NOTICE OF TERMINATION OF SUPERVISION OF A PHYSICIAN ASSISTANT

Please enter required information, sign and date at the bottom. Mail or fax form.

Responsible (Designated)
Physician's Full Name: ______________________________

License No.: ______________________________

As required by the Board in K.A.R. 100-28a-9, I am notifying you of my termination of supervision of the physician assistant:

Physician Assistant Name: ______________________________

License No.: ______________________________

Effective Date of Termination: ______________________________

Signature ______________________________
Responsible (Designated) Physician

Date ______________________________

800 SW Jackson, Lower Level-Suite A., TOPEKA KS 66612
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