERSTAND THAT THE PHYSICIAN ASSISTANT (PA) AND THE PHYSICIAN WORK TOGETHER AS A TEAM TO PROVIDE MY MEDICAL CARE.

I AGREE TO BE SEEN BY THE PHYSICIAN ASSISTANT, BUT MAY CHANGE THIS DECISION AT ANY TIME BY REQUESTING TO SEE THE PHYSICIAN.

THIS AGREEMENT WILL REMAIN IN EFFECT UNTIL OTHERWISE STATED BY ME.

______________________________	______________
Patient/Parent/Guardian Signature	**Date**

______________________________	______________
Witness Signature	**Date**