**Louisiana State Board of Medical Examiners**

**P.O. Box 30250, New Orleans, LA 70190-0250**

**Phone: (504) 568-6820**

**Notice to Terminate Supervision**

of Supervising Physician(s) or Physician Assistant(s)

Date:

Name of supervising physician or physician assistant (circle one):

Date of termination:

Reason for termination:

|  |  |  |  |
| --- | --- | --- | --- |
| Name of SPs or PAs | License # | Name SPs or PAs | License # |
| 1)       |       | 11)       |       |
| 2)       |       | 12)       |       |
| 3)       |       | 13)       |       |
| 4)       |       | 14)       |       |
| 5)       |       | 15)       |       |
| 6)       |       | 16)       |       |
| 7)       |       | 17)       |       |
| 8)       |       | 18)       |       |
| 9)       |       | 19)       |       |
| 10)       |       | 20)       |       |

(Use continuation sheet if necessary).

* RX authority will be terminated (if applicable).
* I have/will notify above SPs/PAs of this termination.

By signing this document I certify that all information on this form is truthful and authentic.

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 Signature of PA or SP License # Cell/contact #

Submit form to LSBME: Fax: (504) 324-0902 Mail: LSBME, PO Box 30250, New Orleans, LA, 70190-0250.

**Termination can be verified on the LSBME website** [**www.lsbme.la.gov**](http://www.lsbme.la.gov)**. Click on Verify a License.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Below is for LSBME use only\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Processed By:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_