✓MetroPlusHealth

50 Water St., 7th Floor • New York, NY 10004
1.800.303.9626 • TTY: 711 • metroplus.org

# Physician Assistant Supervision Statement

NAME of Physician Assistant: _____

NAME of Supervising Physician: _____

The undersigned physician assistant affirm that, pursuant to New York State Education Law, I perform medical services under supervision of a physician and only when such acts and duties as assigned to me are within the scope of my supervising physician.

Physician Assistant Signature: _____Date: _____

Supervising Physician Signature: _____Date: _____