



**New Mexico Medical Board**  
2055 South Pacheco Street, Bldg, 400  
Santa Fe, NM 87505  
(505) 476-7220 voice (505) 476-7233 fax

New Applicant  Replacing Previous Employer  Change of Supervising Physician  Adding Alternate Supervisors

**Payment Information: Fee \$25 (\$25 fee does not apply for new applicants)**

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**SUPERVISING PHYSICIAN STATEMENT OF RESPONSIBILITY**

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**THIS SECTION TO BE COMPLETE BY PHYSICIAN ASSISTANT**

Name: \_\_\_\_\_  
Last First Mi Maiden

Home: \_\_\_\_\_  
Number and Street

City State Zip/Postal Code

Office Telephone: ( ) \_\_\_\_\_ Home Telephone: ( ) \_\_\_\_\_

Fax Number: ( ) \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Physician Assistant Signature: \_\_\_\_\_  
NM License Number

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**THIS SECTION TO BE COMPLETED BY SUPERVISING PHYSICIAN**

Name: \_\_\_\_\_  
Supervising Physician (Print or Type) NM License Number Field of Practice

Business Name: \_\_\_\_\_

Address

City State Zip/Postal Code

Business Telephone: ( ) \_\_\_\_\_ Fax Number: ( ) \_\_\_\_\_

Supervision Beginning Date: \_\_\_\_\_ Supervision Ending Date: \_\_\_\_\_  
(Board must approve) (If known)

**Credit card payment information page attached.**  
**Please return completed page if you choose to pay by Visa or MasterCard.**

**Thank you!**

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Physician Assistant's Name

License Number

**ALTERNATE SUPERVISING PHYSICIAN:**

In my Absence, the following physician (s) agrees to serve as alternate supervising physician (s) for the above-named physician assistant. Copy if needed.

Physician Name	NM License Number	Field of Practice	Signature
Physician Name	NM License Number	Field of Practice	Signature
Physician Name	NM License Number	Field of Practice	Signature
Physician Name	NM License Number	Field of Practice	Signature
Physician Name	NM License Number	Field of Practice	Signature
Physician Name	NM License Number	Field of Practice	Signature
Physician Name	NM License Number	Field of Practice	Signature
Physician Name	NM License Number	Field of Practice	Signature
Physician Name	NM License Number	Field of Practice	Signature
Physician Name	NM License Number	Field of Practice	Signature

I certify that I am the supervising physician named in this document and assume full responsibility for the supervision of the physician assistant named above. I also acknowledge that I have read and understand the rules pertaining to the supervision of a physician assistant. I further acknowledge that in submitting these forms to the New Mexico Medical Board, I agree that supervision will be in accordance with the New Mexico Medical Practice Act and Rules.

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Signature of Supervising Physician \_\_\_\_\_ Date \_\_\_\_\_

Approved By: \_\_\_\_\_  
Signature Title Date

Effective date of Supervision: \_\_\_\_/\_\_\_\_/\_\_\_\_

New Mexico Medical Board  
Credit Card Authorization Form

Applicant/Licensee Name:  (Print) Lic. No.:  (if applicable)

Please charge the total amount of \$

to the credit card number listed below. VISA OR MASTERCARD ONLY (Excluding Debit Card).

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	

Exp. Date (month & year)			

I agree to pay above total amount according to card issuer agreement for the following:

- Renewal
- Application for Licensure
- Inactive Status
- Reinstatement
- Background Check
- Changing Supervisors (PA's)

\_\_\_\_\_  
(Print) Cardholder's Name (as shown on credit card)

\_\_\_\_\_  
(Signature) Cardholder's Name (as shown on credit card)