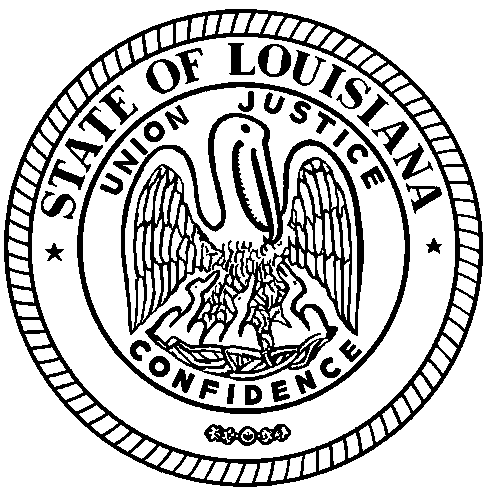
**Louisiana State Board of Medical Examiners**

**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.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_