

**Physician Assistant / Supervising Physician  
Notification of Termination of Supervisory  
Relationship**

Use this form to notify the Oregon Medical Board that the Board approved supervisory relationship between the physician and physician assistant indicated below has ended. The Board must receive notice of termination within fifteen days following termination of supervision. This form will be returned if not complete.

**PHYSICIAN ASSISTANT** complete the following section:

PRINT Full Name: \_\_\_\_\_ License Number: PA \_\_\_\_\_

Reason for Termination:

Termination Effective Date: \_\_\_\_\_

PA Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

**SUPERVISING PHYSICIAN** complete the following section:

PRINT Full Name: \_\_\_\_\_ License Number: \_\_\_\_\_

Reason for Termination:

Termination Effective Date: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_