ATTACHMENT 5

TENNESSEE BOARD OF MEDICAL EXAMINERS’
COMMITTEE ON PHYSICIAN ASSISTANTS

AUTHORIZATION FOR PRESCRIBING FOR PHYSICIAN ASSISTANTS

<table>
<thead>
<tr>
<th>Supervising Physician</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td></td>
</tr>
<tr>
<td>City</td>
<td>State</td>
</tr>
<tr>
<td>Phone Number</td>
<td></td>
</tr>
<tr>
<td>Field of Practice</td>
<td></td>
</tr>
<tr>
<td>Medical License Number</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physician Assistant</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Field of Practice</td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td></td>
</tr>
<tr>
<td>City</td>
<td>State</td>
</tr>
<tr>
<td>Phone Number</td>
<td></td>
</tr>
<tr>
<td>TN License Number</td>
<td></td>
</tr>
</tbody>
</table>

Check the class of drugs you desire to delegate:

- [ ] Analgesics
- [ ] Anesthetics
- [ ] Antihistamines
- [ ] Anti-infective Agents
- [ ] Anti-inflammatory Agents
- [ ] Anti-neoplastic Agents
- [ ] Antispasmodics and Anticholinergics
- [ ] Antivirals
- [ ] Arthritis Medications
- [ ] Autonomic Drugs
- [ ] Blood Derivatives
- [ ] Blood Formation and Coagulation
- [ ] Birth Control Drugs and Devices
- [ ] Bronchodilators/Anti-asthma Drugs
- [ ] Cardiovascular Drugs
- [ ] Central Nervous system Drugs
- [ ] Contraceptives
- [ ] Diabetic Agents
- [ ] Diagnostic Agents
- [ ] Decongestants
- [ ] Electrolytic, Caloric, and Water Balance
- [ ] Enzymes
- [ ] Expectorants and Cough Preparations
- [ ] Eye, Ear, Nose, and Throat Preparations
- [ ] Gastrointestinal Drugs
- [ ] Hormones and Synthetic Substitutes
- [ ] Hyperglycemic Agents
- [ ] Migraine Preparations
- [ ] Muscle Relaxant Preparations
- [ ] Narcotic Antagonists
- [ ] Oxytocics
- [ ] Psychotropics
- [ ] Serum, Toxoids, and Vaccine
- [ ] Skin and Mucous Membrane Preparations
- [ ] Smoking Cessation Aids
- [ ] Smooth Muscle Relaxants
- [ ] Spasmolytic Agents
- [ ] Sympathomimetics and Combination
- [ ] Vitamins
- [ ] Unclassified Therapeutic
- [ ] Other

---

PH-3563(Rev. 10/06) RDA 1786
Check the type and schedule of controlled drugs you desire to delegate:

<table>
<thead>
<tr>
<th>Type</th>
<th>Schedule II</th>
<th>Schedule III</th>
<th>Schedule IV</th>
<th>Schedule V</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Barbiturates</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depressants</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Narcotics</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stimulants</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (Please List)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I, ___________________________ MD/DO, License Number _______________________
I, ___________________________ MD/DO, License Number _______________________
I, ___________________________ MD/DO, License Number _______________________
I, ___________________________ MD/DO, License Number _______________________

Please print

I, ___________________________ MD/DO, License Number _______________________
I, ___________________________ MD/DO, License Number _______________________
I, ___________________________ MD/DO, License Number _______________________
I, ___________________________ MD/DO, License Number _______________________

Please print

I, ___________________________ MD/DO, License Number _______________________
I, ___________________________ MD/DO, License Number _______________________
I, ___________________________ MD/DO, License Number _______________________
I, ___________________________ MD/DO, License Number _______________________

Please print

Do hereby delegate the above prescribing authority to ____________________________ PA of whom I am the supervising physician and will assume the responsibility according to TCA §63-19-107.

I, ___________________________ PA do hereby accept the delegated function of prescribing authorization and will utilize it as such according to TCA §63-19-107.

________________________________________  Signature of Physician Assistant  Date

________________________________________  Signature of Supervising Physician  Date

________________________________________  Signature of Supervising Physician  Date

________________________________________  Signature of Supervising Physician  Date

________________________________________  Signature of Supervising Physician  Date